3. WHAT'S THE EVIDENCE THAT WE SPEND ENOUGH? UP TO ONE-HALF OF HEALTH SPENDING IS WASTED

22 August 2026

Kissick posited an iron triangle: that health spending must rise or quality must fall (or both) if all Americans are to be covered.[1404] Carroll has popularized this notion.[1405] Fiorentini identifies 10 things she'd give up to get free health care.[1406]

But this pessimism is as deadly as it is absurd. It's deadly because it paralyzes action. It is absurd because it flies in the face of three realities.

First, a look over time at the rise in U.S. health spending reveals enormous increases—while the improvements in the quantity or outcomes of health care are not remotely commensurate with those increases.

Second, a look across the world's rich democracies offers persuasive evidence that current U.S. spending is enough to finance the health care that works for the people who need it. Remarkably, other nations cover all people, deliver more care, spend one-half as much as the U.S., and enjoy greater longevity. To spend so much to achieve such inferior care is the American health care tragedy.

Third, up to one-half of U.S. health spending is wasted. Clinical waste is unneeded, incompetent, or low-value/high-cost care—or delivered by the wrong caregivers in the wrong places. Administrative waste stems from complexity of U.S. methods of covering people and paying caregivers, and from soaring mistrust between payers and caregivers. High prices boost spending unnecessarily. And outright theft diverts dollars from care to crooks.

This waste is the main reason U.S. health care costs twice as much per person as the rich democracy average, while providing less care to fewer people.

The iron triangle theory supposes that political, financial, legal, and care delivery reforms can't squeeze out waste—that waste is somehow baked into U.S. health care. That better coverage, lower cost, or higher quality must inevitably harm one or both of the others.

This view—like the belief that prevention substitutes for health care or the belief that investing in SDLs is possible today and could save health care dollars tomorrow—lets health care off the hook. It relieves health care of the duty to reform—and absolves us if we fail to try to reform it.

The iron triangle view also serves to rationalize ever-higher health care spending to boost access or quality.

Americans spend enough on health care. Enough to finance high-quality care that works for all the people who need it. Enough to pay for medical security for all Americans.

Not enough for immortality. As noted in chapter 2, pathology is remorseless but resources are finite. Medical care, like prevention, has a 100 percent failure rate. The first challenge is to recognize how much we spend; the second is to find ways to spend better. That means cutting the waste that clings parasitically to U.S. health care.

A. Changes over time

A startling picture emerges when we compare U.S. health spending in 2020 with that five decades earlier. As shown in Exhibit 3-1, real (inflation-adjusted) health care spending per American has more than quintupled in 50 years. That is, it rose 5.2-fold from $2,401 in 1970 to $12,459 in 2020.[1407]

Exhibit 3 – 1

U.S. Health Spending, 1970 and 2020

	1970	2020	2020 multiple of 1970
NHE, current $M	$74,563	$4,124,010	55.3
GDP, current $B	$1,073.3	$20,893.7	19.5
Population, M	210.2	331	1.6
CPI-U, 82-84 base	38.8	262.6	6.8
Health % GDP	6.9%	19.7%	2.8
Health $/person, current	$355	$12,459	35.1
CPI-adjusted constant 2020 NHE, $M	$504,645	$4,124,010	8.2
Health $/person, constant $s	**$2,401**	**$12,459**	**5.2**

This might not initially seem startling today. But let's conduct a short thought experiment. Suppose we were to enter the world of 1970. Suppose we interviewed many health care experts—in federal or state governments, in hospital associations or medical societies or drug companies, in insurance companies or HMOs, and in universities.

And suppose we were to ask them, then, whether they thought it possible to quintuple real health care spending per person in five decades—by 2020—without financially protecting all Americans against cost of care, and without substantially boosting health outcomes.

I suspect they would all have said that this would be impossible. The bulk of this chapter describes the types and causes of waste that helped make it possible. Subsequent chapters will set out the political, financial, and medical forces, intentions, decisions, accidents, and miscalculations that made the waste possible.

B. Changes across nations, 1970 to 2020

Interestingly, the world's other rich democracies build better health care in radically different ways. Some rely on single payers but most use multiple payers. Some pay doctors mainly by salary while others rely heavily on fee-for-service or capitation or even fee-for-time. In very different ways, they cover all people and give more care at much lower cost and live longer.

The world's other rich democracies spend, on average, less than one-half as much per-person on health care as does the U.S.[1408] They cover everyone. They give more health care services per person. They live longer and suffer lower levels of disability.

Moreover, they do this even though their population shares over age 65 are higher than the U.S., and even though their health care workers are substantially likelier to be unionized.[1409]

Remarkably, the U.S. is the only rich democracy to find ways to fail to do all these good things.

