Commercial Health Ins Issues

Section 1

HealthInsuranceCE
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Preface

I wrote this book as a text version of various lectures I gave to health insurance brokers over the past decade. It describes, briefly, the functions of health insurance then, in more detail, the problems we face implementing it in the US today and some possible solutions to those problems.

Each chapter addresses a stand alone issue or set of issues but these often overlap. I apologize for redundancy but, in health insurance, similar problems appear in different guises.

In addition, I have included summaries of some recent legislation since brokers, and all of us, tend to over-simplify these complex statutes occasionally. Sometimes re-reading detailed summaries helps us better understand the legislation itself. I have also included two Surgeon General advisories at the end of this text for two main reasons: first to introduce two specific healthcare risks to brokers and second to indicate the types of research materials available from public sources. There is an astonishing amount that brokers can use.

Health insurance brokers are generally expert at applying regulations and understanding financial concepts but weak at understanding how the benefits they sell actually affect people medically. I hope this book will address some of that deficiency.

I take the issues discussed here personally and seriously. As a child of the 1960s who, among other things, worked for CARE in Chad, Africa building primary schools and planting orchards - the latter in a leaper colony outside N'Djamena - I have a great passion for activities that improve people's lots in life. I have an equal passion for opposing destructive activities, with unnecessary and overly expensive medical care being prime examples.

I hope you find reading this book a worthwhile experience.

Gary Fradin

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Commercial Health Insurance Origins and Structures

Our healthcare financing system evolved from a vertically integrated 'financing + care provision' system to a non-vertically integrated one. This theme runs throughout today's course.

- Vertical integration means that medical care and medical financing are the same entity, with physicians on salary. Both the financing arm and medical care arm work together to generate the best patient outcomes at the lowest cost. This is the basic concept of a Managed Care Organization or a Health Maintenance Organization (HMO).

  'Managed competition' is competition among vertically integrated healthcare providers. Those generating the best outcomes at the lowest costs will gain customers; those operating at higher costs and generating poorer outcomes will lose. [1]

  Vertically integrated healthcare entities compete with each other on ***value***: outcomes per dollar spent. This incentivizes Managed Care Organizations to improve patient outcomes (life expectancy, diabetes control, post-surgical functionality and similar) without unduly raising prices. It ***dis***incentivizes Managed Care Organizations from providing excessive, unnecessary or low quality care, or raising prices too aggressively. Vertically integrated entities are, therefore, more ethically structured than the alternatives.

  The better a Managed Care Organization improves patient outcomes without raising prices, the more value it creates, the greater the company's market share and the bigger its business. This fits the Utilitarian view of an ethical healthcare system; it provides the greatest good for the greatest number. Good ethics, from this point of view, equals good business. So goes the theory at least.

- A 'non-vertically integrated system' has separate companies handling financing and medical care. Today we call financing companies 'insurance carriers' and medical care provision companies like hospitals and physician groups 'providers.'

  In this non-vertically integrated system, financiers want to pay service providers less and service providers want to bill more. The relationship between the two is 'war' according to Atul Gawande, professor at Harvard Medical School and staff writer for the New Yorker, 'every step of the way'.[2]

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[1] Alain Enthoven of Stanford University, perhaps our greatest managed care theorist and proponent, has written widely about this which is somewhat outside the scope of this particular chapter. See his seminal article The History and Principles of Managed Competition for more.
http://elsa.berkeley.edu/pub/users/webfac/held/157_VC2.pdf

[2] See Gawande's second book 'Better', chapter entitled Piecework

In a non-vertically integrated system, carriers and hospitals argue over payment amounts and formulas. A very different focus from the vertically integrated model above where the entity's singular goal is outstanding patient outcomes at a reasonable price.

Non-vertically integrated systems, as I suggested above, are designed to generate jobs, incomes, and benefits for participants in it, like doctors, financiers and all the rest.

The more our healthcare system resembles a vertically integrated one, the more ethical it is because it serves the medical needs of patients, creating the greatest health good for the greatest number of patients. The less vertically integrated it is, the less ethical it is because it is designed to serve the needs of relatively few participants.

Ethical brokers, according to the Utilitarians, should help clients emulate the benefits of a vertically integrated system despite the current structure of our healthcare system. This is a heavy lift. We'll address some ways to do this in Chapter 3.

But first, we'll discuss how our healthcare system developed around this vertically / non-vertically integrated idea below. Then, in Chapter 2, we'll discuss various problems that arise from our systemic development.

How Commercial Healthcare Started

As commonly accepted among health insurance historians, commercial health insurance started in Dallas around 1929 as a reaction to the stock market crash and financial meltdown.[3] Baylor University Hospital in Dallas faced a cash crunch and designed a creative solution to pay its bills.

Prior to the stock market cash, hospitals raised funds in two ways. First, they had customers who paid for services rendered - a fairly modest percentage of the population because most people didn't have a lot of money. Second, the community chest, the charitable organizations - the wealthy would donate to the hospital because it was a good place to donate your extra money. Charity made you feel good and was good for the community.

But after the 1929 stock market crash, unemployment reduced the number of patients able to pay, the wealthy didn't have as much money to donate, and the hospital faced a difficult financial landscape. So, Baylor University Hospital made a deal with the Dallas School System. They said, "School system, you always have money; you raise money from taxes. Pay us $.50 per employee per month and when they get sick, they can come to us and we'll take care of them." Commercial health insurance arrived.

A few comments about this.

[3] This suggestion comes from Richmond and Fein, The Healthcare Mess, page 30.

First, it's a nice deal. It's a nice deal for the hospital because they stay in business. They don't have to worry about going out of business. They didn't have to worry about turning people away as long as they got the numbers right, which apparently they did at $.50 per employee per month. The school system payments protected the hospital's cash flow so the hospital stayed in business.

Second, this was very efficient. The hospital signed one contract with one employer group and received back enough money to stay in business. That was a pretty good incentive to look for other large employer groups.

Third, there was no prevention or provider choice, but theoretically the teachers and other employees of the school system were happy because they got medical care essentially for free.

Fourth, this was for hospitalization only; no outpatient or physician office coverage.

Fifth, community rating. The Dallas School System paid $.50 per person per month, regardless of individual medical status. No medical underwriting.

Sixth, there were no quality controls, no outcome-based incentives, no holdbacks for poor hospital performance. Health insurance began simply to save the financial health of the hospital.

This was a vertically integrated system, almost textbook variety. And it exhibited the classic flaw of vertically integrated healthcare systems: lack of consumer choice. As initially developed with Baylor University Hospital, the Dallas school system employees could only go to one hospital. This has advantages and disadvantages.

Advantages:

1. Lower Costs

2. Reasonable medical care from a small number of in-network providers

Disadvantage:

1. Little provider choice as few hospitals are 'in-network'

The Baylor Hospital / Dallas School System deal worked so well that other hospitals copied it. Different hospitals looked for different large employers, offering the same kind of deal. Large manufacturers, the Dallas Morning News, and others. What problem begins to arise?

The Choice Problem

Consumers - school system employees or manufacturing workers, for example - wanted to choose among various hospitals. 'What do I know about Baylor University Hospital? I only know one thing. I know someone who went there and didn't get good care

(whatever ‘didn’t get good care’ means), so I want to go somewhere else.’ Someone always knows of someone else who had a negative experience there. So you want to go somewhere else - consumers want choice.

A different way to understand our demand for choice in healthcare: we don’t *really* trust our own doctor or, indeed, the overall medical system. We somehow think that we – patients – have better medical care insights than the various trained professionals in our network. This uninformed demand for choice has plagued our system since inception.

> The way out of this problem, according to Michael Porter and Elizabeth Olmsted Teisberg in their massive tome Redefining Health Care, is for the government to require results reporting, things like 30-day readmission rates for coronary procedures, 3-6-and-9 month follow-up data on orthopedic patient range of motion and pain, infant and maternal mortality rates and similar. As Porter and Teisberg put it back in 2006: *Mandatory measurement and reporting of results is perhaps the single most important step in reforming the healthcare system*.[4]
>
> We still haven’t made sufficient progress along these lines. That, it seems to me, is a fertile arena for ethical broker interventions. Indeed, that will be our focus in Chapter 3, below.

Remember vertical integration, where finance and service provision are the same company? Once you introduce choice, then you have one group handling finance and another handling service provision. You have a split and you lose vertical integration.

That split happened shortly after the Baylor – Dallas School System deal. A clever entrepreneurial company offered to provide financing for lots of Dallas hospitals. ‘Dallas teachers’ they might have said, ‘you can sign up with Baylor University Hospital only, or, for just a little more money, sign up with us and we’ll give you the choice of many hospitals in Dallas. We contract with lots of hospitals. We have a large network.’

These new companies competed with vertically integrated hospitals, like Baylor University Hospital and the Dallas School System.

The insurance entrepreneurs developed a couple of clever ideas in the 1930s. First, from a marketing point of view, they offered this very attractive provider choice option.

Second, they began searching for the healthiest subscribers. If they could find the healthiest people, they could offer lower priced policies and gain a competitive edge vs. their vertically integrated competitors signing up large employers at a fixed price per person.

Underwriting vs. Community Rating

[4] Porter and Teisberg, Redefining Health Care page 7

The entrepreneurs – we'll call them 'insurance carriers' - figured that they would underwrite better than the competition so people would join them because their premiums would be a little bit lower. The community rating folks faced higher premiums because they took all employees. In a very real sense, underwriting is a form of rationing: people unable to pass the underwriting standard don't get covered. Or they pay a lot more.

Underwriting serves the economic interests of the carriers. It doesn't improve healthcare outcomes. It doesn't improve the healthcare system. It doesn't differentiate medical quality. It doesn't create patient value. It only makes one carrier lower cost than another carrier by having sick people pay more. It's a zero–sum exercise – healthy pay less, sick pay more - since total community medical costs remain the same.

Our private healthcare financing system had little to do with getting people healthy or creating value. That was not its intention. It was designed to protect physician and hospital income, the original Baylor idea. Then carriers came along to make a profit from consumer demand for choice. The demand for choice led to the Split.

The Split and the Provider Payment Problem

Once you split finance from service provision, you have a wider consumer choice and you have to figure out how to pay doctors and hospitals. We're still, today, trying to get this one right.

The original and still most popular payment mechanism is fee-for-service. The doctor gets paid $100 for treating each broken arm and $350 for each rotator cuff surgery, or whatever.

As soon as you split finance and service provision, service providers have an incentive to do more. The more they do, the more they earn.

The insurance carrier, on the other hand, wants to limit the number of treatments only to those necessary to control costs. They ask service providers if they absolutely need to do that procedure. Insurers and providers fight all the time. It's a fight between

- provider clinical judgment, influenced, perhaps, at least psychologically, by the fee-for-service payment formula, and
- carrier financial judgment, influenced, perhaps, at least psychologically, by the same fee-for-service formula. Insurers don't *really* trust provider clinical judgment, at least not without discussion and justification.

That's the conflict between healthcare payers and medical service providers.

Fee-for-service / component financing is inflationary and expensive and not designed to improve patient health. It's designed to reward providers, which it did quite well historically. We, in the US, have traditionally performed more procedures / 1000 of population than similar developed countries around the world. Things today like spinal

fusion surgery, hip replacements, knee replacements, coronary bypass surgeries. The Split between finance and service provision led us down this road. It continues to this day.

The Impact of World War II

World War II plays an important role in our story for three main reasons.

First, the soldiers who received health coverage while in the military wanted to continue with it afterward. They saw the advantages of having health coverage. They married and wanted their families to receive coverage also. This created ***demand*** for health insurance.

Second, our wartime economy devoted significant resources to medical technology improvements. Perhaps most significant was the introduction of sulfa drugs to combat infections and ultrasound, originally used to determine tank structural integrity after battles. Sulfa drugs helped turn hospitals from infection breeding institutions into patient treatment and improvement centers. Ultrasound ultimately became a routine pregnancy evaluation tool. These and other new technologies improved the quality of medical care, or the ***supply.***

Third, the Federal wartime wage and price freezes fostered the development of 'fringe benefits' and the entire benefits industry. That's the financing arm and it's a pretty interesting story.

The government implemented wage and price freezes during the War to avoid domestic economic difficulties and help focus our economy on war production. Employers, in other words, could not raise wages to attract new workers or to reward their best employees. But they could offer 'fringe benefits' such as health insurance. This allowed employers to attract new talent and retain their current employees without raising wages. The concept of 'fringe' meant 'outside the normal compensation' and 'benefits' meant 'advantages of working here'. Employers couldn't simply raise wages, the traditional way of attracting labor, since that was illegal during the war. Fringe benefits were a mechanism to get around the wartime wage freeze.

These 3 factors – increased demand, improved supply, and creative financing - led to a tremendous increase in our insured population. Some coverage data points:

1942: 10 million hospital insurance / health insurance subscribers

1946: 32 million

1951: 77 million[5] out of a total US population of 150 million.

The health insurance industry arrived, grew and gained political power.

[5] Richmond and Fein, The Health Care Mess pages 30 - 38

The Hill Burton Act and an IRS decision strengthens hospitals

Congress, just after World War II, passed the Hill Burton Act to fund hospital expansion. This increased the number of hospital beds in this country by about 40%, from 3.2 per 1000 people to 4.5. It also made hospitals the centerpiece of our medical care system; the travelling doctor who made house calls began to disappear.

Shortly thereafter, in 1953, the IRS decided that fringe benefits were exempt from federal income tax: those became *tax deductible to the employer* but *not income taxable to the employee.* This was essentially a government subsidy for hospital care since that's where most medical care took place. The government stimulated sales of commercial health insurance by subsidizing the price through the tax exemption.

This subsidy for health insurance was so effective that by 1963, 77% of us had hospital coverage, and about 50% had some form of physician coverage.[6]

- Employees liked the system because it appeared free to them.
- Carriers liked the system because the government subsidized their product, tax deductible health insurance policies.
- Hospitals loved the system because they received patients and insurance payments – a wonderful recipe for making money.
- Employers objected somewhat to this system, but not terribly strenuously. After all, the government subsidized their health insurance payments, so they felt the pain only partially.

Through this period, roughly 1930 – 1965, healthcare discussions generally focused on insurance coverage, medical technology, hospital capacity and access. Indeed, access issues took center stage in the mid-1960s because of the potential political power of the elderly and the poor, both of which were left out of the employer based financing system.

Medicare and Medicaid Remove Potential Political Threats to Employer Based Insurance

One potential political threat to our employer based health insurance system could have come from the unemployed – that significant percent of the population that was too old to work or unable to find full time work with benefits. This was potentially a very potent political force that could have lobbied in favor of single payer healthcare, universal coverage or similar, like in other countries.

[6] Enthoven and Fuchs, 'Employment Based Health Insurance: Past, Present and Future' Health Affairs, Nov/Dec 2006

By introducing Medicare and Medicaid in the 1960s, this political force went away. Elderly folks were happy. They didn't demand or need universal coverage because they had Medicare. Ditto the poor with Medicaid. No large, identifiable voting block favored a single payer, universal healthcare system post-Medicare and Medicaid. M & M took that potential voting block off the table.

Here is an estimate of the population size that these two entitlement programs satisfied. I'll use Medicare, because this covers the elderly who vote in particularly high numbers and in particularly important electoral states like Florida.

Medicare Enrollment 1970 – 2020

Year	Number Medicare Enrollees	% of US population
1970	20 million	10%
1980	28 million	12%
1990	34 million	13.5%
2000	39 million	13.8%
2010	47 million	15%
2020	58 million	18%

Medicaid covers about the same population size.

The argument is that Medicare and Medicaid are key supporters of our employer based, commercial health insurance system. They allowed the system to grow and become entrenched nationally in the second half of the last century.

Post passage of Medicare and Medicaid, i.e. by the late 1960s, healthcare costs and cost increases became an issue. Indeed, in 1969 Robert Finch, then Secretary of Health, Education and Welfare warned Congress that "the nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by government and the private sector". Both costs and the very structure of our healthcare delivery system became a topic of national debate, leading to a reconsideration of vertical integration.

Nixon's HMO Act of 1973

Nixon had to do something to address the rising costs of healthcare, but felt politically wedged-in. He couldn't support a Democratic healthcare plan sponsored by one of his chief rivals, Ted Kennedy. Nor could support a Republican plan sponsored by another political rival, Nelson Rockefeller – especially a plan that potentially harmed the physicians, hospitals and insurance carriers that supported Nixon politically.

He chose, instead, to pursue Health Maintenance Organizations, then conceived as a prepaid healthcare system that would motivate doctors and hospitals to control costs

and keep patients healthy. Many conservative politicians and organizations agreed with the HMO idea because it was flexible, inexpensive, encouraged private investment in profit-making organizations and imposed few mandates or regulations. It sorta, kinda, almost resembled Baylor's original plan with the Dallas School System.

Nixon's plan faced opposition from both the left and right between 1970 – 1973. Kennedy and the Left consistently fought for higher levels of guaranteed benefits, community rating, open enrollment periods and significant Federal grants and loans to help HMOs proliferate. The American Medical Association and the Right wanted only basic levels of guaranteed benefits, less government funding and individual underwriting.

As a result of these competing pressures and Nixon's determination to implement his own plan (i.e. not Kennedy's or Rockefeller's), the HMO Act of 1973 deviated from our ideal vertically integrated model in three main ways:

First, under Nixon's law, HMO meant simply 'prepayment'. Healthcare delivery and healthcare finance were separate functions handled by separate companies. This satisfied independent insurance carriers, physician groups and general hospitals - all parts of Nixon's political base. But it lacked the key integration feature that made real managed care organizations like Kaiser-Permanente so successful.

Why did carriers, physician groups and general hospitals dislike vertical integration? The short answer: they wanted to compete for revenues with each other.

Carriers hoped to dominate the marketplace and dictate economic terms to providers. The American Medical Association wanted its members to remain free from carrier or hospital meddling so they could protect their incomes. Hospitals wanted to determine patient lengths of stay to protect their own cash flow.

None of these groups trusted the others or the government to protect their interests.

Second, Nixon's law called for a loose physician structure, in which practitioners could opt in or out of any HMO. Again, this satisfied the insurance, physician and hospital groups. But it was the opposite of vertical integration's tight structure in which physicians were fully integrated into both the hospital and financial system. The loose physician structure meant that providers lacked loyalty to any specific HMO.

Third, Nixon's law allowed providers to bill insurance carriers on a fee-for-service basis, not on a capitation basis.

In a capitated system, the vertically integrated HMO only received a specified amount of money per patient per year. The old Baylor – Dallas school system model charged $6 per employee per year. As long as Baylor University Hospital kept its costs below $6 per employee, it made money. But if Baylor's costs exceeded $6, it lost money and potentially went out of business.

Capitation, in other words, forced HMOs to control costs and use their resources efficiently. Absent capitation as in Nixon's Act, much of the underlying financial discipline disappeared.

These three factors – separate companies for finance and service provision, loose relationships between physicians and HMO entities and little-to-no capitation - drastically altered the original vertical integration model. Stanford Medical School Professor Alain Enthoven, for example, a key managed care theorist, argued in 1993, 'Some say that managed care has failed. I say that managed care has not yet been tried' since Nixon's HMO Act so perverted the vertical integration model.[7]

By the early 2000s, American healthcare had given up on the vertical integration / managed care approach in fact, if not in name, in favor of the fee-for-service based billing platform. Stanford's Enthoven articulated the fee-for-service flaws in his 2004 book 'Toward a 21st Century Health System' page xxix.

1. Fee-for-service creates an adversarial relationship between doctors and payers;
2. Fee-for-service has little accountability – poor data collection and provider motivations for economy;
3. Fee-for-service 'free choice of provider' leaves patients to make remarkably poorly informed choices;
4. Fee-for-service generates excess hospital capacity, high tech equipment and open-heart surgeries;
5. Fee-for-service generated an excess supply of specialists;
6. Fee-for-service misallocates resources, as no incentive to use the least costly settings for treatment;
7. Fee-for-service has no capacity to plan care processes from diagnosis to treatment to rehabilitation;
8. Fee-for-service has led to a dangerous proliferation of facilities for complex and costly procedures without the volumes necessary to maintain good outcomes;
9. Fee-for-service cannot practice total quality management due to lack of service integration;
10. Fee-for-service cannot organize the rational use of technology.

We created, in other words, a healthcare structural mess in our quest for patient choice, profits and jobs.[8]

Consumer Driven Healthcare to the rescue (or not)

[7] Enthoven, Why Managed Care Has Failed to Contain Health Costs, Health Affairs, 1993, paraphrased for context here.

[8] 'Mess' comes from the title of Richmond and Fein's 2005 book, The Healthcare Mess, op cit.

With the failure of the HMO movement, our commercial healthcare industry needed a new paradigm. One attempt was CDHC or Consumer Driven Health Care. The term ‘consumer driven health care’ arose from the Medicare Modernization Act of 2003 which established Health Savings Accounts.

‘Consumer driven products’ are high deductible health insurance policies with certain tax benefits. Each consumer spends the deductible as he/she sees fit, for physician visits, medications, tests, therapies etc. Only after satisfying the deductible does insurance pay. Then, depending on the specific plan design, insurance pays all or part of additional medical expenses.

CDHC policies embrace the notion of consumer sovereignty. Consumer sovereignty means each individual consumer makes decisions in ways he or she deems best for themselves; individual patient decision making for themselves, not physician decision making for patients would now drive our healthcare system.

Consumer driven healthcare implicitly accepts The Split between healthcare finance and service delivery as a given. Effectively, HSAs and the entire CDHC movement says ‘The Split exists and we can’t figure out how to fix the problems it causes, so we’ll turf the whole thing onto patients. Maybe they can rationalize our otherwise irrational system’. Maybe, in other words, they can make the system operate more ethically.

It didn’t go well.

Problems equating high deductibles with consumerism in healthcare

Consumer driven healthcare as practiced using Health Savings Accounts, similar tax-deductible programs, and medical care price lists fail in healthcare for two main reasons.

First, an annual $1000 deductible (or even $3000) is too small to act as a real medical spending brake. Once satisfied, and depending on the specific plan design, all other medical care is free.

A patient might satisfy that deductible hurdle in January and then enjoy lots of excessive and unnecessary medical care for free during the next 12 months. Patients could even ‘play’ the system by scheduling all their expensive medical treatments during the same calendar year.

Or the deductible has little impact on a patient facing an expensive procedure. What’s the difference to the patient if the procedure costs $45,000 …. $50,000….$60,000 or $100,000? Once the deductible is satisfied, the rest is free. ‘Consumerism’ fails to affect patient behavior in these expensive cases.

This fundamental flaw in the ‘high deductible = consumer driven healthcare’ thesis exists because the vast majority of healthcare spending goes to a very small group of

high cost patients. Here's spending by percentage of the population. These numbers have remained remarkably constant for years.

Healthcare Consumption by % of Our Population [9]

1% of our population accounts for about 24% of medical spending

5% of our population accounts for about 49% of medical spending

10% of our population accounts for about 64% of medical spending

50% of our population accounts for about 97% of medical spending

50% of our population also accounts for 3% of medical spending.

The healthiest half of our population costs very little medically. These are typically the folks who purchase CDHC products and who often spend less than $1000 annually. Cutting their spending by 20 or 30% would have virtually no impact on *overall* medical spending or trend.

Here's the same chart using 2022 spending amounts, not percentages. In 2022, total US healthcare costs reached about $4.4 trillion for the approximately 333 million of us. Though the average annual healthcare spending per person that year was about $13,400,

The 1% heaviest users (3.3 million people) averaged about $320,000 each;

The 5% heaviest users (16.7 million people) averaged about $129,000 each;

The 10% heaviest users (33 million people) averaged about $85,000 each;

The 50% lightest users (167 million people) averaged about $790 each.

Very few of the 10% of users who account for about 2/3 of all medical spending will change their medical choices based on a $1000 (or even $2500 or $5000) deductible. *Whatever* the deductible, their medical care needs far exceed it.

Second, medical consumers have little meaningful quality information, and even if they have it, they rarely know how to use it. This makes medical decisions different from, say, car purchasing decisions. The car buyer can compare the quality of various cars before deciding which to purchase. Large or small, good gas mileage or poor, lots of luxuries or few, high resale value or low, etc.

But the medical purchaser generally has very little similar information. Which doctor has the best outcomes? Which hospital? How effective is this medication compared to that one? We generally lack detailed answers to these questions.

[9] Yu, et al, 'Medical Expenditure Panel Survey Statistical Brief #81', May 2005, Agency for Healthcare Research and Quality

For these two reasons – unequal healthcare spending and lack of medical quality information / well educated medical consumers - so-called Consumer Driven Health Care had only a small impact on medical trend which has run at our gdp growth rate plus 3 – 5% annually for years. CDH policies became the vogue in the early 2000s. They pretty much ran their course within about a dozen years.

Americans continue to spend about twice as much on healthcare as other developed countries without getting any value for the excess spending, just as we did prior to CDHC policy introduction. Here are estimates for 2019, the last year before Covid hit and altered these statistics with a unique set of circumstances. (I don't know if or how Covid is representative of 'normal' healthcare trends, so I'll leave that out of this analysis.) [10] I could have included more countries but you get the idea from this limited comparison.

2019	Annual spending / capita	Life expectancy at birth
US	$10,855	78.8
Canada	$6,730	82.3
France	$4,014	83
Spain	$2,412	84
UK	$3,334	81.4

These other countries live 4 – 5% longer than us while spending about half as much on healthcare. We clearly haven't figured out how to generate good value for our healthcare system investment. We haven't figured out how to generate the greatest good for the greatest number.

The Affordable Care Act gives up on vertical integration in favor of wider coverage

The 2010 Affordable Care Act, a massive piece of legislation, is more-or-less a business plan for our entire healthcare economy.

Vast in scope and complexity, it's far too big to summarize quickly here. Instead, I'll focus only on 2 components: coverage expansion and patient decision-making assistance.

Why healthcare reform in 2009

[10] OECD Health Data statistic updated annually https://stats.oecd.org/Index.aspx?ThemeTreeId=9

President Obama decided to move aggressively on healthcare because of several disturbing trends. From 2000 - 2006

- Health insurance premiums rose by about 80% while
- Overall inflation only rose by 20%, but
- Median household income was actually down 3% in real (after inflation) terms.

Obama and his aides worried about two different health insurance death spirals especially affecting the individual and small group markets.

The **first** would occur when healthy people decide not to purchase health insurance, thus leaving only sick people in the insurance pool. Premiums would rise quickly forcing 'healthier' sick people opt out, leaving only the sickest of the sick still in. Health insurance then would become a payment program for sick people. It wouldn't, under these conditions, play its traditional role of protection against catastrophic financial calamity due to an unexpected illness for the vast majority of Americans.

The **second**, separate though somewhat related death spiral would occur when young people decide that health insurance is too expensive to purchase. Young 'Invincibles' – so called because they don't think they'll get sick – exit the market, leaving only older and more expensive participants in the pool. Again premiums rise, causing more and more young, healthy people to leave the pool and thus depriving the insurance pool of this healthy, inexpensive population.

Obama worried that continued economic stagnation - as began with the stock market crash in 2007 - would exacerbate both situations. Indeed, the number of uninsured had risen by about a million people per year from under 44 million in 2002 to over 50 million in 2009.

Among the reasons for this huge uninsured problem was our change in national economic circumstances. Our post-World War II economic dominance had lessened and along with it, businesses' ability to generate sufficient margin to cover all employee benefits. Employers responded to the changed economy by shifting benefit costs to their employees and outsourcing. That's why the percent of Americans covered by commercial / employer based health insurance shrunk from 59% to 48% between 2000 and 2020. Meanwhile, the number of Medicaid recipients and uninsured Americans grew. [11] (I included the 2020 numbers to show trend and the ACA impact.)

[11] Medicaid data from stasta.com https://www.statista.com/statistics/245347/total-medicaid-enrollment-since-1966/. Uninsured data from the CDC including https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201106.htm#:~:text=Results-,Lack%20of%20health%20insurance%20coverage,(Tables%201%20and%202) and https://www.google.com/search?q=number+uninsured+americans+2020&rlz=1C1ONGR_enUS1065US1

Year	Number of Medicaid Beneficiaries
2000	34 million
2010	54 million
2020	76 million

Year	Number Uninsured Americans
2000	39 million
2010	49 million
2020	32 million

Thus, the prime focus and effect of the Affordable Care Act was coverage expansion, perhaps somewhat ethical in that it provided a greater good – health insurance – to a greater number of Americans. I'm underwhelmed by the ethical achievement of giving more people financial access to our otherwise unethical system. Our overall life expectancy numbers – flat since 2010 - support this skepticism. See below pages 25 – 26.

One way the ACA addresses vertical integration and The Split

The ACA also, in a relatively hidden and small way, addressed problems cause by The Split between healthcare finance and service delivery. We have already discussed how this grew out of the Baylor – Dallas School System's initial commercial insurance venture, how Nixon attempted to put this genie back into the bottle, and how the introduction of Health Savings Accounts and similar products cemented The Split into our healthcare system architecture.

Section 3506 of the Affordable Care Act discusses Shared Decision Making. Here is the legislative summary:

> The purpose of this section is to facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decision making, provides patients, caregivers or authorized representatives with information about trade-

066&oq=number+uninsured+americans+2020&gs_lcrp=EgZjaHJvbWUyBggAEEUYOdIBCDYwMzdqMGo3qAIAsAIA&sourceid=chrome&ie=UTF-8

> offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

We can read this as an attempt to circumvent The Split by helping patients make wise decisions in conjunction with but not entirely based on, their physician's recommendations. It harkens back to Porter and Teisberg's position on the importance of publicly available outcome measurement and results reporting. The ACA in this section recommends that patients not rely blindly on their physician's advice for two main reasons:

> First, the ACA recognizes the economic reality of physicians providing excessive care – sometimes – in response to the economic incentives they face.
>
> Second, the ACA understands that preference-sensitive care exists.

Preference-sensitive simply means that various treatment alternatives often exist. Some patients might reasonably prefer orthopedic surgery while others, equally reasonably, might prefer physical therapy. Or medication vs. surgery. Or other options.

Section 3506 implicitly accepts The Split as reality and legislates a mechanism to ameliorate its most negative consequences.

Where We Are Today
Post HMO, post ACA, post Split

Managed care as vertical integration has disappeared from our healthcare landscape. Today, post-Consumer Driven Healthcare and post-ACA, we live in a fee-for-service based medical billing environment. Each individual actor in our healthcare system faces various economic incentives either to provide or control care severity; each individual patient is supposed to make wise healthcare decisions while relying on the advice of financially compromised actors.

We don't do this very well. At $4.4 trillion – our 2022 healthcare spending - our *healthcare* economy was larger than France's total gdp (about $2.8 trillion) or Britain's ($3.0 trillion) and about twice as big as Russia's ($2.2 trillion).[12]

We have the highest healthcare expenditures per capita or as a percentage of our GDP in the world. See below, a list of per capita healthcare spending in countries that live longer than the US national average or any individual US state average:[13]

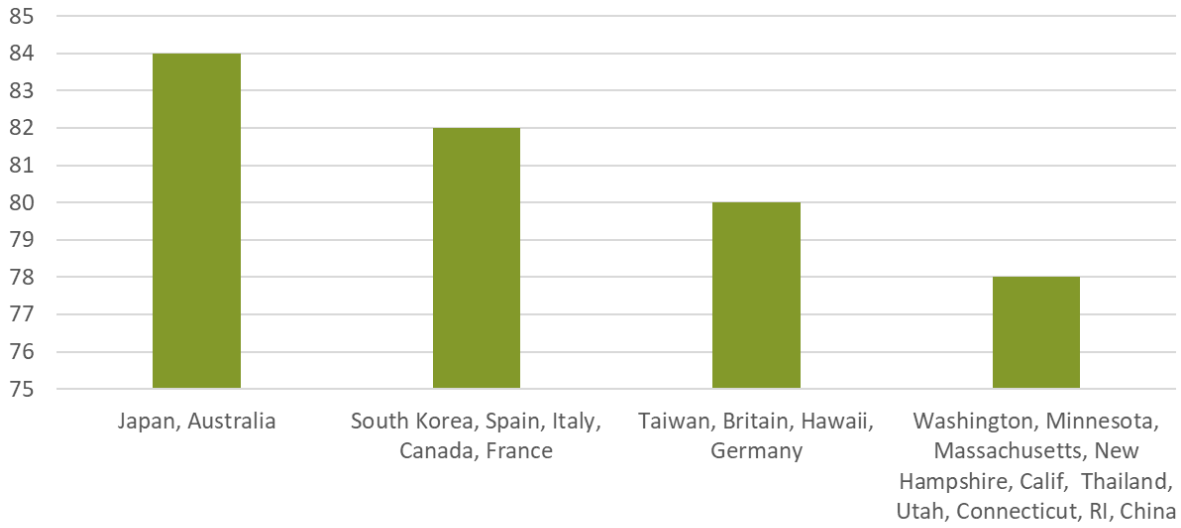
[12] World Bank, Gross Domestic Products 2022 https://data.worldbank.org/indicator/NY.GDP.MKTP.CD

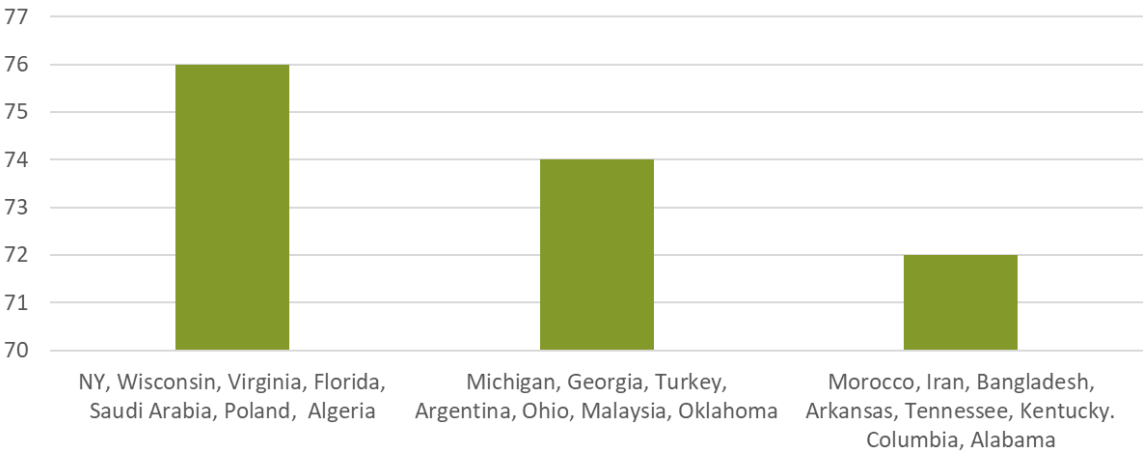
[13] Data from Statistica https://www.statista.com/statistics/236541/per-capita-health-expenditure-by-country/#:~:text=In%202022%2C%20the%20United%20States,highest%20per%20capita%20health%20expenditure.

Country	2022 per capita health spending
US	$12,555
Australia	$ 6,569
France	$ 6,516
Canada	$ 6,319
Japan	$ 5,250
South Korea	$ 4,569
Spain	$ 4,461
Italy	$ 4,290

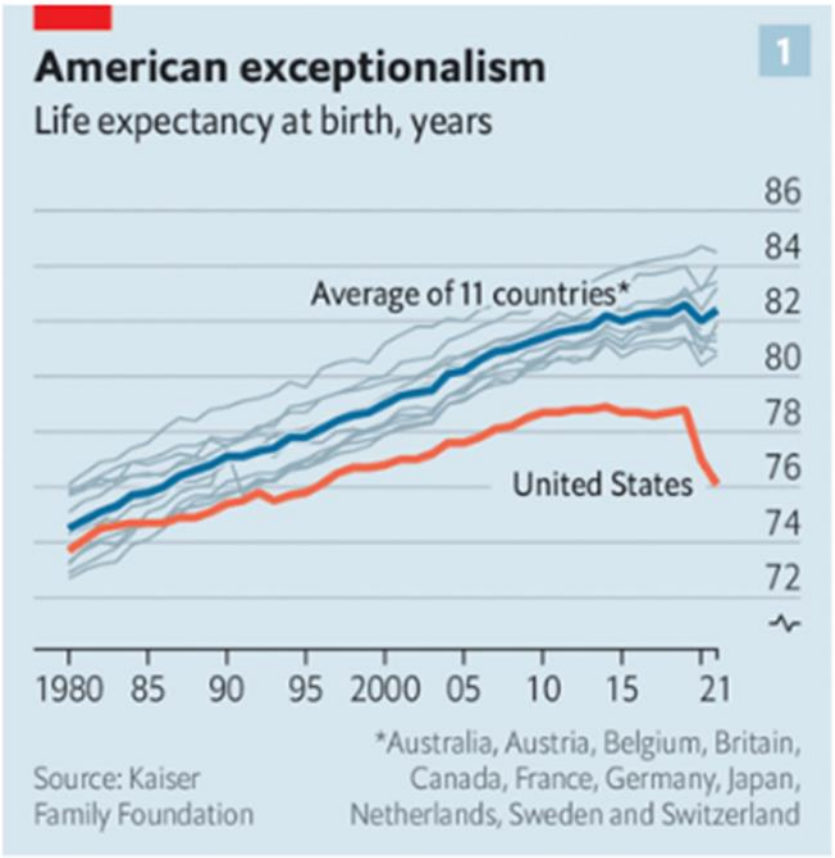
One way to see the magnitude of our healthcare system inefficiency is to see how those various countries compare to US state longevity at birth averages. These data were originally developed by the National Center for Health Statistics at the United Nations and presented by Nicholas Kristof in the New York Times, August 17, 2023. As you review these charts, consider this question: if private, commercial health insurance is as beneficial a system as its proponents claim, then why do we see such mediocre outcomes?

Average Longevity at Birth
Various countries compared to US States
Life expectancy in 2 year age bands on the left
‘82’ means ’82 – 84 years’; ‘78’ means '78 – 80 years’





Equally or perhaps more upsettingly, we have experienced **no** national life expectancy gains since about 2009, despite spending more each year on medical care. This differs from other advanced, industrialized countries. See the chart below published in The Economist, July 13, 2023. Note first that Americans, while spending more on medical care than the others, enjoyed shorter life expectancies. Equally interesting (upsetting), see the 2009 – 2020 period, before Covid, when our life expectancy was flat – despite spending more on medical care each year - while the others improved. Finally, note the relative impact of Covid on American and other life expectancies.



All this looks to me like a living, working, breathing definition of an ineffective, inefficient healthcare system. It *always* rewards the relatively few participants in it but only *sometimes* benefits the huge number of patients who need it.

Why do we have this spending-to-outcome discrepancy? Why does our largely private sector, commercial healthcare system perform so poorly?

Some Commercial Health Ins Structural Problems

Brokers know many of the specific problems that afflict our healthcare system. These range from complicated insurance rules that differ by carrier to complicated billing rules that differ by provider to complicated access rules that differ by policy, to many others. Additional system problems also include high overheads caused by having so many different insurance carriers, providers, treatments, medications and options. I originally thought about simply listing a bunch of problems that brokers face regularly and discussing some ethical issues that arise from dealing with them.

But let's go in a different direction. Instead of simply listing a bunch of problems, let's try to identify a core structural issue caused by The Split that underlies many – maybe even most – of these specific issues. This helps us address our ethical problem and understand why our commercial healthcare system fails to produce the greatest good for the greatest number.

We'll do all this by introducing an economic concept alternately called The Tyranny of Small Decisions or The Tragedy of the Commons. The first – the Tyranny of Small Decisions – often leads to the second, the Tragedy of the Commons.