How is all this possible?

Exhibit 3-2

U.S. and OECD Health Statistics, 1970 and Latest, with U.S. Multiple of OECD

Characteristic (and initial year - if not 1970)	1970 OECD	1970 US	1970 US multiple of OECD		OECD latest	US latest	Latest US multiple of OECD	Year	No. of EOCD nations
Health % GDP	4.7%	6.2%	1.3		10.0%	17.0%	1.7	2019	20
Health $/person, PPPs	$184.5	$327.0	1.8		$5,206.3	$11,071.7	2.1	2019	20
Doctor visits/person		4.6			6.6	4	0.6	2018	35
Beds/1,000 (initial year is 1980)	8.0	6.9	0.9		5.1	2.9	0.6	2018	19
Hospital discharges/100,000 (1990)	13,886	16,575	1.2		16,319	12,550	0.8	2018	25
Average length-of-stay, days (1990)	13.9	9.1	0.7		8.1	6.1	0.8	2018	26
Patient-days/100,000 (1990)	193,015	150,833	0.8		132,184	76,555	0.6	2018	25
Life expectancy at birth	69.8	70.9	1.02		80.7	78.7	0.98	2018	36
Life expectancy at 65, women	15.6	17	1.09		21.4	20.7	0.97	2018	31
Potential years of life lost, men	15,404	16,559	1.07		5,407	8,293	1.53	2016	27

Sources: For all items but U.S. 1970 doctor visits per person, see OECD, Frequently Requested Health Statistics, June 2020. For 1970 U.S. doctor visits per person, is average of 1968 and 1972 ratios.
For 1968, see National Center for Health Statistics (NCHS), *Vital and Health Statistics*, Data from the National Health Survey, Series 10, No. 60, June 1970, https://www.cdc.gov/nchs/data/series/sr_10/sr10_060acc.pdf, table 19.

For 1972, see NCHS, Vital and Health Statistics, Series 10, No. 85, September 1973, https://www.cdc.gov/nchs/data/series/sr_10/sr10_085.pdf, table C.

PPP is purchasing power parity, the measure used to convert other nations' spending into U.S. dollar equivalents. Potential years of life lost is years lost before age 70, per 100,000 men.

One clear lesson is that formulaic reforms like "single payer" are not the only possible answer. Single payer is fine if people want it. But all payer arrangements are also a fine way to affordably and equitably cover all people. We need to dig under the bumper sticker slogans to identify what might work.

How has the U.S. devised arrangements that are inferior in so many ways? What key elements are missing from U.S. health care coverage, methods of raising money or paying caregivers, efforts to influence caregiver configuration, and other things that influence health care?

As shown in Exhibit 3-2, despite faster growth in health care spending and substantial efforts to improve coverage, the U.S. fell further behind the typical rich democracy on most care, cost, and outcome measures during the five decades between 1970 and 2020.[1410]

U.S. health spending—both as a share of GDP and in dollars per person—was higher in 1970 than in the rich democracies on which data were available, and higher still in 2020.

Even as spending rose relative to the other nations examined, use of care in the U.S. fell relative to those nations. Average U.S. doctor visits per person fell from an estimated 4.6 per person in 1970 to 4.0 per person in 2020. In 2020, Americans visited the doctor only 60 percent as often as did citizens of other rich democracies.

Hospital beds per person fell from 90 percent to 60 percent of the OECD average. The rate of discharges from the hospital fell from a 20 percent excess over the OECD average to only 80 percent of the OECD average. Patient-days of inpatient care per person fell from 80 percent to 60 percent of the rich democracy average.

During these five decades, as spending rose and use of care fell in the U.S. relative to the other nations examined, health outcomes deteriorated. In 1970, life expectancy at birth for all Americans and at age 65 for American women had been slightly greater than in the other nations; both fell to slightly lower by 2020. Potential years of life lost by age 70 for men had been 7 percent greater in the U.S. in 1970 but rose to 53 percent greater in 2020.

All this means, first, that the U.S. spends more money to give less care to fewer people and suffers inferior health outcomes. And second, that the relative position of the U.S. deteriorated by almost all measures over the five decades just examined.

Nolte and McKee reinforced this finding of deterioration when they examined preventable death rates in OECD nations in 1997 and 2002. They reported that the U.S. fell from 15th-worst in 1997 to worst in 2002.[1411]

C. Waste

Introduction – 2 views of waste – deep or shallow?

The U.S. spends enough to finance affordable high-quality needed health care for all 340 million who live here. Our failure to do so signals enormous waste—or care, of money, of opportunities to do better.

Substantial waste is widely disseminated throughout U.S. health care. This is the third type of evidence that our nation's health spending suffice to finance the care that works for all the people who need it.

This has been well-understood in some quarters for at least a half-century.

Denenberg's 1974 analysis of "The Wasteland" identified 7 main wasteful failings of U.S. health care. One was the shortage and maldistribution of professionals and facilities. A second was unwillingness to contain costs. A third was weak mechanisms to protect quality. A fourth was vast clinical waste. A fifth was hospitals' bad management and status-seeking expansion. A sixth was failure of doctors—said to control over four-fifths of health spending—to learn what care works and who needs it. A seventh was payers' disinterest in improving the effectiveness and efficiency of the care they financed.[1412] [1413] Denenberg sees most of this waste as deeply embedded in the current structure of U.S. health care.

By contrast, in an important editorial, Berwick examined 3 possible reasons for the failure to attack health care waste: disinterest, technical difficulty of extracting it, and political paralysis.[1414] Berwick focuses on the last.

That might seem reasonable but it has the effect of minimizing the difficulty and complexity of fighting waste.

Waste in health care is not marbled like fat in prime cuts of beef. Nor is it conveniently concentrated in slabs at the sides of the cuts, ready to be sliced off. Rather, most is tightly integrated into the most intricate daily operations of U.S. health care. It is embedded.

Denenberg's view is generally more realistic.

Prior authorization is a prime example. Political paralysis might explain its persistence. But a more likely reason for its survival is that, wasteful as it is, it suppresses access to care and use of care, holding down costs. Prior approval is a very inefficient, unfair, and infuriating way to hold down costs. Even so experienced and intelligent an analyst as Altman regretfully insists that removing prior authorization from today's wasteful armamentarium of cost controls would

boost spending substantially.[1415] He concludes that today's U.S. health care lacks alternatives ways to cut cost and deny unneeded or high-cost/low-value services.

Which means that administrative simplification is unlikely without establishing simple but trustworthy methods of containing cost and of paying caregivers.

Waste thrives in U.S. health care because few fight it effectively. The main reasons for failure to do so parallel the reasons for failure to contain cost: little perceived direct gain by politically organized interests, paralysis by advocates of traditional free market competition or traditional government regulation, and fear that containing cost or extracting waste would mean less money to finance business as usual in health care.

I do not believe that enormous waste in U.S. heath care is intentionally desired for the reason constant warfare is desired by the Eurasia, East Asia, and Oceania superstates in Orwell's *1984*. That is, waste is not embraced as conspicuous destruction of resources that would otherwise be plentiful—in order to keep health care in short supply—in order to reward elites and impoverish, weaken, and distract everyone else.[1416] But health care waste has a similar effect in the U.S. today.

No machine, organization, or activity is 100 percent efficient.

For example, wide variations are reported in the efficiency of various uses of fossil fuels. Internal combustion engines that power cars attain fuel efficiency of some 18 to 36 percent—the share of energy that moves the car. The rest is lost to heat, wind resistance, and friction.[1417] Generating electricity with fossil fuels is typically 35 to 45 percent efficient. Conventional home heating with fossil fuels can be 56 to 70 percent efficient, but new systems can be up to 98 percent efficient.[1418]

Critics have decried waste and inefficiency in many sectors. LePatner, for example, nominated construction as the least productive industry in the U.S.[1419]

Waste is double the cost of reform

The mid-point of the estimates of waste shown in Exhibit 3 – 4 is $1.8 trillion in 2024, about 37 percent of 2024 NHE of $4.9 trillion. Chase's review estimated waste between 30 and 50 percent of health spending.[1420]

This is double the estimated cost of 9 major reforms sketched in Exhibit 3 – 3.

Squeezing, capturing, and recycling about one-half of waste will suffice to pay for the strategic reforms and investments that will win durable medical security for all Americans.

Small- or medium-size discrete steps versus coordinated larger steps? Importantly, some assert that a substantial share of waste can be excised directly and incrementally by targeted or mechanical reforms.[1421] Rosenbloom points to the "scam" of prior authorization and cites the value of requiring insurance companies to publish their rates of denying prior authorization as one strategic step.[1422]

Decrying greed and the high health costs that result from greed—in the absence of competitive free markets (chapter 4), Fisher and Isham identify a number of useful federal, state, and other steps.[1423]

Federal actions include coverage for all people, compiling better information on risks and benefits of all meds and surgical procedures, preparing better—but less burdensome—measures of performance of both caregivers and insurers, anti-trust enforcement, price regulation when needed, and transition to mandatory global payments.

State actions include Medicaid expansions and state experimentation with ways to contain cost and cover more people—subject to federal ERISA amendment.

Locally, Fisher and Isham call on caregivers and payers to adopt a fiduciary mindset, acting as stewards to make the best use of scare resources. I think this is essential but that it must be combined both with rejection of market competition and traditional government regulation in health care, and with coverage for all people, cost controls, and caregiver reconfigurations.