Consider the visual image of a paradigm old English village to introduce these ideas. In this little village, a bunch of farmers lived in small houses around a central public open space called 'the Common' in which cows grazed. Each farmer had a cow or two and the Common provided sufficient room and grass for them all to graze and grow.[14]

Now imagine that our old English village prospered and grew. Families bought a second, third, fourth or fifth cow. New families moved in, each with a few cows. After a while the Commons became too small to support all these cows. Each individual cow lost weight and produced less milk. Villagers' incomes fell. The Commons became overgrazed. Its topsoil began to erode after each rain and eventually the grass disappeared. It ultimately became useless for grazing. We might call this the Tragedy of the Commons v1, in which everyone uses too many resources so there are not enough for all. [15]

In v1, each individual's small decision, made in each individual's own interest, diminished the overall good. The Tyranny of Small Decisions led to overgrazing and, in turn, to the Tragedy of the Commons in which everyone ended up worse off.

As an alternate version of this story, instead of each villager buying an extra cow, a new person moves to town with 30 cows. The Commons couldn't support this increase and

[14] Many New England towns have a Common today. Think of Boston Common or Cambridge Common in Massachusetts, places where cows grazed in colonial times but today are nice public parks.

[15] Apparently this happened to the Mayans in Central American centuries ago and the environmental degradation led to their civilization's destruction, though I'm not a Mayan historian. I did, however, enjoy a fascinating trip to Belize and Guatamela in 2020.

the tragedy unfolded. In the Tragedy of the Commons v2, one person consuming too much destroys the benefit that everyone enjoyed from their shared resource.

In either case, the Tyranny of Small Decisions, in which people individually made decisions to maximize their own welfare, led to overgrazing and, in turn, to the Tragedy of the Commons.

Another way to phrase this: the Tragedy of the Commons decreases the amount of good for the great number of people.

Let's update this to a real situation in Pomfret Vermont, 2023. Pomfret, a small town, apparently enjoys spectacular foliage each fall. [16] A relative handful of tourists annually enjoyed it. In 2021 or 2022 though, a Tic Tok influencer, apparently one of those tourists, broadcast descriptions of Pomfret's beauty to his or her audience. A few local inns also advertised the town's beauty. Thousands of tourists arrived. The town became overwhelmed. Among the problems:

- Tourists blocked Margarete Pierce's driveway, parked illegally on her land, and used her garden house as a toilet,
- Cathy Emmons watched tourists stroll onto her farm and steal tomatoes from her vine,
- Mike Doten got tired of pulling tourists out of ditches with his tractor.

According to the Boston Globe's description, 'The town's selectboard … voted to block the road to anyone except residents for three weeks at the height of the foliage season, from Sept. 23 to Oct. 15…Windsor County deputy sheriffs will staff checkpoints at the bottom of Cloudland Road in neighboring Woodstock and at the top of the road here in Pomfret." (I don't know how this is legal but that's a separate issue.)

The Tyranny of Small Decisions – individual publicity for individual interests - led to the Tragedy of the Commons, so now no tourists can enjoy Pomfret's beauty during foliage season.

The Tyranny of Small Decisions and the Tragedy of the Commons can provide a framework to understand many of our healthcare system problems. Let's explore some of them.

Medical Care Rationing. Rationing or 'the limiting of goods or services that are in high demand and short supply' per Investopedia, is a classic unintended, indirect consequence of the Tyranny of Small Decisions. We'll consider two case studies.

[16] This story comes from the Boston Globe, Sept 18, 2023 https://edition.pagesuite.com/popovers/dynamic_article_popover.aspx?artguid=04b5fe08-f5ff-489d-acbe-ae0c5035891e

First, pediatric bed rationing in Boston. Tufts Medical Center, Boston, closed its 41 bed inpatient pediatric unit in July 2022, then repurposed them as adult inpatient beds.[17] The justification, according to Dr. Daniel Rauch, Tufts Chief of Pediatric Medicine: “Should we take care of kids we don’t make any money off of, or use the bed for an adult who needs a bunch of expensive tests?...If you’re a hospital, that’s a no-brainer.”[18] Tufts could bill more for adults than kids. A small decision that clearly benefited Tufts’ bottom line. Pretty simple to understand.

But a local Tragedy of the Commons followed, documented with Boston Globe headlines like:

October 21, 2022:

Hospitals scramble to find beds as pediatric admissions rise

By Jessica Bartlett Globe Staff, Updated October 21, 2022, 8:08 p.m. 126

November 10, 2022

Hospitals postpone pediatric surgeries as capacity crunch escalates

By Jessica Bartlett Globe Staff, Updated November 10, 2022, 5:37 a.m. 25

Hospital executives said pediatric intensive care unit beds at Massachusetts General for Children were operating at 150 percent capacity, and there were few signs the surge was nearing an end.

December 11, 2022

Hospital finances play a major role in the critical shortage of pediatric beds for RSV patients

Health Dec 11, 2022 10:33 AM EDT

[17] Boston Globe ‘Who will care for our sickest children’, Oct 26, 2022

[18] NY Times As Hospitals Close Children’s Units…, Baumgaetner, Oct 11, 2022

This Commons Tragedy continued with higher prices. According to the Massachusetts Health Policy Commission report in September 2023, Children's Hospital and Mass General Brigham, representing about 73% of pediatric discharges in Massachusetts, have the highest commercial prices in Massachusetts. Among the data points in that report, the average commercial price per pediatric discharge at Boston Children's was 47 percent higher than at other state hospitals with significant inpatient volume, even after adjusting for the illness of the patient.[19]

Here, the few service providers benefit financially while the rest of us pay higher prices for the same care … if we can find it. Our national total number of inpatient pediatric beds fell by 19% from 2008 to 2018. The Tufts closing followed this trend. Pediatric hospitals have recently closed or partially closed in Richmond Virginia, Colorado Springs Colorado, Raleigh North Carolina, Doylestown Pennsylvania and Shriners New England because 'kids are not lucrative'. [20]

The Tyranny of Small Decisions – each hospital followed its own economic self-interest and closed less profitable beds in favor of more profitable ones to earn more money – led to a tragedy for the rest of us. A few service providers and investors made more money while many sick kids and their families suffered longer waits for care, longer ambulance or med flights to hospitals, higher prices and perhaps ended up medically much worse as a result.

Greatest good for the greatest number? I think not.

Second, maternity ward rationing in central Massachusetts and nationally. Leominster Hospital closed it maternity ward in 2023. Their justification: "reimbursement rates paid to hospitals for treating maternity unit patients on Medicaid are far lower than what private insurance plans pay" particularly harming Gateway cities like Leominster according to the Boston Globe's June 25, 2023 analysis.

Maternity beds in Gateway Cities were, in other words, unprofitable or at least less profitable than other types of hospital wards or other types of patients.

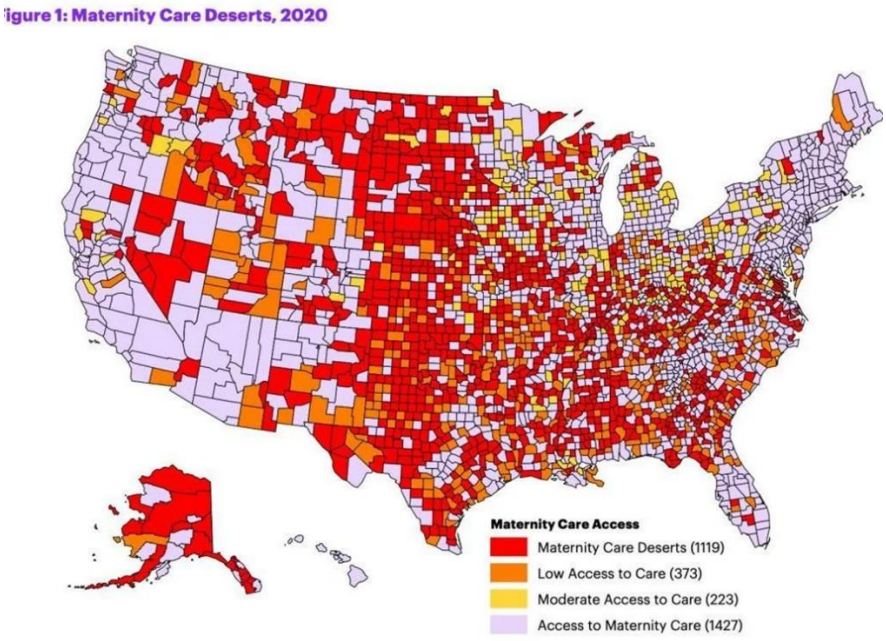
Leominster's closure also followed a state trend. Holyoke Medical Center closed its maternity center in 2020. Harrington Hospital in Southbridge closed its center in 2017.

And all this follows a national trend. According to the March of Dimes, the number of maternity deserts in this country – counties with no hospital providing maternity care, no

[19] Jessica Bartlett, Boston Globe, Sept 10, 2023

[20] Boston Globe 'Who will care for our sickest children', Oct 26, 2022

birth center, OB/GYN, and no certified nurse midwife – has increased over time, mainly in rural areas.[21] Here's their 2020 map



Pregnant women had to drive farther for their appointments and to give birth. This negatively affects them. Health Affairs reported that, after controlling for socioeconomic factors and clinical conditions, "rural residents had a 9 percent greater probability of severe maternal morbidity and mortality, compared with urban residents."[22]

Hospitals made more money – Tyranny of Small Decisions. Patients ended up worse off – Tragedy of the Commons. The same story unfolds time and time again, in specialty after specialty and treatment arena after treatment arena.

Let's switch focus now away from rationing and explore other clinical and ethical implications of the Tyranny and Tragedy.

Excessive care. Excessive care incentives so permeate our post-Split, commercially based healthcare system that Andrew Dreyfus, former CEO of Blue Cross Blue Shield of Massachusetts, claims healthcare today 'is designed around the needs of institutions and health professionals and not around the needs of patients'. [23]

[21] March of Dimes maternity desert report https://www.marchofdimes.org/maternity-care-deserts-report

[22] Rural-Urban Differences In Severe Maternal Morbidity And Mortality In The US, 2007–15, Health Affairs, December 2019

[23] Boston Globe, June 22, 2018

Excessive care through disease mongering. Disease mongering means hyping treatments for little known diseases, more or less advertising diseases for which your company has a treatment. This instills fear among patients, expands markets and positions your product as a solution. Look for disease mongering on TV ads and in your local newspapers.

I want to move on and discuss two other, related concepts: *overdiagnosis* and *overtreatment*. Overdiagnosis means broadening disease definitions so more people quality for medical care. Overtreatment means providing more care than necessary to patients. Both overdiagnosis and overtreatment can cause patients to experience higher care treatment risks and side effects without also enjoying higher chances of treatment benefit.

Excessive care through overdiagnosis. Overdiagnosis means broadening disease definitions so more people quality for medical care. According to H. Gilbert Welch, the overdiagnosis guru, it occurs "when individuals are diagnosed with conditions that will never cause symptoms or death."[24] Overdiagnosed patients, in other words, ***can't*** benefit from care because they weren't sick to begin with. But medical care providers, testers, drug manufacturers and similar *can* benefit financially by treating these patients. We'll consider just one example, overdiagnosis of hypertension.[25]

In 1997, the definition of hypertension (high blood pressure) changed from diastolic blood pressure of 160 over systolic blood pressure of 100 to 140 / 90. That immediately switched about 13 million people from having normal blood pressure to having high blood pressure, or, in our terms, increased the market for blood pressure lowering medications by 13 million people.

The definition of hypertension changed more times, always increasing the number of people so-diagnosed. In 2017, for example, the American College of Cardiology and American Heart Association redefined hypertension as greater than 130 / 80, again increasing the number of hypertension patients and the market for hypertensive medications. I don't know how many people this affected.

During this time period, sales of ACE inhibitors, medications to treat hypertension, grew at an annual compound growth rate of 5%, hitting $6.9 billion in 2023. Ditto for various other anti-hypertensive medications. The hypertension redefinition appears to have stimulated these medication's sales (or, at least, didn't hurt) and again, benefited a few participants in our healthcare system.

Did the redefinition help the Commons? First, some data. The age adjusted heart disease mortality rate fell in this country from 170.5 per 100,000 in 2012 to 161.5 in 2019 or, using my back-of-the envelope calculation, by about 30,000 people annually

[24] H. Gilbert Welch, Overdiagnosed, page xiv

[25] This case study comes largely from Welch, Overdiagnosis pages 20 - 23

nationally.[26] 30,000 fewer deaths divided by 13 million new patients = about 0.2% benefit. That's two tenths of one percent. About 99.8% of the newly diagnosed patients did not benefit from the new hypertension definition while 0.2% did. Maybe. That's the most optimistic reading of these data.

This interpretation assumes the redefinition itself led directly to the 30,000 fewer deaths. We don't know that to be the case. The entire mortality decrease could have been caused by other factors – less smoking, better diets, better overall physician advice or something else. We just don't know. At best 0.2% of the newly redefined-as-sick folks benefited from the redefinition. Perhaps none did.

All this raises some troubling questions, including

- How impactful were the redefinitions in preventing heart disease deaths?
- How impactful were ACE inhibitors in reducing heart disease mortality?
- How important were other medications?
- How many people were harmed either physically, emotionally, or financially by taking these medications after they were redefined as 'sick', not 'normal'?
- Could we have reduced heart disease mortality by a similar amount in less expensive ways than redefining at-risk folks and prescribing medications for them?
- Did the increase in hypertension medication sales and associated corporate profits affect the new hypertension definition?

A disturbing consideration of this last point comes from Otis Brawley, former Chief Medical and Scientific Officer of the American Cancer Society in his book How We Do Harm. He suggests that of our 555 guidelines (555!) for treating hypertension, "some are self-interested and harmful. Many are commercial documents"[27] meaning they're designed to sell products, more-or-less a form of disease mongering. No one, according to Brawley, promulgates good practices for guideline composition or hypertension redefinitions. Might the 1997 and other redefinitions reflect commercial pressures? Might this simply be the Tyranny of Small, Self-Interested Decisions on the part of hypertension treaters?

All we know for sure is that more Americans are now diagnosed with hypertension and that a very small percent of them benefit from redefinition as measured by age adjusted mortality rates per year. Medical statisticians could parse this analysis far better than I – this is simply an introductory overview – but at first cut, a 2/10s of 1% benefit rate appears underwhelming or, in our terms, like overdiagnosis.

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[26] Mortality rate data from the National Center for Health Statics, part of the US Centers for Disease Control and Prevention https://www.cdc.gov/nchs/hus/topics/heart-disease-deaths.htm

[27] Brawley, How We Do Harm, page 243

But the drug makers, labs and related folks made more money.

We could expand this analysis, as Welch did in Overdiagnosed, to include hyperlipidemia (high cholesterol), diabetes, osteoporosis in women and many more. I hope, though, this one example can suggest what overdiagnosis is, why it's a systemic problem and, more directly for our purposes today, why it's an ethical one for brokers.

Excessive Care Through Overtreatment. Overtreatment means providing more care than necessary to patients. Patients can't benefit from overtreatment by definition; overtreatment is care that does not provide benefit. But patients can be harmed by it because all medical treatments involve some element of risk. The more care someone receives, the higher the chance of risk. An overtreated patient gets all the risks without the possibility of benefit.

But the overtreatment *providers* still get paid.

Consider coronary stents as one overtreatment example. According to research from the Lown Institute, between 2019 – 2021, US hospitals performed over 229,000 unnecessary coronary stent procedures, or about 1 every 7 minutes. [28] That's about 22% of all coronary stents and the unnecessary care cost Medicare alone up to $2.4 million. Rates of overuse varied widely by hospital: at some, more than 50 percent of all stents met criteria for overuse, while at others, fewer than 5 percent were unnecessary.

In all cases, the providers got paid – an economic incentive-based Tyranny of Small Decisions. But 229,000 people undertook the procedure risks without much or any likelihood of benefit because the stent was unnecessary, and everyone's health insurance premiums increased. An economic cost and tragedy for the rest of us.

Let's move from a specific to the general case and estimate the size of the overtreatment problem from a 2017 physician survey published by PLOS, an online medical journal. [29] According to physicians themselves, 20% of all medical care is unnecessary, including 22% of prescription drugs, 25% of tests and 11% of procedures. Among the most common excuses for this by the physicians were fear of malpractice and patient pressure or demands. In other words, in our post-Split healthcare system, no one pushes back sufficiently aggressively when patients want unnecessary treatment. That opens the door to our Tyranny and Tragedy.

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[28] Lown Institute Hospital Index 2023, Avoiding Overuse: Coronary Stents. https://lownhospitalsindex.org/avoiding-coronary-stent-overuse/ Lown defines overuse as inserting stents in patients with a diagnosis of ischemic heart disease at least six months prior to the procedure, excluding patients with a diagnosis of unstable angina or heart attack within the past two weeks, and excluding patients who visited the emergency department over the past two weeks.

[29] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970

By contrast, in a vertically integrated system where healthcare finance and service delivery are the same company, there is a brake on overtreatment; the finance arm, in its desire to keep premiums competitive, won't allow it. Unfortunately, though, today in much of America, one large hospital system typically controls 50-75% of the beds in a region, while the largest insurance carriers in a region – organizations potentially able to push back on overtreatment – typically only have about a 15 – 30% market share. This unequal playing field contributes to our unnecessary care problem; organizations incentivized to provide more care dominate.

One personal experience with overtreatment. I had a sore ankle in September 2023 that felt tight early in the morning, then loosened up during the day. I felt under time pressure to resolve the issue as I was going hiking with my kids in November, about 6 weeks in the future. I first tried rest but that didn't work. I then considered my treatment options:

- Option 1, see an orthopedist. That would take a couple months as orthopedists typically book weeks or months in advance. I suspected there was insufficient time to pursue this option. The orthopedist would probably (my uninformed guess here) want to run some tests, then have me return for a second visit and maybe prescribe therapy or medications (my guess again). I expected that the orthopedist would resolve my ankle pain problem but, most likely, after I returned from my hiking vacation.
- Option 2, see a physical therapist. My limited experience with PT suggested that I would visit once or twice a week for a few weeks. My experience also suggested that the therapy would work. I decided to keep this option on hold.
- Option 3, see my local chiropractor. Note here that I am not a shill for the chiropractic industry and do not understand anatomy; I'm just a commentator here. However, I like chiropractic primarily for one, virtually overwhelming reason: I can get an appointment in a day. Plus it's cheap. I had no idea if chiropractic would resolve my ankle pain problem, but I figured 'why not?'. Very low risk. I could learn quickly – in one afternoon since my chiropractor is about 15 minutes from my house – if chiropractic could help and it only cost $8.80 for a copayment. I figured it was worth the time to find out.

My chiropractor felt my ankle, gave me a couple stretches, and sent me home with 'come back if you still feel pain next week'. I did the stretches a couple times and, astonishingly to me, the pain disappeared. Problem solved. In one day. For $8.80.

Would the physical therapist or orthopedist have overtreated my problem? It certainly seems likely to me though I can't know for sure. But I feel like I maneuvered around the tyranny of their own small, incentive based decisions for my own benefit.

Excessive care through lack of high quality, randomize, comparative studies. We'll first discuss Vitamin D supplements to prevent bone fractures or extend life.

Millions of Americans take vitamin D supplements and labs run 10 million vitamin D level in patients tests every year.[30] Vitamin D sales and testing has become a billion dollar industry with about 25% of Americans over age 60 taking vitamin D supplements.[31]

Though use of vitamin D supplements may make biochemical sense – the body needs vitamin D to help it absorb calcium, a mineral necessary for strong bones – a 2022 comparative study of 25,000 people with half taking the supplements and half taking a placebo found little-to-no benefit to the vitamin D supplements.[32] Indeed and perhaps more interesting from our perspective, that 2022 study found that 'no large randomized, controlled trials had previously tested the effects of daily supplemental vitamin D alone (without coadministered calcium) in preventing fractures in the U.S. population.'

Why were there no studies on such a widely prescribed vitamin? One answer may be that the American Clinical Laboratory Association, the trade association for the laboratory and diagnostic health industry, spent around $1 million on political lobbying annually since 2014 [33] though I don't know exactly where all this money went.

Another answer may be that the Endocrine Society – the leading organization in the fields of endocrinology and metabolism according to Wikipedia, that 'influences a wide range of policies' according to its website [34] – argues that "vitamin D deficiency is very common in all age groups" and advocated a huge expansion of vitamin D level testing in patients in the 2010s.[35] Though the Endocrine Society's financial lobbying is relatively small, only about $120,000 in 2020 for example, it plays a large role in 'helping to shape healthcare and research policy in the US and around the world' according to its website.[36]

A third answer maybe be that 'it's obvious' that vitamin D helps people, based on a simplistic, linear, biochemical analysis. 'Bones need calcium, vitamin D helps bones absorb calcium so vitamin D supplements will help bones remain strong'. If only the human body was so simple! We have an extensive history of *medical reversal* in this

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[30] Gina Kolata, Study Finds Another Condition that Vitamin D Pills Do Not Help, New York Times, July 27, 2022

[31] Szabo, Selling American on Vitamin D, Kaiser Health News, August 20, 2018, https://www.nbcnews.com/health/health-news/selling-america-vitamin-d-reaping-profits-n902276

[32] LeBoff et al, Supplemental Vitamin D and Incident Fractures in Midlife and Older Adults, NEJM, July 28, 2022.

[33] Open Secrets https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2022&id=D000023934

[34] https://www.endocrine.org/advocacy

[35] Szabo op cit

[36] https://www.endocrine.org/advocacy

country; medical reversal means 'high quality comparative studies show that something that makes sense in theory does not provide patient benefit in real life'. See Ending Medical Reversal by Adam Cifu and Vinay Prasad for more on this.

I'll go out on a limb now and suggest that the financial lobbying impact of the American Clinical Laboratory Association, plus the intellectual clout of the Endocrine Society, combined with the 'obviousness' of vitamin D's benefit, supported an environment for continued vitamin D level testing in patients and supplement prescriptions, *always* to the economic benefit of the industry but *only sometimes*, if ever, to the medical benefit of patients. That's one impact of our profit motivated, private sector based medical industry post-Split.

We'll switch focus now to discuss excess care and medical spending on over-the-counter-decongestants**.** The US over-the-counter decongestant market was worth about $1.8 billion in 2023,[37] including common, over-the-counter medications such as Sudafed PE, Vicks Nyquil Sinex Nighttime Sinus Relief and Benadryl Allergy Plus Congestion. The problem with these and similar phenylephrine-based medications: they don't work. That's the unanimous conclusion of an FDA panel that reviewed several existing studies of phenylephrine-based medications in September 2023.

From our point of view, though – the impact of private sector medicine's lobbying for its own financial gain and not necessarily for patient benefit - the back story of how ineffective medications came to market and remained on the market so long is more compelling than the scientific analytics.

We begin in 1976 when the (then new) Food and Drug Administration adopted a 'safe and effective' standard for medications. [38] After an initial purge of unsafe or ineffective drugs in the 1970s, the agency's approval criterion morphed, in real life, from 'safe and effective' to 'safe' with few if any drugs were removed from the market during the ensuing 50 years due to their lack of effectiveness. The agency apparently lacked the resources to police medications as rigorously as, perhaps, it would have liked, and so focused more on product safety.

We'll jump ahead 30 years, bypassing drug reformulations and FDA oversight issues, to 2007 when two University of Florida researchers, Leslie Hendeles and Randy Hatton, filed a citizen's petition for the FDA to review various phenylephrine-based medicine studies. Hendeles and Hatton had themselves reviewed dozens of original studies and determined that over-the-counter, phenylephrine-based oral decongestants performed no better than a placebo. In other words, these medications were safe but ineffective. The FDA, in response, assembled the Non-Prescription Drug Advisory Committee

[37] Berkeley Lovelace Jr, FDA Panel Says Common Over-The-Counter Decongestant Doesn't Work, NBC News, September 12, 2023

[38] Much of this section comes from Haley Weiss, With the Decongestant Snafu, the FDA Tries Something New, Time, September 14, 2023

(NDAC), composed of petitioners, manufacturers and the Consumer Healthcare Products Association, the industry trade group. The NDAC decided that the evidence on phenylephrine was “suggestive of efficacy” so left these drugs on the market. (I’m not sure what ‘suggestive of efficacy’ means, especially after years of patient utilization. ‘Suggestive of efficacy’ is not a standard statistical, regulatory or legal concept.)

Fast forward 8 more years and several new studies, and Hendeles and Hatton again filed a citizen’s petition, this time to remove phenylephrine-based oral decongestants from the market. The FDA reviewed the newest information, this time with enhanced powers granted to it by the Coronavirus Aid, Relief, and Economic Security Act, passed in 2020. Post-2020, the agency could more easily revise over-the-counter approvals and recommendations.

That brings us to September 2023 when an advisory panel to the FDA concluded that phenylephrine-based oral decongestants are ineffective, more-or-less returning to the 1976 ‘safe and effective’ standard. During those 50 years, Americans took a safe but ineffective medication thanks, in part, to weak FDA oversight (lobbying impact?) and weak regulations (lobbying impact?).

> I left out the history of Schering-Plough, since bought out by Merck and the maker of Claritin D. Their internal studies showed that phenylephrine-based oral decongestants were, in fact, ineffective. That’s why they continued making Claritin D, a prescription medication, and didn’t switch to a phenylephrine-based over the counter formulation. The Schering-Plough story suggests that the pharmaceutical industry knew of phenylephrine-based oral decongestant ineffectiveness but still promoted the medications to patients.

The net result of that 50 year lag, according to Hendeles and Hatton:

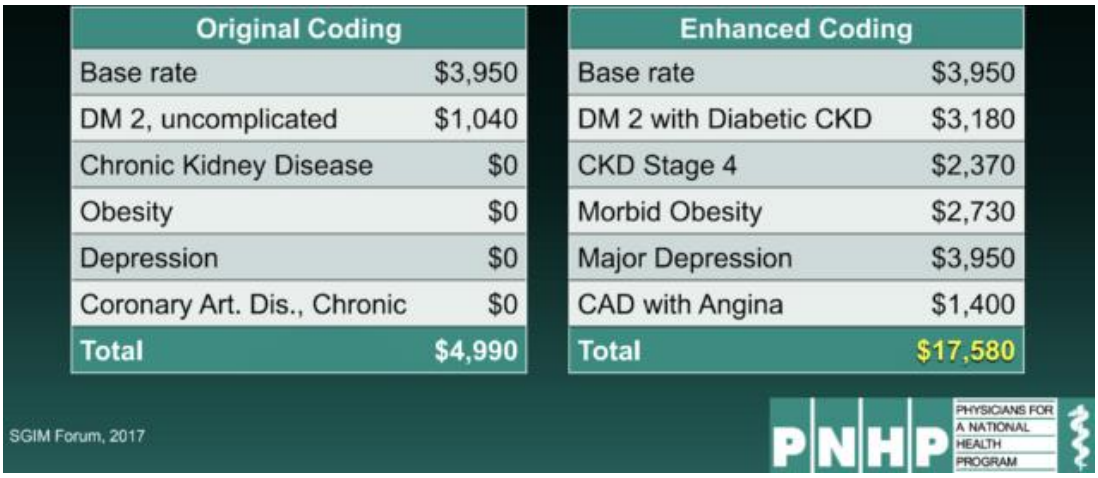
> Americans spend billions on drugs that contain ingredients that will not help them. That’s not just a waste of money — it could mean they are delaying appropriate treatment, which can lead to more severe illnesses.

But the OTC drug provision industry made billions thanks, in large part, to their industry lobbyists.

Excess billing. Somewhat like the excess care problems, our post-Split healthcare system allows for excess billing. In this excess billing case, patients don’t gain additional benefits – they (or their insurance carrier, which ultimately means their premiums) just pay more for the same care…at best. The excess billing problem may ultimately lead to overtreatment.

In our non-vertically integrated, post-Dallas healthcare system, providers typically bill by code. We have, in this country, thousands of codes, many subject to interpretation. The Physicians for a National Health Plan offers one example, below, showing the difference

in potential billing for the same patient.



The players in our health insurance melodrama understand this, as do investors like private equity firms. Private equity firms purchased 355 physician practices between 2013 and 2016 and 578 between 2017 – 2021. Individual physician practices can have dozens or hundreds of doctors. [39]

Private equity investors seek high returns from their investments, up to 20% annually according to some estimates. Our post-Split healthcare system offers only 3 ways to accomplish this: see more patients, provide more treatments and/or bill at higher rates. PE owned firms apparently do all three, according to research published the Journal of the American Medical Association in 2022. [40] That study noted "Following a private equity acquisition, physician practices saw a 20.2 percent increase in charges per claim…and a 37.9 percent increase in new patient visits." Additionally, PE owned firms generated a 16% increase in the total number of encounters. (Encounters = lab tests, imaging, procedures).[41]

Little to none of this helps patients get healthier (personal opinion and probably an overstatement) while all benefit system participants – physicians, nurses, private equity investors, drug companies, etc - just like Andrew Dreyfus observed. This helps explain why we enjoy more healthcare spending year over year, while failing to enjoy improved outcomes as measured by increased longevity.

[39] Robert Pearl, Private Equity And The Monopolization Of Medical Care, Forbes, Feb 20, 2023

[40] Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization, JAMA, Sept 2, 2022.

[41] Discussion with Jane Zhu, co-author of the JAMA study and assistant professor of medicine at Oregon Health & Safety University https://www.opb.org/article/2022/09/16/what-happens-to-healthcare-spending-and-use-under-private-equity-ownership/

Medical procedure approvals. Let's turn now to a case study of spinal fusion surgery research and information dissemination to see how the Tyranny of the few can affect the well being of the Common. This comes from research published in Scientific American[42] by two researchers, Sanjaya Kumar, Chief Medical Officer at Quantros, a healthcare analytics company, and David Nash, dean of the Jefferson School of Population Health at Thomas Jefferson University.

We'll start in the 1990s when the Federal Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality) released findings from a five-year investigation of the effectiveness of various treatments for low back pain. Here's Kumar and Nash's summary from their Scientific American article:

> Between 1989 and 1994, an interdisciplinary Back Pain Patient Outcomes Assessment Team (BOAT) at the University of Washington Medical School in Seattle set out to determine what treatment strategies work best and for whom. Led by back expert Richard A. Deyo, MD, MPH, the team included orthopedic surgeons, primary-care physicians, physical therapists, epidemiologists and economists. Together, they examined the relative value of various diagnostic tests and surgical procedures.
>
> They conducted a comprehensive review of clinical literature on back pain. They exhaustively examined variations in the rates at which different procedures were being used to diagnose and treat back pain. Their chief finding was deeply disturbing: what physicians thought worked well for treating low back pain doesn't. The implication was that a great many standard interventions for low back pain may not be justified. And that was immensely threatening to physicians, especially surgeons who perform back operations for a living.
>
> Among the researchers' specific findings: no evidence shows that spinal-fusion surgery is superior to other surgical procedures for common spine problems, and such surgery leads to more complications, longer hospital stays and higher hospital charges than other types of back surgery.
>
> Disgruntled orthopedic surgeons and neurosurgeons reacted vigorously to the researchers' conclusion that not enough scientific evidence exists to support commonly performed back operations. The surgeons joined with Congressional critics of the Clinton health plan to attack federal funding for such research and for the agency that sponsored it. Consequently, the Agency for Healthcare Policy and Research had its budget for evaluative research slashed drastically.

[42] Kumar and Nash, 'Myth: There is a high degree of scientific certainty in modern medicine', Scientific American, March 25, 2011.

> The back panel's guidelines were published in 1994. Since then, even though there are still no rigorous, independently funded clinical trials showing that back surgery is superior to less invasive treatments, surgeons continue to perform a great many spinal fusions. The number increased from about 100,000 in 1997 to 303,000 in 2006.

In 2023, twelve years after Kumar and Nash's Scientific American article, I searched for rigorous, independently funded clinical studies on back surgery. The most recent available was a 2018 summary of the evidence about spinal fusion surgery. Those researchers concluded "We found no high-quality systematic reviews and the risk of bias of the randomized controlled trials in the reviews was generally high." [43]

I also googled 'number of spinal fusion surgeries per year' and learned from various sources, that we in the US experienced 500,000 in 2011 and 1.3 million in 2021, though that later number may include a wider definition. [44] These procedures cost about $50,000 each for an annual national total of perhaps $68 billion.[45]

Since the Baylor – Dallas School System initial foray into health insurance, medical providers, suppliers, financiers and others have made Small Decisions for their own financial benefit. Many have harmed The Commons. That's the tragedy of commercial health insurance today.

[43] Harris, et al, Lumbar spine fusion, what is the evidence? Internal Medicine Journal, Dec 5, 2018

[44] iData Research 8/16/23

[45] Cost of spinal fusion surgery in the 30 biggest US cities, Becker's Spine Review, Carly Behm, Feb 21, 2022 https://www.beckersspine.com/spine/53684-cost-of-lumbar-spinal-fusion-in-the-30-biggest-us-cities.html . Boston's cost was $50,150

Employer Based Health Insurance Features and Issues

The US is the only advanced industrialized country to finance medical care primarily through employment. Most other countries use employer based financing either to supplement a national healthcare system (e.g. the United Kingdom) or ban it from competing with the national system (Canada).

About 160 million Americans receive health insurance from work. That's about half of our population. The other half either receives health insurance through a government program – Medicare, Medicaid for example – from a state exchange or is uninsured. About 30 million Americans are medically uninsured.

Employers who offer health insurance worry about the costs. They need to balance their firm's financial health with their employee's medical health so provide plans that are good enough to comply with the various state and federal regulations and provide satisfactory employee coverage without costing too much. It's a delicate and confusing balance.

Employees should also worry about their employer's health insurance costs but too few actually do. Most employees think health insurance is a 'benefit' – a freebie that the employers offer. Labor economists virtually universally reject this assumption. They claim that the actual cost of each employee is the total of salary plus benefits, so if the employer pays less in benefits, the employee will receive more in salary.

In other words, the employee actually pays for employer-based health insurance via foregone wages.

Employer based health insurance has set the paradigm of healthcare financing in this country. We rely on 1 year long insurance policies to finance medical care even though 70% of healthcare spending goes to chronic disease treatment, i.e. treatments that take longer than 1 year. This sets up a fundamental inefficiency, treating long term problems with short term financing, a mismatch resulting in higher costs and, apparently, poorer outcomes than optimal.

Other healthcare financing systems, most notably Medicare, follow this one year long policy format. I'll discuss this in more detail below.

Three structural problems with employer based healthcare financing
#1: Moral hazard

Our employer based system finances all medical care with **insurance** rather than **payment plans** probably for historical reasons that we'll discuss shortly.

This confuses *insurance* (protection against financial harm caused by random events) with financing normal, routine and expected medical events like flu shots and knee replacements.

Compare health insurance to auto insurance. Auto insurance pays for *un*expected events, like crashes; it doesn't pay for expected events like oil changes, tire rotations or transmission rebuilds. Yet we expect health insurance to cover all medical events, from the most routine and predictable to the most random and unpredictable. This leads to enormous inefficiencies because, many argue, insurance is the wrong financing mechanism for routine medical events.

- Insurance pools risk inefficiently based on timing; those *not having* medical events this year pay for those having.
- This suppresses any market mechanisms from pooling more efficiently and developing better, more targeted, more actuarially based medical financing products - orthopedic payment plans for example, or pediatric immunization payment plans.

  We can imagine lots of medical payment programs, underwritten and priced for individuals or banded for groups. Middle aged men might buy 5 or 10 year orthopedic and urologic plans but not birthing; younger women the opposite.

  This kind of program pools need more efficiently than blanket insurance plans that cover every possible medical situation, for all people, that might occur this year. 'Insurance' then provides a safety net for the unexpected or random events not covered by specific payment plans.[46]

A fundamental problem using insurance to finance all medical activities is **moral hazard**. Insurance programs *always* face concerns about moral hazard. Moral hazard is the phenomenon in which people get more care than they need because it appears free to them. Insurance financing that includes this moral hazard component is a great foundation for a healthcare jobs program but a poor one for an efficient medical care financing system.

The moral hazard concept originated when home fire insurance was developed centuries ago. Underwriters were concerned that people with 'poor moral character' would burn their houses to collect the insurance proceeds then rebuild a less expensive house and pocket the difference. This translates in the health insurance arena to people having tests and treatments because –why not? It's free to me and may offer some benefits.

Medical care providers understand this issue and can generate income from it: 'let's send you for another test just to rule something out. Don't worry – it's covered by insurance' and medical testing and treatment industries develop. Dr. Sandeep Jauhar, Director of the Heart Failure Program at Long Island Jewish Medical Center, has written

[46] Regina Herzlinger has written extensively and creatively about this type of program. See especially her book Who Killed Healthcare.

eloquently and painfully about this. Consider these various quotes from his 2014 book Doctored:

> Bob and Joe and Dave have an unwritten agreement to call one another when patient issues arise outside their scope of expertise. If Bob, the nephrologist, sees a patient, he finds a cardiac and a gastrointestinal issue and consults the other two specialists and vice versa…a mutual scratching of backs…**Insurance companies can restrict medications, tests and payments. But they still cannot tell us who or when we can ask for help.** (page 97, emphasis added)
>
> A large percentage of healthcare cost is a consequence of induced demand – that is, physicians persuading patients to consume services that they would not have chosen if they were better educated. (page 107)
>
> [Describing one particular physician] …he was doing a plethora of tests – eye exams, audiometry, pulmonary function tests, even Holter monitoring – to generate revenue … he avoided the high-risk cases… 'Those we would send to a cardiologist' …[and, quoting a gastroenterologist] 'If a doctor doesn't do excess testing, forget it, he isn't going to be able to live.' (page 167)

Dr. Jauhar's unsettling conclusion about the impact of moral hazard:

> In our healthcare system, if you have a slew of physicians and a willing patient, almost any sort of terrible excess can occur. (page 94)

Others have, of course, also written expansively about the impact of moral hazard on our healthcare system. My point in this discussion: by relying on insurance to finance all aspects of healthcare, the employer based model exacerbates, rather than ameliorates, this problem. By basing our entire healthcare financing system on and around the employer model, the moral hazard problems permeate all aspects of American healthcare financing, creating more healthcare jobs and less healthcare value.

While we can't calculate an exact cost of moral hazard in our healthcare system, credible research suggests that 30% + of all medical spending is wasted on unnecessary care. That's generally estimated at about $700+ billion annually or $2500+ per employer based policy. The Dartmouth researchers primarily responsible for that estimate, though, are quick to note that we 'view these as an underestimate given the potential savings even in low cost regions' [47] meaning that even they have no real solid idea how much moral hazard exists in our system.

But they and others admit that it's a lot.

[47] Dartmouth Atlas of Healthcare, Reflections on Variation, answer to the question 'The Atlas is often cited as a source for the estimate that 30% of the nation's spending is unnecessary --- what is the evidence? http://www.dartmouthatlas.org/keyissues/issue.aspx?con=1338

A very lot.

Structural problem #2: Disconnecting payers from users

Payers in the employer based model are employers, often acting through their benefits department. Payers decide what network size employees want, what deductible levels, what drugs to include in the formulary and what copayments to have. This is particularly true in small companies covering the bulk of American workers that may offer only 1 policy to all employees.

Consider the impact of payer's decisions. A company opting for a wide provider network decides that each employee would prefer *paying more for health insurance* to *having more disposable income available* (and using a smaller network).

Or a company opting for a smaller network decides that employees prefer *more disposable income* to *having the most expensive doctors and hospitals available in-network.*

Employees, though, are the consumers and each may seek different things from our healthcare financing system. One may want higher deductibles or lower, wider networks or smaller, bigger drug formularies or not. Each facing his or her own specific medical issues can reasonably have his or her own set of preferences.