Mechanical, incremental, and uncoordinated individual reforms should be attempted by those who believe in their efficacy. But I believe that most waste can be squeezed out (or blasted out) only by deep and coordinated efforts. And that this must be done in ways that capture saved dollars and recycle them. This will allow the U.S. to escape the irresponsible and anarchic financial, political, and bureaucratic game-playing that have pervaded U.S. health care for decades.

The most important reforms are expected to cost close to $983 billion yearly, or 20.0 percent of NHE in 2024. The estimated costs and their derivations are set out in Exhibit 3 – 3.

Exhibit 3 – 3

Major Reforms and Their Estimated Costs in 2024

Reform	No. in need	Est. 2024 $M
1. Fully protecting currently uninsured Americans	25,600,000	$260,000
2. Halving OOPs for currently insured	315,000,000	$255,000
3. Adding dental insurance for those lacking it	170,000,000	$183,000
4. Adding solid hearing and eye care coverage to Medicare	66,000,000	$25,000
5. Assuring all needed hospitals revenue sufficient to pay for efficient delivery of needed services, @ mean of $20 M/hospital	5,000	$100,000
6. Boosting primary caregivers' incomes and lowering panel size to 1,000 for doctors and 500 for NPs/PAs	103,000,000	$100,000
7. Putting in place simpler, effective, and durably politically acceptable methods of containing health care costs,		$10,000
8. Improving efficacy/effectiveness of clinical services, and		$25,000
9. Boosting appropriateness and quality of care.		$25,000
Total, initial year		$983,000

Notes

1. 25.6 million uninsured in 2022[1424] * age adjusted spending per person in 2020,[1425] - and raised by 19.5 percent to reflect the rise in NHE between 2020 and 2024.
2. OOPs were roughly 11 percent of NHE in 2022.

11% of $4.9T in 2024 = $540 billion.

An estimated $31 billion in 2024 OOPs was paid by uninsured people.

That leaves about $510 billion in OOPs paid by insured people. One-half of that is $255 billion.
3. Added cost of dental insurance for all is simply an increment equal to projected 2024 dental spending.
4. This yearly sum is double that estimated by CBO in 2019 for less generous benefits; this figure is net of current MA spending on hearing and eye care.[1426]
5. A crude estimate would be to add $5M to the revenue of the average acute care hospital.
6. Boost FTE MD or DO PCs' incomes to $400,000 + 30% fringe benefits = $520,000.
Boost FTE NP or PA income to $200,000 + 30% fringe benefits $260,000.
Add enough primary caregivers to drop panel size to 1,000 for docs and 500 for others.

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Summary of different estimates and sources of waste

The four main types of waste are clinical, administrative, high prices, and theft. Various estimates of each type of waste are now catalogued. Then, causes of each of the types are analyzed. Methods of weakening the power of these causes are presented in subsequent chapters.

Exhibit 3 – 4 summarizes six sets of estimates of waste and its sources. The clinical waste category combines three types of clinical waste, failures of care delivery and quality, failures of care coordination, and over-treatment that are sometimes estimated separately.

Exhibit 3 – 4

Six Views of Waste, Categorized

	Turner + others	Shrank + others	Berwick + Hackbarth	Sager + Socolar	Mc-Kinsey	Lehman Brothers
Clinical	?	7.3	13.1	22.0	8.8	11.0
Administrative	15.0	7.0	9.2	15.0	5.8	18.0
High prices	12.5	6.2	4.9	8.0	16.7	11.0
Theft	* 5.0	1.9	6.6	5.0	* 5.0	5.0
Other	2.5					6.0
Total	35.0	22.3	33.7	50.0	36.3	51.0
Year estimated	2023	2019	2011	2005	2003	2000

Note
* 5.0 percent imputed for theft—added to estimates of Turner and others and McKinsey

Sources

Ani Turner, George Miller, and Elise Lowry, "High U.S. Health Care Spending: Where Is It All Going?" Commonwealth Fund, 4 October 2023, https://www.commonwealthfund.org/publications/issue-briefs/2023/oct/high-us-health-care-spending-where-is-it-all-going.

William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, "Waste in the U.S. Health Care System: Estimated Costs and Potential for Savings," *Journal of the American Medical Association,* Vol. 322, No 15 (15 October 2019), pp. 1501-1509, https://jamanetwork.com/journals/jama/fullarticle/2752664. Midpoint of estimates.

Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," *Journal of the American Medical Association,* Vol. 307, No. 14 (11 April 2012), pp. 1513-1516, https://pubmed.ncbi.nlm.nih.gov/22419800/. Middle estimates.