We call this 'consumer sovereignty' meaning that the most efficient economic distribution system is one in which consumers express their desires through purchases. We have seen this work quite effectively in other markets for hundreds of years.

Take the grocery market for example. A typical supermarket has thousands of products available because some people like expensive cuts of meat while others are vegetarians. Some people like ice cream while others are lactose intolerant. Some people like rye bread, others white bread and still others prefer bagels. And so on, for canned foods, soups, fruit and many other food products.

Our food distribution system is 'efficient', or so goes the argument, because individual consumers, casting their own dollar-votes, decide which products should be available and how much shelf space stores should allocate to each product. As consumers demand more soup, the store supplies more soup. Ditto for apples, mangoes and bread.

Imagine the impact on our food choices if these decisions were made by your employer! 'Apples are good for my employees, so stock a lot. Cut down on cookies and fatty meats. And, since more and more people are lactose intolerant, switch to carrying more skim milk.' (As if your employer had any interest in making those decisions. Your employer wants to make and sell widgets, not decide what you should eat. Hmmm, sounds like healthcare, doesn't it?)

Restrictions on consumer sovereignty lead to higher prices, less choice and sometimes poorer quality. Would apple producers focus as much energy on their product quality if they knew that all stores had to buy more apples from them? Maybe – or maybe they'd focus more on quantity and price.

In the employer based health insurance model, consumers have far less sovereignty than many would like, since benefits administrators make many of their key consumption decisions. But remember the economic axiom: the more consumer sovereignty, the more efficiency. And vice versa.

Structural Problem #3: One year long policies

Some 70% of healthcare expenditures go toward chronic, long term and on-going medical care as opposed to episodic, acute care. A chronic condition is, for example diabetes and an on-going care example might be post-operative cancer treatment. Dozens more examples exist. The best outcomes result from continuity of treatment from the same provider. Medically, thus, *long term financing programs* tend to generate the best outcomes, generally at the lowest costs since care discontinuities can lead to errors, which add treatment costs.

Employers, however, oppose funding multi-year health insurance policies. Business conditions may change they reason, their employee census may change, prices may fall – why encumber themselves with long term liabilities? Employers like 1 year long policies so they can change the program if business conditions warrant.

This creates a conflict between *employee medical needs* and the *employer's business considerations*. We have, nationally, adopted the employer's position as the basis of our healthcare financing system, not the medical need position. Financing medicine based on anything other than medical concerns adds inefficiencies (costs) to the system without any related benefits or value increases.

The employer financing model forces health insurance carriers to compete on short term medical cost controls rather than long term patient outcomes. I'll explain how all this works and some impacts later in this chapter.

These three structural problems – financing routine medical care through insurance, disconnecting payers from users and embracing 1 year health insurance plans - lead to an inefficient system with skewed incentives. Good for healthcare jobs growth but bad for system value creation.

But that's what we get with employer based financing as the core of our national healthcare financing system.

Three consequences of employer based health insurance

Uwe Reinhardt, professor of healthcare economics at Princeton, suggests 3 consequences of placing employer based health insurance at the center of healthcare financing. [48]

First, it is tremendously expensive. In 2021, for example, the average family health insurance annual premium was $22,221 [49] up about $17,000 from $4,969 in 2011.[50] This compares to a median annual family income in 2021 of about $79,900. That's 28% of the average annual family income going to health insurance. Under what definition of 'affordable' does this make any sense?

Reinhardt wonders how any employer who finances employee healthcare, carrier that designs plans or broker who implements benefit programs can take pride in his/her work product. So do I.

Second, having employment at the center of our healthcare financing system requires lots of 'fill in' programs for people unable to obtain employer based insurance. Each of those programs – Medicare and Medicaid, for example, or SCHIP – develops their own regulations, licensure requirement, codes and prices resulting in overlapping and confusing payment categories.

We have, as a result:

- One healthcare system for fulltime, employed people. This system has its own access rules, reporting rules, prices and payment rules.
- A second healthcare system for elderly people, with its own (different) access rules, reporting rules, prices and payment rules.
- A third healthcare system for very poor, unemployed people who (for lots of bureaucratic and political reasons but no medical ones) must *also* be either i children, ii blind or disabled, iii elderly, iv mentally ill, v pregnant or vi mothers. [51] This system, as the two previously mentioned, also has its own access rules, reporting rules, prices and payment rules
- A fourth healthcare system for slightly poor, partly employed people (we sometimes call this 'non-group', a financial distinction but not a medical one)
- A fifth system for children not otherwise accounted for

[48] This section based on Reinhardt's lecture at the Pioneer Institute in Boston, 2014. I updated the premium numbers in this text but his core argument remains valid.

[49] KFF.org 2021 Employer Health Benefits Survey

[50] How much does health insurance cost, Nov 2, 2011, eHealth news release

[51] Ezekiel Emanuel makes this point in Redefining American Healthcare, page 47

- A sixth system for military veterans, but only if they're also either old or accessing medical care as a result of combat injuries, or both, and finally
- A seventh system for people with kidney disease, provided it's end-stage.[52]

Inefficient and irrational are two polite ways to summarize this chaos: nuts might be more appropriate. Having all these overlapping, irrational categories creates confusion and complexity that makes our system far less efficient and effective than we would like or hope for, leading to more jobs, higher costs and, unfortunately, poorer outcomes than patients would hope for.

I wonder if that's the system goal.

These different categories exist, again, because of the employer basis of healthcare financing. We needed to develop all these programs to address groups left out of the employer coverage model.

And **third**, having all these different categories has led to different prices for the same service. [53]

- The **List Price** exists though is rarely paid. It's reserved for rich foreigners and uninsured Americans. It's the highest price hospitals charge.
- The **Medicare rate**, completely transparent, is stipulated by Medicare. It's generally about 80% of hospital costs, meaning hospitals must overbill some other category of patients to remain financially solvent.
- The **Commercial Insurance rate**, higher than Medicare and lower than List Price, varies by carrier based on their market clout and negotiating skills. It tends to run about $135% of hospital costs though this can vary significantly.

  One reason for the high price and variation: market clout. A carrier with 8% of the market generally negotiates relatively ineffectively with a hospital network that controls 60% of the beds.
- The **Usual and Customary rate** is the rate hospitals charge carriers with which they don't have a contract – a Colorado hospital that treats Florida insureds who injures themselves while skiing for example.
- The **Medicaid rate** is typically the hospital's lowest rate, often quoted as a percentage of Medicare's rate.

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[52] We also have the Indian Healthcare System which, you'll be pleased to read, is funded under the Indian Healthcare Improvement Act, signed by President Obama in 2010 and which is included in the Affordable Care Act. Probably others too, but that falls outside my area of expertise.

[53] This section comes from Ezekiel Emanuel's book Reinventing American Healthcare, pages 72 -76. It follows from Reinhardt's analysis.

- The **Actual Cost** of providing the service is generally unknown. Many medical professionals interact with each patient, requiring detailed time-and-motion studies which are expensive to produce.

Note that in other – efficient – parts of our economy, the service provider determines his/her price for the service and then sells it to anyone who will buy with, perhaps, some quantity discounts to account for scale. But in medical care, the same service varies in price by patient and the same patient can switch from category to category, thus inducing different prices from the same providers for the same care. See why I suggested this is nuts?

This huge, complex, irrational and inefficient system exists, again, because of the employer centric structure of our healthcare financing system.

Two problems that employer based health insurance fails to address
#1: Unnecessary Care

Unnecessary care, defined as care that does not improve patient health, is the largest single category of medical spending in this country. Credible estimates, as from the Dartmouth Atlas of Healthcare and Dartmouth Institute for Health Policy, suggest that up to about 1/3 of all healthcare spending or some $700 billion annually is unnecessary. I think this a low estimate, but at 30% of medical spending, it trumps

- Heart disease, about 10% of medical spending
- Diabetes and cancer, about 5% of medical spending each.

In fact, according to Jonathan Bush, founder and CEO of Athenahealth, 'unnecessary care is part of the hospital business model'. [54]

The interesting question for this section: who, in the employer financing model, tackles unnecessary care as a function of his/her job?

- **Does the benefits administrator care?**

  Probably not. The benefits administrator generally wants to keep premium inflation around 'trend', the industry definition of healthcare inflation.

  If his/her company's premiums inflate at trend, then he or she can take a CYA approach: 'I did my job. Our premiums reflect trend.'

  If his/her company's premiums inflate faster than trend, then alter plan designs, generally by increasing deductibles and copayments and shrinking the provider network.

[54] Jonathan Bush, Where Does It Hurt?

Engaging with carriers and providers to reduce unnecessary care is time consuming, a task for which the benefits administrator probably doesn't get paid and is probably ill-equipped. It will likely be an unsuccessful effort anyway. That's why most benefits people tend to take the CYA approach and settle for the 'we're at trend' justification for mediocrity.

- **Does the CFO care?**

  Again, probably not. The CFO is busy, responsible for the company's financial health and less interested in the internal operations of a hospital. As long as premiums inflate at an 'appropriate' rate, then the CFO will focus on his/her company's core business, making widgets for example, and generate profit on those.

  CFO's lacks both the time and expertise to work with doctors and hospitals on reducing unnecessary care. A huge company CFO might have the time and interest to work with a select group of providers on this issue. But hospitals that engage with this particular large company may well then turn around and bill other, smaller companies more to make up the difference.

- **Does the employer care, especially the small and mid-sized ones?**

  Again, probably not. Most economists argue that employers simply reduce wage increases to fund health premiums. (See below). If premiums rise quickly, wages rise more slowly.

  The employer corporation doesn't care – economically – if it pays employees wages or premiums. It's only concerned with the total employee costs.

#2: Underfunded Social Programs

Among developed countries, the US has the highest rates of diabetes, sexually transmitted diseases, teen pregnancy and auto mortality. We also have the second highest rates of heart and lung disease and lose more years of life before age 50 to drug and alcohol abuse. [55]

Are sexually transmitted disease and teen pregnancy the *employer's* problem? The patients typically don't work for the employer but the employer pays for treatments through 'trend'.

We know that social and behavioral factors affect more than

- 70% of colon cancer and strokes.
- 80% of coronary heart disease

[55] For Americans Under 50, Stark Findings on Health, Tavernise, NY Times, Jan 9, 2013

- 90% of adult on-set diabetes, and
- Probably most leg amputations (we lead the developed world)

But the underlying social and behavioral factors exacerbating these problems are not addressed by employer based health insurance. These are 'social' problems, appropriate for some government agency or non-profit to address – or so believe many employers and benefits administrators.

Perhaps as a result, we spend far less on social determinants of health (housing and rent subsidies, training programs for poorly educated or unemployed folks, disability cash benefits and social services in general) and far more on medical treatments after someone gets sick than do most other developed countries.

In fact, though we're #1 in medical spending per capita in the world, we're #13 in 'medical and social spending' combined. We have the ratios reversed from most others. The OECD average is about 2/3 of combined 'medical and social spending' going to social and about 1/3 going to medical; we're the opposite, joining only Korea and Japan as spending the majority of 'medical and social' on medical. [56]

This situation developed largely because employers lobbied more successfully for health insurance premium tax breaks than did social service agencies for funding. (More on this below when we discuss the history of employer based health insurance.)

How well do employers negotiate for their employees?

In 1964, the average wage in this country was $2.53/hour and the average health expenditure $197 per person per year, requiring the average person to work about 78 hours (2 weeks) to pay for healthcare. [57] Divide $197 by $2.53 to see this.

In 2019, the last year before Covid, the average wage had risen to $22.98 / hour, healthcare cost to about $11,500 per person, requiring the average person to work 500 hours (12.5 weeks) to pay for healthcare.[58]

This strikes many as a pretty poor track record. One wonders if individuals, negotiating for their own policies, might have done better than employers and brokers working together. [59]

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[56] See The American Healthcare Paradox by Bradley and Taylor for more on this. I only summarized their research here.

[57] This example comes from Philip Longman's excellent book on the Veteran's Administration Healthcare system, Best Care Anywhere

[58] Wage estimates from the Bureau of Labor Statistics 'Usual Weekly Earnings of Wage and Salary Workers, Third Quarter 2019'

[59] See in particular David Goldhill's Catastrophic Care. Philip Longman compares cost inflation in the Veteran's Healthcare Administration system to the employer based system in his book Best Care

‘But my employer pays 75% of my premiums’

This misconception pervades the employer based health insurance model. Let me explain what most people believe first, and then show the real costs. [60]

Consider Mary, a single woman who earns $35,000 a year. In this hypothetical example, the company’s single premium is $649/month ($7791 annually) of which Mary pays 27% or $2112 per year. She also pays a $250 annual deductible and has 4 office visits at $25 each.

Mary thinks her healthcare costs about $2462, or roughly 7% of salary. Not too bad.

There’s only one problem with this analysis: it’s completely wrong. Not even close to correct.

Here’s what Mary actually pays:

- The entire **$7791** premium in foregone wages. Remember that her employer doesn’t care if Mary receives compensation as salary or benefits. The employer only cares about the total annual cost of employing Mary.
- $1276 in state taxes at a 3.6% state tax rate. Since states average spending about 10% of their budgets on healthcare costs for employees and Medicaid, Mary pays about **$128** in healthcare costs to the state.
- $3827 in Federal taxes, about 11% of her income. Since 20% of the federal budget goes to healthcare, Mary pays another **$765** here.
- Medicare taxes (1.45%) plus the employer match (foregone wages again), another **$1015**.

Mary actually spends about **$10,000** on healthcare annually, not $2462. See why all the healthcare system inefficiencies we’ve been discussing really matter?

Part 2: How Employer Based Health Insurance Developed

An historical accident

Let’s consider two historical themes to understand both why we have an employer-centric healthcare financing model and why it works so poorly.

First, remember that healthcare and social services evolved independently and differently. Healthcare was a profitable industry, supported by powerful special interests;

Anywhere. The VHA did a better job controlling costs while, according to Longman, generating better outcomes.

[60] This analysis comes from David Goldhill’s ‘Catastrophic Care’, chapter 2 ‘The Hidden Beast’. I’ve adjusted the numbers slightly and changed the woman’s name to Mary, though unclear exactly why.

social services were not but, but rather were disorganized, politically weak and stigmatized for helping the 'undeserving'. [61]

Consider this story from Bradley and Taylor's book The American Healthcare Paradox about Joe, a 28 year old, very low income diabetic: [62]

- His poor diet, including very little fresh food, exacerbates his condition
- He wears old, holey shoes that keep his feet constantly damp.
- His doctor admonishes him to eat better, take his insulin and keep his feet dry, but he can't afford to do these things often enough
- Last year he had 2 toes removed costing $7000 and next year likely two more for $14,000
- His doctor discussed the possibility of a foot amputation ($18,000) plus rehab (total medical costs about $30,000), plus a wheelchair ($1000). This would make finding a job far more difficult, reducing Joe's chance of earning much income and consequently paying taxes (more or less paying for the social welfare of others). A leg amputation might permanently relegate him to surviving on government benefits, not a job.

Perhaps the most ironic or depressing part of this story: new shoes cost $75 and an apple costs $1 per day. Our (underfunded, disorganized) social services can't manage these minimal costs while our (well funded, powerful) medical system racks up tens of thousands in fees by implementing medical solutions to social problems.

Second, our healthcare financing system evolved inefficiently, from a vertically integrated 'financing + care provision' system to a non-vertically integrated one.

- Vertical integration means medical care and medical financing are the same entity with salaried physicians. Both the financing arm and medical care arm work together to generate the best patient outcomes at the lowest cost, at least in theory.

  'Managed competition' is competition among vertically integrated healthcare providers. Those generating the best outcomes at the lowest costs will gain customers; those operating at higher costs and generating poorer outcomes will lose. [63]

[61] See Bradley and Taylor, The American Healthcare Paradox for a longer explanation of this point.

[62] Ibid. page 1

[63] Alain Enthoven of Stanford University, perhaps our greatest managed care theorists and proponent, has written widely about this which is somewhat outside the scope of this particular chapter. See his

Vertically integrated healthcare entities compete with each other on *value*: outcomes per dollar spent, since they control their own income (i.e. the premiums they charge customers.)

- A 'non-vertically integrated system' has separate companies handling financing and medical care. Today we call financing companies 'insurance carriers' and medical care provision companies 'providers', generally hospitals and physician groups.

  In this system, financiers always want to pay service providers less and service providers always want to bill more. The relationship between the two is 'war' - according to Atul Gawande, professor at Harvard Medical School and staff writer for the New Yorker – 'every step of the way'. [64]

  In a non-vertically integrated system, carriers and hospitals argue over payment formulas since hospitals do not control premiums. A very different focus from the vertically integrated model above.

How Employer Based Healthcare Started

(A version of this section appeared previously in this text. Readers may wish to skim the next 10 pages. GF)

The myth – or perhaps truth - is that it started in Dallas around 1929 as a reaction to the stock market crash and financial meltdown. [65] The business problem for Baylor University Hospital in Dallas was that it didn't have enough money to pay its bills.

Prior to the stock market cash, hospitals raised funds in two ways. First they had paying customers who were billed for services rendered - a fairly modest percentage of the population because most people didn't have a lot of money. Second, the community chest, the charitable organizations - the wealthy would donate to the hospital because it was a good place to donate your extra money. Charity made you feel good and was good for the community.

But with the stock market crash, the wealthy didn't have as much money to donate, unemployment increased (reducing the number of patients able to pay), and the hospital faced a difficult financial landscape. So Baylor University Hospital made a deal with the Dallas School System. They said, "School system, you raise money from taxes. You

seminal article The History and Principles of Managed Competition for more. http://elsa.berkeley.edu/pub/users/webfac/held/157_VC2.pdf

[64] See Gawande's second book 'Better', chapter entitled Piecework

[65] This suggestion comes from Richmond and Fein, The Healthcare Mess, page 30.

always have money. Pay us $.50 every other week, $.25 a week, for each of your employees and when they get sick, they come to us and we'll take care of them." Employer based health insurance arrives.

A few comments about this.

First, it's a nice deal. It's a nice deal for the hospital because they stay in business. They don't have to worry about going out of business. They don't have to worry about turning people away as long as they get the numbers right (which apparently they did), $.50 per employee every other week. That was the true cost. The school system payments protected the hospital's cash flow, so the hospital stayed in business.

Second, this was very efficient. The hospital signs one contract with one employer group and received back enough money to stay in business. Sweet. That's a pretty good incentive to look for more large employer groups.

Third, there was no prevention or provider choice, but theoretically the teachers and other employees of the school system were happy because they got medical care essentially for free.

Fourth, this was for hospitalization only. There was no outpatient doctor's coverage.

Fifth, community rating. The Dallas School System paid $.50 per person every other week, regardless of individual medical status. There was no medical underwriting.

Sixth, there were no quality controls, no outcome based incentives, no holdbacks for poor hospital performance. Health insurance began simply to save the financial health of the hospital.

This was a vertically integrated system, almost textbook variety. And it exhibited the classic flaw of vertically integrated healthcare system: lack of consumer choice. As developed initially with Baylor University Hospital, the Dallas school system employees could only go to one hospital. This has advantages and disadvantages.

Advantages:

1. Lower Costs

2. Reasonable medical care from a small number of 'in-network' providers

Disadvantage:

1. Little provider choice as few hospitals 'in-network'

The Baylor Hospital / Dallas School System deal worked so well that other hospitals soon copied it. Different hospitals looked for different large employers, offering the same kind of deal. Large manufacturers, the Dallas Morning News, and others. What problem begins to arise?

The Choice Problem

Consumers (school system employees or manufacturing workers, for example) wanted to chose among various hospitals. 'What do I know about Baylor University Hospital? I only know one thing. I know someone who went there and didn't get good treatment, so I want to go somewhere else.' Someone always knows of someone else who had a negative experience there. So you want to go somewhere else - consumers want choice.

Remember vertical integration, where finance and service provision are the same company? Once you introduce choice, then you have one group handling finance and another handling service provision. You have a split and you lost vertical integration. (More on this coming up soon.)

Back to Dallas. The hospitals are cranking along with the employer based financing model. They're very happy. They're making money. And then one of the Blues brothers comes along – Cross or Shield, I don't remember which – and offers to provide financing for lots of Dallas hospitals. 'Dallas teachers' they might have said, 'you can sign up with Baylor University Hospital only, or, for just a little more money, sign up with us and we'll give you the choice of many hospitals in Dallas. We contract with lots of hospitals. We have a large network.' Sounds pretty appealing, right?

Doctors looked at this and said, "Hey, we want in on this too." They organized a second Blues brother so doctors could get paid because the same depression was affecting all medical providers, both hospitals and physicians. Blue Cross for your doctor's bills and Blue Shield for your hospital bills (or maybe the other way around. Wikipedia didn't say when I looked it up.) Both organized to protect provider incomes.

And both – conceptually, if not in real life – competed with vertically integrated hospitals, like Baylor University Hospital was at the beginning with the Dallas School System.

The Blues developed a couple of very clever ideas in the 1930s. First, from a marketing point of view, they offered this very attractive provider choice option. Very appealing to many consumers.

Second, they began searching for the healthiest subscribers. An interesting business idea: if they could find the healthiest people, they could offer lower priced policies and gain a competitive edge vs. their vertically integrated competitors signing up large employers at a fixed price per person.

Underwriting vs. Community Rating

The Blues figured that they would underwrite better than the competition so people would join them because their premiums would be a little bit lower. The community rating folks faced higher premiums because they took all employees.

Underwriting serves the economic interests of the carriers. It doesn't improve healthcare outcomes. It doesn't improve the healthcare system. It doesn't differentiate medical quality. It doesn't create patient value. It only makes one carrier lower cost than another carrier by having sick people pay more. The healthy pay less, the sick pay more but there's no value created: the total medical costs remain the same. But some people win and others lose.

This financing system has little to do with getting people healthy, or creating value. That was not its intention. It was designed to protect physician and hospital income. That was the original Baylor idea. Then carriers came along to make a profit on consumer demand for choice. The demand for choice leads to the Split.

The Split and the Provider Payment Problem

Once you split finance from service provision, you have a wider consumer choice and you have to figure out how to pay doctors and hospitals. We're still, today, trying to get this one right.

The original and still most popular payment mechanism is fee-for-service. The doctor gets paid $100 for treating each broken arm and $350 for each rotator cuff surgery.

As soon as you split finance and service provision there's an incentive on me, the doctor, to do more treatments. You're paying me by treatments, so I will do more treatments. 'That guy's got a sore shoulder that's probably due to a rotator cuff tear, so I'll operate on his rotator cuff.' Fee for service provides an incentive for doctors to do more procedures and hospitals to admit more people.

You, on the other hand, the carrier, want to limit the number of treatments. You want to ask if I have to do that procedure. We fight all the time. My clinical judgment (influenced, perhaps – at least psychologically – by the fee-for-service payment formula) vs. your financial judgment (influenced, perhaps – at least psychologically – by the same fee-for-service formula. You don't really trust my clinical judgment.) That's the conflict between healthcare payers and medical service providers.

Let's remember where we are. We're still in the 1930's and we're talking about the growth of the employer based system. Little cost control. We've developed the split between finance and service provision. Finance people will say, "You really don't need to do that procedure," and the service provider says, "Yes I do. Yes I do."

The Problem of Measurement in Fee for Service Medicine

There's a related problem in fee-for-service medicine – the problem of measurement. How well does a particular physician treat his/her patients? How well does a particular hospital perform certain surgical procedures? How well does a particular treatment work?

These are enormously difficult questions to answer. We do not even today have good measurement criteria or good data – and we had even poorer criteria and data in the 1930s. The data that we can measure might not be the most important. Remember that our healthcare goal is to extend life or improve life quality. We do not yet fully understand which treatments today will lead to longer lives in 30 or 40 years. Nor do we fully understand which treatment qualities will lead to long term life quality improvements.

We can only measure some aspects of medical treatments – surgical mortality rates, hospital infection rates, 30-day hospital readmission rates, for example. These may not always be the most significant outcome data, though they may be useful for some patients.

Whose interests are served by measuring or publicizing this information? Not the providers. They get paid fee-for-service for the *quantity* of medical care, not the *quality*. Publicizing outcome data may harm them economically. Thirty day hospital readmission rates may show that Hospital A provides poorer patient treatments than Hospital B. Or that Surgeon Z has a higher mortality rate than Surgeon X.

The risks of either inappropriate or unflattering outcome data becoming public were so great during the inception of our employer based system that providers fought against its release. The fee-for-service system suited their interests far better than any outcome based payment mechanism.

The fee-for-service / component payment structure suited their interests in a different way also. Absent good data collection, each physician – responsible only for his/her specific tasks – can argue 'I did my job correctly. The fault lies elsewhere.' Physicians act as subcontractors, narrowly defining their individual tasks, rather than as general contractors responsible for the life of the patient. This follows directly from payment systems that developed from the Split between finance and service delivery.

Fee-for-service / component financing serves provider interests, is inflationary and expensive, and is not designed to improve patient health. It's only designed to reward providers, which it did quite well historically. We, in the US, have traditionally performed more procedures / 1000 of population than similar developed countries around the world. Things today like spinal fusion surgery, hip replacements, knee replacements, coronary bypass surgeries. The Split between finance and service provision led us down this road.

The Impact of World War II

Let's continue with our historical / conceptual history of employer based health insurance.

During World War II, or perhaps as a function of it, more and more people got insured, most notably people in the military. They continued with insurance coverage after the

war. In the relatively short post-war period we get lots more Americans covered for hospitalization insurance.

1942: 10 million hospital insurance / health insurance subscribers

1946: 32 million

1951: 77 million [66]

World War II plays an important role in our story for three main reasons.

First, the soldiers who received health coverage while in the military wanted to continue with it afterward. They saw the advantages of having health coverage. They married and wanted their families to receive coverage also. This created demand for health insurance.

Second, our wartime economy devoted significant resources to medical technology improvements. Perhaps most significant was the introduction of sulfa drugs to combat infections. These helped turn hospitals from infection breeding institutions into patient treatment and improvement centers. Other technological innovations followed. These improved the quality of medical care, or the supply.

Third, the Federal wartime wage and price freezes fostered the development of 'fringe benefits' such as health insurance. These reduced the cost of insurance to the individual consumer and further helped stimulate demand. It's a pretty interesting story just how these developed.

The government decided during the War to freeze wages and prices - to avoid domestic economic difficulties and help focus our economy on war production. Employers could not raise wages to attract new workers or to reward their best employees. The government controlled this aspect of employee compensation very tightly.

But the government allowed employers to offer fringe benefits such as health insurance. This was how employers could attract new talent and retain their current employees. The concept of 'fringe' meant 'outside the normal compensation' and 'benefits' meant 'advantages of working here'. Employers couldn't simply raise wages – the traditional way of attracting labor – as that was illegal during the war. Fringe benefits were simply a mechanism to get around the wartime wage freeze.

As we grew in 9 years from having 10 million to 77 million insurance subscribers in this country, the health insurance industry developed and gained political power. It lobbied Congress for favorable legislation. It applied political pressure. It acted, in short, just like all other powerful industrial groups.

The Hill Burton Act and IRS decisions strengthen hospitals

[66] Richmond and Fein, The Health Care Mess pages 30 - 38

Congress, just after World War II, passed the Hill Burton Act to fund hospital expansion. This increased the number of hospital beds in this country by about 40%, from 3.2 per 1000 people to 4.5. It also made hospitals the centerpiece of our medical care system; the travelling doctor who made house calls started to disappear.

Shortly thereafter, in 1953, the IRS decided that fringe benefits were exempt from federal income tax: those became *tax deductible to the employer* but *not income taxable to the employee.* **This was essentially a government subsidy for hospital care,** since that's what health insurance ultimately financed. The government stimulated sales of employer based health insurance by subsidizing the price through the tax exemption.

To understand how this is a subsidy, let's look at both the employer and employee tax situations. The employer buys a $100 insurance policy for an employee, and, prior to the IRS regs, pays corporate income tax on the $100 ---- let's say that was 50%. So the employer's total cost was $150: $100 for the policy and $50 for the income tax on that $100.

By making the payment tax deductible to the employer – that means by foregoing the corporate income tax on that $100 - the government reduced the cost. Health insurance now only costs the employer $50; the employer takes a 50% tax deduction on the $100 payment. That's a big savings compared to the previous $150 expense.

The employee received this $100 employment benefit. Prior to the IRS regulatory change, he/she would have paid their marginal tax rate on this income --- let's say 30%. By making this tax free to the employee – that means by foregoing the personal income tax on the $100 – the government contributed $30. In other words, the government subsidized the employee who received health insurance by $30.

An interesting note from the employee point of view. $100 in benefits is more valuable than $100 in salary. The $100 in salary is taxable, so nets only $70. Remember our discussion above that 'My employer pays 75% of my premium.' I suggested that the employer doesn't care if he/she pays salary or benefits – the employer only cares about the total cost.

But the employee, according to many economists, does care. The employee prefers benefits since they're not taxed. The employee's foregone salary, according to this argument, is more valuable than benefits since it's not taxed. (I'm not sure I buy this argument completely but it does give me pause to consider.)

This subsidy for health insurance was so effective that the rate of Americans with hospital coverage skyrocketed. In the mid-1950s, about 45% of Americans had hospital

insurance. By 1963, 77% had hospital coverage, and an additional 50% had some form of physician coverage.[67]

The favorable tax treatment of fringe benefits led to healthcare inflation from higher *hospital* prices – because more people could afford to use hospitals.

Over this time period two strange incentives evolved in our healthcare marketplace: an *excessive hospitalization* incentive and an incentive to *cover the unemployed*. These two conditions merged in the late 1960s and 1970s. Their combined effect became clear by the 1980s as our health insurance costs skyrocketed and our employer based financing model became even more firmly entrenched.

Excessive Hospitalization Incentives

By the mid-1960s over three quarters of Americans had hospitalization insurance, paid for by employers and subsidized by the government. Hospitalizations became essentially free to patients, creating, in the words of Harvard Professors Richmond and Fein a 'not-so-subtle perverse incentive to hospitalize individuals.'

This was the case even for diagnostic tests that could have been performed on a less costly outpatient basis, they say. Over time the hospital became all the more important and central to the delivery of healthcare services.

This increased the need for health insurance:

Since medical care became more costly, insurance became more useful (indeed, necessary). In turn, the presence of insurance helped underwrite a buildup of resources and an upgrading of technology that added to costs and made insurance even more valuable. [68]

Remember the incentives here.

- Employees liked the system because it appeared free to them;
- Carriers liked the system because the government subsidized their product (health insurance policies);
- Hospitals loved the system because they received patients and insurance payments – a wonderful recipe for making money.
- Employers objected somewhat to this system, but not terribly strenuously. After all, the government was subsidizing their health insurance payments, so they felt the pain only partially.

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[67] Enthoven and Fuchs, 'Employment Based Health Insurance: Past, Present and Future' Health Affairs, Nov/Dec 2006

[68] Richmond and Fein, op. cit., pages 38 - 39

Our healthcare system was hospital based – not really interested in preventive care (hospitals couldn't charge much for that); not really interested in public health (the field was only just developing); not really interested in outpatient or chronic care. Providers focused on hospital care because that's where the money was.

Hospital insurance stimulated the excess use of hospitals, which created more need for hospital insurance. Three byproducts:

- First, we used hospitals for almost all medical care, even if less expensive setting existed;
- Second, we developed fewer outpatient, home based, preventive or non-hospital types of medical care;
- Third, we continued to underfund social program. All this hospital growth and funding (largely from government programs and tax subsidies) crowded out social service investments.

Yet this third issue was tremendously important. Let me quote Professors Richmond and Fein on the relative importance of hospital investment and public health investments. [69] And remember: these were two highly respected Harvard Medical School professors. Richmond, in fact, was US Surgeon General in the Carter administration.

- 'A growing professional consensus holds that the health gains since WWII were largely **the consequence of applying our knowledge of health promotion and disease prevention rather than improved clinical care…' (**i.e. public health investments**)**
- 'The revolution in biology subsequent to World War II, a revolution that had brought many advances to clinical care, as yet **had only marginal effects on improving our vital statistics'**

Social spending had a bigger impact on our national health gains than did hospital investments! We invested the wrong way (assuming our healthcare investments were aimed at promoting health).

How Could Employers Afford Health Insurance Premiums after World War II?

What set of circumstances allowed this system to develop? Why was the employer based system healthy and growing until the late 1900's, then in decline?

It turns out that for a number of years, this 40 year period more or less, many countries were (a) recovering from World War II or (b) gaining independence and expanding their

[69] Richmond and Fein, op cit, pages 92 and 94

educational systems. They were not economic threats to the United States – countries like Japan, India, Korea, China, or Western Europe. We dominated economically.

Our big firms in particular were very profitable. They didn't have much foreign competition. They could afford to pay for employee healthcare. They could raise prices because nobody was competing with them to keep prices low. That's the trend that you see from World War II to about the 1980s or so. Big firms could set the standard and then small businesses filled in the holes. All competed for labor based on offering attractive 'salary + benefits packages' and all could because the big firms were managing the world economy.

This allowed the U.S. to have an extra cushion of money available for healthcare benefits. Even though people complained, the economy could support the excess premiums. Regulated industries - for political and various other reasons - were able to pass on the cost because our economy was stronger than any other. Unions were strong. They could demand health insurance and the big firms could afford it.

The key factors that fostered employer based health insurance post World War II all changed in the 1980s and 1990s:

<u>World Economy, 1945 – 2000 +/-</u>

Little foreign competition for American manufacturers;

Japan and Western Europe needed time to rebuild;

US manufacturers could keep prices high and afford health benefits

<u>Importance of Large Firms, Regulated Industries and Unions</u>

GM, US Steel, ALCOA, etc – profitable with little foreign competition. Able to share profits with employees as benefits;

Regulated industries (AT&T) – regulated monopolies were able to pass health insurance costs to consumers; they had little or no competition;

Unions were relatively strong, could bargain effectively for benefits

All these conditions changed in the 1980s and 1990s. Our ability to generate excess profits, if you will, to afford for the employers to pay for healthcare starts to disintegrate as foreign competition gets going. From World War II until about 1980 or 1990 we could afford employer based health insurance and there was no significant political group that was lobbying or arguing against it.

Medicare and Medicaid Remove Potential Political Threats to Employer Based Insurance

One major potential political threat to our employer based health insurance system could have come from the unemployed – that significant percent of the population that is

too old to work or unable to find full time work with benefits. This is potentially a very potent political force that could have lobbied in favor of single payer healthcare, universal coverage or something like that – like in other countries.

By introducing Medicare and Medicaid in the 1960s, this political force goes away. People are happy. They're not under pressure. They're not demanding universal coverage because they've got coverage. Where are politicians going to find a block of supporters who are going to argue for single payer systems, universal healthcare? They don't exist because Medicare and Medicaid took the potential block off the table.

Here is an estimate of the population size that these two entitlement programs satisfied. I'll use Medicare, because this covers the elderly who vote in particularly high numbers and in particularly important electoral states like Florida. This large voting bloc could have become a potent political force for universal coverage. Instead it became satisfied with Medicare.

Medicare Enrollment 1970 – 2000

Year	Number Medicare Enrollees	% of US population
1970	20 million	10%
1980	28 million	12%
1990	34 million	13.5%
2000	39 million	13.8%

Medicaid covers about the same population size.

The argument is that Medicare and Medicaid are key supporters of our employer based health insurance system. They allowed the system to grow and become entrenched nationally in the second half of the last century.

The employer based system reaches its peak of 165 million people in 2000 and then it starts to decline. Why did it decline? Because the international economic conditions changed. American firms could no longer pass on benefit costs to their customers.

At the same time, the hospital lobbies and related groups had done such a good job of protecting their constituencies that healthcare became hugely expensive. Healthcare grew from about 4% of US GDP in 1950 to 14% in 2000 to about 19% today.

Lower cost alternatives to large general hospitals – freestanding outpatient clinics, for example – never took hold, presumably due to hospital lobbying efforts. Similarly, specialty hospitals – local diabetes clinics, for example – also failed to establish themselves, again presumably, for the same reasons. The Affordable Care Act, for example, didn't actually prohibit establishment of physician-owned specialty hospitals, but placed such burdensome requirements on their establishment as to destroy this as a potential market force.

By the early 2000s we had developed a perfect storm for healthcare system financial catastrophe. Our healthcare costs – primarily hospitalizations due to the government subsidies of fringe benefits – rose far faster than GDP. Meanwhile, American businesses' abilities to pay for their employee's health coverage diminished in the face of foreign economic competition.

Mandates

As healthcare became increasingly costly, carriers (reflecting employer's interests) tried denying services to patients. This spurred a political reaction, pitting patients and medical provider interests against employers. Perhaps the most impressive display of patient and special interest power presented itself by the growth of healthcare mandates.

The number of state mandated services grew from 7 in 1965 to 1961 in 2008. These reflected the political power of special interests to protect the incomes of their members. Chiropractors lobbied for chiropractic to be included as a benefit in insurance policies. Nurses lobbied for minimum nurse-to-patient ratios. Voters generally supported mandates as protection against insurance carrier abuses.

Mandates raise prices. This increases the need for insurance but makes insurance less affordable, which increases the need for government subsidies (tax breaks and, in some states like Massachusetts, premium supports), which reduces the amount of money available for social programs and 'health promotion and disease prevention' activities (in the words of Richmond and Fein [70]) which in turn medicalizes social problems and raises costs.

But perhaps most disappointing of all, mandates don't improve patient health much. Consider this graph comparing American life expectancies to French and Canadian as we increased the number of healthcare mandates between 1965 and 2010. You can see how our life expectancy rates fell slightly below the trend line of the French and Canadians even as we required more healthcare services for our patients.

Instead, healthcare mandates are political reflections of the economic power of various healthcare groups. They have, apparently, little impact on health. But they ensure that the various medical interest groups get paid.

Consumer Driven Healthcare to the rescue (or not)

The first major attempt to adapt employer based healthcare to these new economic realities was CDHC or Consumer Driven Health Care. The term 'consumer driven health care' arose primarily from the Medicare Modernization Act of 2003 which established Health Savings Accounts.

[70] Richmond and Fein, The Healthcare Mess, page 92

'Consumer driven products' are high deductible health insurance policies with certain tax benefits. Each consumer spends the deductible as he/she sees fit – for physician visits, medications, tests, therapies etc – more or less employing the consumer sovereignty idea we discussed earlier in this chapter. Only after satisfying the deductible does insurance pay. Then, depending on the specific plan design, insurance pays all or part of additional medical expenses.

Problems equating high deductibles with consumerism in healthcare

Unfortunately, CDHC policies as 'consumer sovereignty light' fail in healthcare for two main reasons.

First, an annual $1000 deductible (or even $3000) is too small to act as a real medical spending brake. Once satisfied, and depending on the specific plan design, all other medical care is free.

A patient might satisfy that deductible hurdle in January and then enjoy lots of excessive and unnecessary medical care for free during the next 12 months.

Or the deductible has little impact on a patient facing an expensive procedure. What's the difference to this patient if the procedure costs $45,000 …. $50,000….$60,000 or $100,000? Once the deductible is satisfied, the rest is free. 'Consumerism' fails to affect patient behavior in these expensive cases.

This fundamental flaw in the 'high deductible = consumer driven healthcare' thesis exists because the vast majority of healthcare spending goes to a very small group of high cost patients. Here's spending by percentage of the population. These numbers have remained remarkably constant for the past several years.

Healthcare Consumption by % of Our Population [71]

1% of our population accounts for about 24% of medical spending

5% of our population accounts for about 49% of medical spending

10% of our population accounts for about 64% of medical spending

50% of our population accounts for about 97% of medical spending

So the healthiest 50% of our population accounts for only about 3% of medical spending. These are typically the folks who purchase CDHC products and who often spend less than $1000 annually. Cutting their spending by 20 or 30% would have *virtually no impact* on *overall* medical spending or trend.

[71] Yu, et al, 'Medical Expenditure Panel Survey Statistical Brief #81', May 2005, Agency for Healthcare Research and Quality

Here's the same chart using 2010 spending data. In 2010, total US healthcare costs reached about $2.7 trillion for the approximately 310 million of us. Though the 2010 average annual healthcare spending per person was about $8,700,

The 1% heaviest users (3.1 million people) averaged about $209,000 each;

The 5% heaviest users (15.5 million people) averaged about $85,000 each;

The 10% heaviest users (33 million people) averaged about $52,000 each;

The 50% lightest users (155 million people) averaged about $500 each

Very few of the 10% of users who account for about 2/3 of all medical spending will change their medical choices based on a $1000 (or even $2500 or $5000) deductible. *Whatever* the deductible, their medical care needs far exceed it.

Second, medical consumers have little meaningful quality information, and even if they have it, they rarely know how to use it. This makes medical decisions different from, say, car purchasing decisions. The car buyer can compare the quality of various cars before deciding which to purchase. Large or small, good gas mileage or poor, lots of luxuries or few, high resale value or low, etc.

But the medical purchaser generally has very little similar information. Which doctor has the best outcomes? Which hospital? How effective is this medication compared to that one? We generally lack detailed answers to these questions.

For these two reasons – unequal healthcare spending and lack of medical quality information / well educated medical consumers - so-called Consumer Driven Health Care had only a small impact on medical trend which has run at our gdp growth rate plus 3 – 5% annually for years. CDH policies became the vogue in the early 2000s. They pretty much ran their course within about a dozen years.

Americans continue to spend about twice as much on healthcare as other developed countries without getting any value for the excess spending, just as we did prior to CDHC policy introduction. Here are the estimates for 2019, the last year before Covid hit and altered these statistics with a unique set of circumstances. (I don't know if or how Covid is representative of 'normal' healthcare trends so try to leave that out of this analysis.) [72] I could have included more countries but you get the idea from this limited comparison.

[72] OECD Health Data statistic updated annually https://stats.oecd.org/Index.aspx?ThemeTreeId=9

2019	Annual spending / capita	Life expectancy at birth
US	$10,855	78.8
Canada	$6,730	82.3
France	$4,014	83
Spain	$2,412	84
UK	$3,334	81.4

We clearly haven't figured out how to generate good value for our healthcare system costs.

Three additional problems with having employer based health insurance as the centerpiece of our healthcare financing system

Price structure: Today's health insurance policies are priced at 'employer contribution + employee contribution'. Losing your job may lead to a quadrupling of your health insurance premiums, assuming that your employer pays 75% of the premium.

Labor market distortions: Some employees either choose jobs or remain on their jobs for the health insurance. Two main reasons for this are

- cost – employer contributions reduce employee costs, and
- access – pre-existing conditions traditionally made health insurance unavailable to some people if they changed from their current jobs, though the Affordable Care Act has changed much of this.

One research paper estimated that employer based insurance reduced job mobility by 25 – 40% [73] at least until the ACA impacts work their way through our healthcare system.

Impact on the Federal budget: Tax breaks for employer based health insurance (not income taxable to the employer or employee) constitute the biggest tax break / loophole in the federal budget, an estimated $260 billion annually. [74] This is roughly 3x the mortgage interest tax deduction.

[73] Gruber & Madrian, 'Health Insurance, Labor Supply and Job Mobility' Workng Paper 8817, NBER, March 2002

[74] Health Affairs *Health Policy Brief*, August 1, 2013 'Premium Tax Credits', http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=97

This tax break is regressive: higher income people with expensive policies are subsidized by lower income people with less expensive policies.

Many on Capitol Hill seek to reduce this tax break. Here, for example, is Representative Paul Ryan who ran for Vice President in 2012 with Mitt Romney. The tax deductibility of employer based health premiums

> tilts the compensation scale toward ever-greater (tax free) benefits and away from higher (taxable) wages. This isn't just a big driver of runaway healthcare costs, as more dollars chase the same amount of services. It's also a big reason why too many Americans haven't seen a raise in a long time. [75]

Ryan, among other things, echoes my suggestion that employers pay premiums by withholding wage increases from employees. $1 of benefits is worth more to the employee than $1 of wages since the wages are taxed.

Paul Starr, Princeton Professor of Sociology who normally sits far to the left of Ryan, agrees with him on this point, saying the employer based premium tax exclusion has

> long been the target of criticism on both distributive and allocative grounds: it provides the biggest subsidies to higher income employees with the most generous insurance, and it contributes to America's inflated health spending by obscuring the true costs. Nixon and Clinton considered limiting the exclusion, but each rejected the idea because of political opposition.[76]

Summary: Employer Based Health Insurance

Employer based insurance provides some 160 million Americans with health coverage. But it does so remarkably poorly.

- By setting powerful employer business interest groups against far weaker population health interest groups, it's a key cause of underfunding our various (health related) social services
- The employer based structure harms **employers** by putting an unnecessary (for widget production) economic and administrative burden on them.
- It harms **employees** by reducing their medical care options
- It harms **patients** by locking our system into one focused on short term cost control rather than long term outcome improvement, or, in economic terms, value creation

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[75] Turner, Capretta, Miller and Moffit, Why ObamaCare is Wrong for America, Forward

[76] Paul Starr, Remedy and Reaction, page 258

- It harms **carriers** by reducing their ability to develop high value products and by forcing them to satisfy employer needs rather than patient, and
- It harms **providers** – doctors and hospitals – by reducing their ability to focus on long term outcomes and treatment excellence, but rather on short term costs, carrier and network referral requirements and associated administrative tasks aimed at reducing moral hazard.

Where will this take our healthcare system? Stanford Business School Professor Alain Enthoven summarizes in prophetic terms. Our employer based model, he suggests, will unfold 'like a Shakespearean tragedy: known, tragic flaws taking their inexorable toll.' [77]

Or, as Lady Macbeth might put it,

> *The employer based healthcare financing system simply doesn't work. Bandaids and piecemeal reforms cannot not fix this fundamentally flawed model.*

(I've admittedly taken some pretty generous poetic liberties here. Lady Macbeth actually said 'Here's the smell of the blood still. All the perfumes of Arabia will not sweeten this little hand'. It's not easy ending a chapter on employer based healthcare financing with a Shakespearean quote!)

[77] Health Affairs, Forum on Employer Sponsored Health Insurance, 2006 http://content.healthaffairs.org/content/25/6/1537.full

Review Questions

Answers on next page

1. This chapter suggested that Moral Hazard is endemic to health insurance. What is moral hazard?

a. People get more care than they need because it appears free to them
b. People with poor moral standards get more care than appropriate because they are greedy
c. There is a close correlation between high morals and low healthcare costs
d. 'Moral hazard' addresses the mind-body relationship. Basically moral people sleep better so remain healthier than lose moral people who more typically suffer from sleep disorders

2. This chapter suggested that disconnecting health insurance payers from healthcare users leads to inefficiencies. What does 'disconnecting health insurance payers from users' mean?

a. Payers are employers but users are employees
b. Payers are generally government entities that pass rules and legislation but users – who must implement those rules – are employers
c. Payers are, in reality, tax payers who fund most healthcare in this country even though employers are the biggest cohort of users
d. Payers are carriers who actually pay doctors and hospitals for their services while 'users' are all the entities that make up the bills, like pharmaceuticals, device manufacturers etc

3. This chapter suggested that having 1 year long health insurance policies leads to systemic inefficiencies. Why?

a. Carriers and providers try to control short term spending to keep renewal increases low, while some 70% of spending goes to patients with chronic diseases that require a long term focus.
b. Renewing annually creates far more paperwork, and therefore costs, than a more efficient system would have
c. Most employers would prefer longer term policies – 10 or even 20 year long policies – so they could plan and cut overhead
d. One year long policies opens the door to expanded lobbying on Capitol Hill from groups that offer the 'newest and greatest' short term health insurance fixes

4. This chapter suggested that having employment as the core of our healthcare financing system leads to underfunding social programs (that often have a major impact on health). Why is that?

a. Many of the social causes of medical problems – poor nutrition or poor housing, for example – are not the employer's financial responsibility. As such,

they are often left out of our health insurance discussion, since carriers and employers focus so intently on the next year's policy renewal price.
b. Social programs, as many studies have shown, have little to no impact on medical care or spending
c. Employers lobby aggressively to cut social spending programs which might, if they worked well, increase the employer's premium costs
d. Employers, brokers and carriers combine to develop fully comprehensive insurance plans. Anything not included in those plans, virtually by definition, is not relevant to promoting good health.

5. Who pays health insurance premiums?

a. The employee by foregoing wages
b. The employer by foregoing profits
c. The government by crediting the premiums equally to the employer and employee
d. Hospitals by undercharging for their service

6. Why do we have healthcare mandates in this country?

a. To improve care quality. Since the introduction of mandates our 30 day readmission rates have fallen almost to zero
b. To improve care outcomes. Since the introduction of mandates, our average longevity at birth has increased by almost 100 years
c. To reduce infant mortality. Since the introduction of mandates, our infant mortality rates have fallen to the lowest in the world
d. To reward lobbying by influential groups like nurses (who lobby for nursing mandates), chiropractors (who lobby for chiropractic mandates), pharmaceuticals (who lobby for pharmaceutical mandates) and similar.

7. Which country exhibits the shortest life expectancy at birth?

a. US
b. France
c. Canada
d. Britain

8. Which country uniquely bases healthcare financing on employment?

a. Britain
b. Canada
c. US
d. France

9. About how much medical care is 'unnecessary' according to scholars at Dartmouth and other research institutions?

a. 1%
b. 30%
c. 90%
d. 95%

10. Who actually pays the employee's premiums in our employer based system?

a. The employer
b. The employee via foregone wages and the government via foregone taxes
c. The insurance carrier
d. The primary care doctor

11. How does our employer based healthcare financing system affect job mobility?

a. It has no impact on job mobility
b. It increases job mobility
c. It reduces job mobility because people may be reluctant to switch insurance types and coverage because the switch may lead to provider and treatment differences
d. It increases job mobility in the public sector but reduces it in the private sector

12. Which is the biggest tax break allowed by the IRS?

a. Employer based healthcare premiums
b. State sales taxes
c. Foreign travel
d. Home office deduction

Review Questions

Correct answers in bold

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Managed Care

Managed care is classically defined as:

> large multispecialty group practices [that] provide a comprehensive set of healthcare services at a per capita price set in advance.[1]

These large practices include both a financial and service provision component. According to the theory, managed care organizations include both the insurance function and healthcare treatment function in the same company. Thus in a true managed care society we would no longer have separate health insurance carriers, independent physicians, independent general hospitals and fee-for-service billing. Instead, we would have large organizations that integrate finance and treatment functions for the good of the subscriber / patient.

In the ideal model managed care organizations compete with each other to provide the best value to subscribers.[2] Members of one organization could use all facilities owned by, or integrated into, that practice, but none of a competitor. Each local hospital, for example, would join only one managed care organization. Competition among these is called 'managed competition' and follows a set of prescribed rules. More on this below.

Managed healthcare differs from the three other forms of healthcare financing.

First, managed care differs from indemnity insurance. The traditional US medical insurance until about 1990 was indemnity coverage. Insurers indemnify – or pay back - subscribers for medical treatment after-the-fact. The subscriber receives treatment, pays the provider, and then submits the bill to the carrier for indemnification. Carriers indemnify (pay) the subscriber according to coverage provisions. (Carriers might bill the hospital directly and then balance bill the subscriber.) Typically indemnification plans include a deductible and a co-insurance rate. For example, the subscriber might have an annual deductible of, say $500 and 80% co-insurance - means the carrier pays 80% of all allowed costs above the deductible.

Carriers often pay 'usual and customary' or 'cost plus' fees to providers according to the carriers' fee schedule, and will generally pay any licensed healthcare provider. Under indemnity financing, there is no particular corporate or cultural relationship between any particular healthcare financing entity and provider. The relationship is entirely financial.

Indemnity health insurance plans only pay for medical services provided, creating a potentially powerful financial incentive for physicians and hospitals to perform tests and procedures. Indemnity plans typically pay very little (or nothing) for <u>preventing</u> medical treatments. With cost-plus reimbursement, providers have little financial incentive to offer low cost treatments, and a significant financial incentive to perform the most expensive available procedures. At the same time, indemnity carriers typically allow physicians and hospitals wide latitude to use their best judgements when designing medical treatments.

Indemnity insurance has three major drawbacks. **First**, it is very inflationary. Fee-for-service indemnification offers hospitals incentives to perform unnecessary or excessive treatment; it is a major contributor to Moral Hazard and the Medical Arms Race.

Second, indemnity results are often relatively poor, as we see above with Uneven Treatment Quality and Poor Safety Investments. It does not invest in prevention. Its' fee-for-service model is inappropriate for chronic disease care.

And **third**, indemnity insurance offers little, if any, data collection resources to inform carriers or providers which treatments generate which results. This makes results-based competition among carriers exceedingly difficult to implement.

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Second, managed care differs from single payer healthcare. Under single payer financing, one entity – often the government – pays for all healthcare for all citizens. Most advanced industrialized countries use some form of single payer healthcare financing as we do in the US with Medicare and the Veterans Administration Healthcare system.

Proponents of single payer financing argue that it is more equitable than any other form of healthcare financing, for all citizens are treated the same. Indeed, a key positive element of single payer financing compared to our current healthcare system is the universal nature of health coverage. In addition, supporters claim that single payer overhead is far less than private insurance, often citing Medicare's 2% overhead factor compared to private carriers 10 – 15%.

Interestingly, proponents of single payer systems sometimes use international outcome statistics to bolster their case. The British and Canadians for example, live longer than we do, exhibit lower infant mortality rates than us but spend less on healthcare. The conclusion offered by single payer advocates: the British or Canadian healthcare financing system is not only cheaper, but also better than ours. (We evaluate this argument in our course on Single Payer systems.)

Opponents of single payer financing claim that public financing leads to underfunding of healthcare. This in turn leads to less investment in medical technologies and long waits for medical services. Opponents of single payer systems often point to the relative dearth of the latest technologies available in the UK or Canada, or to the extensive waits for many services in these countries.

Opponents also claim that single payer financing eliminates competition from healthcare to the detriment of the entire system. Only through competition, many believe, can we simultaneously reduce healthcare costs and improve outcomes. Managed care proponents, as you will see below, subscribe to this position.

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Third, managed care differs from consumer driven healthcare. Under CDHC, consumers make their own decisions about their healthcare. CDHC proponents believe that healthcare is essentially like other goods and services in our economy and that consumers are perfectly able to shop among providers for the best value.

Consumer driven theorists believe that competitive shopping pressures from individuals will control healthcare costs and improve healthcare quality. Impediments to competition such as mandates, regulated term insurance policies and group-based policies reduce consumer sovereignty thus harm our system. Consumer driven advocates want to treat health insurance like typical goods and services in our society such as automobiles, retirement funds or houses.

Managed care theorists disagree. They believe that healthcare is fundamentally unlike other goods and services in our economy, and that consumers by themselves are unable to shop wisely for health services for reasons of information availability, risk and price.

Consumers, according to managed care theory, cannot access good information about important aspects of our healthcare system. They cannot self-diagnose nor determine which specialists are 'better' than others. They can't determine which treatment is most appropriate, which hospital is best for a specific ailment, or which providers offer the best value. Consumers need advisors to navigate through our healthcare system. In the managed care vocabulary, the advisor is the Primary Care Physician.

MANAGED CARE DESCRIBED: As envisioned by perhaps its foremost proponent Alain Enthoven, Professor Emeritus at Stanford Business School, managed care organizations are integrated entities that include both healthcare delivery systems (providers, labs, etc) and an insurance (financing) function. The critical components are:

1. Multispecialty group practices, comprised of primary care physicians, nurses, specialists, etc;
2. A voluntarily enrolled population that understands the advantages (price and hopefully quality) and disadvantages (reduced provider choice) of membership;
3. Comprehensive care;
4. Per capita prepayment;
5. Accountability by the organization; and
6. A close relationship between the financial and healthcare service delivery arms. [3]

The goal of managed competition, according to Enthoven is 'to divide providers in each community into competing economic units and to use market forces to motivate them to develop efficient delivery systems.' Only through competition can the health plans that do the best job of improving quality, cutting costs and satisfying patients be rewarded.

Competition occurs at the level of integrated financing and delivery plans, not at the individual provider level.

This environment will force competing prepaid group practices to innovate and improve care quality while reducing costs. As such it is far superior to single payer healthcare which has no such competition forcing innovation and cost control. For managed care / managed competition to work, perfect premium price competition among plans must be preserved. Any interference with price competition – including government practices, taxes, employer contributions, union demands or other artificial market imperfections – will modify the competition and reduce its positive effects.

Prepaid group practices originally developed through competition with the traditional fee-for-service / indemnity coverage. To survive, the flagships of the HMO movement had to outperform traditional medical practices. These original groups included Group Health Association in DC (founded in 1935), Group Health Cooperative of Puget Sound (founded in 1945) and Kaiser Permanente (founded in the 1930s) the largest of all. Kaiser is generally regarded as the prime model of a successful prepaid group practice or managed care organization.

A LOOK AT KAISER PERMANENTE: Kaiser Permanente was formed in the 1930s when industrialist Henry Kaiser contracted with physician / entrepreneur Sidney Garfield to provide healthcare to Kaiser employees. Garfield owned a small chain of health clinics. For $.05 per employee per day he offered to cover industrial medical care (workers comp), and for an additional $.05, non-industrial healthcare (major medical) for all Kaiser employees.

As this business grew, Garfield contracted with the Permanente medical group. Kaiser became Permanente's exclusive client, and Permanente, Kaiser's exclusive provider. The organization became known as Kaiser-Permanente.

KP integrated the financial and service provision functions into a single company. It owned its own hospitals to eliminate the conflict between hospitals wanting higher occupancy and carriers wanting lower. It hired physicians on salary to eliminate the potential for moral hazard excess testing and billing. KP emphasized prevention, for it had incentives to keep people healthy and out of the hospital. Remember that it received a fixed payment per subscriber from the Kaiser industrial business, today commonly called capitation. If KP could service its subscriber population for less than $.05 per employee per day, it remained financially solvent. If not, it lost money.

As KP grew, it innovated to maintain quality while reducing costs:

1. Kaiser hospitals in the 1950s reported 25% shorter stays than the US hospital average;
2. Kaiser' ratio of outpatient visits to hospital admissions was 50% higher than the US average in 1969;

3. In the 1960s, Kaiser was among the first to offer home nursing services as a substitute to expensive lengthy hospitalizations;
4. Through the 1970s and 80s, Kaiser continued to emphasize outpatient care, becoming one of the first institutions to offer freestanding surgery and emergency care facilities.[4]

In 1971, Dr. Cecil Cutting, the executive director of the Kaiser Permanente Medical Group in northern California wrote that the 'direct relationship of prepayment to providers become an incentive for the physician to develop economies in spending the medical dollar while maintaining quality'. [5] This differentiated Kaiser Permanente from the more common indemnity form of insurance.

Kaiser Permanente developed a unique institutional culture emphasizing prevention, waste reduction and a constant search for the least expensive / best treatment option.[6] Much of this came from Sidney Garfield. His waste control fanaticism became legendary: employees could only get a new pencil if they turned in a pencil stub of less than 3 inches. 'This period of stringent economy established a pattern of frugal allocation of resources that persisted even into more prosperous years' suggests Harvard Business School's Regina Herzlinger. [7]

The Kaiser culture formed in opposition to – and under attacks from – organized medicine. Garfield established his medical operations in the Mojave Desert in the early 1930s. He battled Great Depression economics and organized medicine that viewed his physicians as an economic threat. (Independent medical practitioners worried that prepayment would motivate physicians to provide fewer services than needed, thus harming both the profession's reputation and pocketbook.)

Garfield hired only true believers in his model, people interested in making the plan work. He claimed that 'if you don't have the [people] who have it in their hearts to make it work and who believe in prepaid practice, it won't work.'[8] His physicians worked 6 days per week. They formed tight social groups. 'We picked people who liked each other – we felt like we were enjoying ourselves.' Garfield worked alongside staff physicians and continually sought their input and new ideas. His clinics were dynamic worksites.

This bonding experience was one factor in the development of KPs' culture. Other factors included its business structure that integrated physicians, hospitals and insurance with each other, long term relations with patients and prepayment / capitation. This set of factors was unique to KP among health insurance companies.

In business terms, KP successfully vertically integrated the provider and financial functions for the overall good of the organization – very difficult to do. (See discussion of vertical integration and transfer prices, below.) KP's evolution and economic incentives allowed financial controllers, for example, to make decisions for the patient's long-term benefit, rather than focus on short term cost control. In part this was because KP had subscribers for life theoretically – or at least as long as they worked for the Kaiser

industrial enterprises. The subscribers' future health had a direct bearing on KP's future success. Also in part, this was because the KP management established a corporate culture that superceded specific division or functional loyalties.

Thus Kaiser Permanente had a very different economic and corporate approach to the business of patient care than did most of its competitors.

NIXON'S HMO ACT OF 1973: Richard Nixon used Kaiser Permanente as the basis of his HMO Act of 1973, because KP was the largest and most successful of the HMO models.

Nixon felt pressured to do something to control rising healthcare costs. [9] National healthcare expenditures almost tripled from $27 billion in 1960 to $73 billion in 1970, creating economic and political problems. Robert Finch, then Secretary of Health, Education and Welfare warned Congress in 1969 that 'the nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by government and the private sector'.

Politicians and special interest groups lobbied the Nixon administration to overhaul our healthcare system, though from many different points of view. The Special Committee on Aging wanted Congress to extend Medicare and Medicaid programs to the entire population. The 1969 National Governor's Conference endorsed New York Governor Nelson Rockefeller's (one of Nixon's key rivals for the Republican nomination in 1968) plan for national health insurance. Massachusetts Senator Ted Kennedy and the United Auto Workers led the prestigious Committee of 100 for National Health Insurance in drafting it's own universal healthcare plan.

Even Nixon's own assistant Secretary of Health, Education and Welfare, Lewis Butler, wrote that 'ultimately some kind of national health insurance should be enacted.' And Dr. Vernon Wilson, Nixon's chief of Health Service and Mental Health Administration at HEW said that Kennedy's plan 'was a well-conceived, comprehensive approach to solving the nation's health delivery problems.'

Nixon's problem: he had to do something, but he couldn't support a Democratic healthcare plan sponsored by one of his chief rivals, Ted Kennedy. Nor could support a Republican plan sponsored by another political rival, Nelson Rockefeller – especially a plan that potentially harmed the physicians, hospitals and insurance carriers that supported Nixon politically. He had to develop his own plan.

Dr. Paul Ellwood Jr, sometimes called the father of the HMO came to Nixon's rescue in 1970. Ellwood recommended a prepaid healthcare system that would motivate doctors and hospitals to control costs and keep patients healthy. Assistant Secretary Butler (see above) supported Ellwood's ideas because they fit with the Republican philosophy of support for free markets and competition to reduce costs. Butler also believed that these HMOs would be inexpensive to implement, optional and self regulating. Many conservative politicians and organizations agreed with the HMO idea because it was

flexible, inexpensive, encouraged private investment in profit-making organizations and imposed few mandates or regulations. Nixon's new HEW Secretary, Elliot Richardson predicted in 1970 some 450 HMOs by the end of fiscal 1973 and 1700 by end 1976.

The Republican HMO plan faced opposition from both the left and right between 1970 – 1973. Kennedy and the Left consistently fought for higher levels of guaranteed benefits, community rating, open enrollment periods and significant Federal grants and loans to help HMOs proliferate. Richardson, the AMA and the Right wanted only basic levels of guaranteed benefits, less government funding and individual underwriting. Richardson in particular, feared that community rating would put HMOs at a competitive disadvantage compared to indemnity coverage that routinely rejected people with significant medical needs.

The AMA in particular, lobbied enthusiastically against the HMO idea. Dr. Malcolm Todd, for example, chair of the Physician's Committee to Reelect the President claimed 'We used all the force we could bring to bear against this legislation. As a result, there has been some backtracking on the part of the White House, [which] directed the [HEW] Secretary to slow down this thing.'

As a result of these competing pressures and Nixon's determination to implement his own plan (i.e. not Kennedy's or Rockefeller's), the HMO Act of 1973 was not a particularly close copy of the Kaiser Permanente model. Indeed, the changes to KP's model doomed the entire effort for three main reasons:

First, under Nixon's law, HMO meant simply 'prepayment' – not vertical integration. Healthcare delivery and healthcare finance were separate functions handled by separate companies. This satisfied independent insurance carriers, physician groups and general hospitals - all parts of Nixon's political base. But the key integration feature that made Kaiser-Permanente so successful was lost in the legislation.

Why did carriers, physician groups and general hospitals dislike vertical integration? The short answer: they wanted to compete for revenues with each other.

Carriers hoped to dominate the marketplace and dictate economic terms to providers. The American Medical Association wanted its members to remain free from carrier or hospital meddling so they could protect their incomes. Hospitals wanted to determine patient lengths of stay to protect their own cash flow.

None of these groups trusted the others or the government to protect their interests.

Second, Nixon's law called for a loose physician structure, in which practitioners could opt in or out of any HMO. Again, this satisfied the insurance, physician and hospital groups. But it was the opposite of KPs tight structure in which physicians were fully integrated into both the hospital and financial system. The loose physician structure meant that providers had no particular loyalty to any specific HMO. Another key feature of KP was lost.

Third, Kaiser-Permanente used a capitated financial structure to motivate providers to control costs. Nixon's law allowed providers to bill insurance carriers on a fee-for-service basis. Absent capitation, much of the underlying financial advantage disappeared.

What were the results of Nixon's legislation? 'The HMO Act of 1973 clearly inhibited HMO development' claims Jan Coombs in *The Rise and Fall of HMOs*. Some 124 HMOs developed from 1970 – 1974, but only 40 developed from 1974 – 1978. Also, the enticement of public funding was insufficient to overcome federal legislative and regulatory requirements, so many HMOs turned to Wall Street financing and state approvals. In 1981, 88% of HMOs were nonprofit; by 1986 this had fallen to 41%.

Nixon's act legitimized HMOs and managed care, but so drastically altered the Kaiser Permanente model that insurers and providers had to develop new organizational forms. No longer did managed care equal Kaiser Permanente's closely integrated finance and service provision model. Instead three different types of managed care appeared in the marketplace.

Staff model managed care looked most like KP. Under a staff model, physicians were paid salaries by the integrated carrier/provider, which generally also owned its own hospitals. This allowed the carrier the greatest amount of cost and quality control over providers. Staff models are the most expensive to establish, take the longest time to get up and running, and offer subscribers the most limited networks of providers. They are generally the least attractive model to consumers for this reason.

Group model HMOs look like the original version of Kaiser Permanente. Here a carrier and provider group have mutually exclusive contracts. Carriers still exert cost and quality controls, through perhaps to a lesser degree. Quicker to establish than staff model HMOs, the limited network is still relatively unappealing to consumers.

Independent Practice Associations or Network Models offer the widest provider networks and the least carrier cost and quality control. The American Medical Association favored this form of managed care after Nixon's law – because it allowed AMA members the best opportunity for financial gain.

With IPAs, multiple carriers contract with any willing provider and carriers have the least amount of input and control. This managed care form also has the highest degree of consumer satisfaction as it generally offers the largest provider network and the least restrictions. Some commentators wonder if IPAs are really managed care at all, or instead simply fee-for-service / indemnity healthcare with a price list.

Post Nixon, HMOs grew because managed care premiums were lower than the alternative, indemnity coverage. As a result:

By 1980, 9 million Americans enrolled in HMOs;

By 1990, 33 million enrolled;
By 2000, 60 million enrolled.

However, the majority of subscribers entered IPA or network models:

Group and Staff Market Share [10]

Date	# of subscribers	% of all HMO subs
1980	7.4 million	81%
1990	13.1 million	39%
2002	7.5 million	10%

This raises a key question: Was the US moving toward true managed care or something else?

COST AND QUALITY CONTROLS 1970 – 2000 Nixon's managed care legislation was supposed to use market forces to control healthcare costs and improve quality, just like Kaiser Permanente's experience. Unfortunately, the legislation differed so significantly from KP's model that various government agencies had to step in and devise new cost and quality control mechanisms. These were previously unseen at KP or other managed care organizations. Many of these controls became codified in our healthcare operations and still continue today; they institutionalized a non-Kaiser Permanente type of 'managed care.'

According to Northwestern Professor David Dranove, these cost and quality control programs 'utterly failed on all accounts.'[11] Bureaucrats and administrators – not physicians and medical practitioners – took over and sabotaged the managed care reform movement. They turned it into something that Sidney Garfield would not have recognized.

Hospital Cost Control Programs

New York State had developed the first **rate setting program** in 1970. The New York legislature tried to cap Medicaid hospital payments and included private carriers in the program to avoid hospital cost shifting. This system was already in place when Nixon's HMO legislation passed. It continued since Nixon's plan allowed hospitals to bill carriers fee-for-service.

New York State was the first to try serious Medicaid cost controls since it had such a large Medicaid population. Medicaid costs are split between the federal and each state government. New York officials worried that continued Medicaid inflation might require politically unpopular tax increases. Hence their motivation to control costs.

The New York State Prospective Rate Setting System established a flat fee per patient per day. The fee was set at the beginning of each year so hospitals could budget and

plan, and was approximately equal to the average cost per patient per day the previous year with an inflation factor and regional cost variations applied.

New York officials figured that the patient population would be about the same each year – about the same number of births, broken legs, heart attacks, etc - so on average hospitals would receive the same income year after year, adjusted for inflation. This assumption proved incorrect.

Hospitals quickly learned how to game the system. Since they received the same reimbursement from Medicaid for all patients, they earned more by admitting the healthy and denying care to the sick. Hospital competition quickly switched from providing excellent service to all patients, to denying service to expensive patients. Not a good solution.

New Jersey observed the experience in New York and sought to improve on New York's model by devising its own Prospective Payment System in the late 1970s – a few years after Nixon's HMO legislation. New Jersey modified New York's calculation of average cost/patient/day by introducing some 470 Diagnosis Related Groups (DRGs). This system, designed by Yale Medical School, divided patient costs into diagnostic groups. Cancer surgery now received a higher reimbursement than a simple overnight observation. New Jersey hoped to deny hospitals the ability to game the system as hospitals had in New York.

Under the New Jersey plan, hospitals would receive appropriate payment for medical treatment, but no more; patients would receive necessary care, but no more; and medical cost inflation would be controlled, at least in theory. Again this changed the KP model: there were no DRGs in Garfield's original system because there was no fee-for-service billing. Medicare took the New Jersey system national in the mid-1980s.

How did hospitals control their costs? Many shifted to more outpatient surgeries – not necessarily a bad thing. In 1984 some 28% of all community hospital surgeries were outpatient; by 1996 that percentage had increased to 59%, mirroring KPs' experience.

Other hospitals simply focused on DRG management. Some hired DRG experts to help 'up-classify' patients to receive higher reimbursements. Others began 'dumping' expensive patients who exceeded their DRG reimbursements by transferring them to other hospitals - presumably with less sophisticated admissions procedures. Some hospitals practiced 'skimming', by admitting only potentially profitable patients. Still others engaged in 'unbundling' services, or requiring patients to make more hospital visits at higher reimbursements, often with no additional health benefits. Hospitals, in other words, figured out how to game the DRG reimbursement system just as hospitals had in New York State.

Perhaps the biggest effect of DRG imposition, though, was a change in hospital culture. Hospitals previously were generally non-profits, funded by charitable contributions and cost-plus reimbursement. They were typically run by physicians who were more

interested in providing service to the community than in maximizing revenues. They faced little financial risk. Perhaps they were more inclined to negotiate cooperative financial arrangements with carriers. As Northwestern's David Dranove says

> Until the early 1980s, the managers of nonprofit health care organizations were under little financial pressure. Market conditions enabled even badly managed hospitals to survive. Private insurers either paid whatever price the hospital charged or paid the hospital for its costs plus a predetermined profit margin…(hospitals) that provided unprofitable services or cared for the uninsured covered the expenses by charging higher prices to everyone else.[12]

Physicians had traditionally run hospitals, leaving administrators to manage bookkeeping, purchasing and other defined line functions. These physicians could, perhaps, have worked in vertically integrated operations.
But DRGs changed this. By putting hospitals at financial risk, DRGs put hospitals and carriers on a competitive collision course. If the hospital managed its DRGs better than the carrier, then it received higher reimbursements – and earned more money - at the carrier's expense. Alternately, if the carrier out-managed the hospital, it made money at the hospital's expense. No longer was collaboration even possible – competition ruled.

Hospitals addressed this competition by hiring MBAs to put them on a level playing field against carrier financial expertise. Hospitals at first hoped to continue business as normal, with the MBA folks focusing on their specific DRG and financial areas of expertise. But this model disintegrated as the business school graduates began assuming true management responsibility.

This responsibility shift opened a Pandora's box. Once hospitals began hiring sophisticated MBAs - to fight the DRG battle - and giving them true responsibility, the MBAs learned how to manage hospitals…and then began buying them.

MBAs saw three particularly attractive reasons to own hospitals. First, hospitals had good long term cash flow provided by the government and private carriers. Second, implementing sound business practices could control hospital expenses – something previously insufficiently widespread in non-profit hospitals. And third, hospitals could design sophisticated accounting and billing systems to increase profits.

So attractive were these opportunities that investor-owned systems acquired over 100 hospitals by 1975; 273 hospitals by 1980 and nearly 500 hospitals (plus 200 more under management contract) by 1985.[13] By about 2000, investor-owned hospital networks dominated the landscape, and companies such as Partners Community Health Plan in Boston and the Sutter system in California were 'unabashed about flaunting their power, publicly stating their intention to use their leverage when negotiating rates with managed care purchasers.'[14]

The DRG subtle accounting change altered the mindset of hospital administrators and investors and began our national shift to investor-owned and professionally managed hospitals. Hospitals felt they had to maintain control over their billing function. Though carriers and regulators won some DRG battles, within 25 years hospitals won the DRG war.

The loser: true managed care. Rather than developing a national system of integrated financing / treatment operations like Sidney Garfield developed for the Kaiser industrial workers, we instead became an investor-owned, private hospital based healthcare system skilled at competing with financing organizations. The unintended consequence of Nixon's legislation became a stronger, more ingrained fee-for-service reimbursement system based on hospital vs. HMO competition. This was not at all what Sidney Garfield had originally developed.

Hospital Quality Control Programs

Just as Diagnosis Related Groups were aimed at controlling hospital costs, so various measures were introduced in the 1970s to control hospital quality. These aimed primarily at ensuring that patients received appropriate, high quality hospitalization and care.

They fared no better than DRGs and none supported close cooperation between carriers and hospitals. None, in other words, supported the development of true managed care.

The first Professional Standard Review Organizations (PSROs) began in 1972. These were established by the Social Security Amendments of 1972 to 'promote the effective, efficient, and economical delivery of health care services of proper quality for which payments may be made.'[15] PSROs were local physician organizations designed to monitor the necessity, appropriateness and quality of hospital care. PSROs established standards of care for a wide range of diseases, with a goal of treatment practice uniformity – rather like guilds.

These organizations were quite ineffective. Local physicians, it turned out, were generally reluctant to judge or punish their colleagues. PSROs created dilemmas for physicians who observed questionable quality or potentially excessive treatment in others. Should they report on physicians who unnecessarily bring patients into the hospital - but increase everyone's income? Should they be team players? Or should they fight other physicians and hospital administrators and create political or professional problems for themselves?

Most physicians decided their interests – financial and professional - lay in getting along with their colleagues rather than reporting on them. Hence PSROs failed to have much impact on US medical quality.

Regulators grasped this problem and modified the PSRO concept when creating the next quality control mechanism, the Professional Review Organization (PRO) in 1983. These were private companies, initially contracted by Medicaid. PROs were designed to assure the necessity and appropriateness of Medicaid services by reviewing hospital records for evidence of upcoding, dumping or unbundling of services. PROs established elaborate guidelines and enforcement protocols, again focusing on physicians and hospitals working in a particular locale.

Unfortunately, the process of developing guidelines introduced an even bigger problem - startling variations in medical practice across seemingly similar communities.[16] A famous early study 'Are Hospital Services Rationed in New Haven or Over-Utilized in Boston' reported that rates of certain procedures including coronary artery bypass graft surgery were much higher in New Haven than Boston, but rates of other procedures such as carotid endarterectomy were higher in Boston than New Haven.[17]
Studies such as this[18] suggested the PRO focus was too narrow and that the real hospital quality problem involved treatment variations. These put patients at risk, for some were under-treated while others were over-treated.

Once our medical community realized that treatment variation was a huge healthcare systemic problem, the question arose about how to address it. The medical community decided to continue measuring and controlling treatment inputs – costs, types of procedures, second opinions, etc. (It could, alternatively, have started to measure treatment outcomes – mortality and infection rates for example. The medical community apparently decided these outcome quality measurements were inappropriate, undesirable or too difficult to quantify.)

The exclusive focus on input measurement doomed future quality control programs to failure.

The first such post-PRO program was development of Treatment Guidelines. These had a goal of standardizing medical treatments to control both quality and costs. Treatment guidelines typically provide the medical staff with detailed day-by-day instructions for testing, nursing, surgery, rehabilitation and discharge planning. Guidelines also provide a systemized method of ordering tests.

Unfortunately, contradictory treatment guidelines proliferated. By 1994 the AMA reported over 1600 sets of guidelines designed by potentially competing special interests. Hospital guidelines sometimes said 'treat' (presumably to increase hospital occupancy) while carrier guidelines said 'don't treat' (presumably to control costs). Some guidelines were developed by pharmaceuticals and recommended drug therapy; others by surgical supply manufacturers and recommended surgery. Hospital bureaucracies and physicians often resisted the imposition of guidelines, which ultimately became voluntary and only marginally effective.

Regulators next turned to Utilization Review to overcome the narrow focus of PROs and ambiguity of Treatment Guidelines.

Utilization Review is a screening procedure to determine (a) if the patient should be admitted, (b) surgical second opinions and (c) on-going review of high cost cases.

Independent 'objective' companies perform Utilization Review. These companies have developed best practice criteria. Procedurally, the hospital admissions nurse reports clinical data and a treatment plan to the UR nurse who may agree to hospitalization, recommend outpatient treatment or even refuse the treatment plan. Typically there is also an appeal procedure.

Supporters claim Utilization Review achieves two goals. First, UR companies keep their screening procedures current with the medical literature, something no physician or hospital could possibly do given the hundreds of studies published annually. Second, they claim that UR reduces inpatient costs by reducing unnecessary hospitalizations and treatment.[19]

Detractors see UR as an unwanted intrusion in the physician-patient relationship, with some physicians even lying to get around UR restrictions.[20] Other detractors claim the UR companies have a financial bias to show cost reductions in order to get their contracts renewed. Interestingly this is the opposite of hospitals' financial bias to perform treatments.