Carlos Angrisano, Diana Farrell, Bob Kocher, and others, "Accounting for the Cost of Health Care in the United States," McKinsey&Company, January 2007, https://www.mckinsey.com/industries/healthcare/our-insights/accounting-for-the-cost-of-health-care-in-the-united-states.

Lehman Brothers, "The Health Care Industry is Large and Inefficient," presentation to Harvard Business School Alumni Association, 18 January 2000.

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As also shown in Exhibit 3 – 4, credible estimates range from 22 percent to just over 50 percent. A number of others place waste's share at one-half of national health expenditures. Applied to the nearly $4.9 trillion in projected NHE for 2024, those estimates translate into between $1.1 trillion and $2.5 trillion in waste in 2024. The mid-point of these estimates is $1.8 trillion in 2024.

Unsurprisingly, estimates of the share of U.S. health spending that is wasted disagree substantially. One reason is difference in focus. Different analysts seem to have been more concerned about some sectors than others. For example, one study estimated waste owing to high prices at one-sixth of health spending while two others put that waste in the 5 to 6 percent range.

Waste comes in 4 main forms: clinical, administrative, excess prices, and theft. Various writers have sought to estimate them. Some are comprehensive but others address only a few forms. Some provide separate estimates of components of each type of waste.

Boundaries between some of the 4 categories of waste are sometimes sharp but sometimes cloudy. The same act could fit mainly in one category of another, often depending partly on what motivated the act. One example: providing low-value but profitable care out of ignorance would be clinical waste. But doing so out of greed borders on theft. A second example: many MA plans harvest diagnoses to make their enrollees look substantially sicker than they really are. These might be efforts to set high prices to garner high revenues to finance more care for MA patients. But if these efforts to milk risk-adjustment aimed to maximize profits, they are closer to theft.

Investigators have taken two main approaches to estimating and categorizing waste. Berwick and Hackbarth, along with Shrank and colleagues, rely on published and gray literature. They identified substantial ranges for waste in many of the categories. Angrisano and others, along with Turner and others, began with an estimate of total waste that was derived from the U.S. spending in excess of other rich democracies' spending, adjusted for purchasing power. Seeking to explain causes of the excess, they also rely on published and gray literature.

Berwick and Hackbarth estimated waste at between 21 and 47 percent of health care spending.[1427] They also divide clinical waste into three sub-types: failures of care delivery, failures of care coordination, and over-treatment. Exhibit 3 – 5 A shows Berwick's and Hackbarth's estimates of waste as a share of NHE in 2011. These range between one-fifth and

almost one-half of health care spending. Pooled clinical waste is greatest, followed by administrative complexity, theft, and high prices.

Exhibit 3 – 5 –A
Berwick's and Hackbarth's Estimates of Waste as Shares of National Health Expenditures, 2011

	Low	Midpoint	High	
Failures of care delivery*	3.8%	4.7%	5.7%	
Failures of care coordination*	0.9%	1.3%	1.7%	
Over-treatment*	5.9%	7.1%	8.4%	
Administrative complexity	4.0%	9.2%	14.4%	
Pricing failures	3.1%	4.9%	6.6%	
Fraud and abuse	3.0%	6.6%	10.1%	
Total	20.7%	33.7%	46.8%	
Total NHE, $B				$2,701
*Clinical waste sub-total, pooled	10.6%	13.1%	15.7%	

Source: Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," *Journal of the American Medical Association,* Vol. 307, No. 14 (11 April 2012), pp. 1513-1516, https://pubmed.ncbi.nlm.nih.gov/22419800/.

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In 2019, Shrank and colleagues suggested waste was about one-quarter of spending and that only about one-quarter of it could be eliminated. They relied on peer-reviewed reports of efforts to cut waste and did not include savings to be won by cutting administrative waste.[1428] Applying the resulting one-sixteenth share to the $4,898 billion in projected NHE for 2024 yields a potential saving of $306 billion in that year.

In 2003, Berenson wrote that "as much as 30 percent of Medicare spending might be excessive and unnecessary."[1429] That points to clinical waste. Bartlett, former chief actuary for the Social Security Administration, thought that 30 to 40 percent of medical care is unnecessary.[1430]

Boat and colleagues, writing in 2008, accepted a share wasted of between 30 and 50 percent.[1431]

In 2012, Brent James asserted that "there's very good evidence that half of all health care dollars are wasted."[1432]

A report from PriceWaterhouseCoopers in 2008 put waste's share at 55 percent of health care spending, though it did include medical costs associated with behavior-related health problems like smoking.[1433] PwC highlighted 9 percent of health spending wasted on defensive medicine and another 9 percent on inefficient claims processing.