Some commentators have concluded that UR has failed to provide the desired level of cost and quality control. The Journal of the American Medical Association reported a 'Retrospective Drug Utilization Review' study in 2003 that concluded 'we were unable to identify an effect of retrospective drug utilization review on…clinical outcomes'.[21] The New England Journal of Medicine reported that a studied utilization review program 'reduced the number of diagnostic and surgical procedures performed that required second opinions…(but) otherwise the program had little effect'.[22] The Canadian Medical Association Journal published a research study 'How valid are utilization review tools in assessing appropriate use of acute care beds?' and found that some UR companies underestimate – while others overestimate – appropriate hospital admission stays.[23] The CMAJ article concluded that

Although utilization review tools are widely accepted, these considerations…raise serious questions about the value of the tools…and whether they should be used at all.

Effects of Cost and Quality Control Programs on Managed Care Development

Some carriers like Utilization Review while others do not. But that misses our point:

None, in other words, mitigate the conflict wrought by DRGs. But all became codified in US healthcare practices post-Nixon. All supported the deviation from true managed care. And all – especially when combined with DRGs - make a return to real 'managed

care' a la Kaiser-Permanente increasingly difficult. The reason: to implement true managed care now, we must first undo all the post-1973 healthcare systemic and bureaucratic evolution based largely on conflict between hospitals and carriers. No small task.

Our 1973 – 2000 experience with managed care did, however, superficially appear somewhat successful. Healthcare spending in 2000 was $300 billion less than had been forecast by the Congressional Budget Office only 7 years earlier.[24] Unfortunately these savings were primarily the result of two features, neither of which appeared in the original managed care plan design:

1. Hospital overcapacity in the 1990s (resulting from overbuilding in the 1980s plus treatment constraints in the 1990s) allowed carriers to gain significant price concessions from providers;
2. Managed care insurance companies controlled costs by service denial: denial of provider payments, denial of specialist referrals, denial of hospital admissions. 'At the peak of managed care's sway, in 1999, far more physicians were financially rewarded for productivity [i.e. number of patients seen] by insurers than for patient satisfaction' claims Harvard Business School's Regina Herzlinger. [25]

Providers hated managed care. Carriers squeezed hospital revenue. Physicians lost control of their incomes and professional independence – in both cases to administrators – largely because of DRGs and Utilization Review. Subscribers hated it for they felt at the mercy of a heartless insurance carrier that denied necessary services for the sake of profit. The popular 2002 film John Q played on these concerns – a father whose insurance company wouldn't pay for his son's medical treatments takes an Emergency Room hostage until doctors agree to operate. John Q could be any American according to the film's marketing; it grossed over $71 million in the first 2 months.

Meanwhile, the US Institute of Medicine in 2001, during the heyday of managed care, released its shattering study 'Crossing the Quality Chasm' claiming

> The US healthcare system does not provide consistent, high quality medical care to all people…between the healthcare that we now have and the healthcare that we could have lies not just a gap, but a chasm…
>
> The nation's healthcare delivery system has fallen far short in it's ability to translate knowledge into practice…

This and other observations led ***The Economist*** to claim that managed care just 'treated the symptoms' – like every other healthcare control strategy. [26]

THE MANAGED CARE PROPONENTS CALL FOUL: The US healthcare system that developed post 1973 was not the healthcare system envisioned or designed by true

managed care proponents. It strayed from their original concept and Kaiser Permanente's model, and thus failed to realize its true potential due to Nixon's political compromises and subsequent market evolution. The proponents called for a return to basics so managed care could finally replicate KP's financial and quality results nationally; they did not want to be blamed for managed care's failure.

Thus Stanford's Alain Enthoven wrote ***The History and Principles of Managed Competition*** and ***Why Managed Care Has Failed to Contain Health Costs*** both in 1993 [27] just as the Clinton administration began considering national healthcare reform…apparently hoping that this time a President would bring his ideas to life. In these back-to-basics pieces Enthoven reminded readers that Nixon had perverted his ideal, creating 'a system dominated by the cost-increasing incentive of fee-for-service payment combined with the cost-unconscious demand of insured patients' whose insurance was paid by employers and subsidized by taxpayers.

US HMOs developed provider networks, Enthoven claimed, simply by cobbling together independent physicians and paying them according to a fee schedule – in other words, IPAs. This was not the Kaiser Permanente model!

Enthoven went on to decry fee-for-service for 11 reasons:

1. Fee-for-service creates an adversarial relationship between doctors and payers;
2. Fee-for-service has little accountability – poor data collection and provider motivations for economy;
3. Fee-for-service 'free choice of provider' leaves patients to make remarkably poorly informed choices;
4. Fee-for-service generates excess hospital capacity, high tech equipment and open-heart surgeries;
5. Fee-for-service generated an excess supply of specialists;
6. Fee-for-service misallocates resources, as no incentive to use the least costly settings for treatment;
7. Fee-for-service has no capacity to plan care processes from diagnosis to treatment to rehabilitation;
8. Fee-for-service has led to a dangerous proliferation of facilities for complex and costly procedures without the volumes necessary to maintain good outcomes;
9. Fee-for-service cannot practice total quality management due to lack of service integration;
10. Fee-for-service cannot organize the rational use of technology
11. Organized systems, unlike fee-for-service, can emphasize prevention, early diagnosis and effective chronic disease management.

He further reiterated how to structure the market by a set of rules 'laid down once and for all.' These include appropriate types of plan sponsors, rules to ensure equity, rules to manage the enrollment process, rules for managing risk selection, rules for

monitoring specialty care and quality, and lots more rules to make the system work. His goal: define a system involving

> Intelligent, active collective purchasing agents contracting with healthcare plans on behalf of a large group of subscribers and continuously structuring and adjusting the market to overcome attempts to avoid price competition.

Any deviation from this ideal system reduces its effectiveness. Groups that dreamt up ways to get around the rules for their own advantage upset Enthoven. He lamented the self centered interests of many involved in healthcare: 'Whatever set of rules one proposes, critics could and did dream up ways for health plans to get around them to their advantage.'

Nixon's HMO Law of 1973 and subsequent healthcare evolution so perverted his managed care ideal that he wrote in *Why Managed Care Has Failed to Contain Health Costs* 'Some say that competition has failed. I say that competition has not yet been tried.'

He described Health Insurance Purchasing Cooperatives as the mechanism of implementing true managed care, just as Hilary Clinton was developing her healthcare plan. Enthoven's *History and Principles* seemed to serve as the intellectual basis to promote true managed care for all.

BILL AND HILARY CLINTON TAKE ON HEALTHCARE

Bill Clinton had campaigned for President on four healthcare platforms:

1. To provide healthcare coverage for all Americans;
2. To slow runaway medical care cost inflation;
3. To minimize governmental intrusion; and
4. To avoid harming most special interest groups. [28]

He delegated responsibility for the specific healthcare plan design to his wife, Hilary. She introduced her plan in mid-September 1993.

The plan itself was broad, ambitious and founded in Enthoven's theories. It would set up one or more large 'healthcare purchasing alliances' in each region. These would restructure the health insurance market by serving as the group purchaser for people not on Medicare, including small and medium sized employers. Large companies with 5000+ employees could act as their own purchaser.

These alliances would manage competition among plans and carriers, along the lines that Enthoven envisioned. They would – theoretically – offer people their choice of health plans and would provide them with competitive information about costs, services and quality. As envisioned by the authors, consumers would have a minimum of 3 plan options, varying by cost-sharing, out of network restrictions and specific services

covered (above the mandated minimums). The alliances' responsibilities would include maintaining competition among plan options so those that operated most efficiently would get rewarded in the marketplace.

The Clinton Plan would require carriers to offer a comprehensive minimum set of benefits including hospital and office care, clinical prevention services, hospice care and home health and long term care. By 2001 it would add mental health and substance abuse services.

The entire healthcare distribution operation would be run by a complex administration including a National Health Board responsible for oversight, budgets and national quality. States would also have responsibility for establishing risk-adjustment procedures, monitoring carrier fiscal stability and monitoring the quality of local care. This combined state and federal administrative effort was deemed necessary to ensure two things:

1. That our healthcare system would function well both during and after the transition to the Clinton Plan; and
2. That Enthoven's dual theories of managed care and managed competition would be made operational.

Hilary Clinton presented her 1000+ page healthcare plan in 1993. For about a year proponents and opponents discussed, debated, analyzed and considered her healthcare plan for America. Articles appeared in learned journals; interest groups spent over $100 million lobbying and campaigning for or against it. Ultimately, in 1994, Congress voted the plan down.

The interesting question from this story is 'why'. Why did the American people – and ultimately Congress – reject Hilary's plan?

Public opinion polling during this period highlighted contradictory and confusing indicators. The American public apparently liked the ideas – while disliking the Clinton plan. Understanding how this can be helps explain the fundamental problem with establishing true managed care in the US.

The Wall Street Journal reported in 1994 that 'Many Don't Realize It's the Clinton Plan They Like'. The article summarized results of a WSJ-NBC news poll asking people their reaction to a health plan that contained the same features as the Clinton plan but without revealing that it actually was the President's. Some 76% found 'some' or 'a great deal' of appeal in Clinton's plan – even while indicating in other polls their opposition to 'the Clinton Healthcare Plan'.

How can people actually like the plans' features while opposing the plan itself? According to former Harvard University President Derek Bok, there are two answers: [29]

First, Americans distrust government imposed solutions to problems;

Second, special interests (intentionally or otherwise) play on popular fears with targeted marketing campaigns.

Bok reports that polls taken during the 1993 – 1994 healthcare debate showed that 80% of the population believed healthcare costs would rise more than the Clintons claimed, including 54% who thought costs would rise 'much more'. Similarly although only 25% of Americans said that they understood what a health alliance actually was, 65% assumed that the President's plan would lead to more bureaucracy. Perhaps the Clintons marketed their plan poorly. But perhaps also, popular distrust of government made their marketing task impossible.

Plan opponents understood this popular sentiment and played on it. The over $100 million spent to lobby the public for or against healthcare reform, according to Bok, 'seemed designed less to inform than to arouse latent fears and anxieties'. He reports on an infamous Harry and Louise TV commercial paid for by the Health Insurance Association of America:

> This plan forces us to buy our insurance through those new mandatory government health alliances,' complained a prototypical wife, Louise... 'Run by tens of thousands of new bureaucrats,' added husband Harry. 'Having choices we don't like is not choice at all,' replied Louise. 'They choose, we lose,' both concluded with evident disapproval.

The University of Pennsylvania's Annenberg School of Communications found that 59% of all TV ads on healthcare reform were misleading, with most attacking rather than advocating one position or the other. Opponents said the Clinton plan was 'involuntary enthanasia' that deprived families of their choice of a doctor. Proponents claimed that 'unless the Clinton plan is passed, million of Americans will have no access to healthcare.' Fearmongering on both sides led less to education and compromise than to rejection amidst a climate of fear and mistrust.

This shows the fundamental problem with the Clinton healthcare plan – the same problem that has plagued every other government attempt to reform healthcare. Government designed, top-down solutions imposed on Americans fail due to the lack of buy-in by participants. Americans, it appears, do not want to be told what kind of healthcare to purchase.

Top-down solutions attempt to impose the values of some group – Stanford academics, Washington liberals, Texas conservatives or whomever – on the rest of Americans. It matters less that the healthcare plan is good or bad; what matters is that it is imposed. Americans need time to evolve solutions to our healthcare problems, to feel comfortable with and to embrace healthcare reform. This is not, as in the Clinton case, a 12 – 15 month process. It is a process in which Americans gain positive experiences necessary to 'buy-in'. (Remember that it took years and years for Garfield to develop the Kaiser-Permanente operation.)

Absent this buy-in, we will, apparently, reject a health plan we like (according to the Wall Street Journal polling data) simply because it is imposed on us.

In short, any attempt to implement reform healthcare need focus at least as strongly on the acceptance process as on the plan itself. At least that appears the major lesson of this story. And popular acceptance is likely a multi-year, long term process.

The Clinton Administration ultimately failed to pass its huge healthcare reform plan. American culture and politics intervened, and for the second time in 20 years an attempt to take Kaiser Permanente national failed. That political debacle led to another 15+ years of fee-for-service healthcare that deviated from the 'true' managed care model, with economic and quality results that harmed Americans.

MANAGED CARE PROPONENTS POST CLINTON REFORMS: The true believers, though, weren't finished yet. In 2002, Enthoven and Laura Tollen edited 'Toward a 21st Century Health System' which again extolled the virtues of Kaiser Permanente. In the Foreword, William Roper, Dean of the University of North Carolina School of Public Health, claimed

> Prepaid group practices have remained the health reform prescription of choice of many in the health policy community…and I proudly put myself among them.

The problem with managed care in the 1980s-1990s, says Roper, was that it was forced on people, which planted the seeds of consumer backlash. Enthoven echoes this in his Preface by stating that 'Patient satisfaction depends a great deal on whether or not the patient became an HMO member voluntarily or involuntarily.' (He apparently had learned from the Clinton's failure.) If only people would want to join prepaid group practices like Kaiser Permanente, then our healthcare system would improve. If only we could diffuse the model, then people would see its successes and want to join.

Chapter 1 of 'Toward a 21st Century…' discusses the two key barriers to diffusion of this model:

1. Lack of a group / corporate culture, and
2. Lack of financial incentives.[30]

Are these surmountable problems? Can the Kaiser Permanente model be successfully replicated? In other words, ***can managed care ever work?***

The Corporate Culture Problem: By the late 1990s, Kaiser Permanente began losing money – some $270 million in 1997 alone. This was due to its rapid growth; some 50% of top managers were new to their positions by the late 1990s, and 20% of them were new to the organization. 'The culture-imbued physicians, the hospitals managed directly by Kaiser, the seasoned insurance officials who worked with the providers to balance healthcare quality and cost, the tense interplay among the three elements of the system

– all were diminished' in this process, suggests Harvard's Herzlinger. Kaiser's membership soared, but it nearly lost its soul in the process. [31]

Remember Sidney Garfield who claimed you need true believers to make prepaid group practices work. He went on to state that 'they aren't going to work unless they get men [and women] who really believe in giving service to the people.' In our market based economy, especially with our post-1973 experiences with DRGs and the like, it's very difficult to hire seasoned, experienced managers, skilled in competition but with the right care-giving, philosophical orientation.

Absent culture, HMOs manage costs by denying claims – not nearly the same as managing health. Even Enthoven agrees that developing a corporate culture takes time, energy and effort – they are 'difficult to develop and slow to grow' [32] - and then still may not succeed. Corporate culture grows from shared experiences and difficulties. You can't recreate Kaiser's culture without its evolutionary past. Absent soul and shared evolution, you're doomed to fail.

This is apparently what happened to Kaiser Permanente during it's failed attempt to expand into North Carolina.[33] KP entered North Carolina in 1984 and exited in 1999, where is operated mainly as a Group Model HMO. It peaked at 134,000 subscribers in 1997. According to the University of North Carolina researchers who studied this expansion, corporate culture problems plagued the enterprise from the beginning:

- KP struggled to find the right balance between giving the North Carolina operation the flexibility and autonomy necessary to respond to local market conditions while maintaining the overall corporate goals and policies. In other words, KP struggled to find the right mix of national corporate culture with local medical culture;
- The original KP – North Carolina leadership was supposed to replicate the California model, not innovate. Managers referred to the 'cookbook formula' imposed from KP headquarters;
- KP – North Carolina managers found it hard enough to build the familiar group model delivery system from scratch under less than hospitable market conditions (i.e. local medical cultural norms and specific state regs) – but found that creating a network model (as demanded by local conditions) so far removed from KP's core competence was impossible;
- Managers reported that KP's flirtation with network models nearly cost the company it's soul;
- KP's expansions into Texas, Kansas City, New York and New England also failed.

The University of North Carolina researchers concluded that this failed expansion case illustrates the difficulties of replicating the vertically integrated model in new geographic markets under different market conditions.

Why Vertical Integration Fails (or the Financial Incentive Problem): In Kaiser Permanente's model the providers and financiers work together for the overall good of patients and the organization. This is vertical integration: the financial and provider functions belong to the same corporation.

Merging these functions together is extraordinarily difficult, especially absent the shared values of a meaningful corporate culture. Hospitals, physicians and financiers have fundamental conflicts:

- Hospitals want high bed occupancy to generate income; carriers want low occupancy to reduce expenses;
- Hospitals want high reimbursements per patient; carriers want low;
- Physicians want high compensation / rewards from hospitals for referrals; hospitals want to pay less
- Hospitals want to make money; carriers want to control premium rates

The financial mechanism that links the insurance function to the provider function is called a transfer price. If the transfer price is too high, then the hospital makes money but the insurance carrier loses – a big problem if the insurance managers are compensated based on profits or if the insurance carrier is publicly traded.

If the transfer price is too low, then the carrier makes money but the hospital loses – and hospital managers face the same problems as carrier managers, above.

If the transfer price is set at market, then why integrate? Remember Enthoven's 11 problems with fee-for-service pricing. At market transfer pricing, there seems little advantage to owning both the financial and delivery systems as you just recreate the problems that you integrated to solve.

Vertical integration, according to McKinsey 'is notoriously difficult to set, easy to get wrong and – when a company does get it wrong – very costly to fix.' [34] Enthoven apparently agrees, claiming that managing true prepaid group practices requires 'wise, if not visionary, leadership, which has been relatively rare in American healthcare in recent years.'[35]

The examples of good vertical integration in Prepaid Group Practices – Kaiser Premanente until the 1980s, Group Health Cooperative in Seattle, HealthPartners in Minneapolis, the Mayo Clinic in Minnesota and others – were formed in a different era. That was before hospitals consolidated, before universities trained students in healthcare administration, before American consumers became accustomed to wide provider choice, before DRGs created billing conflicts between carriers and providers and before the myriad of state and federal healthcare regulations. Senior officials at existing Prepaid Group Practices think that 'without substantial changes to the US financial and regulatory systems, it would be difficult for new PGPs to develop and for many of the current ones to expand' due largely to the difficulty of exporting the entrenched group culture.[36] In this, they are probably correct.

Indeed, the UNC researchers who studied Kaiser Permanente's foray into North Carolina suggest several elements necessary for managed care success.

Key Idea: Elements necessary for managed care success today:

1. Broad choice of health plans, so HMOs can demonstrate their value advantages (financial savings and quality improvements vs. fee-for-service plans);
2. Risk adjustment to mitigate adverse selection;
3. Employer contributions that allow employees to retain any savings resulting from an economical choice;
4. A level playing field among HMOs, insurers and self-funded plans;
5. Reliable, comparable information about plan quality and customer satisfaction.

Unfortunately for managed care, if these are the necessary preconditions, the US healthcare market is far from an appropriate environment. Let's review some of these elements:

First, broad choice of health plans. Our current national trend is for fewer carriers to offer a broader choice of plans with broader provider networks. Many employers (mainly smaller) offer only a limited plan selection, often for reasons of administrative expediency. Subscribers demand wide provider choice, perhaps as reaction to managed care excesses of the 1990s. True managed care options with limited provider access in return for (theoretically) lower premiums and better quality run counter to this national trend.

Second, risk adjustment among health plans. In Enthoven's model carriers will use advanced statistical techniques to determine the likely future health costs of a subscriber, and the managed competition system will make financial arrangements (called risk adjustments) among plans to level the risk playing field. These statistical techniques are not yet available. As Enthoven wrote, not particularly comfortingly, in 1993:

> It turns out to be much harder than one might think to turn available diagnostic information into 'risk adjusters'. For example, among patents diagnosed in one year to have breast cancer or HIV, there will be a very wide variation in medical costs the next year. **But it seems reasonable to suppose that diagnosis-based models eventually will be available** [37]

It may or may not be reasonable to make this supposition – but it is certainly a weak premise upon which to base our healthcare policy.

Third, employer contributions should allow employees to retain savings from choosing a true HMO. Unfortunately a number of factors currently mitigate against this.

Employees generally pay half or less of their premiums on a pre-tax basis. Here's a typical scenario:

Total healthcare monthly premiums = $1000
Employee contribution (33%) = $ 333 to employee
Tax deductibility (at 40% combined state and fed) = $199 net to employee

If the HMO cuts costs by 15% or $150/month versus the competition (quite an outstanding achievement), the employee likely would only see a $30 monthly after tax savings. To take advantage of this small savings, the employee may need to change primary care physician, change benefits and access a smaller provider network. Not very attractive to the employee.

But it creates a huge burden for the managed care organization. Since the employee only pays, effectively, about 20% of the premium after tax, the carrier must generate outstandingly good results to get employees to enroll.

Would the employer allow the employee to keep all the savings as managed care proponents desire? Unclear. Many employers want to reduce their own health insurance burden. One rational response by employers: fix the employee contribution at $199/month, regardless of plan. Then let employees choose among a true managed care option or fee-for-service coverage. The employer would keep any savings generated by the managed care organization.

In sum, our business environment is currently not structured as the managed care proponents require.

Fourth, we need reliable, comparable information about plan quality. This is often called transparency and requires both price and outcome data.

Unfortunately, our healthcare system is extremely poor at collecting and disseminating comprehensible outcome data. We don't, currently, know which providers have the best results, which hospitals have the lowest infection rates or which PCPs have the best diagnostic capabilities. Our healthcare system is evolving in this direction, but we're far from there today.

Thus, the pre-conditions outlined by the UNC researchers do not exist in our healthcare system. They agree by noting two real trends in US health insurance:

- More broad network insurance products divorced from provider systems;
- Policies that emphasize copayments and deductibles at time of purchase rather than cost-conscious choice at time of insurance policy purchase.

Their conclusion: true managed care has structural features – narrow networks and lower premiums – at variance with common employer policies and national trends.

CAN MANAGED CARE WORK IN THE US TODAY? The answer: No, managed care cannot work in the US today. Even supporters see this, as Northwestern's David Dranove wrote in 2002: 'my optimistic view of managed care's potential has wavered. I accept the possibility that managed care will never fulfill its promise.'[37]

We had two major attempts to develop the Kaiser Permanente model as our national healthcare. Nixon and Clinton – both brilliant politicians - failed. If neither of them could do it, then we wonder who could? It's time to move on.

Each attempt to replicate Kaiser Permanente – in North Carolina, for example – led either to failure or to such major changes in the model as to make it unrecognizable.

Furthermore, each political attempt to implement Enthoven's ideas nationally – by Nixon and Clinton – proved disastrous. Special interests force political compromises that drastically alter the ideal model. After 40 years of trying we have clear evidence that our society simply cannot implement true managed care.

Managed care's time has passed. It's now time to move on to other, more fruitful, healthcare reform options.

Review Questions
Answers on next page

1. What is the classic definition of managed care?
    a. Large multispecialty group practices that provide a comprehensive set of healthcare services at a per capita price set in advance
    b. An HMO plan that requires referrals from a primary care provider
    c. A PPO plan that does not require referrals to see a specialist

2. How does managed care differ from indemnity insurance?
    a. Managed care differs from indemnity or fee-for-service health insurance, especially in terms of prevention, cost controls and outcome measurements.
    b. Managed care is far more efficient than indemnity insurance
    c. Indemnity insurance allows more access to specialists than managed care

3. How does managed care differ from single payer healthcare?
    a. Managed care uses competition (i.e. managed competition) to keep prices low and quality high while single payer healthcare generally does not embrace competition.
    b. Managed care is generally less expensive than single payer
    c. Single payer is generally less expensive than managed care

4. How does managed care differ from consumer driven healthcare?
    a. CDHC proponents believe that consumers can make their own healthcare choices. Managed care proponents disagree; they think healthcare is fundamentally unlike other consumer products. They think consumers need help navigating among diagnoses and specialists so require Primary Care Providers to act as advisors and gatekeepers.
    b. Managed care is less expensive than CDHC
    c. CDHC generally has higher deductibles than managed care

5. What is the classic example of a managed care organization?
    a. Massachusetts General Hospital
    b. Blue Cross and Blue Shield
    c. Kaiser Permanente

6. How did Nixon change the Kaiser Permanente model in his HMO Law of 1973?
    a. He did not require vertical integration between finance and service delivery
    b. He required vertical integration between finance and service delivery
    c. He restricted the number of HMOs that any given physician could join

Answers to review questions
Correct answers in bold

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   a. CDHC proponents believe that consumers can make their own healthcare choices. Managed care proponents disagree; they think healthcare is fundamentally unlike other consumer products. They think consumers need help navigating among diagnoses and specialists so require Primary Care Providers to act as advisors and gatekeepers.
   b. Managed care is less expensive than CDHC
   c. CDHC generally has higher deductibles than managed care

5. What is the classic example of a managed care organization?
   a. Massachusetts General Hospital
   b. Blue Cross and Blue Shield
   c. Kaiser Permanente

6. How did Nixon change the Kaiser Permanente model in his HMO Law of 1973?
   a. He did not require vertical integration between finance and service delivery
   b. He required vertical integration between finance and service delivery
   c. He restricted the number of HMOs that any given physician could join

Public Health Insurance

Medicare became law on July 30, 1965, when President Lyndon B. Johnson signed the Social Security Amendments of 1965 into law. The legislation created both the Medicare and Medicaid programs as amendments to the Social Security Act.[78]

Medicare was established to provide health insurance coverage for Americans aged 65 and older, as well as certain younger individuals with disabilities. It was designed to address the growing healthcare needs of older adults and provide them with access to affordable healthcare services. Prior to the establishment of Medicare, many older Americans struggled to afford medical care, leading to significant financial burdens and barriers to accessing necessary healthcare services.

The creation of Medicare was a significant milestone in U.S. healthcare history, marking the federal government's commitment to ensuring access to healthcare for older adults and individuals with disabilities. Since its inception, Medicare has undergone several expansions and reforms to improve coverage and access to care for its beneficiaries, making it one of the most important and widely used healthcare programs in the United States.

Medicare consists of 4 main parts:

1. **Part A (Hospital Insurance)**:
    - Covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care services.
    - Most people do not pay a premium for Part A if they or their spouse paid Medicare taxes while working.
2. **Part B (Medical Insurance)**:
    - Covers outpatient care, doctor visits, preventive services, and some medical equipment and supplies.
    - Requires a monthly premium, which can vary depending on income.
3. **Part C (Medicare Advantage)**:
    - Private insurance plans approved by Medicare that provide all Part A and Part B benefits.
    - Often includes additional benefits such as vision, dental, and prescription drug coverage.
    - Plans may have different costs and coverage rules.

[78] Much of this section comes from ChatGPT, written in April 2024.

4. **Part D (Prescription Drug Coverage)**:
    - Helps cover the cost of prescription drugs.
    - Offered by private insurance companies approved by Medicare.
    - Monthly premiums, deductibles, and copayments or coinsurance apply.
5. **Medigap (Medicare Supplement Insurance)**:
    - Sold by private insurance companies to fill "gaps" in Original Medicare coverage, such as copayments, coinsurance, and deductibles.
    - Helps pay for expenses not covered by Original Medicare.
6. **Other Coverage Options**:
    - Some people may qualify for other Medicare programs, such as Medicare Savings Programs or programs for people with specific health conditions.

Overall, Medicare provides essential healthcare coverage for millions of Americans, though it's crucial for individuals to understand the different parts and options available to choose the coverage that best suits their needs.

The Four Components Medicare

Medicare Part A, often referred to as Hospital Insurance, covers a range of inpatient hospital services and certain types of post-hospital care. Here's a more detailed breakdown of what Medicare Part A covers:

1. **Inpatient Hospital Care**:
    - Part A covers semi-private rooms, meals, general nursing, and other hospital services and supplies when you're formally admitted as an inpatient by a doctor.
    - It includes care received in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals.
2. **Skilled Nursing Facility (SNF) Care**:
    - Part A covers a stay in a skilled nursing facility (SNF) if it's medically necessary following a hospital stay of at least three days.
    - SNF care includes services such as skilled nursing care, rehabilitation services, and other related health services.
3. **Hospice Care**:
    - Part A covers hospice care for individuals with a terminal illness whose life expectancy is six months or less.

- Hospice care includes services like pain relief, symptom management, and emotional and spiritual support for both the individual and their family.

4. **Home Health Care**:
    - Part A covers certain home health services if you're homebound and require skilled nursing care, physical therapy, speech-language pathology services, or continued occupational therapy.
5. **Blood**:
    - Part A covers the cost of the first three pints of blood you receive in a calendar year, or the blood you get as a hospital inpatient during a stay, after you've paid a deductible.

It's important to note that while Medicare Part A covers a significant portion of inpatient hospital services and related care, it doesn't cover everything. For example, it typically doesn't cover private-duty nursing, a private room (unless medically necessary), or personal care items like toothpaste or razors.

Most people don't have to pay a premium for Medicare Part A if they or their spouse paid Medicare taxes while working. However, there are deductibles, coinsurance, and copayments associated with Part A services. It's essential to understand these costs and coverage limitations to make informed decisions about your healthcare needs.

Inpatient hospital care covered by Medicare Part A includes a range of services and supplies necessary for treating acute medical conditions and providing necessary care during a hospital stay. Here are some services that are typically included:

1. **Room and Board**:
    - Coverage for semi-private rooms (unless medically necessary for a private room), meals, and general nursing care.
2. **Nursing Care**:
    - Skilled nursing services provided by registered nurses (RNs) or licensed practical nurses (LPNs) for the management and monitoring of medical conditions.
3. **Medical Services and Supplies**:
    - Physician services, including consultations, exams, and medical procedures performed during the hospital stay.
    - Necessary medical supplies and equipment used during the hospitalization, such as IVs, oxygen, and other medical devices.
4. **Diagnostic Tests and Procedures**:

- Coverage for diagnostic tests, laboratory work, and medical imaging procedures necessary for diagnosing and treating the patient's medical condition.

5. **Surgical Services**:
    - Coverage for medically necessary surgeries performed during the hospital stay, including pre-operative and post-operative care.
6. **Hospital Services**:
    - Coverage for hospital services such as operating rooms, recovery rooms, and emergency room services used during the hospital stay.
7. **Medications**:
    - Coverage for medications administered during the hospitalization, including those administered intravenously or through other means.
8. **Therapies**:
    - Coverage for therapies provided during the hospital stay, such as physical therapy, occupational therapy, and speech-language pathology services.

Services typically excluded from Medicare Part A coverage for inpatient hospital care include:

1. **Personal Comfort Items**:
    - Personal comfort items such as telephone or television services, unless provided as part of the hospital's standard care.
2. **Private Duty Nursing**:
    - Nursing services provided by individuals not employed or contracted by the hospital, unless specifically authorized by Medicare under certain circumstances.
3. **Private Room Charges**:
    - Charges associated with a private room unless medically necessary as determined by the attending physician.
4. **Certain Medical Procedures and Treatments**:
    - Some elective procedures or treatments not deemed medically necessary by Medicare may not be covered.

Medicare Part A covers skilled nursing facility (SNF) care under certain circumstances. A Medicare beneficiary can stay in a skilled nursing facility as long as they meet specific criteria and as long as the care remains medically necessary. Here are the key points regarding Medicare coverage for skilled nursing facility stays:

1. **Qualifying Hospital Stay**:
    - The beneficiary must have a qualifying hospital stay of at least three consecutive days as an inpatient. Observation days do not count toward this requirement.
2. **Medically Necessary Care**:
    - The skilled nursing care must be medically necessary and related to the condition for which the beneficiary was hospitalized.
3. **Skilled Care Requirement**:
    - The care provided in the skilled nursing facility must require skilled nursing or rehabilitation services on a daily basis. This includes services such as physical therapy, occupational therapy, or skilled nursing care.
4. **Coverage Period**:
    - Medicare Part A covers up to 100 days of skilled nursing facility care per benefit period.
    - The first 20 days are covered in full by Medicare.
    - For days 21 through 100, the beneficiary is responsible for a daily coinsurance amount.
5. **Benefit Period**:
    - A benefit period begins the day the beneficiary is admitted to a hospital or skilled nursing facility as an inpatient and ends when they haven't received any inpatient hospital care or skilled nursing care in a skilled nursing facility for 60 consecutive days.
    - If the beneficiary needs skilled nursing care again after the benefit period ends, a new benefit period begins, and they may qualify for another 100 days of coverage.

While Medicare covers skilled nursing facility care for a limited period, it does not cover long-term care services or custodial care (assistance with activities of daily living like bathing, dressing, and eating) in a skilled nursing facility. After Medicare coverage ends, beneficiaries may need to explore other options for long-term care, such as Medicaid or private long-term care insurance, if they require ongoing assistance.

Medicare makes a distinction between skilled nursing care and long-term care based on the level of care required and the specific services provided. Understanding this difference is crucial for Medicare beneficiaries to determine their coverage eligibility. Here's how Medicare distinguishes between skilled nursing care and long-term care:

1. **Skilled Nursing Care**:
    - Skilled nursing care refers to services provided by licensed healthcare professionals, such as registered nurses (RNs) or licensed practical nurses (LPNs), that are necessary for the treatment and management of a medical condition.
    - Skilled nursing care involves services that require the expertise of trained medical professionals and cannot be safely performed by individuals without medical training.
    - Examples of skilled nursing care include wound care, intravenous medication administration, physical therapy, and rehabilitation services following surgery or illness.
2. **Rehabilitation Services**:
    - Medicare covers skilled nursing facility care when it is primarily for skilled nursing or rehabilitation services on a daily basis. This includes services such as physical therapy, occupational therapy, or speech-language pathology services that are needed to improve the beneficiary's condition or help them regain function.
3. **Time-Limited Care**:
    - Skilled nursing care provided under Medicare is typically time-limited and intended to help the beneficiary recover from an acute illness, injury, or surgical procedure.
    - Medicare Part A covers up to 100 days of skilled nursing facility care per benefit period, with the understanding that the care is expected to result in improvement or stabilization of the beneficiary's condition.
4. **Long-Term Care**:
    - Long-term care refers to assistance with activities of daily living (ADLs) and other support services that are needed on an ongoing basis due to chronic illness, disability, or advanced age.
    - Long-term care includes services such as assistance with bathing, dressing, eating, toileting, and mobility, as well as supervision and assistance with medications.

- Medicare does not generally cover long-term care services, as they are considered custodial care and not primarily skilled nursing or rehabilitative services.

Medicare Part B, also known as Medical Insurance, covers a wide range of outpatient services, preventive care, and medically necessary services that are not covered by Medicare Part A. Here's an overview of what Medicare Part B covers:

1. **Doctor Visits and Services**:
    - Coverage for visits to doctors, including primary care physicians, specialists, and other healthcare providers.
    - Services provided during doctor visits, such as physical exams, consultations, and evaluations.
2. **Outpatient Care**:
    - Coverage for outpatient medical services and procedures received outside of a hospital setting.
    - This includes services such as lab tests, X-rays, diagnostic imaging, and outpatient surgeries.
3. **Preventive Care**:
    - Coverage for preventive services to help prevent illness or detect health problems early when they are most treatable.
    - Examples include flu shots, vaccines, screenings for various conditions (e.g., cancer screenings, mammograms, colonoscopies), and counseling services.
4. **Durable Medical Equipment (DME)**:
    - Coverage for durable medical equipment prescribed by a doctor for use at home.
    - Examples include wheelchairs, walkers, oxygen equipment, and hospital beds.
5. **Ambulance Services**:
    - Coverage for emergency and non-emergency ambulance transportation to a hospital or other medical facility when medically necessary.
6. **Outpatient Mental Health Services**:
    - Coverage for outpatient mental health services, including individual and group therapy sessions, counseling, and psychiatric evaluations.

7. **Outpatient Rehabilitation Services**:
    - Coverage for outpatient therapy services, including physical therapy, occupational therapy, and speech-language pathology services.
8. **Some Prescription Drugs**:
    - Limited coverage for certain outpatient prescription drugs that cannot be self-administered and are typically administered by a healthcare provider.
9. **Some Preventive Medications**:
    - Coverage for certain preventive medications, such as certain vaccines (e.g., flu shots) and injectable osteoporosis drugs.
10. **Clinical Research Studies**:
    - Coverage for certain costs associated with participating in approved clinical research studies.

While Medicare Part B covers many services, beneficiaries are generally responsible for paying a monthly premium, an annual deductible, and coinsurance or copayments for covered services. Additionally, not all services are covered at 100%, so beneficiaries may have out-of-pocket costs associated with their care.

> What are some physician or outpatient services that typically are not covered by Medicare?

While Medicare Part B covers a wide range of physician and outpatient services, there are certain services and expenses that are typically not covered by Medicare. These may include:

1. **Routine Dental Care**: Medicare does not cover most routine dental care, including cleanings, fillings, extractions, dentures, and dental plates.
2. **Routine Vision Care**: Medicare does not cover routine eye exams for eyeglasses or contact lenses. However, it does cover some vision-related services if they are deemed medically necessary, such as exams for diabetic retinopathy or glaucoma.
3. **Routine Hearing Care**: Medicare does not cover routine hearing exams or hearing aids. However, it may cover diagnostic hearing and balance exams if they are ordered by a doctor for the evaluation of a suspected medical condition.
4. **Cosmetic Procedures**: Medicare does not cover cosmetic procedures or surgeries performed solely for cosmetic purposes. This includes procedures such as cosmetic surgery, Botox injections for wrinkles, and hair transplants.

5. **Acupuncture**: While acupuncture may be considered an alternative therapy for certain medical conditions, Medicare typically does not cover acupuncture treatments.
6. **Long-Term Care**: Medicare does not cover custodial or long-term care services, such as assistance with activities of daily living (e.g., bathing, dressing, eating) provided in a nursing home or at home.
7. **Over-the-Counter Medications**: Medicare does not cover most over-the-counter medications, vitamins, or supplements, even if they are recommended by a doctor.
8. **Alternative Medicine**: Medicare generally does not cover alternative or complementary medicine services, such as chiropractic care, massage therapy, or herbal supplements.
9. **Medical Services Outside the United States**: Except in certain limited circumstances, Medicare does not cover medical services received outside of the United States.
10. **Experimental or Investigational Procedures**: Medicare typically does not cover services or treatments that are considered experimental or investigational and not proven to be effective.

How can a Medicare beneficiary get access to these services? Specifically, how can a beneficiary get financial coverage for these?

Medicare beneficiaries seeking coverage for services that are not covered by traditional Medicare Part A and Part B have a few options to explore alternative coverage or financial assistance:

1. **Medicare Advantage (Part C) Plans**:
    - Medicare Advantage plans are offered by private insurance companies approved by Medicare. These plans provide all of the benefits covered by Medicare Part A and Part B and often include additional benefits beyond what Original Medicare covers.
    - Many Medicare Advantage plans offer coverage for services such as routine dental care, vision care, and hearing care that are not covered by Original Medicare.
    - Some Medicare Advantage plans also offer coverage for services like acupuncture, chiropractic care, and fitness programs that are not covered by traditional Medicare.
    - Beneficiaries should review the specific benefits and costs associated with each Medicare Advantage plan to determine if it meets their needs.

2. **Medicare Supplement Insurance (Medigap)**:
    - Medigap plans are supplemental insurance policies sold by private insurance companies to help fill the "gaps" in Original Medicare coverage, such as copayments, coinsurance, and deductibles.
    - While Medigap plans do not typically cover services that are not covered by Medicare, they can help beneficiaries pay for out-of-pocket costs associated with covered services.
    - Some Medigap plans may offer additional benefits beyond what Original Medicare covers, such as coverage for foreign travel emergencies.
3. **Other Insurance Coverage**:
    - Some beneficiaries may have access to other insurance coverage through employer-sponsored plans, retiree health plans, or union plans that offer coverage for services not covered by Medicare.
    - Veterans may be eligible for coverage through the Department of Veterans Affairs (VA) for certain healthcare services not covered by Medicare.
4. **State and Local Assistance Programs**:
    - Some states offer assistance programs that provide coverage or financial assistance for services not covered by Medicare, such as prescription drugs, dental care, and vision care.
    - Beneficiaries can contact their State Health Insurance Assistance Program (SHIP) or State Medicaid office to inquire about available assistance programs in their area.
5. **Out-of-Pocket Payment**:
    - In some cases, beneficiaries may need to pay out-of-pocket for services that are not covered by Medicare or other insurance plans.
    - Beneficiaries can explore payment options with healthcare providers, such as setting up payment plans or negotiating discounted rates for services.

Medicare Part C, also known as Medicare Advantage, is an alternative way for Medicare beneficiaries to receive their Medicare benefits through private insurance plans approved by Medicare. Unlike traditional Medicare (Parts A and B), which is administered by the federal government, Medicare Advantage plans are offered by private insurance companies that contract with Medicare to provide all of the beneficiary's Part A and Part B benefits.

Here are some key features of Medicare Part C or Medicare Advantage:

1. **All-in-One Coverage**:

- Medicare Advantage plans provide all of the benefits covered by Medicare Part A (Hospital Insurance) and Part B (Medical Insurance), and often include additional benefits beyond what Original Medicare covers.
- These additional benefits may include coverage for prescription drugs (Part D), routine dental care, vision care, hearing aids, and wellness programs.

2. **Variety of Plan Options**:
    - Medicare Advantage plans come in various types, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service (PFFS) plans, Special Needs Plans (SNPs), and Medicare Medical Savings Account (MSA) plans.
    - Each plan type has different rules and restrictions regarding network providers, out-of-pocket costs, and coverage limitations.
3. **Managed Care Approach**:
    - Many Medicare Advantage plans use a managed care approach to healthcare delivery, which may involve network restrictions and requirements for referrals to see specialists.
    - HMOs typically require beneficiaries to use network providers and obtain referrals from a primary care physician to see specialists.
    - PPOs offer more flexibility in provider choice but may have higher out-of-pocket costs for services received out of network.
4. **Annual Enrollment Period**:
    - Beneficiaries can enroll in or switch Medicare Advantage plans during the annual Medicare Open Enrollment Period, which runs from October 15 to December 7 each year.
    - Some beneficiaries may also be eligible for special enrollment periods based on certain qualifying events, such as moving to a new area or losing other coverage.
5. **Premiums and Cost-Sharing**:
    - Medicare Advantage plans may have premiums in addition to the standard Medicare Part B premium, although some plans offer $0 premium options.
    - Beneficiaries are still responsible for paying their Medicare Part B premium, as well as any copayments, coinsurance, and deductibles associated with their Medicare Advantage plan.
6. **Coverage Limitations**:

- While Medicare Advantage plans must provide at least the same level of coverage as Original Medicare, they may have different rules, restrictions, and coverage limitations.
- Beneficiaries should carefully review the benefits and costs of each Medicare Advantage plan to ensure it meets their healthcare needs and budget.

Medicare Part C has become increasingly popular among Medicare beneficiaries for several reasons:

1. **All-in-One Coverage**:
    - Medicare Advantage plans often provide comprehensive coverage that includes all the benefits of Original Medicare (Parts A and B), along with additional benefits such as prescription drug coverage (Part D), dental, vision, and hearing benefits, wellness programs, and sometimes even gym memberships.
    - This all-in-one coverage simplifies healthcare management for beneficiaries by consolidating their coverage into a single plan.
2. **Cost Savings**:
    - Medicare Advantage plans may offer lower out-of-pocket costs compared to Original Medicare, including lower deductibles, copayments, and coinsurance.
    - Many Medicare Advantage plans have annual out-of-pocket maximums, providing financial protection for beneficiaries in case of significant medical expenses.
    - Some Medicare Advantage plans offer $0 monthly premiums, providing an affordable option for beneficiaries on a fixed income.
3. **Additional Benefits**:
    - Medicare Advantage plans often offer additional benefits beyond what Original Medicare covers, such as vision, dental, and hearing benefits, which can be particularly appealing to beneficiaries who need these services.
    - Many plans also offer wellness programs, preventive care services, and access to telehealth services, which can help beneficiaries stay healthy and manage chronic conditions more effectively.
4. **Provider Networks**:

- While some Medicare Advantage plans have restrictive provider networks, others offer broader networks or even out-of-network coverage in certain circumstances, providing beneficiaries with flexibility in choosing their healthcare providers.
- Beneficiaries who prefer having a primary care physician to coordinate their care may find the managed care approach of Medicare Advantage appealing.

5. **Value-Added Services**:
    - Some Medicare Advantage plans offer value-added services such as care coordination, disease management programs, transportation assistance, and home health services, which can improve the overall quality of care for beneficiaries.
6. **Annual Enrollment Period**:
    - The annual Medicare Open Enrollment Period provides beneficiaries with an opportunity to review and change their Medicare coverage each year, including switching to a Medicare Advantage plan if it better meets their needs.
7. **Market Competition**:
    - Medicare Advantage plans are offered by private insurance companies competing for beneficiaries' business, leading to innovation, improved benefits, and enhanced customer service.
    - The availability of a wide range of plan options allows beneficiaries to choose a plan that best suits their individual healthcare needs and preferences.

Still, some 35% of Medicare beneficiaries remain in traditional Medicare for several reasons.

1. **Freedom of Provider Choice**:
    - Original Medicare allows beneficiaries to see any healthcare provider who accepts Medicare, without the need for referrals or obtaining permission from a primary care physician.
    - Some beneficiaries prefer the flexibility of choosing their healthcare providers, including specialists and hospitals, without restrictions imposed by network limitations.
2. **Predictable Coverage**:

- Original Medicare provides standardized coverage, making it easier for beneficiaries to understand their benefits and costs.
- While copayments, coinsurance, and deductibles still apply, beneficiaries may appreciate the transparency and predictability of costs associated with Original Medicare.

3. **Consistency of Coverage**:
    - Original Medicare coverage remains consistent regardless of where beneficiaries live or travel within the United States.
    - Beneficiaries who frequently travel or live in multiple states may find Original Medicare more convenient than Medicare Advantage plans, which may have limited provider networks or coverage areas.
4. **Access to Specialists**:
    - Some beneficiaries with complex medical conditions or specialized healthcare needs may prefer Original Medicare because it allows them to see specialists without requiring referrals or network restrictions.
    - Original Medicare generally offers more flexibility in accessing specialized care, which can be important for individuals with chronic or serious health conditions.
5. **Supplemental Coverage Options**:
    - Beneficiaries who choose Original Medicare can supplement their coverage with a Medicare Supplement Insurance (Medigap) policy to help cover out-of-pocket costs, such as deductibles, copayments, and coinsurance.
    - Medigap plans offer standardized benefits across different insurance companies, providing beneficiaries with additional financial protection and peace of mind.
6. **Preference for Fee-for-Service Model**:
    - Some beneficiaries prefer the fee-for-service model of Original Medicare, where healthcare providers are paid for each service rendered, rather than the managed care approach of Medicare Advantage plans.
    - Fee-for-service Medicare allows beneficiaries to have more control over their healthcare decisions and treatment options.
7. **Concerns About Plan Stability**:

- Medicare Advantage plans may change their benefits, provider networks, premiums, and formularies annually, which can be a concern for beneficiaries who prefer the stability and consistency of Original Medicare.

8. **Lack of Availability**:
    - In some areas, particularly rural or underserved areas, there may be limited availability of Medicare Advantage plans, making Original Medicare the only viable option for beneficiaries.

Some beneficiaries may prefer the flexibility, consistency, and freedom of choice provided by Original Medicare. The decision to remain in traditional Medicare versus enrolling in Medicare Advantage is highly individual and depends on each beneficiary's healthcare needs, preferences, and priorities.

Medicare Part D is the prescription drug coverage component of Medicare. It was introduced as part of the Medicare Modernization Act of 2003 and became effective in 2006. Part D is designed to help Medicare beneficiaries afford the costs of prescription drugs, whether they are taken at home or administered in a clinical setting. Here are the key features of Medicare Part D:

1. **Coverage through Private Insurance Plans**:
    - Medicare Part D is provided through private insurance plans approved by Medicare. These plans are offered by insurance companies and other private companies that contract with Medicare.
    - Beneficiaries can choose from a variety of Part D plans available in their area, each offering a different list of covered drugs (formulary), premiums, deductibles, and copayments or coinsurance.
2. **Prescription Drug Formulary**:
    - Each Medicare Part D plan maintains a formulary, which is a list of covered prescription drugs. Formularies vary between plans and can change from year to year.
    - Part D plans are required to cover at least two drugs in each therapeutic category and class, ensuring beneficiaries have access to a range of treatment options.
3. **Annual Enrollment Period**:
    - Beneficiaries can enroll in or make changes to their Medicare Part D coverage during the annual Medicare Open Enrollment Period, which runs from October 15 to December 7 each year.

- Outside of this period, beneficiaries may be eligible for a Special Enrollment Period if they experience certain qualifying events, such as losing other prescription drug coverage.

4. **Premiums and Cost-Sharing**:
    - Beneficiaries typically pay a monthly premium for Medicare Part D coverage, in addition to any premiums they pay for Medicare Part A (if applicable) and Part B.
    - Part D plans also have an annual deductible, which beneficiaries must pay out-of-pocket before their plan begins to cover prescription drug costs.
    - After meeting the deductible, beneficiaries typically pay a copayment or coinsurance for each prescription filled, and the plan covers the remaining cost.
5. **Coverage Gap (Donut Hole)**:
    - Until recently, Medicare Part D included a coverage gap, often referred to as the "donut hole," where beneficiaries had to pay a larger share of their prescription drug costs.
    - However, due to changes in the Affordable Care Act, the coverage gap has been gradually closing. As of 2021, beneficiaries only pay 25% of the cost of their brand-name drugs and 25% of the cost of generic drugs while in the coverage gap.
    - The coverage gap will be fully phased out by 2024, at which point beneficiaries will pay no more than 25% of the cost of their drugs, both generic and brand-name, until they reach catastrophic coverage.
6. **Catastrophic Coverage**:
    - Once a beneficiary's out-of-pocket spending on prescription drugs reaches a certain threshold, they qualify for catastrophic coverage. At this point, they pay a reduced copayment or coinsurance for covered drugs for the remainder of the year.

Medicare Part D provides essential prescription drug coverage for millions of Medicare beneficiaries, helping them afford the medications they need to manage chronic conditions, prevent illness, and improve their overall health and well-being.

The George W. Bush administration proposed and championed Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) as part of the Medicare Modernization Act of 2003. There were several reasons behind the decision to propose these additions to Medicare:

1. **Addressing Rising Prescription Drug Costs**:

- One of the primary motivations for introducing Medicare Part D was to address the rising costs of prescription drugs for Medicare beneficiaries.
- Prescription drug coverage was seen as a critical component of comprehensive healthcare coverage, particularly as prescription drug costs were becoming increasingly burdensome for seniors and individuals with disabilities.

2. **Expanding Medicare Coverage Options**:
    - Medicare Part C (Medicare Advantage) was introduced to provide beneficiaries with more choices and flexibility in how they receive their Medicare benefits.
    - Medicare Advantage plans, offered by private insurance companies, were intended to offer additional benefits and services beyond what Original Medicare covers, such as prescription drug coverage, dental, vision, and wellness programs.
3. **Promoting Competition and Market-Based Solutions**:
    - The Bush administration favored market-based solutions and competition to improve efficiency and drive down costs in healthcare.
    - By introducing Medicare Advantage and Part D, the administration aimed to encourage competition among private insurance plans, leading to innovation, improved benefits, and better value for beneficiaries.
4. **Political and Legislative Priorities**:
    - The proposal for Medicare Part D and Medicare Advantage was part of the broader legislative agenda of the Bush administration, which sought to enact significant reforms in healthcare and social policy.
    - Medicare Part D and Medicare Advantage were ultimately included in the Medicare Modernization Act of 2003, which was passed by Congress and signed into law by President Bush in December 2003.

Overall, the introduction of Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) was driven by a combination of factors, including the need to address rising prescription drug costs, expand coverage options for beneficiaries, promote market competition, and advance the administration's legislative priorities in healthcare reform.

Medicare is generally quite popular among its beneficiaries. Surveys and polls consistently show high levels of satisfaction with Medicare among older adults and individuals with disabilities who are enrolled in the program. According to data from the

Centers for Medicare & Medicaid Services (CMS), the vast majority of Medicare beneficiaries express satisfaction with their coverage and access to care.

Here are some key factors contributing to the popularity of Medicare among beneficiaries:

1. **Comprehensive Coverage**:
    - Medicare provides comprehensive healthcare coverage, including hospital insurance (Part A), medical insurance (Part B), and prescription drug coverage (Part D), as well as options for supplemental coverage through Medicare Advantage (Part C) and Medigap plans.
    - The breadth of coverage offered by Medicare helps ensure that beneficiaries have access to essential healthcare services without facing significant financial barriers.
2. **Provider Choice**:
    - Medicare beneficiaries have the freedom to choose their healthcare providers, including doctors, specialists, hospitals, and other healthcare facilities.
    - The ability to see the providers of their choice without needing referrals or obtaining permission from a primary care physician is highly valued by many beneficiaries.
3. **Affordability**:
    - While beneficiaries may still have out-of-pocket costs such as premiums, deductibles, and coinsurance, Medicare generally offers more affordable coverage options compared to private insurance plans, particularly for older adults and individuals with pre-existing health conditions.
4. **Stability and Reliability**:
    - Medicare is a longstanding and well-established program with a strong track record of providing healthcare coverage to millions of Americans.
    - The stability and reliability of Medicare contribute to its popularity and trustworthiness among beneficiaries.

Comparatively, private insurance plans vary widely in popularity among subscribers, depending on factors such as plan features, network coverage, cost, and individual preferences. While some individuals may prefer the flexibility and additional benefits offered by private insurance plans, others may find that Medicare provides more comprehensive coverage and greater peace of mind, particularly as they age and their healthcare needs become more complex.

How Medicare is Funded

Medicare is funded through a combination of general revenue contributions, payroll taxes, beneficiary premiums, and other sources. Here's an overview of how Medicare is funded:

1. **Payroll Taxes**:
    - The largest source of funding for Medicare comes from payroll taxes paid by employees and employers under the Federal Insurance Contributions Act (FICA).
    - The Medicare payroll tax is composed of two parts: the Hospital Insurance (HI) tax and the Supplementary Medical Insurance (SMI) tax.
    - The HI tax funds Medicare Part A (Hospital Insurance), while the SMI tax funds Medicare Part B (Medical Insurance) and Medicare Part D (Prescription Drug Coverage).
2. **General Revenue Contributions**:
    - Medicare Part A (Hospital Insurance) is primarily funded through payroll taxes, but it also receives contributions from general revenues to cover any shortfalls in funding.
    - General revenue contributions help ensure that Medicare Part A remains adequately funded to cover the costs of hospital and inpatient care for beneficiaries.
3. **Beneficiary Premiums**:
    - Medicare beneficiaries also contribute to the funding of Medicare through premiums for certain parts of the program.
    - Most beneficiaries do not pay premiums for Medicare Part A if they or their spouse paid Medicare taxes while working. However, beneficiaries may be required to pay premiums for Medicare Part B (Medical Insurance) and Medicare Part D (Prescription Drug Coverage).
    - Premiums for Medicare Part B and Part D are set annually and may vary depending on factors such as income level and enrollment status.
4. **Medicare Advantage Payments**:
    - Medicare Advantage plans receive payments from the federal government to provide Medicare-covered benefits to beneficiaries enrolled in their plans.

- These payments are based on a complex formula known as the Medicare Advantage capitated payment system, which takes into account factors such as beneficiary demographics, health status, and regional costs.

5. **Other Sources**:
    - In addition to payroll taxes, general revenue contributions, and beneficiary premiums, Medicare may receive funding from other sources, such as interest earned on the Medicare trust funds, state contributions to the Medicaid program (which helps cover some Medicare costs for dually eligible beneficiaries), and certain taxes on high-income individuals.

Medicare cost about $929 billion in 2021, or about $13,000 per beneficiary. The cost per beneficiary has been increasing at a slower rate than overall inflation and private insurance costs over the past 5-8 years. Here are some key points:

- According to data from the Centers for Medicare & Medicaid Services (CMS), Medicare costs per beneficiary grew by about 2-3% annually from 2015 to 2022. This is well below the overall inflation rate during this period.
- Specifically, Medicare spending per beneficiary increased 2.3% in 2021 and 2.9% in 2022, while overall inflation was around 7-9% those years.
- In comparison, private health insurance premiums for employer-sponsored family coverage increased around 4-6% annually from 2015-2022 according to the Kaiser Family Foundation.
- The slower growth in Medicare costs is attributed to payment reforms, increased use of cheaper generic drugs, and delivery system reforms encouraging more cost-effective care.
- However, Medicare costs are expected to rise more rapidly in the coming years due to an aging population and rising healthcare costs overall.

Medicare's funding situation has been a longstanding issue of concern. The program currently gets funding from three main sources:

- Payroll taxes
- Premiums paid by beneficiaries
- General revenues from the federal government

There are two separate trust funds - one for Hospital Insurance (Part A, covering inpatient hospital care) and one for Supplementary Medical Insurance (Parts B and D, covering outpatient care and prescription drugs).

The often-cited projection that the Medicare Hospital Insurance Trust Fund will be depleted or "run out of money" in around 7 years (specifically 2028 according to the

latest Medicare Trustees report) does not mean Medicare itself is going bankrupt or will cease operating altogether.

What it means is that the Hospital Insurance Trust Fund's reserves will be depleted by 2028 based on current income and expenditure projections. After 2028, income to the fund from payroll taxes and other revenue would cover only 90% of projected Part A costs.

The Supplementary Medical Insurance Trust Fund is expected to remain adequately financed into the indefinite future because its funding can be adjusted through changes in premiums and general revenue contributions.

However, shoring up the financial condition of the Hospital Insurance Trust Fund will likely require significant legislative reforms by Congress, such as increasing payroll taxes allocated to Medicare, reducing expenditures through further cost-saving measures, or supplementing the fund with general revenues.

Here are some key points to consider:

1. **Trust Fund Depletion**:
    - The Medicare Trustees issue annual reports that project the financial status of the HI Trust Fund based on revenue and expenditure projections. These reports include estimates of when the trust fund will be depleted if current trends continue.
    - The projected depletion date has fluctuated over time due to various factors such as changes in healthcare costs, enrollment trends, economic conditions, and legislative changes.
2. **Impact on Benefits**:
    - If the HI Trust Fund were to be depleted, it would not mean that Medicare benefits would disappear entirely. Instead, it would mean that the trust fund would no longer have sufficient funds to cover all of its obligations fully.
    - In the event of trust fund depletion, Medicare Part A would still be able to pay a portion of its costs through ongoing revenue from payroll taxes and other sources, but benefits might need to be reduced, or additional funding sources might need to be allocated to cover the shortfall.
3. **Need for Policy Changes**:
    - The projected depletion of the HI Trust Fund underscores the need for policy changes to address the long-term financial sustainability of the Medicare program.

- Potential policy solutions to address trust fund depletion include increasing revenue through payroll taxes or other sources, reducing expenditures through benefit reforms or cost-saving measures, improving the efficiency of healthcare delivery, and implementing measures to address the underlying drivers of healthcare costs.

Measuring Medicare's Outcomes

The easiest way to measure a healthcare system's outcomes or quality is by measuring life expectancy. I like this admittedly imperfect metric for a couple of reasons:

- The data are relatively easy to access.
- Life expectancy generally improves in lock-step with a healthcare system. A well functioning system generally will generate longer life expectancies than a poorly functioning one.
- Life expectancy data also include variables that a narrowly defined medical care system might miss. Access to healthy foods, for example, probably play a life expectancy role. This suggests that a well functioning healthcare system should address the population's nutritional needs, not just their acute care needs.

Let's compare American life expectancies at age 65 to other countries.[79]

- For American men who survived to age 65 in 2021, their remaining life expectancy was around 18.1 years.
- For American women at age 65, remaining life expectancy was around 20.6 years in 2021.
- This places the U.S. below the average among OECD countries for life expectancy at age 65. For example, a 65-year-old man in Switzerland could expect to live around 19.8 more years on average.

Some key comparisons on life expectancy at birth and age 65 from 2021 OECD data:

- Switzerland: 81.1 years at birth, 21.1 remaining at age 65
- Norway: 82.7 years at birth, 20.3 remaining at 65
- Australia: 83.3 years at birth, 21.1 remaining at 65
- Canada: 82.2 years at birth, 21.3 remaining at 65
- United States: 77.0 years at birth, 18.5 remaining at 65

The correlation between life expectancy and overall healthcare system quality is complex, as life expectancy can be influenced by many socioeconomic and

[79] This section comes from Claude.ai, April 2024

environmental factors beyond just the healthcare system itself. However, most research suggests there is a meaningful but moderate correlation.

- Access to high-quality healthcare is undoubtedly a key determinant of life expectancy, especially through prevention and effective management of chronic diseases that affect mortality.
- Countries that rank highly on measures of healthcare access, affordability, and clinical outcomes tend to have higher life expectancies on average.

However, factors like poverty, education levels, diet, rates of smoking/obesity, air pollution, and income inequality also significantly impact life expectancy independently of healthcare.

Statistical analysis estimates that differences in healthcare system performance may account for around 25-40% of the life expectancy gap between the U.S. and other wealthy nations.

The remaining gap is attributed to the socioeconomic, environmental, and behavioral factors prevalent in the U.S. population.

Within countries, individuals with higher incomes and better healthy behaviors tend to experience longer life expectancies, even with similar healthcare access.

That's why I suggest that life expectancy is a good but definitely imperfect measure of Medicare's quality.

Summary

Medicare has been one of the most significant and impactful social programs in American history since its establishment in 1965.

What Medicare Accomplished:

- Provided access to health insurance for millions of elderly Americans age 65+ who previously could not afford or qualify for private coverage.
- Helped dramatically reduce elderly poverty and financial insecurity by covering major hospital and medical expenses.
- Improved access to preventive services and treatment for the elderly population.
- Along with Medicaid, helped desegregate some hospitals that previously refused Black patients.
- Established a national health insurance model and system that other programs like Medicaid and CHIP were built upon.

How Medicare Changed the World:

- Served as a model for other nations to establish universal healthcare programs for their citizens.
- Shifted the physician reimbursement system and expanded the role of private health insurance companies as contractors.
- Created a massive new sector of the economy around the administration of government-funded health insurance.
- Facilitated the integration of new medical technologies and drugs by covering them nationwide.
- Demonstrated how a large social insurance program could be successfully implemented and administered.

Overall Quality and Impact:

- While not perfect, Medicare has been incredibly successful in providing essential health coverage to the elderly.
- It remains one of the most popular and solidly supported government programs in American public opinion.
- Medicare has greatly improved quality of life and financial security for tens of millions of American seniors.
- However, its long-term financial sustainability remains an ongoing challenge that may require reforms.

Overall, Medicare drastically improved access to healthcare for America's senior citizens, served as a model for other countries, fundamentally changed the healthcare system's economics, and continues to provide vital health security today despite future financing concerns.

A word about Medicaid

Medicaid fills critical gaps in health coverage for tens of millions of America's most vulnerable low-income populations.[80] It is a joint federal and state program that provides health coverage to low-income Americans. Here's an overview of this major government health insurance program:

Purpose & Eligibility:

- Medicaid's main purpose is to provide health coverage for low-income adults, children, pregnant women, elderly adults, and people with disabilities.
- Eligibility is based on income level, which must be below a certain federal poverty line threshold. This threshold varies by state.

[80] Much of this section comes from Claude ai.

- As of 2022, over 83 million Americans were enrolled in Medicaid and the related Children's Health Insurance Program (CHIP).

Benefits Covered:

- Mandatory benefits covered by all state programs include inpatient/outpatient hospital services, physician services, laboratory/x-ray services, and early and periodic screening for children.
- States can choose to provide additional optional benefits like prescription drug coverage, physical therapy, dental, vision, and others.

Funding:

- Medicaid is funded jointly by the states and the federal government.
- The federal government pays states a matching rate (averaged 64% in 2020) based on the state's per capita income.
- Total Medicaid spending was over $670 billion in 2020.

Program Administration:

- Medicaid is a federal-state partnership program. The states administer their own Medicaid programs while following federal guidelines.
- This allows for state flexibility in program rules, benefits, eligibility, and provider payments.

Impact:

- Medicaid covers a large share of low-income children, pregnant women, seniors in nursing homes, and people with disabilities.
- It helps provide services that promote care in home/community settings rather than institutions.
- Critics argue for more uniformity across state programs and better cost control measures.

Medicaid generally provides more comprehensive benefits particularly for long-term care services. Here’s a brief summary of benefits in both programs:

Medicare Benefits:

- Hospital Insurance (Part A) - Inpatient hospital care, skilled nursing facility care, hospice, home health services
- Medical Insurance (Part B) - Physician services, outpatient care, preventive services, durable medical equipment

- Prescription Drug Coverage (Part D) - Outpatient prescription drugs
- Medicare Advantage (Part C) - Managed care plans that provide Parts A, B and usually D

Medicaid Benefits:

- Inpatient/outpatient hospital services
- Physician/certified nurse practitioner services
- Lab/x-ray services
- Nursing facility/home health care services for over 21
- Early periodic screening, diagnosis and treatment for under 21
- Family planning services
- Rural health clinic/FQHC services
- Transportation to medical care

Additionally, states can choose to provide optional Medicaid benefits like:

- Prescription drugs
- Rehabilitation services
- Personal care services
- Dental, vision, physical therapy and other therapies

Key Differences:

- Medicaid provides more comprehensive long-term care coverage
- Medicaid covers a broader range of benefits like dental, vision, therapies that Medicare does not
- But Medicaid varies significantly by state, while Medicare benefits are nationally uniform
- Lower-income Medicare beneficiaries can have Medicaid as a supplement

Medicaid generally provides more comprehensive benefits particularly for long-term care services and non-medical benefits that promote overall health for low-income populations.

Medicaid’s financial strength and sustainability are an ongoing issue of concern, though its funding outlook is somewhat better than Medicare's in the near-term.

Funding Sources:

- Medicaid is jointly funded by the federal government and states.
- The federal share is around 64% on average, though this federal matching rate varies by state based on per capita income.
- Total Medicaid spending was over $670 billion in fiscal year 2020.

Cost Growth:

- Medicaid costs have been growing faster than the overall economy, driven by enrollment growth, rising healthcare costs, and expansion of benefits.
- Total Medicaid spending increased by around 6% annually from 2017-2020.
- This growth rate is projected to continue in the range of 5-6% per year over the next decade.

Future Outlook:

- Medicaid's funding is not facing the same insolvency projections as Medicare's Hospital Insurance Trust Fund in the short-term.
- As an entitlement, federal/state funding is obligated to match enrollment and costs.
- However, the program's growing expense poses significant budgetary pressures long-term.
- Cost-controls and potential delivery system reforms may be needed to rein in spending growth.

Challenges:

- Economic downturns increase Medicaid enrollment as more people qualify due to low incomes.
- An aging population will increase Medicaid long-term care costs substantially in coming decades.
- State budgets can be strained during recessions, making their matching funding requirements difficult.

Medicaid accounts for a significant portion of state budgets across the country. According to data from the Kaiser Family Foundation:

- In fiscal year 2021, Medicaid made up 16.8% of total state spending on average across all 50 states and D.C.
- However, there is considerable variation between states in terms of how much of their budget goes to Medicaid:

High Percentages:

- New York (34.8%)
- Missouri (33.4%)
- Pennsylvania (31.3%)
- New Mexico (30.9%)
- West Virginia (30.8%)

Low Percentages:

- Wyoming (7.9%)
- Nevada (8.9%)
- Utah (9.9%)
- Idaho (10.6%)
- Hawaii (11.1%)
- The 10 states with the highest percentage of spending on Medicaid averaged 28.9% in 2021.
- The 10 states with the lowest percentage averaged 13.3%.

This high degree of variation is due to factors like:

- A state's Medicaid enrollment and eligible population
- The state's Federal Medical Assistance Percentage (FMAP) match rate
- Decisions to expand Medicaid eligibility under the ACA
- Cost of living and healthcare costs in each state

So while Medicaid does not face the same short-term funding crisis as Medicare, its long-term cost trajectory and pressure on state/federal budgets remain major fiscal policy concerns that could necessitate cost-saving reforms or measures to raise more program revenue over time.

An Eye on the Future
Medicare for All

"Medicare for All" is a healthcare policy proposal that advocates for a single-payer, government-funded healthcare system in which all residents of a country are covered

for medical services.[81] While opinions on this approach may vary, proponents highlight several potential advantages:

1. **Universal Coverage:**
    - One of the primary advantages is the achievement of universal healthcare coverage. Under Medicare for All, everyone would have access to necessary medical services, regardless of income or employment status.
2. **Simplified Administration:**
    - A single-payer system could reduce administrative complexity by streamlining billing and paperwork. This simplification might lead to cost savings and more efficient healthcare delivery.
3. **Cost Control:**
    - Proponents argue that a single-payer system could potentially control healthcare costs more effectively through negotiation with providers, bulk purchasing of medications, and overall cost management.
4. **Preventive Care Emphasis:**
    - With a focus on preventive care, Medicare for All could encourage early intervention and wellness programs, potentially reducing the overall burden of disease and the associated costs.
5. **Elimination of Health Disparities:**
    - Advocates claim that a single-payer system could help address health disparities by ensuring that everyone, regardless of socioeconomic status, has equal access to healthcare services.
6. **Financial Security:**
    - With universal coverage, individuals would not face financial ruin due to medical expenses. This could provide greater financial security and reduce the fear of bankruptcy related to healthcare costs.
7. **Improved Health Outcomes:**
    - By providing access to healthcare services for everyone, proponents argue that Medicare for All could lead to improved health outcomes on a population level.
8. **Simplified Choice of Providers:**

[81] Much of this section comes from ChatGPT

- A single-payer system could simplify the choice of healthcare providers for individuals, as everyone would be covered under the same system.

9. **Reduced Administrative Costs:**
    - Streamlining administrative processes and reducing the complexity of dealing with multiple insurers could lead to significant cost savings.

It's important to note that while these advantages are highlighted by proponents, there are also concerns and criticisms related to the potential costs, the impact on the healthcare industry, and the role of government in healthcare. The debate over healthcare policy is complex, and different stakeholders may have varied perspectives on the best approach.

How Medicare for All Achieves Universal Coverage

Medicare for All aims to achieve universal coverage by implementing a single-payer healthcare system, where the government serves as the sole payer for healthcare services. This means that all residents of a country would be covered under a single, comprehensive healthcare plan. Here are key features of how Medicare for All achieves universal coverage:

1. **Single-Payer System:**
    - In a single-payer system, the government is the primary entity responsible for paying healthcare providers for medical services. This eliminates the need for multiple private insurance plans.
2. **Comprehensive Benefits:**
    - Medicare for All typically proposes comprehensive coverage, including hospital services, preventive care, mental health services, prescription drugs, and other necessary medical treatments. This ensures that all essential healthcare needs are covered.
3. **No Exclusions for Pre-Existing Conditions:**
    - Unlike some private insurance plans that may deny coverage or charge higher premiums based on pre-existing conditions, Medicare for All is designed to provide coverage without such exclusions or discriminatory practices.
4. **Automatic Enrollment:**
    - The system may involve automatic enrollment for all residents, ensuring that everyone is covered by default. This eliminates the need for individuals to navigate complex insurance markets or worry about being uninsured.

5. **No Out-of-Pocket Costs for Essential Services:**
    - Medicare for All proposals often aim to eliminate or significantly reduce out-of-pocket costs for essential healthcare services, making healthcare more affordable and accessible.
6. **Standardized Benefits:**
    - The system typically establishes standardized benefits, ensuring that everyone receives the same level of coverage for basic healthcare needs. This promotes equity in access to medical services.
7. **Public Funding:**
    - Medicare for All relies on public funding, usually through taxation. This ensures that the financial burden is distributed across the population, and everyone contributes to the healthcare system based on their ability to pay.
8. **Negotiation with Healthcare Providers:**
    - The government, as the single payer, can negotiate directly with healthcare providers, pharmaceutical companies, and other stakeholders to control costs and ensure fair pricing for medical services and medications.
9. **Preventive and Primary Care Focus:**
    - By emphasizing preventive and primary care, Medicare for All aims to address health issues at an early stage, reducing the overall burden of disease and potentially lowering long-term healthcare costs.

It's important to note that the specific details of Medicare for All proposals can vary, and the implementation process may involve significant legislative and administrative changes. The concept of achieving universal coverage through a single-payer system is a central tenet of these proposals. The success of such a system depends on effective planning, funding mechanisms, and public support.

How Medicare for All Simplifies Healthcare Administration

Medicare for All simplifies healthcare administration in several ways:

1. **Elimination of Multiple Payers:**
    - Medicare for All envisions a single-payer system, where the government becomes the sole payer for healthcare services. This eliminates the need for multiple private insurance companies, each with its own set of policies, forms, and administrative processes.
2. **Streamlined Billing and Claims Processing:**

- With a single-payer system, healthcare providers would submit claims to the government payer. This simplifies billing and claims processing, reducing the complexity and paperwork associated with dealing with numerous private insurers.

3. **Standardized Benefits and Reimbursement:**
    - Medicare for All proposals often include standardized benefits and reimbursement rates for healthcare services. This standardization simplifies the process for both healthcare providers and payers, reducing the need for negotiations and complex contracts.
4. **Automatic Enrollment:**
    - The system may involve automatic enrollment for all residents, eliminating the need for individuals to navigate private insurance markets or apply for coverage. This reduces administrative overhead associated with enrollment processes.
5. **Reduced Administrative Costs:**
    - By consolidating the administration under a single-payer, Medicare for All aims to reduce administrative costs related to marketing, underwriting, and managing multiple insurance plans. This can lead to overall cost savings within the healthcare system.
6. **Simplified Provider Networks:**
    - Healthcare providers would deal with a single payer, simplifying their interactions with payers and reducing the need to navigate and contract with multiple insurance networks.
7. **Unified Electronic Health Records (EHR):**
    - A single-payer system could facilitate the development of a unified electronic health records (EHR) system, making it easier to share patient information among healthcare providers and reduce the need for disparate systems.
8. **Consistent Coverage Rules:**
    - With standardized benefits and coverage rules, Medicare for All seeks to create consistency in healthcare coverage. This reduces confusion for both patients and healthcare providers regarding what is covered under the plan.
9. **Efficient Negotiation and Drug Pricing:**

- The government, as the single payer, would have more bargaining power to negotiate with pharmaceutical companies for drug prices. This could lead to more efficient negotiations and potentially lower drug costs.

While the simplification of healthcare administration is a significant goal, it's important to acknowledge that the transition to a single-payer system involves complex challenges and considerations. Critics argue that the potential benefits should be carefully weighed against the potential disruptions and changes to the existing healthcare infrastructure.

How Medicare for All Controls Healthcare Spending

Proponent of Medicare for All argue that it helps control healthcare spending through various mechanisms. While there are different proposals and variations, here are common ways in which Medicare for All aims to control healthcare spending:

1. **Negotiating Power:**
    - A single-payer system consolidates the negotiating power of the government, allowing it to negotiate directly with healthcare providers, pharmaceutical companies, and other stakeholders. This can lead to lower prices for medical services, drugs, and other healthcare-related expenses.
2. **Bulk Purchasing of Medications:**
    - With a single-payer system, the government can engage in bulk purchasing of medications, negotiating lower prices for prescription drugs. This can result in significant cost savings and contribute to controlling overall healthcare spending.
3. **Administrative Efficiency:**
    - By eliminating the administrative complexity associated with multiple private insurance plans, Medicare for All aims to increase administrative efficiency. Streamlining billing, claims processing, and administrative tasks can reduce overhead costs within the healthcare system.
4. **Preventive Care Emphasis:**
    - Medicare for All often emphasizes preventive care and early intervention. By addressing health issues at an early stage, the system aims to reduce the overall burden of disease, potentially lowering long-term healthcare costs.
5. **Standardized Benefits and Reimbursement:**
    - Standardizing benefits and reimbursement rates across the healthcare system can contribute to cost control. Healthcare providers and payers operate under consistent rules, reducing the need for complex negotiations and individual contracts.

6. **Global Budgeting:**
    - Some Medicare for All proposals consider implementing global budgeting for healthcare spending. This involves setting a predetermined budget for healthcare expenditures, which can encourage efficiency and resource allocation within the system.
7. **Reduced Administrative Costs:**
    - The consolidation of administrative functions under a single-payer system is expected to reduce administrative costs associated with marketing, underwriting, and managing multiple private insurance plans.
8. **Preventing Price Gouging:**
    - Advocates argue that a single-payer system can prevent price gouging by setting reasonable reimbursement rates for healthcare services. This can prevent excessive charges from healthcare providers.
9. **Addressing Overutilization:**
    - Some Medicare for All proposals include measures to address overutilization of healthcare services. By promoting evidence-based practices and discouraging unnecessary procedures, the system aims to control costs associated with unnecessary medical interventions.

It's important to note that the effectiveness of these cost-control measures depends on the specific details of the Medicare for All proposal and its implementation. Critics argue that potential savings may be offset by increased demand for healthcare services, and the overall impact on healthcare spending is a subject of ongoing debate.

How Medicare for All Emphasizes Preventive Care

Medicare for All emphasizes preventive care as a key component of its healthcare approach. The goal is to shift the focus from treating illnesses and conditions after they occur to preventing them in the first place. Here are ways in which Medicare for All aims to prioritize and promote preventive care:

1. **Comprehensive Coverage:**
    - Medicare for All proposals typically include comprehensive coverage for preventive services. This can include routine check-ups, vaccinations, screenings, and other preventive measures without cost-sharing for patients.
2. **Early Detection and Screening:**
    - The emphasis is placed on early detection and screening for common diseases and conditions. Regular screenings, such as mammograms,

colonoscopies, and vaccinations, are included in the covered services to detect potential health issues early when they may be more treatable.

3. **Immunizations:**
    - Medicare for All supports and promotes access to immunizations for preventable diseases. By ensuring that vaccinations are readily available and covered, the goal is to protect individuals and communities from vaccine-preventable illnesses.
4. **Health Education and Promotion:**
    - The system may include health education and promotion efforts to inform individuals about healthy lifestyles, nutrition, exercise, and other factors that contribute to overall well-being. Educating the public about healthy choices can help prevent various health issues.
5. **Chronic Disease Management:**
    - Medicare for All aims to address chronic diseases through preventive measures and management strategies. By providing ongoing care and support for individuals with chronic conditions, the system seeks to prevent complications and improve overall health outcomes.
6. **Access to Primary Care:**
    - Ensuring access to primary care is a fundamental aspect of preventive care. Medicare for All aims to provide individuals with consistent access to primary care physicians, promoting regular check-ups and health maintenance.
7. **Community-Based Health Initiatives:**
    - Some proposals may allocate resources for community-based health initiatives. These initiatives can include programs that promote healthy living, provide education on preventive measures, and engage communities in activities that support overall well-being.
8. **Incentives for Providers:**
    - Medicare for All proposals may include incentives for healthcare providers to prioritize preventive care. This can involve reimbursement models that reward healthcare professionals for delivering preventive services and promoting patient health.
9. **Integration of Behavioral Health Services:**
    - Addressing mental health is often part of preventive care. By integrating behavioral health services into the healthcare system, Medicare for All

aims to identify and address mental health concerns early on, preventing more serious issues.

By incorporating these elements into the healthcare system, Medicare for All seeks to create a proactive and preventive approach that not only improves health outcomes for individuals but also contributes to the overall health of the population.