In 2006, Robert Mecklinburg, chief of medicine at Seattle's Virginia Mason Medical Center, asserted one-half of health spending is wasted owing to poor quality, unsafe care, and perverse incentives that financially reward waste.[1434]

Exhibit 3 – 5 B displays projected dollar waste for 2024. It applies Berwick's and Hackbarth's estimates of waste as shares of NHE in 2011 to the projected NHE of $4,898 billion for 2024.

There are reasons to suspect that efficiency of U.S. health spending is currently even lower than Shrank and colleagues thought—and that it may well exceed Berwick's and Hackbarth's high estimate of waste.

In 2012, Berwick and Hackbarth reported that the median estimate of waste was about 34 percent of health care spending. Late in 2025, Berwick avers that "it's actually quite a bit higher." [1435]

I agree.

Exhibit 3 – 5 – B

Projected Billions of Dollars Wasted in 2024, by Type of Waste

	Low	Midpoint	High	
Clinical waste, pooled	$517	$644	$771	
Administrative complexity	$194	$450	$705	
High prices	$152	$238	$323	
Theft	$149	$321	$493	
Total	$1,012	$1,650	$2,290	
Total NHE				$4,898

Calculated from 2011 shares of waste, applied to projected 2024 NHE. Shares of waste are from Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," *Journal of the American Medical Association,* Vol. 307, No. 14 (11 April 2012), pp. 1513-1516, https://pubmed.ncbi.nlm.nih.gov/22419800/.

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In 2005, Deborah Socolar and I suggested that fully one-half of U.S. health spending paid for medically appropriate care but that the other half was wasted. We thought that clinical waste was 22 percent of NHE, administrative waste was 15 percent, excessive prices took 8 percent, and theft took 5 percent. A modest share of our estimate of clinical waste included care of marginal worth (high-cost/low-value care). This recognizes that not all waste is solid or absolute; some is simply relative.

Given the substantially higher prices won by drug makers and by many powerful hospital and physician groups in recent years, I'd suggest modifying those 2005 estimates slightly. Clinical waste might be 20 percent of U.S. health spending; administrative *waste, 15 percent; high prices, 10 percent; and theft, 5 percent.*

The comparison of U.S. health spending per person with the rich-democracy average, earlier in this chapter, offers a measure of support for our suggestion. If they spend, on average, about one-half as much per-person as does the U.S., adjusted for purchasing power, and if they cover everyone, provide more doctor visits and hospital admissions, and if they live longer, on average, it is reasonable to conclude that about one-half of U.S. spending is wasted.

A 2007 analysis by Anrisano and others at McKinsey sought to explain the U.S. excess over a sample of other rich OECD democracies. They believed that high prices were accountable for double the share attributed to clinical waste and administrative waste.[1436]

Turner and colleagues sought to explain the U.S. excess. Like Shrank and others, they relied on a number of published and gray literature reports. They were able to obtain more complete evidence on administrative waste and high prices.[1437]

And in 2000, a Lehman Brothers group estimated "required care" at only 49 percent of U.S. health spending, with 18 percent going to administration, 11 percent to adverse drug costs, another 11 percent to other inappropriate care, and the remaining 11 percent wasted in other ways.[1438]

Skeptics

Unsurprisingly, some are skeptical about waste's share or about the feasibility of cutting it, capturing it, or putting it to better use. Writing in 1994, Schwartz and Mendelson indicated their belief that "eliminating waste and inefficiency can do little to contain costs."[1439] This view appears to rest on fairly narrow assumptions about the types and extents of waste, and on fairly weak efforts to squeeze waste. One reason is that their analysis was prepared a number of years before any of the detailed analyses of the types, extent, and causes of waste. Another is that they consistently credit pessimistic estimates of savings and downplay more hopeful ones.

Each of the four types of waste manifests in several ways and has a variety of causes. Waste and its causes are discussed here. For a few causes—such as malpractice's role in increasing clinical waste—remedies are also discussed briefly here. But for most of the causes, a wide variety of methods of squeezing out wasted care and money are taken up in chapters 7 through 16.

1. Clinical waste—about $1 trillion in 2024

This is care that is dangerous, simply ineffective, or markedly less valuable than alternatives relative to its cost. Some care is wasted when it is given in the wrong setting or at the wrong time. Clinical waste is widely disseminated throughout U.S. health care.[1440] Duclos and others found that almost two-fifths of randomly chosen surgical patients at 11 U.S. hospitals suffered adverse events, with 16 percent suffering major adverse events. About three-fifths of the adverse events were deemed potentially preventable; one-fifth were definitely or probably preventable.[1441] Makary and Daniel ranked medical error as the third-leading cause of death in America.[1442]