How Medicare for All Eliminates Health Disparities

Medicare for All aims to address and reduce health disparities through various mechanisms designed to ensure equitable access to healthcare services. Here are ways in which Medicare for All seeks to eliminate health disparities:

1. **Universal Coverage:**
    - By providing universal coverage, Medicare for All ensures that everyone, regardless of socioeconomic status, has access to necessary healthcare services. Universal coverage is a fundamental step toward reducing disparities in healthcare access.
2. **Equal Access to Services:**
    - Medicare for All seeks to provide equal access to a comprehensive set of healthcare services for all individuals. This includes preventive care, primary care, specialty services, mental health services, and other essential healthcare components.
3. **Elimination of Cost Barriers:**
    - By eliminating or significantly reducing out-of-pocket costs for essential services, Medicare for All aims to remove financial barriers that can disproportionately affect individuals with lower incomes. This can help ensure that cost is not a barrier to receiving necessary medical care.
4. **Standardized Benefits:**
    - Standardizing benefits across the healthcare system helps ensure that all individuals receive the same level of coverage for basic healthcare needs. This consistency can contribute to reducing disparities in access to specific services.
5. **Culturally Competent Care:**
    - Medicare for All proposals often emphasize the importance of culturally competent care. This involves recognizing and addressing the unique cultural, linguistic, and social factors that can impact healthcare outcomes, particularly for marginalized communities.
6. **Community-Based Health Initiatives:**

- Some proposals may allocate resources for community-based health initiatives. These initiatives can address social determinants of health and focus on improving health outcomes in specific communities facing disparities.

7. **Focus on Preventive Care:**
    - Preventive care is a key aspect of Medicare for All, and promoting early detection and intervention can help address health issues before they become more severe. This approach is crucial for reducing disparities in health outcomes.
8. **Health Education and Outreach:**
    - Medicare for All may include initiatives to provide health education and outreach to underserved communities. Informing individuals about preventive measures, healthy lifestyles, and available healthcare resources can empower communities to make informed decisions about their health.
9. **Investment in Underserved Areas:**
    - Some proposals may prioritize investments in healthcare infrastructure in underserved areas. This can involve increasing the number of healthcare facilities, ensuring an adequate healthcare workforce, and addressing geographic disparities in healthcare access.
10. **Data Collection and Monitoring:**
    - Implementing robust data collection and monitoring systems can help identify and address disparities in healthcare outcomes. By understanding the specific challenges faced by different populations, policymakers can tailor interventions to reduce disparities.

It's important to note that while Medicare for All aims to address health disparities, the effectiveness of these measures depends on the specific details of the proposal, its implementation, and ongoing efforts to monitor and adapt strategies to evolving needs. Reducing health disparities requires a comprehensive and sustained approach across multiple dimensions of healthcare delivery and social determinants of health.

How Medicare for All Improves the Financial Security of All Americans

Medicare for All proponents argue that implementing a single-payer healthcare system could improve the financial security of all Americans through several mechanisms. Here are ways in which Medicare for All aims to enhance financial security:

1. **Elimination of Out-of-Pocket Costs:**

- Medicare for All typically envisions reducing or eliminating out-of-pocket costs for essential healthcare services. By doing so, individuals would be less likely to face financial hardship due to medical expenses.

2. **Universal Coverage:**
    - The provision of universal healthcare coverage ensures that all Americans have access to necessary medical services. With everyone covered, individuals are less likely to face financial ruin due to medical emergencies or untreated health conditions.
3. **No Medical Bankruptcy:**
    - By removing the financial burden associated with high healthcare costs, Medicare for All aims to reduce the incidence of medical bankruptcies. Individuals and families would not face the prospect of financial devastation due to overwhelming medical bills.
4. **Preventive Care Emphasis:**
    - Medicare for All emphasizes preventive care, which can help identify and address health issues before they become more severe and costly. Preventive measures can contribute to long-term financial savings by avoiding expensive treatments for advanced illnesses.
5. **Stable Premiums and Deductibles:**
    - A single-payer system could lead to more stable premiums and deductibles. With a government-administered healthcare plan, the pricing structure may be more predictable, providing individuals with a clearer understanding of their healthcare expenses.
6. **Income-Linked Financing:**
    - Financing Medicare for All through progressive taxation ensures that individuals contribute based on their ability to pay. This approach aims to distribute the financial burden more equitably, reducing the strain on lower-income individuals and families.
7. **Negotiation for Lower Drug Prices:**
    - The government, as the single payer, would have more negotiating power over drug prices. This could lead to lower prescription drug costs, contributing to financial relief for individuals who rely on medications.
8. **Financial Predictability:**
    - Knowing that essential healthcare services are covered without significant out-of-pocket costs provides individuals with greater financial predictability.

This stability allows for better financial planning and reduces the anxiety associated with unexpected medical expenses.

9. **Freed-up Disposable Income:**
    - With reduced or eliminated healthcare costs, individuals and families may have more disposable income. This can be used for other essential needs, contributing to overall economic well-being.
10. **Job Flexibility:**
    - Individuals may experience increased job flexibility as they are not tied to employer-sponsored health insurance. This can facilitate career changes, entrepreneurship, and other professional pursuits without the concern of losing healthcare coverage.

While proponents argue that Medicare for All could enhance financial security, critics raise concerns about potential tax implications, the overall cost of implementing such a system, and potential trade-offs. The debate over the financial implications of Medicare for All is complex and involves considerations of both costs and benefits.

How Does Medicare for All Improve Health Outcomes

Proponents of Medicare for All argue that implementing a single-payer healthcare system could lead to improved health outcomes for the population. Here are ways in which Medicare for All aims to enhance health outcomes:

1. **Universal Access to Healthcare:**
    - Medicare for All provides universal access to healthcare services, ensuring that all residents have coverage for essential medical treatments, preventive care, and health services. This universal access is intended to reduce disparities in healthcare utilization and outcomes.
2. **Early Detection and Prevention:**
    - The emphasis on preventive care and regular check-ups in Medicare for All aims to detect health issues at an early stage. Early detection allows for timely intervention and preventive measures, reducing the severity of illnesses and improving overall health outcomes.
3. **Comprehensive Coverage:**
    - Medicare for All typically offers comprehensive coverage, including preventive services, primary care, specialty care, mental health services, and prescription drugs. Comprehensive coverage addresses a wide range of health needs and contributes to holistic healthcare.
4. **Elimination of Financial Barriers:**

- By reducing or eliminating out-of-pocket costs for essential healthcare services, Medicare for All aims to remove financial barriers that may prevent individuals from seeking necessary medical care. Financial accessibility is crucial for timely and appropriate healthcare utilization.

5. **Focus on Social Determinants of Health:**
    - Medicare for All may incorporate initiatives addressing social determinants of health, such as housing, education, and nutrition. Addressing these broader factors can positively impact health outcomes and contribute to overall well-being.
6. **Health Education and Promotion:**
    - Initiatives promoting health education and prevention can be integrated into the healthcare system. Educating the public about healthy lifestyles, nutrition, and disease prevention contributes to better health awareness and outcomes.
7. **Reduced Delayed Care:**
    - With universal coverage, individuals are less likely to delay seeking medical care due to concerns about affordability. Timely access to healthcare services can prevent the progression of illnesses and improve outcomes.
8. **Coordination of Care:**
    - A single-payer system can facilitate better coordination of care among healthcare providers. Improved communication and collaboration can enhance the management of chronic conditions and complex medical cases, leading to better health outcomes.
9. **Mental Health Integration:**
    - Integrating mental health services into the overall healthcare system addresses the importance of mental health in overall well-being. Comprehensive mental health support can positively impact mental health outcomes.
10. **Evidence-Based Medicine:**
    - Medicare for All may emphasize evidence-based medicine, encouraging healthcare providers to follow established guidelines and practices supported by scientific evidence. This approach can lead to more effective and standardized care.

It's important to note that the effectiveness of Medicare for All in improving health outcomes depends on various factors, including the specific design of the program,

implementation strategies, and ongoing efforts to address challenges in the healthcare system. The debate around the impact of Medicare for All on health outcomes is multifaceted and involves considerations of access, quality of care, and overall public health.

Simplified Choice of Providers

Medicare for All simplifies the choice of healthcare providers by streamlining the healthcare system and offering a single, comprehensive coverage plan. Here are ways in which it aims to simplify the choice of providers:

1. **Universal Coverage:**
    - Medicare for All provides universal coverage, ensuring that everyone has access to the same set of healthcare providers. This eliminates the need to navigate complex networks associated with multiple private insurance plans.
2. **No Network Restrictions:**
    - Unlike many private insurance plans that may have specific networks of providers, Medicare for All aims to eliminate network restrictions. Individuals can choose healthcare providers based on their preferences, without concerns about in-network or out-of-network distinctions.
3. **Freedom to Choose Any Doctor or Hospital:**
    - With Medicare for All, individuals have the freedom to choose any doctor, specialist, or hospital that accepts the coverage. This flexibility simplifies the process of selecting healthcare providers and allows individuals to maintain existing relationships with their preferred providers.
4. **Consistent Benefits Across Providers:**
    - Standardized benefits across the healthcare system mean that individuals receive the same level of coverage regardless of the healthcare provider they choose. This consistency simplifies the decision-making process for individuals seeking medical care.
5. **No Referral Requirements:**
    - Some insurance plans require referrals from primary care physicians to see specialists. Medicare for All typically eliminates the need for referrals, allowing individuals to directly access the healthcare providers they need without additional administrative steps.
6. **Simplified Billing and Administration:**

- Medicare for All streamlines billing and administrative processes. Healthcare providers deal with a single payer, reducing the administrative burden associated with managing multiple insurance plans with varying reimbursement rules.

7. **Access to Primary Care:**
    - The system emphasizes access to primary care, ensuring that individuals can easily find and choose a primary care physician. Access to primary care is crucial for preventive services and managing overall health.
8. **Continuity of Care:**
    - Medicare for All supports continuity of care, allowing individuals to maintain relationships with their healthcare providers over time. This can contribute to better-coordinated and personalized care.
9. **Elimination of Employer-Based Networks:**
    - With Medicare for All, individuals are not bound by employer-based networks. This flexibility is particularly beneficial for those who change jobs or pursue self-employment, as their choice of providers is not tied to employer-sponsored plans.
10. **Reduced Administrative Complexity for Providers:**
    - Healthcare providers experience reduced administrative complexity by dealing with a single payer. This simplification can contribute to more efficient and streamlined interactions between providers and the healthcare system.

While the aim is to simplify the choice of providers, it's important to consider that the actual implementation and the specifics of the Medicare for All plan can vary. Additionally, ongoing efforts are needed to monitor and address any challenges that may arise in the transition to a single-payer system.

How Does Medicare for All Reduce Healthcare Administration Costs

Medicare for All is designed to reduce healthcare administration costs through the implementation of a single-payer system. Here are ways in which it aims to achieve this:

1. **Simplified Billing and Claims Processing:**
    - With Medicare for All, healthcare providers would submit claims to a single payer (the government), streamlining billing and claims processing. This simplification reduces the administrative burden associated with dealing with multiple private insurers, each with its own billing processes and requirements.

2. **Reduced Administrative Overhead for Providers:**
    - Healthcare providers would experience reduced administrative overhead as they interact with a single, standardized system. This includes fewer resources dedicated to managing billing, claims, and administrative tasks associated with multiple insurers.
3. **Elimination of Private Insurance Administrative Costs:**
    - Medicare for All aims to eliminate the administrative costs associated with managing private insurance plans. This includes marketing, underwriting, and administrative overhead specific to each private insurer, leading to overall cost savings.
4. **Standardized Benefits and Reimbursement:**
    - Standardizing benefits and reimbursement rates across the healthcare system simplifies the negotiation process for healthcare providers. This reduces the need for complex negotiations and individual contracts, contributing to administrative efficiency.
5. **Reduced Marketing and Advertising Expenses:**
    - Private insurers currently spend significant resources on marketing and advertising to attract and retain customers. With a single-payer system, the need for such marketing efforts diminishes, leading to cost savings.
6. **Efficient Allocation of Resources:**
    - Medicare for All eliminates the need for insurance companies to allocate resources for tasks such as profit margins, shareholder returns, and executive compensation. This allows for a more efficient allocation of resources directly to healthcare services.
7. **Consolidated Administrative Functions:**
    - Administrative functions related to insurance coverage, claims processing, and other tasks are consolidated under a single-payer system. This consolidation reduces redundancy, simplifies processes, and minimizes administrative complexity.
8. **Savings on Fraud Prevention:**
    - A single-payer system can result in more effective fraud prevention measures. With a unified system, it becomes easier to implement standardized fraud detection and prevention practices, reducing the resources required for individual insurers to combat fraud.
9. **Streamlined Enrollment Processes:**

- Medicare for All typically involves simplified enrollment processes. With universal coverage and potentially automatic enrollment, the need for complex enrollment procedures and paperwork is reduced, leading to administrative efficiency.

10. **Lower Administrative Costs per Beneficiary:**
    - The administrative costs per beneficiary can be lower in a single-payer system due to economies of scale. The efficiency gained from serving a larger population under a unified system can contribute to lower administrative costs per individual covered.

It's important to note that while proponents argue that Medicare for All can lead to significant administrative cost savings, critics raise concerns about potential challenges in implementing and managing such a system. The actual impact on administrative costs may depend on the specific design and implementation of the single-payer system.

Why Medicare for All is a Bad Idea

Critics of Medicare for All typically raise several concerns and potential drawbacks, including:

1. **Cost:**
    - Critics argue that implementing Medicare for All could result in substantial increases in government spending. Financing such a program might require higher taxes, which could impact the economy and individual incomes.
2. **Impact on Quality of Care:**
    - Some opponents express concerns about potential reductions in the quality of healthcare. They argue that a single-payer system may lead to longer wait times for medical services and less innovation in the healthcare sector.
3. **Disruption to Existing Systems:**
    - Transitioning to a single-payer system could involve significant disruptions to existing healthcare systems, including the private insurance industry. Critics worry about the potential negative impact on jobs and the overall economy during the transition.
4. **Loss of Choice:**
    - Critics argue that a single-payer system may limit individuals' choices by eliminating private insurance options. Some people value the ability to

choose their healthcare plans and providers, and they fear that a government-controlled system could restrict those choices.

5. **Bureaucracy and Administrative Challenges:**
    - Concerns are raised about potential bureaucratic challenges and administrative inefficiencies in a government-run healthcare system. Critics worry that a single-payer system might lead to increased red tape, delays in care, and administrative complexities.
6. **Incentives for Innovation:**
    - Opponents argue that a competitive healthcare market fosters innovation and technological advancements. They express concerns that a government-dominated system might reduce the incentives for medical research and innovation.
7. **Potential Tax Burden:**
    - Implementing Medicare for All could require substantial tax increases to fund the program. Critics are concerned about the potential burden on taxpayers and the economic consequences of higher taxes.
8. **Resistance to Change:**
    - Some individuals may resist the idea of a major overhaul of the healthcare system, especially if they are satisfied with their current insurance arrangements. Opposition may come from those who fear uncertainty or perceive a loss of control over their healthcare choices.
9. **Variability in Healthcare Needs:**
    - Critics argue that a one-size-fits-all approach may not adequately address the diverse healthcare needs of different populations and demographics. Tailoring healthcare plans to individual preferences and needs may be more challenging in a single-payer system.
10. **Political and Ideological Divisions:**
    - The debate over Medicare for All is often influenced by political and ideological divisions. Opposition may stem from differing views on the role of government in healthcare and the balance between individual freedom and collective responsibility.

It's important to note that these concerns are raised by critics, and supporters of Medicare for All contend that the proposed system would address current shortcomings in the healthcare system, provide universal access to care, and reduce overall healthcare costs. The ongoing debate revolves around finding a balance that addresses

the needs of the population while considering the potential drawbacks and challenges associated with a significant healthcare system overhaul.

How Will Medicare for All Raise Healthcare Costs

Some potential ways Medicare for All might increase healthcare spending:

1. **Increased Demand for Services:**
    - Critics suggest that the elimination of out-of-pocket costs and the provision of universal coverage could lead to an increase in the demand for healthcare services. A surge in demand, especially for elective or non-urgent procedures, could strain the healthcare system and potentially lead to higher costs.
2. **Reduced Incentives for Cost Containment:**
    - Some critics argue that a government-run, single-payer system may reduce incentives for cost containment and efficiency. In a competitive market, providers and insurers have an incentive to control costs to remain competitive. In a single-payer system, critics express concerns that such market forces may be diminished.
3. **Potential for Overutilization:**
    - Critics worry that the absence of cost-sharing measures could lead to overutilization of healthcare services. Without financial barriers, individuals might be more inclined to seek unnecessary or excessive medical care, contributing to increased healthcare costs.
4. **Challenges in Controlling Drug Prices:**
    - While proponents argue that a single-payer system could negotiate lower drug prices, critics express concerns about the potential challenges in effectively controlling pharmaceutical costs. Negotiating with drug manufacturers may not guarantee significant reductions in drug prices.
5. **Transition Costs:**
    - Critics point out that the transition to a Medicare for All system may involve significant upfront costs. The process of implementing the new system, including changes to administrative structures, workforce training, and infrastructure development, could lead to temporary increases in overall healthcare spending.
6. **Potential for Bureaucratic Inefficiencies:**
    - Concerns are raised about the potential for bureaucratic inefficiencies in a government-administered system. Critics argue that a single-payer system

might introduce administrative complexities, red tape, and delays in decision-making, which could impact overall healthcare costs.

7. **Impact on Provider Reimbursement:**
    - Critics express concerns that a government-run system might result in lower reimbursement rates for healthcare providers. If reimbursement rates are set too low, there could be challenges in maintaining an adequate supply of healthcare professionals and facilities, potentially affecting the quality of care.
8. **Resistance from Healthcare Industry:**
    - Some critics argue that the healthcare industry, including pharmaceutical companies, insurers, and certain healthcare providers, may resist cost containment efforts associated with a single-payer system. This resistance could pose challenges in achieving cost savings.
9. **Economic Impact of Tax Increases:**
    - Financing Medicare for All could require substantial tax increases to fund the program. Critics argue that higher taxes could have broader economic consequences, potentially impacting economic growth, individual incomes, and job creation.

It's important to recognize that the potential impact on healthcare costs is a complex and debated aspect of Medicare for All. Proponents argue that the system could lead to overall cost savings through administrative efficiencies, negotiation of lower prices, and a focus on preventive care. The ongoing discussion revolves around finding a balance that addresses cost concerns while ensuring access to quality healthcare for all.

How Medicare for All Will Reduce Medicare Care Quality

Medicare for All critics raise concerns about potential challenges that could affect the quality of care. Here are some arguments made by critics:

1. **Provider Reimbursement Rates:**
    - Critics express concerns that Medicare for All might lead to lower reimbursement rates for healthcare providers. If reimbursement rates are set too low, there could be challenges in attracting and retaining skilled healthcare professionals. This, in turn, could potentially impact the quality of care provided.
2. **Reduced Incentives for Innovation:**
    - Some opponents argue that a single-payer system might reduce incentives for innovation in healthcare. In a competitive market, providers and pharmaceutical companies have incentives to invest in research and

development to stay ahead. Critics worry that a government-dominated system may result in fewer innovations in medical treatments and technologies.

3. **Impact on Access to Specialized Care:**
    - Critics express concerns about the potential impact on access to specialized and advanced medical treatments. If reimbursement rates are not sufficient, healthcare providers may limit certain services or technologies, potentially affecting the availability of specialized care options.
4. **Bureaucratic Inefficiencies:**
    - Concerns are raised about the potential for bureaucratic inefficiencies in a government-run healthcare system. Critics argue that increased bureaucracy, red tape, and administrative complexities could slow down decision-making processes, potentially affecting the efficiency and quality of care.
5. **Difficulty in Addressing Regional Variances:**
    - Critics worry that a single-payer system might face challenges in addressing regional variances in healthcare needs and costs. Healthcare requirements can vary significantly across different regions, and critics argue that a one-size-fits-all approach may not adequately address these variations.
6. **Possible Impact on Provider Networks:**
    - The restructuring associated with Medicare for All could potentially impact existing provider networks. If healthcare providers face challenges in adapting to the new system, it may lead to disruptions in established patient-provider relationships, potentially affecting the continuity and quality of care.
7. **Potential for Longer Wait Times:**
    - Critics express concerns that increased demand for healthcare services, especially in the absence of cost-sharing measures, could lead to longer wait times for medical treatments. Longer wait times may impact patient outcomes and satisfaction.
8. **Resistance to Change:**
    - Some individuals and healthcare professionals may resist the significant changes associated with transitioning to a single-payer system.

Resistance to change could pose challenges in adapting to new care delivery models and may affect the overall quality of healthcare services.

It's important to note that these concerns are raised by critics, and proponents of Medicare for All argue that the system could lead to improved quality through better coordination of care, emphasis on preventive services, and standardized benefits. The debate over the impact on healthcare quality involves considerations of access, efficiency, and the overall healthcare delivery model. The effectiveness of Medicare for All in maintaining or enhancing healthcare quality would depend on the specific design and implementation of the program.

How Medicare for All Will Negatively Disrupt the Existing Healthcare System

The transition to Medicare for All could potentially lead to disruptions in the existing healthcare system, and critics often raise concerns about various aspects of this transformation. While proponents argue that a single-payer system could bring about positive changes, opponents highlight potential negative impacts. Here are some concerns raised by critics:

1. **Job Displacement:**
    - Critics worry that the shift to Medicare for All could result in job displacement, particularly in the private health insurance sector. Employees working in administrative roles related to private insurance may face challenges during the transition.
2. **Impact on Private Insurance Industry:**
    - The implementation of Medicare for All could have a significant impact on the private health insurance industry. Critics argue that the elimination or reduction of private insurance options could disrupt the existing market and lead to economic challenges for companies in this sector.
3. **Transition Costs:**
    - The transition to a single-payer system may involve significant upfront costs. Critics express concerns about the financial implications of the transition, including the costs associated with restructuring administrative systems, implementing new technology, and retraining healthcare professionals.
4. **Potential for Provider Disruptions:**
    - Healthcare providers may experience disruptions during the transition, especially if there are changes in reimbursement rates or adjustments to administrative processes. Critics worry that these disruptions could impact the stability of healthcare delivery.

5. **Resistance from Stakeholders:**
    - Various stakeholders in the healthcare system, including healthcare providers, pharmaceutical companies, and insurers, may resist the changes associated with Medicare for All. Resistance from these stakeholders could pose challenges in the implementation of the new system.
6. **Uncertainty for Healthcare Professionals:**
    - Healthcare professionals may face uncertainties about the impact of Medicare for All on their practices, reimbursement rates, and overall job stability. This uncertainty could potentially affect the morale and job satisfaction of healthcare professionals.
7. **Potential for Reduced Innovation:**
    - Critics argue that a government-run system might reduce incentives for innovation in healthcare. In a competitive market, providers and pharmaceutical companies have incentives to invest in research and development. The shift to a single-payer system may impact these incentives.
8. **Challenges in Managing Increased Demand:**
    - The elimination of out-of-pocket costs and the provision of universal coverage could potentially lead to increased demand for healthcare services. Critics express concerns about the healthcare system's ability to effectively manage and respond to this surge in demand.
9. **Regional Variations in Healthcare Needs:**
    - Healthcare needs can vary significantly across different regions. Critics worry that a one-size-fits-all approach may not adequately address regional variations in healthcare requirements, potentially leading to disparities in access and quality of care.
10. **Political and Public Resistance:**
    - The implementation of Medicare for All may face political and public resistance. Some individuals may be resistant to major changes in the healthcare system, and opposition could pose challenges in achieving widespread acceptance and support.

It's important to note that these concerns are raised by critics, and proponents of Medicare for All argue that the system could address current shortcomings in the healthcare system, provide universal access to care, and reduce overall healthcare

costs. The ongoing debate involves finding a balance that considers the potential disruptions while aiming to achieve the goals of improved access and affordability.

How Medicare for All Will Reduce Patient Choices and Options

Medicare for All could potentially impact patient choices and options in the healthcare system. While proponents argue that a single-payer system may enhance access to care for all individuals, critics express concerns about potential limitations on patient choices. Here are some arguments made by critics regarding how Medicare for All might reduce patient choices:

1. **Limitation of Private Insurance Options:**
    - Medicare for All proposals often involve the elimination or significant reduction of private health insurance options. Critics argue that this could limit individuals' ability to choose from a variety of plans with different coverage options and provider networks.
2. **Restrictions on Provider Choices:**
    - In a single-payer system, the government may negotiate reimbursement rates with healthcare providers, potentially leading to limitations on the number of providers willing to accept those rates. Critics express concerns that this could restrict patients' choices of healthcare providers.
3. **Standardized Benefits:**
    - Medicare for All typically involves standardizing benefits across the healthcare system. While this simplifies the process, critics argue that it may limit the ability of individuals to choose plans tailored to their specific healthcare needs and preferences.
4. **Impact on Specialty Care Access:**
    - Critics worry that the emphasis on cost containment in a single-payer system might lead to limitations in access to specialized or elective medical services. Patients may have fewer options for seeking specialized care or choosing specific healthcare facilities.
5. **Reduced Flexibility in Plan Selection:**
    - The elimination of private insurance options could result in reduced flexibility for individuals to choose plans that align with their preferences, including factors such as deductibles, co-pays, and coverage for specific medical services.
6. **Potential for Longer Wait Times:**

- Increased demand for healthcare services, coupled with potential cost-containment measures, could lead to longer wait times for medical treatments. Critics argue that this may limit patients' ability to promptly access the care they need.

7. **Impact on Provider Networks:**
    - The restructuring associated with Medicare for All might impact existing provider networks. Critics express concerns that changes in reimbursement rates or administrative processes may lead to disruptions in established patient-provider relationships.
8. **Limited Control Over Healthcare Decisions:**
    - Critics argue that a government-administered system may limit individuals' control over their healthcare decisions. The standardization of benefits and potential restrictions on certain medical services could reduce patient autonomy in choosing the care that best suits their needs.
9. **Potential for Reduced Innovation in Care Models:**
    - In a single-payer system, critics express concerns about potential reductions in innovation in healthcare delivery models. A more centralized system may be less conducive to experimentation with new care models and approaches.
10. **Resistance to Change:**
    - Patients and healthcare professionals may resist major changes in the healthcare system. The transition to Medicare for All could face opposition from those who value their current insurance arrangements and fear a loss of control over their healthcare choices.

It's important to note that these concerns are raised by critics, and the actual impact on patient choices and options would depend on the specific design and implementation of Medicare for All. Proponents argue that the system could increase overall access to care and simplify the healthcare process, while opponents highlight potential trade-offs in terms of choice and flexibility.

Medicare for All Raises Bureaucratic and Administrative Challenges

Here are some of the bureaucratic and administrative challenges that some critics have been raised:

1. **System Overhaul and Implementation:**
    - The shift to a single-payer system involves a comprehensive overhaul of the existing healthcare infrastructure. Implementing new administrative

structures, technology systems, and processes on a national scale can be a complex and resource-intensive task.

2. **Transition Costs:**
    - The transition to Medicare for All may come with significant upfront costs. Adapting to new administrative requirements, retraining healthcare professionals, and updating technology systems could require substantial financial investments.
3. **Workforce Training:**
    - Healthcare professionals and administrative staff may require training to adapt to the new system. Training a large workforce to navigate changes in billing, claims processing, and administrative procedures is a logistical challenge.
4. **Data Integration and Standardization:**
    - Achieving seamless data integration and standardization across the healthcare system is crucial for the efficient operation of a single-payer system. This involves addressing interoperability issues and ensuring that diverse healthcare entities can effectively share information.
5. **Provider Reimbursement:**
    - Establishing fair and effective provider reimbursement rates is a complex task. Determining rates that are acceptable to healthcare providers while maintaining cost control requires careful negotiation and administrative coordination.
6. **Coordination with State Programs:**
    - Coordination with existing state-level healthcare programs and Medicaid systems may present challenges. Ensuring a smooth transition and integration with state-specific programs requires effective collaboration and administrative planning.
7. **Claims Processing and Billing:**
    - Streamlining claims processing and billing is a key aspect of administrative efficiency. The implementation of a single-payer system requires the development of standardized processes to handle claims and billing on a national scale.
8. **Technology Infrastructure:**
    - Upgrading and modernizing the technology infrastructure to support a national healthcare system is a significant undertaking. Ensuring the

security, interoperability, and efficiency of healthcare information systems is a complex administrative task.

9. **Resistance from Stakeholders:**
    - Stakeholders, including healthcare providers, insurers, and pharmaceutical companies, may resist administrative changes associated with Medicare for All. Overcoming potential resistance and ensuring buy-in from diverse stakeholders is a challenge.
10. **Public Education and Communication:**
    - Effectively communicating changes to the public and educating individuals about the new system is crucial. Public awareness campaigns and communication strategies are necessary to inform individuals about their rights, benefits, and changes in healthcare procedures.
11. **Addressing Regional Variations:**
    - The administrative challenges include addressing regional variations in healthcare needs, costs, and delivery. Tailoring administrative processes to accommodate these variations while maintaining national standards requires careful consideration.
12. **Ensuring Adequate Healthcare Workforce:**
    - The transition to a single-payer system may require adjustments in the healthcare workforce to meet increased demand. Ensuring an adequate number of healthcare professionals and support staff is an administrative challenge.

It's important to note that while critics highlight these administrative challenges, proponents argue that the long-term benefits of Medicare for All, such as improved access, simplified billing, and overall cost savings, could outweigh these initial complexities. The effectiveness of addressing administrative challenges would depend on the planning, implementation, and ongoing management of the transition to a single-payer system.

How Medicare for All Might Reduce Healthcare Innovation

Critics of Medicare for All express concerns that a transition to a single-payer healthcare system could potentially reduce incentives for healthcare innovation. While proponents argue that a single-payer system could lead to cost savings and increased access to care, opponents highlight potential challenges related to innovation. Here are some arguments made by critics regarding how Medicare for All might impact healthcare innovation:

1. **Reduced Financial Incentives for Research and Development:**

- Critics argue that a single-payer system might reduce financial incentives for pharmaceutical companies and healthcare providers to invest in research and development. In a competitive market, the potential for high profits can drive innovation. A more centralized system may alter these financial dynamics.

2. **Risk Aversion in a Government-Run System:**
    - Some critics express concerns that a government-administered healthcare system may be more risk-averse when it comes to adopting new and innovative medical technologies. Bureaucratic processes and decision-making may prioritize cost containment over embracing novel, yet potentially more expensive, treatments.
3. **Impact on Biotechnology and Life Sciences:**
    - The biotechnology and life sciences sectors heavily rely on private investments for innovation. Critics argue that a reduction in private investment resulting from changes in the market dynamics under a single-payer system could impede progress in these fields.
4. **Potential for Limited Choice of Treatments:**
    - A single-payer system may negotiate prices and coverage for medical treatments on a national level. Critics worry that centralized decision-making could limit the variety of available treatments and reduce options for patients seeking innovative therapies.
5. **Slower Adoption of New Technologies:**
    - Critics express concerns that a more centralized healthcare system may lead to slower adoption of new medical technologies. The bureaucracy associated with decision-making and budgetary constraints may result in delays in incorporating innovative treatments into standard medical practice.
6. **Impact on Academic Medical Centers:**
    - Academic medical centers often play a crucial role in medical research and innovation. Critics argue that changes in funding mechanisms and reimbursement rates under a single-payer system may affect the ability of academic institutions to invest in groundbreaking research.
7. **Potential Brain Drain in Healthcare Professions:**
    - Some critics suggest that the potential for lower earning potential and reduced financial rewards for innovation could lead to a "brain drain" in

healthcare professions. Skilled professionals may be drawn to sectors or countries that offer more favorable incentives for innovation.

8. **Incentives for Cost Control Over Innovation:**
    - In a system that prioritizes cost control, critics argue that healthcare providers may face pressure to focus on cost-effective treatments rather than invest in cutting-edge, albeit more expensive, medical innovations.
9. **Impact on Startups and Small Biotech Companies:**
    - Critics express concerns about the potential challenges faced by startups and small biotech companies in securing funding under a single-payer system. Reduced profitability and increased regulatory hurdles could impact the ability of these entities to contribute to innovation.
10. **Potential Disincentives for Entrepreneurship:**
    - A shift to a single-payer system may alter the incentives for entrepreneurship in the healthcare sector. Critics worry that reduced profit margins and increased regulation may discourage entrepreneurs from entering the healthcare industry.

It's important to note that these concerns are raised by critics, and the impact on healthcare innovation would depend on various factors, including the specific design of the single-payer system, ongoing policy adjustments, and efforts to balance cost containment with support for innovation. Proponents argue that a single-payer system could foster a more efficient and equitable healthcare system, but the potential trade-offs with innovation remain a part of the broader debate.

How Might Medicare for All Affect Individual and Corporate Taxes

While specific policy details can vary, here are general considerations regarding how Medicare for All might affect taxes:

Individual Taxes:

1. **Potential for Increased Taxes:**
    - Financing a comprehensive healthcare system like Medicare for All would likely require additional government revenue. Proponents often discuss funding sources such as progressive income taxes, payroll taxes, and other measures. Consequently, some individuals, particularly those with higher incomes, could see an increase in their tax burden.
2. **Offset by Elimination of Premiums and Out-of-Pocket Costs:**
    - Supporters argue that while taxes may increase, individuals and families would no longer be required to pay premiums, deductibles, or copayments

associated with private health insurance. This could offset the impact of higher taxes, especially for those who currently face significant healthcare-related costs.

3. **Progressive Taxation Approach:**
    - Proponents often advocate for a progressive taxation approach, where higher-income individuals contribute a larger percentage of their income toward funding Medicare for All. This is seen as a way to distribute the financial burden more equitably.
4. **Potential for Savings:**
    - Supporters argue that the overall cost of healthcare for individuals and families would decrease under Medicare for All. While taxes may go up, the elimination of private insurance premiums and reduced out-of-pocket expenses could result in net savings for many households.

Corporate Taxes:

1. **Impact on Employers:**
    - Under Medicare for All, employers may see changes in their financial responsibilities related to employee healthcare. While some proponents argue that businesses could experience cost savings by no longer providing private health insurance plans, critics suggest that increased corporate taxes may offset these potential savings.
2. **Potential for Employer Payroll Taxes:**
    - One proposed funding mechanism for Medicare for All involves implementing payroll taxes on employers. This could be a way to shift the financial responsibility for healthcare from businesses to the broader tax base.
3. **Reduced Administrative Costs for Employers:**
    - Supporters argue that employers could benefit from reduced administrative costs associated with managing private health insurance plans for their employees. A single-payer system may simplify administrative processes for businesses.
4. **Economic Impact:**
    - Critics express concerns that increased corporate taxes could have broader economic consequences, potentially affecting job creation, business investment, and economic growth. Proponents argue that the overall reduction in healthcare costs could positively impact the economy.

5. **Potential for Redistribution of Costs:**
    - The shift to Medicare for All could redistribute the costs of healthcare from employers to the government. This could lead to changes in corporate financial strategies and impact industries differently based on their current healthcare spending.
6. **Sector-Specific Considerations:**
    - Different industries may be affected in varying ways. Some sectors that currently provide generous health benefits may face higher taxes, while others with lower healthcare costs may benefit from a more level playing field.

It's important to note that the specific impact on taxes would depend on the details of the Medicare for All proposal, including the chosen funding mechanisms and how the transition is structured. The debate over the financial aspects of Medicare for All involves considerations of both the costs and potential savings for individuals, employers, and the government.

Can Medicare for All Address the Healthcare Needs of Americans?

While proponents argue that a single-payer system can provide more equitable access to care, critics raise concerns about potential challenges in addressing the diverse healthcare needs of the population. Here are considerations on both sides of the debate:

Proponents' Arguments:

1. **Universal Access to Basic Healthcare:**
    - Proponents contend that Medicare for All aims to ensure universal access to basic healthcare services for all Americans. By providing a baseline level of coverage, the system seeks to address fundamental healthcare needs across the population.
2. **Standardized Benefits:**
    - Medicare for All proposals often include standardized benefits, eliminating variations in coverage between different insurance plans. This standardization is intended to ensure that individuals receive consistent and comprehensive healthcare services regardless of their specific circumstances.
3. **Preventive Care Emphasis:**
    - Supporters argue that a single-payer system can emphasize preventive care, addressing health needs at an earlier stage and potentially reducing

the overall burden on the healthcare system. By focusing on preventive measures, the system aims to improve population health.

4. **Elimination of Disparities in Access:**
    - Proponents suggest that Medicare for All can help eliminate disparities in access to healthcare. By providing coverage to all individuals, regardless of factors such as income or employment status, the system seeks to reduce variations in healthcare access.
5. **Efficient Resource Allocation:**
    - A single-payer system could streamline administrative processes and resource allocation, ensuring that healthcare resources are distributed more efficiently. This efficiency may contribute to a more equitable distribution of healthcare services.

Critics' Concerns:

1. **One-Size-Fits-All Approach:**
    - Critics argue that a single-payer system may adopt a one-size-fits-all approach that does not adequately address the diverse healthcare needs of individuals and communities. Different populations may have unique health requirements that may not be fully accommodated.
2. **Regional Variations:**
    - Healthcare needs can vary significantly across regions due to factors such as demographics, prevalence of certain health conditions, and local healthcare infrastructure. Critics express concerns that a nationalized system may struggle to address these regional variations effectively.
3. **Limited Choice of Providers:**
    - Critics worry that a single-payer system might limit individuals' choices of healthcare providers. While proponents argue for cost containment, critics express concerns that reduced provider options could impact the ability of individuals to access specialized or preferred care.
4. **Inadequate Addressing of Specific Conditions:**
    - Some critics suggest that certain specialized or rare health conditions may not receive sufficient attention or resources in a more centralized healthcare system. Tailoring care to specific conditions or demographic groups could be challenging.
5. **Resistance to Innovations in Care Models:**

- Critics argue that a government-dominated system may be less conducive to experimenting with innovative care models and approaches. The potential for bureaucratic hurdles and resistance to change could impede the adoption of new and effective healthcare solutions.

6. **Potential for Longer Wait Times:**
    - Increased demand for healthcare services, combined with potential resource constraints, could lead to longer wait times for medical treatments. Critics express concerns that longer wait times may negatively impact patient outcomes.

The debate over whether Medicare for All can effectively address variations in healthcare needs revolves around finding a balance between providing universal access and accommodating the diverse health requirements of the population. The effectiveness of the system would depend on the specific design, implementation, and ongoing adjustments made to address these considerations.

How Will Our Divisive Political Environment Affect Medicare for All?

The divisive political environment in the United States has a significant impact on discussions and potential implementations of policies, including Medicare for All. The perspectives and stances of political actors, policymakers, and the general public contribute to the challenges and opportunities for advancing such proposals. Here are key considerations regarding how the divisive political environment may affect Medicare for All:

Challenges:

1. **Partisan Divisions:**
    - Healthcare policy, including proposals like Medicare for All, has become deeply polarized along party lines. Divisions between Democrats and Republicans can hinder bipartisan support for comprehensive healthcare reform, making it challenging to pass legislation.
2. **Ideological Differences:**
    - Ideological differences regarding the role of government in healthcare and the balance between individual choice and collective responsibility contribute to the political divide. Finding common ground on the fundamental principles of healthcare policy is a significant hurdle.
3. **Interest Group Opposition:**
    - Powerful interest groups, including those representing insurance companies, pharmaceuticals, and healthcare providers, may actively oppose or lobby against significant changes to the healthcare system. The

influence of these groups can create obstacles for transformative healthcare proposals.

4. **Public Opinion Variability:**
    - Public opinion on healthcare reform, including Medicare for All, varies across political affiliations. Bridging the gap in public support and addressing concerns from different ideological perspectives is a complex task.
5. **Fiscal Concerns:**
    - Discussions around how to fund Medicare for All often involve debates on tax increases and government spending. Fiscal conservatives may express concerns about the potential economic impact and sustainability of such a large-scale healthcare program.

Opportunities:

1. **Public Demand for Change:**
    - Despite political divisions, there is public demand for improvements in the healthcare system. The impact of the COVID-19 pandemic has further highlighted the importance of accessible and affordable healthcare. Public pressure may create opportunities for policymakers to revisit healthcare reform proposals.
2. **Evolving Policy Discourse:**
    - The political landscape is dynamic, and policy priorities can evolve over time. Shifting public attitudes, changes in leadership, and external factors may contribute to a reevaluation of healthcare policies, potentially creating openings for new proposals.
3. **State-Level Initiatives:**
    - Some states have explored or implemented their own healthcare reforms. State-level initiatives, even if limited in scope, could serve as test cases for certain aspects of healthcare reform and inform national discussions.
4. **Incremental Changes:**
    - Given the challenges of passing comprehensive reform, there may be opportunities for incremental changes to the healthcare system. Policymakers may explore targeted measures that address specific issues, gradually building towards broader reforms.
5. **Coalitions and Compromise:**

- Building coalitions and finding areas of compromise can be crucial for advancing healthcare policy. While comprehensive reform may face hurdles, targeted measures that garner bipartisan support could lay the groundwork for broader changes.

6. **External Events Shaping Priorities:**
    - Unforeseen events, such as public health crises or economic challenges, can reshape political priorities. External factors may create windows of opportunity for reexamining and reforming healthcare policy.

The future of Medicare for All is intricately tied to the dynamics of the political environment. Achieving consensus and overcoming political divisions will require strategic policymaking, effective communication, and a willingness to find common ground on the complex issues surrounding healthcare reform. The interplay of political, economic, and societal factors will continue to shape the trajectory of healthcare policy discussions in the United States.

Rationing and treatment rejection in Medicare

Medicare typically does not cover certain services, treatments, or items that are considered elective, cosmetic, or not medically necessary. Here are some examples:

1. **Cosmetic Surgery**: Procedures performed solely for cosmetic purposes, such as facelifts, breast augmentation, and liposuction, are generally not covered.
2. **Acupuncture**: While some private Medicare Advantage plans may offer coverage for acupuncture, traditional Medicare typically does not cover this service.
3. **Long-Term Care**: Medicare does not cover most long-term care services, including assisted living facilities, custodial care, and nursing home care.
4. **Dental Care**: Routine dental care, such as cleanings, fillings, and extractions, is generally not covered by Medicare. Some Medicare Advantage plans may offer limited dental coverage.
5. **Vision Care**: Routine eye exams, eyeglasses, and contact lenses are typically not covered by Medicare, though there are exceptions for certain eye diseases and conditions.
6. **Hearing Aids**: Medicare does not cover hearing aids or routine hearing exams, though some Medicare Advantage plans may offer coverage for these services.
7. **Foot Care**: Routine foot care, including podiatry services, is generally not covered unless it's related to a medical condition such as diabetes.

8. **Acupressure, Massage Therapy, and Chiropractic Services**: These services are typically not covered by traditional Medicare, though coverage may be available through certain Medicare Advantage plans.
9. **Experimental or Investigational Treatments**: Medicare does not cover treatments that are considered experimental or not proven to be effective.

How does Medicare decide which services to fund and which to reject?

Medicare determines which services to cover based on several factors, including:

1. **Medical Necessity**: Medicare covers services and treatments that are deemed medically necessary to diagnose or treat a medical condition. This means the service must be considered reasonable and necessary for the diagnosis or treatment of an illness or injury.
2. **Evidence-Based Medicine**: Medicare evaluates medical treatments and services based on scientific evidence of their effectiveness. Services that have been proven through clinical studies to improve health outcomes or quality of life are more likely to be covered.
3. **National Coverage Determinations (NCDs)**: The Centers for Medicare & Medicaid Services (CMS) establishes National Coverage Determinations (NCDs) to specify whether Medicare will cover a particular item or service. These determinations are based on factors such as clinical evidence, expert opinions, and public comments.
4. **Local Coverage Determinations (LCDs)**: Medicare Administrative Contractors (MACs) develop Local Coverage Determinations (LCDs) that provide additional guidance on coverage for specific services within their geographic jurisdictions. LCDs may vary by region and can provide more detailed criteria for coverage.
5. **Cost-Effectiveness**: Medicare considers the cost-effectiveness of services when making coverage decisions. While Medicare aims to provide access to necessary healthcare services, it also seeks to manage costs and ensure the sustainability of the program.
6. **Statutory Exclusions**: Some services are explicitly excluded from Medicare coverage by law. For example, Medicare cannot cover most dental care, eyeglasses, and hearing aids under the original Medicare program.
7. **Public Input and Stakeholder Feedback**: Medicare may consider input from healthcare providers, beneficiary advocacy groups, medical societies, and other stakeholders when making coverage decisions. Public comments and feedback are often solicited during the decision-making process for NCDs and LCDs.

Overall, Medicare aims to strike a balance between providing access to essential healthcare services while managing costs and ensuring the quality and effectiveness of

care. Coverage decisions are based on a combination of medical evidence, clinical judgment, statutory requirements, and input from stakeholders.

Medicare's coverage policies evolve over time, and they may update their coverage decisions periodically to reflect advancements in medical technology and changes in clinical evidence. However, there are certain technology-based treatments or services that Medicare historically has been cautious about covering due to various factors such as limited evidence of effectiveness, high costs, or ongoing research. Here are some examples:

1. **Virtual Reality Therapy**: While virtual reality (VR) therapy shows promise in various healthcare applications, including pain management and mental health treatment, Medicare's coverage for VR therapy may be limited due to a lack of extensive clinical evidence supporting its effectiveness in specific medical conditions.
2. **Telehealth Services**: While Medicare has expanded coverage for telehealth services in response to the COVID-19 pandemic, coverage for certain telehealth modalities and services may still be limited. For example, coverage for remote patient monitoring devices or certain telehealth platforms may vary based on specific criteria.
3. **Genetic Testing and Personalized Medicine**: Medicare may cover certain genetic tests for specific medical conditions or hereditary diseases. However, coverage for more comprehensive genetic testing panels or personalized medicine approaches may be limited due to concerns about cost-effectiveness and the need for additional evidence of clinical utility.
4. **Robotic Surgery**: While robotic-assisted surgical procedures have become more common in recent years, Medicare's coverage for robotic surgery may be limited to specific indications and procedures. Coverage decisions may depend on factors such as the availability of clinical evidence demonstrating improved outcomes compared to traditional surgical approaches.
5. **Stem Cell Therapy**: Medicare's coverage for stem cell therapy may be limited due to concerns about the safety, efficacy, and regulation of stem cell treatments. Coverage decisions may vary depending on whether the stem cell therapy is considered standard of care for a specific medical condition or is part of an approved clinical trial.
6. **Artificial Intelligence (AI) Applications**: Medicare's coverage for AI-based diagnostic tools or decision support systems may be limited to specific applications with robust clinical evidence supporting their accuracy and clinical utility. Coverage decisions may also depend on regulatory approval and compliance with Medicare billing requirements.

It's essential to note that Medicare's coverage decisions are subject to change, and coverage for specific technology-based treatments or services may evolve over time as new evidence emerges and healthcare practices evolve. Individuals should consult with healthcare providers and Medicare representatives to understand the current coverage policies and options available to them.

Medicare aims to provide coverage for medically necessary treatments that are proven to be effective and appropriate for the patient's condition. However, there may be instances where Medicare does not cover certain treatments that could be considered potentially life-saving. Here are some reasons why this might occur:

1. **Lack of Sufficient Evidence**: Medicare typically requires strong evidence of a treatment's effectiveness before providing coverage. If there is insufficient clinical evidence to support the effectiveness of a particular treatment for a specific condition, Medicare may not cover it, even if it has the potential to be life-saving.
2. **Experimental or Investigational Treatments**: Medicare generally does not cover treatments that are considered experimental or investigational, meaning they have not yet been proven through rigorous clinical trials to be safe and effective for the intended use.
3. **Off-Label Use of Drugs**: Medicare may not cover the off-label use of drugs, meaning the use of a medication for a condition or indication not approved by the Food and Drug Administration (FDA). While off-label use is common in medical practice, Medicare may only cover medications for FDA-approved indications.
4. **Cost Considerations**: In some cases, the cost of a treatment may be prohibitively high, and Medicare may determine that the cost outweighs the potential benefit, especially if there are other, more cost-effective treatments available.
5. **Statutory Exclusions**: Certain treatments or services may be explicitly excluded from Medicare coverage by law. For example, Medicare cannot cover most dental care, hearing aids, or cosmetic surgery under the original Medicare program.

It's important to note that Medicare's coverage policies may vary depending on factors such as the specific medical condition, the individual's health status, and the availability of alternative treatments. In some cases, individuals may have the option to appeal Medicare's coverage decision or seek coverage through other avenues, such as clinical trials, private insurance, or financial assistance programs.

Medicare typically covers a wide range of cancer treatments that are considered medically necessary and proven to be effective. However, there may be certain cancer treatments or related services that Medicare does not cover or has limitations on coverage. Here are some examples:

1. **Off-Label Use of Drugs**: Medicare may not cover the off-label use of drugs for cancer treatment, meaning the use of a medication for a purpose other than its FDA-approved indication. Coverage for off-label use is evaluated on a case-by-case basis and may depend on the availability of strong clinical evidence supporting the treatment's effectiveness.
2. **Experimental or Investigational Treatments**: Medicare generally does not cover treatments that are considered experimental or investigational for cancer, meaning they have not yet been proven through rigorous clinical trials to be safe and effective. Coverage for experimental treatments may be available through clinical trials or other research studies but is not typically covered by Medicare outside of these contexts.
3. **Alternative or Complementary Therapies**: Medicare typically does not cover alternative or complementary therapies for cancer treatment that have not been proven to be effective through scientific research. This may include treatments such as acupuncture, herbal remedies, and dietary supplements.
4. **High-Cost Drugs or Therapies**: Medicare may have limitations on coverage for certain high-cost cancer drugs or therapies, particularly if the cost exceeds Medicare's established payment limits or if the treatment is considered to be of limited clinical benefit.
5. **Non-Medically Necessary Services**: Medicare generally does not cover cancer treatments that are not considered medically necessary or appropriate for the patient's condition. This may include treatments that are considered to be primarily palliative or supportive in nature and do not directly target the underlying cancer.

It's important for individuals with cancer and their caregivers to work closely with healthcare providers and Medicare representatives to understand the coverage options available and any potential limitations or restrictions on coverage for specific treatments. In some cases, individuals may have the option to appeal Medicare's coverage decision or explore alternative sources of coverage or financial assistance for cancer treatment costs.

Some coronary treatments that Medicare rejects as an example

Medicare generally provides coverage for a wide range of treatments for coronary artery disease and related conditions, particularly those that are considered medically necessary and proven to be effective. However, there may be certain coronary treatments or related services that Medicare does not cover or has limitations on coverage. Here are some examples:

1. **Elective Angioplasty or Stenting**: Medicare may not cover elective coronary angioplasty or stenting procedures if they are not deemed medically necessary.

Coverage is typically provided for these procedures when they are performed to alleviate symptoms of coronary artery disease or to treat acute coronary syndromes.

2. **High-Risk or Investigational Procedures**: Medicare may not cover certain high-risk or investigational coronary procedures that have not been proven through rigorous clinical trials to be safe and effective. This may include emerging techniques or devices for treating coronary artery disease that are still undergoing evaluation.
3. **Preventive Screening Tests**: Medicare generally does not cover routine screening tests for coronary artery disease in asymptomatic individuals who do not have risk factors. Coverage for screening tests such as coronary calcium scoring or coronary CT angiography may be limited to certain high-risk populations or individuals with specific indications.
4. **Alternative or Complementary Therapies**: Medicare typically does not cover alternative or complementary therapies for coronary artery disease that have not been proven to be effective through scientific research. This may include treatments such as chelation therapy, acupuncture, or herbal remedies.
5. **Non-Medically Necessary Services**: Medicare generally does not cover coronary treatments or procedures that are not considered medically necessary or appropriate for the patient's condition. This may include treatments that are considered to be primarily preventive in nature or that do not directly address the underlying coronary artery disease.

It's important for individuals with coronary artery disease and their healthcare providers to carefully review Medicare's coverage policies and guidelines to understand the options available and any potential limitations or restrictions on coverage for specific treatments. In some cases, individuals may have the option to appeal Medicare's coverage decision or explore alternative sources of coverage or financial assistance for coronary treatment costs.

How Medicare’s treatment approval / rejection protocols compare to NICE’s protocols in the UK's National Health Service

Medicare in the United States and the National Health Service (NHS) in the United Kingdom operate under different healthcare systems and have different protocols for determining coverage and treatment approval. While both systems aim to provide access to high-quality healthcare services, there are some key differences in their approaches to treatment approval and rejection:

1. **Medicare in the United States**:
    - Medicare is a federal health insurance program primarily for people aged 65 and older, as well as some younger individuals with disabilities.

- Coverage decisions are made by the Centers for Medicare & Medicaid Services (CMS), which sets coverage policies based on factors such as medical necessity, clinical evidence, cost-effectiveness, and statutory requirements.
- Medicare coverage decisions may vary by region and may be influenced by input from stakeholders, including healthcare providers, beneficiary advocacy groups, and medical societies.
- Medicare generally provides coverage for treatments that are deemed medically necessary and proven to be effective, although coverage for certain treatments may be limited or subject to specific criteria.

2. **National Institute for Health and Care Excellence (NICE) in the United Kingdom**:
    - NICE is an independent organization responsible for providing national guidance and recommendations on health technologies and clinical practices in England and Wales.
    - NICE evaluates the clinical and cost-effectiveness of treatments and interventions through its technology appraisal and clinical guideline programs.
    - NICE assesses the evidence base for treatments and issues guidance on whether they should be recommended for use within the NHS based on considerations such as clinical effectiveness, cost-effectiveness, and impact on patient outcomes.
    - NICE's recommendations are influential in determining access to treatments within the NHS, and healthcare providers are generally expected to follow NICE guidance in their clinical practice.

In terms of stringency, it's challenging to make a direct comparison between Medicare's coverage protocols and NICE's protocols, as they operate within different healthcare systems with unique priorities and constraints. Both systems strive to ensure that patients have access to effective and appropriate treatments while managing costs and promoting high-quality care. However, the specific criteria and processes for treatment approval and rejection may differ between the two systems based on their respective healthcare delivery models and organizational structures.

A brief description of NICE’s rationing protocol

The National Institute for Health and Care Excellence (NICE) in the United Kingdom does not operate under a formal "rationing" protocol per se, but it does employ a rigorous system to assess the clinical and cost-effectiveness of healthcare interventions. Here's an overview of NICE's approach:

1. **Health Technology Assessment (HTA)**: NICE conducts health technology assessments to evaluate the clinical and cost-effectiveness of healthcare interventions, including drugs, medical devices, procedures, and public health programs. These assessments are based on systematic reviews of available evidence, economic analyses, and consultation with clinical experts.
2. **Evidence Review and Appraisal**: NICE reviews the available evidence on the effectiveness and safety of the intervention in question, considering data from clinical trials, observational studies, and other sources. The quality and reliability of the evidence are carefully assessed to ensure robustness.
3. **Cost-Effectiveness Analysis**: NICE evaluates the cost-effectiveness of the intervention by comparing its clinical benefits with its costs. Economic analyses are conducted to assess factors such as the cost per quality-adjusted life year (QALY) gained. NICE uses a cost-effectiveness threshold to determine whether an intervention represents value for money within the context of the NHS budget.
4. **Guidance Development**: Based on its assessment, NICE develops guidance recommending whether the intervention should be adopted within the NHS. This guidance is published in the form of technology appraisals, clinical guidelines, diagnostics guidance, and public health guidance. Recommendations may include advice on which patient groups are most likely to benefit from the intervention, dosage and administration details, and any conditions or criteria for use.
5. **Consultation and Stakeholder Involvement**: NICE involves various stakeholders, including patient representatives, healthcare professionals, industry stakeholders, and the public, throughout the guidance development process. Stakeholder input is sought during scoping, evidence review, and consultation phases to ensure that multiple perspectives are considered.
6. **Implementation**: NICE guidance is intended to inform clinical practice and decision-making within the NHS. While NICE recommendations are not legally binding, healthcare providers and commissioners are generally expected to adhere to NICE guidance in their decision-making processes, subject to local variation and individual patient circumstances.

Overall, NICE's approach aims to ensure that NHS resources are allocated efficiently and that patients have access to effective, evidence-based healthcare interventions that represent value for money. While difficult decisions may arise regarding the funding and provision of certain interventions, NICE's transparent and evidence-based approach seeks to balance clinical need, patient benefit, and affordability within the context of finite healthcare resources.

NICE uses QALYs to determine treatment cost effectiveness

The National Institute for Health and Care Excellence (NICE) in the United Kingdom uses Quality-Adjusted Life Years (QALYs) as a measure of health outcomes to assess the cost-effectiveness of healthcare interventions. QALYs combine both the quantity and quality of life gained from a healthcare intervention into a single measure. Here's how NICE uses QALYs to determine treatment cost-effectiveness:

1. **Definition of QALY**: A QALY is a measure of health outcome that combines both the length of life (quantity) and the quality of life (utility or health-related quality of life) experienced during that time. One QALY is equivalent to one year of life lived in perfect health. Health states considered less desirable than perfect health have QALY values less than 1.
2. **Utility Values**: Utility values represent the quality of life associated with different health states. These values are typically obtained through preference-based measures such as the EuroQol 5-Dimension (EQ-5D) questionnaire, which assesses health-related quality of life across five dimensions (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression). Utility values range from 0 (representing death) to 1 (representing perfect health), with negative values indicating health states worse than death.
3. **Assessment of Health Benefits**: When evaluating a healthcare intervention, NICE considers the impact of the intervention on patients' health-related quality of life over time. This is done by estimating the number of QALYs gained or lost as a result of the intervention compared to the relevant comparator or standard of care.
4. **Cost per QALY**: NICE assesses the cost-effectiveness of a healthcare intervention by calculating the incremental cost per QALY gained compared to the next best alternative or comparator. This involves comparing the additional costs of the intervention (e.g., drug costs, administration costs, monitoring costs) with the additional health benefits in terms of QALYs gained. Interventions with lower incremental cost per QALY gained are generally considered more cost-effective.
5. **Cost-Effectiveness Threshold**: NICE uses a cost-effectiveness threshold to determine whether an intervention represents value for money within the context of the National Health Service (NHS) budget. This threshold represents the maximum amount that the NHS is willing to pay for each additional QALY gained. While the exact threshold may vary over time, it is typically set at around £20,000 to £30,000 per QALY gained.
6. **Decision Making**: Based on its assessment of cost-effectiveness, NICE provides recommendations on whether the intervention should be funded and adopted within the NHS. Interventions with incremental cost-effectiveness ratios below the cost-effectiveness threshold are generally recommended for adoption, while

those above the threshold may face greater scrutiny or may not be recommended for routine use.

Overall, QALYs provide a standardized and quantitative measure of health outcomes that allows NICE to compare the costs and benefits of different healthcare interventions in a consistent and transparent manner. By considering both the costs and health benefits of interventions in terms of QALYs, NICE aims to ensure that NHS resources are allocated efficiently and that patients have access to cost-effective treatments that provide meaningful improvements in health-related quality of life.

What is the EuroQol 5-Dimension (EQ-5D) questionnaire?

The EuroQol 5-Dimension (EQ-5D) questionnaire is a widely used instrument for measuring health-related quality of life (HRQoL) across five dimensions. It is a standardized, generic measure designed to provide a simple, generic measure of health for clinical and economic appraisal. The EQ-5D is used in a variety of healthcare settings, including clinical trials, health technology assessments, and population health surveys. Here's an overview of the EQ-5D questionnaire:

1. **Dimensions**: The EQ-5D assesses health-related quality of life across five dimensions:
    - Mobility: Assessing the respondent's ability to move around.
    - Self-care: Assessing the respondent's ability to perform self-care activities (e.g., bathing, dressing).
    - Usual activities: Assessing the respondent's ability to perform usual activities (e.g., work, study, housework, family or leisure activities).
    - Pain/discomfort: Assessing the respondent's level of pain or discomfort.
    - Anxiety/depression: Assessing the respondent's level of anxiety or depression.
2. **Levels**: Within each dimension, respondents indicate their current health state by selecting one of three levels:
    - No problems
    - Some problems
    - Extreme problems
3. **Scoring**: The EQ-5D descriptive system can be converted into a health utility index by applying country-specific value sets. These value sets are based on preferences elicited from general population surveys using methods such as time trade-off (TTO) or visual analogue scale (VAS). Health utility index scores typically range from 0 (representing death or a health state equivalent to death)

to 1 (representing full health or perfect health). Negative scores are possible, indicating health states considered worse than death.

4. **EQ VAS**: In addition to the EQ-5D descriptive system, the EQ-5D questionnaire includes a visual analogue scale (EQ VAS) where respondents rate their current health status on a vertical scale ranging from 0 (worst imaginable health state) to 100 (best imaginable health state).
5. **Versions**: The EQ-5D questionnaire is available in several versions, including the EQ-5D-3L (3-level version) and the EQ-5D-5L (5-level version), which offers greater sensitivity by providing five response levels for each dimension.

The EQ-5D questionnaire is used to assess and quantify health-related quality of life from the patient's perspective, allowing for comparisons of health outcomes across different populations, interventions, and healthcare settings. Its simplicity and ease of administration make it a valuable tool for health outcome measurement in both research and clinical practice.

QALY value in US dollars, 2024

The value of a Quality-Adjusted Life Year (QALY) in US dollars in 2024 is not a fixed or standard figure. The concept of a QALY is used primarily in health economics and healthcare decision-making to assess the cost-effectiveness of medical interventions. The value of a QALY can vary depending on several factors, including the perspective of the analysis, the healthcare system context, the specific intervention being evaluated, and the willingness-to-pay threshold used by decision-makers.

In the United States, there isn't a universally accepted value for a QALY as there is in some other countries with government-funded healthcare systems. Instead, decision-makers such as insurers, healthcare providers, and policymakers may use different methods or criteria to determine the value of a QALY within their specific contexts.

Some economic evaluations in the US healthcare system may use a willingness-to-pay threshold, which represents the maximum amount that society is willing to pay for a QALY gained. This threshold can vary but is often cited to be in the range of $50,000 to $150,000 per QALY gained. However, it's important to note that these values are not fixed and can vary depending on the context and the preferences of decision-makers.

In summary, the value of a QALY in US dollars in 2024 is not a set figure and would depend on the specific analysis, context, and willingness-to-pay threshold used in the evaluation.

How the dollar value of 1 QALY is determined

The dollar value of 1 Quality-Adjusted Life Year (QALY) is not determined based on an individual's income or earnings. Instead, it is typically assessed in health economics

studies and healthcare decision-making processes using a willingness-to-pay (WTP) threshold or cost-effectiveness threshold.

The willingness-to-pay threshold represents the maximum amount that society is willing to pay for one additional QALY gained from a healthcare intervention. This threshold is often determined based on various factors, including societal preferences, budget constraints, opportunity costs, and the value of health improvements relative to other goods and services.

Decision-makers such as government agencies, insurers, and healthcare providers may use different methods to establish a willingness-to-pay threshold within their specific contexts. Some countries with government-funded healthcare systems have established explicit thresholds for cost-effectiveness analysis. For example, in the United Kingdom, the National Institute for Health and Care Excellence (NICE) has historically used a threshold range of £20,000 to £30,000 per QALY gained as a reference point for assessing the cost-effectiveness of healthcare interventions within the National Health Service (NHS).

In the United States, willingness-to-pay thresholds may vary depending on the payer, the specific healthcare intervention being evaluated, and other contextual factors. While there is no universally accepted threshold, some studies have suggested thresholds in the range of $50,000 to $150,000 per QALY gained based on empirical analyses and surveys of societal preferences.

It's important to note that the dollar value of a QALY is not directly tied to an individual's income or earnings. Instead, it reflects societal preferences and the value placed on health improvements relative to other goods and services. Therefore, 1 QALY gained from a healthcare intervention would generally be considered equally valuable regardless of the individual's income level.

The difference in estimated values of a Quality-Adjusted Life Year (QALY) between Harvard Professor David Cutler's estimation in 2003, in his book Your Money or Your Life, and current estimations can be attributed to several factors:

1. **Methodological Differences**: Different researchers may use different methods and assumptions to estimate the value of a QALY, leading to variation in results. David Cutler's estimation in 2003 may have relied on different data sources, economic models, or approaches compared to more recent estimations.
2. **Changes in Healthcare Costs**: Healthcare costs and the cost-effectiveness of medical interventions can change over time due to factors such as advances in medical technology, changes in treatment patterns, and shifts in healthcare delivery models. These changes can affect the perceived value of health improvements and may contribute to differences in estimated values of a QALY over time.

3. **Changes in Societal Preferences**: Societal preferences regarding the value of health improvements and the allocation of healthcare resources may evolve over time. Attitudes towards healthcare spending, willingness to pay for health benefits, and ethical considerations can influence the perceived value of a QALY and may vary across different time periods and contexts.
4. **Inflation Adjustments**: While inflation is a factor to consider when comparing economic values over time, it's important to note that the value of a QALY is not solely determined by inflation. Changes in healthcare costs, healthcare utilization patterns, and societal preferences can also influence the estimated value of a QALY, independent of inflation.
5. **Data Availability and Quality**: The availability and quality of data used to estimate the value of a QALY may have improved over time, leading to more accurate and reliable estimates in recent years. Advances in data collection methods, health outcomes research, and economic modeling techniques can contribute to more robust estimations of the value of health outcomes.

Overall, the discrepancy in estimated values of a QALY between David Cutler's estimation in 2003 and current estimations may reflect differences in methodology, changes in healthcare costs and societal preferences, and improvements in data availability and quality over time. It's essential to interpret estimates of the value of a QALY within the specific context of the analysis and to consider the underlying assumptions and limitations of the methods used to generate these estimates.

Quality-Adjusted Life Years (QALYs) have been widely used in health economics and healthcare decision-making for several decades, and the theory and methodology behind QALYs are generally accepted within the healthcare research and administration community. Here are some reasons why QALYs are widely accepted:

1. **Standardized Measure**: QALYs provide a standardized and quantitative measure of health outcomes that allows for comparisons across different health interventions, populations, and healthcare settings. This makes QALYs a valuable tool for assessing the effectiveness and value of healthcare interventions in a consistent and transparent manner.
2. **Incorporation of Patient Preferences**: QALYs incorporate patient preferences for health states, as measured through preference-based instruments such as the EuroQol 5-Dimension (EQ-5D) questionnaire or the Health Utilities Index (HUI). By capturing individuals' subjective valuations of health-related quality of life, QALYs provide a patient-centered perspective on health outcomes.
3. **Cost-Effectiveness Analysis**: QALYs are commonly used in cost-effectiveness analysis to assess the value for money of healthcare interventions. By comparing the costs of interventions with the health benefits in terms of QALYs gained,

decision-makers can prioritize resource allocation and identify interventions that offer the greatest health improvements for a given budget.

4. **Regulatory and Reimbursement Decisions**: QALYs are used by government agencies, insurers, and healthcare providers to inform regulatory decisions, reimbursement policies, and coverage determinations. For example, agencies such as the National Institute for Health and Care Excellence (NICE) in the United Kingdom use QALYs to assess the cost-effectiveness of healthcare interventions and provide guidance on their adoption within the healthcare system.
5. **Transparency and Accountability**: QALYs promote transparency and accountability in healthcare decision-making by providing a clear and quantifiable measure of health outcomes. By explicitly considering both the costs and benefits of healthcare interventions in terms of QALYs, decision-makers can justify resource allocation decisions and prioritize interventions that offer the greatest health gains per dollar spent.

While QALYs are widely accepted and commonly used in healthcare research and administration, it's important to acknowledge that they are not without limitations. Criticisms of QALYs include concerns about equity, cultural differences in valuing health states, and challenges in measuring complex health outcomes comprehensively. Despite these limitations, QALYs remain a valuable tool for evaluating health outcomes and informing resource allocation decisions in healthcare.

QALYs and Medicare for All

The inclusion of Quality-Adjusted Life Years (QALYs) in a Medicare for All system would depend on various factors, including the specific design of the healthcare system, policy priorities, and political considerations. Here are some points to consider:

1. **Cost-Effectiveness Analysis**: Medicare for All would likely aim to provide comprehensive healthcare coverage to all residents of the United States. While cost containment measures would be necessary to ensure the sustainability of the healthcare system, the extent to which cost-effectiveness analysis, including the use of QALYs, would be incorporated into decision-making could vary.
2. **Political Considerations**: The use of QALYs in healthcare decision-making is a topic of debate, and opinions on their appropriateness and ethical implications vary. Some stakeholders argue that QALYs can help ensure efficient resource allocation and promote value-based healthcare delivery, while others raise concerns about equity, fairness, and the potential for discriminatory practices.
3. **Patient-Centered Care**: Medicare for All would likely prioritize patient-centered care and equitable access to healthcare services. While QALYs provide a standardized measure of health outcomes, they may not fully capture individual

preferences, values, and priorities. As such, there may be a need to balance the use of QALYs with other considerations, such as patient-reported outcomes and shared decision-making.

4. **Regulatory and Reimbursement Policies**: If QALYs were to be incorporated into a Medicare for All system, they could potentially inform regulatory decisions, reimbursement policies, and coverage determinations. Government agencies responsible for healthcare oversight and administration, such as the Centers for Medicare & Medicaid Services (CMS), could use QALYs to assess the cost-effectiveness of healthcare interventions and guide resource allocation decisions.
5. **Public Perception and Acceptance**: The inclusion of QALYs in a Medicare for All system would likely be subject to public scrutiny and debate. Stakeholder engagement, transparency, and accountability would be important considerations in shaping healthcare policy and ensuring that decision-making processes are perceived as fair and equitable.

Ultimately, the inclusion of QALYs in a Medicare for All system would require careful consideration of the benefits, challenges, and implications for healthcare delivery, patient outcomes, and healthcare spending. Policymakers would need to weigh the potential advantages of using QALYs to inform resource allocation decisions against concerns about equity, access, and patient-centered care.

In Canada, the healthcare system is publicly funded and administered at the provincial and territorial level, with each province and territory responsible for delivering healthcare services to its residents. While Canada's healthcare system, often referred to as Medicare, provides universal coverage for medically necessary healthcare services, the use of Quality-Adjusted Life Years (QALYs) to determine treatment approval or rejection varies across jurisdictions.

Generally, Canadian healthcare decision-making processes prioritize evidence-based medicine, clinical effectiveness, and cost-effectiveness in treatment decisions. Health technology assessment (HTA) agencies, such as the Canadian Agency for Drugs and Technologies in Health (CADTH) and the Institut national d'excellence en santé et en services sociaux (INESSS) in Quebec, play a significant role in evaluating the clinical and economic evidence for healthcare interventions.

While QALYs are commonly used in health economics and healthcare decision-making worldwide, including in countries with government-funded healthcare systems such as the United Kingdom, their use in Canada may vary. Some HTA agencies in Canada may incorporate QALYs or similar measures of health-related quality of life into their assessments of healthcare interventions to assess their cost-effectiveness and value for money.

However, the extent to which QALYs are used to inform treatment approval or rejection decisions in Canada can depend on several factors, including jurisdictional differences,

institutional practices, stakeholder preferences, and public policy priorities. Other considerations, such as patient preferences, equity, and feasibility, may also influence healthcare decision-making in Canada.

In summary, while QALYs may be used as part of health technology assessment processes in Canada, their use and influence on treatment approval or rejection decisions may vary across provinces and territories. Decision-makers in Canada typically consider a range of factors, including clinical effectiveness, cost-effectiveness, patient preferences, and equity, when making decisions about the allocation of healthcare resources and coverage of healthcare interventions.

In France, healthcare decision-making is guided by the principles of solidarity, universality, and equity, with a strong emphasis on ensuring access to high-quality healthcare for all citizens. The French healthcare system, known as "l'Assurance Maladie" or "la Sécurité Sociale," is based on a mix of public and private financing and delivery of healthcare services.

While Quality-Adjusted Life Years (QALYs) are commonly used in health economics and healthcare decision-making in some countries, such as the United Kingdom, their use in France may be less prevalent. Instead, the French healthcare system relies on a combination of clinical effectiveness, evidence-based medicine, and economic evaluation to inform treatment approval or rejection decisions.

The French National Authority for Health (Haute Autorité de Santé, HAS) plays a key role in evaluating the clinical and economic evidence for healthcare interventions and providing recommendations to inform healthcare policy and practice. HAS conducts health technology assessments (HTAs) to assess the clinical benefits, safety, and cost-effectiveness of new drugs, medical devices, procedures, and healthcare technologies.

While HAS may consider measures of health-related quality of life, such as QALYs, as part of its HTA processes, the specific methods and criteria used to evaluate healthcare interventions in France may vary. HAS takes into account a range of factors, including clinical effectiveness, patient safety, public health impact, and economic considerations, when making recommendations about the adoption and reimbursement of healthcare interventions.

Decision-making in France typically emphasizes evidence-based medicine, clinical effectiveness, and patient-centered care to ensure the delivery of high-quality healthcare services to the population.

While the British National Health Service (NHS) incorporates Quality-Adjusted Life Years (QALYs) into its health technology assessment processes to assess the cost-effectiveness of healthcare interventions, and to provide guidance on treatment decisions, it's not accurate to characterize the French system as allowing for more subjective decisions made solely by individual doctors.

Both the NHS in the UK and the French healthcare system (l'Assurance Maladie) rely on evidence-based medicine, clinical guidelines, and health technology assessment to inform treatment decisions. Here's a nuanced view:

1. **British National Health Service (NHS)**:
    - The NHS uses QALYs and other measures of health outcomes as part of its health technology assessment processes conducted by organizations like the National Institute for Health and Care Excellence (NICE). These assessments inform recommendations about which healthcare interventions should be funded and provided within the NHS.
    - While NICE provides guidance on the cost-effectiveness of healthcare interventions, individual treatment decisions are typically made by healthcare professionals in consultation with patients, taking into account clinical considerations, patient preferences, and other factors.
2. **French Healthcare System (l'Assurance Maladie)**:
    - In France, the Haute Autorité de Santé (HAS) conducts health technology assessments to evaluate the clinical and economic evidence for healthcare interventions. HAS provides recommendations to inform healthcare policy and practice, including reimbursement decisions.
    - Like in the UK, individual treatment decisions in France involve healthcare professionals (including doctors) working with patients to make decisions based on clinical evidence, patient preferences, and other relevant factors.

In both systems, treatment decisions are guided by a combination of clinical evidence, patient preferences, and healthcare professionals' expertise. While QALYs and health technology assessment may play a more prominent role in decision-making within the NHS, and individual doctors in France may have more autonomy, both systems aim to ensure access to high-quality, evidence-based healthcare for their populations. Ultimately, treatment decisions are made collaboratively between healthcare professionals and patients, taking into account the best available evidence and the individual needs and preferences of the patient.

1 Alain Enthoven 'The History and Principles of Managed Competition' Health Affairs Supplement, 1993, page 27

2 ibid., page 29

3 Alain C. Enthoven and Laura A. Tollen, editors 'Toward a 21st Century Health System' Jossey-Bass, 2004, page xxix

4 David Dranove, The Economic Evolution of American Healthcare, Princeton University Press, 2000, page 40

5 ibid., page 39

6 Much of this analysis is based on Regina Herzlinger, Who Killed Healthcare, McGraw-Hill, 2007, pages 36 - 46

7 ibid., page 43

8 ibid, pare 47. Next quote ibid, page 43

9 Much of this section comes from Jan Gregoire Coombs, 'The Rise and Fall of HMOs' University of Wisconsin Press, 2005, chapter 2

10 Gitterman, Weiner, Domino, McKethan and Enthoven, Rise and Fall of a Kaiser Permanente Expansion Region, Milbank Quarterly, Vol 81, No 4, 2003

11 Dranove, op cit. page viii. Much of this section is based on Chapter 3.

12 ibid. page 25

13 ibid. page 58

14 ibid. page x

15 CBO Testimony: Statement of Robert d. Reischauer, Deputy Director, Congressional Budget Office before the Subcommittee on Oversight, Committee on Ways and Means, US House of Representatives, June 27, 1979

16 Dranove, op. cit. pages 78 - 79

17 J. Wennberg, et. al. 'Are Hospital Services Rationed in New Haven or Over-Utilized in Boston?' Lancet 1 (1987): 1185-1188

18 See also Dartmouth Atlas of Healthcare, Jack Wennberg, ed (Chicago: American Publishing, 1996, 1999) which shows variation in a wide range of treatments diagnostic tests and drug therapies.

19 T. Wickizer et. al. 'Does Utilization Review Reduce Unnecessary Hospital Care and Contain Costs?' Medical Care 27 (1989): 632-47

20 V. G. Freeman et. al 'Lying for Patients: Physician Deception of Third Party Payers', Archives of Internal Medicine (1999): 2263 - 70

21 Sean Hennessy et. al 'Retrospective Drug Utilization Review, Prescribing Errors and Clinical Outcomes' Journal of the American Medical Association, Vol. 290, No. 11, September 17, 2003

22 Stephen Rosenberg, et. al. 'Effect of Utilization Review in a Fee-for-Service Health Insurance Plan' New England Journal of Medicine, Volume 333: 1326-31, November 16, 1995

23 Norman Kalant et.al. 'How Valid are Utilization Review Tools in Assessing Appropriate Care of Acute Care Beds' CMAJ June 27, 2000: 162(13)

24 Dranove, op cit., page 84

25 Herzlinger, Who Killed, page 48

26 Economist, July 15, 2004

27 Alain C. Enthoven 'The History and Principles of Managed Competition' Health Affairs Supplement, 1993; 'Why Managed Care Has Failed to Contain Health Costs' Health Affairs, Fall 1993. Quotes in this section come from these two articles unless otherwise indicated.

28 Much of this discussion comes from Seven A. Schroeder, 'The Clinton Healthcare Plan: Fundamental or Incremental Reform?' Annals of Internal Medicine, Nov 1, 1993, Volume 119, Issue 9, pages 945 - 947

29 Much of this discussion comes from Derek Bok, 'The Great Health Care Debate of 1993 – 1994' available at www.upenn.edu/pnc/ptbok/html

30 Stephen M Shortell and Julie Schmittdiel 'Prepaid Groups and Organized Delivery Systems: Promise, Performance, and Potential' in Enthoven and Tollen, editors, 'Toward a 21st Century Health System' John Wiley & Sons, 2004

31 Herzlinger, Who Killed, page 47. Next quote from same source, page 48

32 Enthoven and Tollen, eds., op cit. Preface, page xxxi

33 This section comes from Gitterman, Weiner, Domino, McKethan and Enthoven, Rise and Fall of a Kaiser Permanente Expansion Region, Milbank Quarterly, Vol 81, No 4, 2003

34 Regina Herzlinger 'Market Driven Healthcare' op cit. page 148

35 Enthoven and Tollen, op cit. page xxxi

36 Stephen M Shortell, op cit. page 14

37 Enthoven, History and Principles of Managed Compeition, page 34. Emphasis added.

37 Dranove, op cit. Introduction