Rabin described allegations of high volumes of unnecessary surgery at one Virginia hospital. Some 500 plaintiffs—mainly covered by Medicaid—sued the hospital and its current and past CEOs for tolerating "medically unjustified operations, including unnecessary C-sections and sterilizations without consent." The surgeon has been jailed for a 59-year term for Medicaid fraud.[1443]

Kaplan asked why an unsafe and ineffective gene transfer drug costing $3.2 million per dose, approved by the FDA's accelerated review in 2024, was still available. He noted that the drug had been fatal to some patients, and asserted that the quality of the evidence supporting the original approval was weak.[1444]

Deshane and colleagues found a high rate of futile radiation therapy administered to cancer patients very near the end of life—when time was too short to win any clinical benefits.[1445]

Lamm wrote in 1998 that payers can't afford all the care patients might want and need—all the care that might be beneficial, or all the care that today's doctors might believe they should ethically give. And that doctors were in the position of saying "yes" but not "no" to giving care.[1446] He wrote as a former 12-year governor of Colorado who faced demands for public services that inevitably outstripped available revenue.

Cutting clinical waste means getting as much clinical and human value as possible from health spending. Since payers can never know as much as doctors about how to diagnose and treat illness or injury, it's vital to persuade doctors to marshal the vast but finite dollars available to do as much clinical and human good as possible.

That requires paying doctors well but in financially neutral ways—so they don't make more or less money for themselves by giving more care or less care—so we can trust them to deliver care of the highest value with the dollars available. The alternative is to continue to "outsource the no" to payers via prior authorization, or to rely on suppressing use of care via high and regressive premiums, high OOPs, medical debt, narrow networks of caregivers, and other inequitable and inefficient methods.

The only practical and ethical motive for a doctor to say "no" to low-value/high-cost care is to liberate money and time to say "yes" to high-value/low-cost care.

Estimated size – between $350 billion and $1,075 billion in 2024

As shown in Exhibit 3 – 3, estimates of clinical waste ranged from Shrank and others' 7.3 percent of NHE to Socolar's and my 22.0 percent.

Applying Shrank and others' 7.3 percent share to projected 2024 NHE of $4.9 trillion yields estimated clinical waste of $358 billion. Applying Berwick's and Hackbarth's middle estimate of a 13.1 percent share for clinical waste to projected 2024 NHE of $4.9 trillion yields an estimate for clinical waste of $642 billion. (As just mentioned, Berwick has said that overall waste is much higher than the one-third proportion he original suggested.[1447]) At the 22 percent share estimated by Socolar and me, clinical waste in 2024 was $1,078 billion. A share of the difference reflects inclusion of some care of very marginal value and high cost in the highest estimate.

Inconsistent and low-value definitions

Clinical waste is challenging to define. But some of the challenges are self-inflicted. Mafi and colleagues, for example, estimate low-value care's share of health spending at between 10 and 20 percent. But they define low-value care "as "patient care that offers no net benefit in specific clinical scenarios (e.g., antibiotic prescriptions for uncomplicated acute upper respiratory infections)." [1448]

Thus, when they use the phrase "low-value care," they apparently mean no-value care. This is important.

It means that low-value care would consume much more than 10 to 20 percent of health care spending.

Small area variations – inconsistency means clinical waste

Patterns of clinical service vary enormously. Different physicians, in different parts of the nation—or the world—treat the same medical problems in radically different ways. Small area variations reveal this dramatically.

The different rates of use of care mean inconsistency, unreliability. The variations in patterns of care—and lack of correlation of between health outcomes and different types and volumes of care—indicate enormous clinical waste.

Gladwell vividly describes Wennberg's initial work on small area variations in Vermont in 1967. [1449]

In 1973, Wennberg and Gittelsohn found that the two highest of Vermont's 13 hospital service areas had Medicare spending per person that was 2.6 times that of the two lowest-spending service areas. [1450] The areas differed in hospital beds and physicians per capita. Inpatient days per capita for tonsillectomies varied by a factor of 44.9; appendectomy days by 4.9; prostatectomies by 8.1; hysterectomies by 9.6; and mastectomies by 9.4. Medicare spending per capita was not correlated with age-adjusted mortality. Electrocardiogram rates varied by a factor of six and laboratory tests by a factor of seven.

Wennberg and colleagues found that both Boston's and New Haven's teaching hospitals provided high-quality care. Mortality rates for Medicare recipients were close to identical, but total costs per capita were *twice* as high in Boston. There was no evidence of medical rationing in New Haven. Rather, there were indications of *over-service* in Boston. [1451]

Gladwell summarizes evidence of three-fold variation in rates of cardiac catheterization after heart attack between Boulder, Colorado and Buffalo, New York. He also notes that doctors in Buffalo used a safer and less costly method.

These enormous differences strongly suggest that care patterns did not rest on good information. Other factors appear to have been more salient. Physicians, for example, were more densely distributed in higher income areas and those with smaller shares of Medicare

patients. Moreover, since Medicare Part B premiums are equal for all people, some regions' higher use was, in effect, subsidized by regions with lower use.

Three decades later, studies of regional variations across the nation found the same wide gaps in use of care and cost of care per citizen. Higher costs were associated with greater use of inpatient and specialist physician care; neither quality nor access was correlated with spending per capita.[1452] Nor were health outcomes or patient satisfaction.[1453]

These investigations point to enormous clinical waste associated with lack of evidence, non-adherence to evidence, possible supplier-induced demand or supplier-related standards of care, and other factors.

Skinner and Fisher argued that acting on inter-region differences is a better way to contain health care costs than alternatives like pushing patients into MA managed care plans or converting Medicare from an entitlement to voucher-driven subsidies for purchasing private insurance.[1454] Instead, they found, pushing all regions' Medicare spending down to levels of efficient areas like Richmond, Minneapolis, and Hartford would cut program costs by one-fifth. This calculation adjusted for factors like age, race, input prices, and underlying illness levels.

I have found enormous variations in 18 different long-term care professionals'—physicians', nurses', and social workers'—estimates of types and durations of home care services needed by a panel of 50 patients. Coefficients of variation ranged between 40 and 100 percent for various personal care, homemaking, nursing, and medical services.[1455]

Variations extend across nations, also. Smith-Bindman and others compared screening mammography in the U.S. and the U.K. They found rates of recommendations for prompt added testing and of open surgical biopsies to be "twice as high in US settings than in the United Kingdom but cancer detection rates are similar."[1456]

Reid took his injured shoulder to 10 nations and obtained very different recommendations for treatment. They ranged from a complete replacement to PT to massage. The last seemed to work.[1457] [1458]

A German study examined provision of 24 types of low-value care. Low-value care's share was estimated to comprise between 4 and 10 percent of services each year.[1459]

Types of clinical waste

Berwick and Hackbarth separately estimate three categories of clinical waste. Their middle estimate of failures of care delivery is 4.7 percent of NHE. Failures of care coordination account for only 1.3 percent. But over-treatment accounts for 7.1 percent.

Failures of care delivery

Lack of good evidence

One of the main types of failure of care delivery is lack of good information about how to diagnose or treat various problems. Ebell and colleagues found that only 18 percent of primary

caregivers' recommendations were backed by high-quality evidence. Another 34 percent were backed by inconsistent or limited-quality evidence.[1460]

A 1992 Institute of Medicine review of evidence on health care services and patient management methods speculated that only 4 percent were backed by strong evidence. Another 45 percent were backed by evidence of modest quality. But fully 51 percent were backed by very weak or no evidence. Perhaps surprisingly, of the care backed by very weak or no evidence, 20 of the 51 percent were still supported by strong consensus among doctors.[1461]

Trococi and others reviewed the solidity of evidence supporting clinical guidelines in cardiology. They found increasing numbers of guidelines but not commensurate improvement in the evidence supporting them. Only 314 of 2,711 guidelines (11 percent) were supported by the highest level of evidence.

Redberg and Walsh discuss cardiac computer tomographic angiography as an example of a new technology that Medicare paid for—in the absence of evidence that it is beneficial. Interested parties successfully fought Medicare's subsequent effort to back-pedal its approval.[1462] We should ask why the standard the FDA must apply to new meds—that they be demonstrated to be safe and effective—should not apply here. Medicare, instead, must pay for care deemed "reasonable and necessary." Absent evidence of safety and efficacy, it should be improper to conclude that a type of care would be reasonable and necessary.

Gasper and colleagues reported that neonatal mortality per 1,000 U.S. live births fell by 43 percent in the three decades from 1991 to 2020.[1463] During these years, the number of neonatologists per 1,000 live births rose by 227 percent and the number of NICU beds rose by 48 percent. But there was no correlation between rise in care capacity and drop in death rates across the nation's 246 neonatal care regions. Gasper and colleagues therefore call for additional studies of NICU costs and benefits. But, as with other technologies, evaluation is difficult once use becomes widespread.

Some medical treatments seem reasonable, are widely diffused without careful evaluation, and are later discredited or largely discredited. Mammary artery ligation for angina and stenting coronary arteries of patient with angina who have not suffered heart attacks are two examples.

Cochrane reviews have identified a number of common types of care that appear to be ineffective. These include general check-ups for healthy adults,[1464] routine pre-operative testing for cataract surgery,[1465] percutaneous vertebroplasty for osteoporotic vertebral compression fracture,[1466] an excessively liberal use of red blood cell transfusion,[1467] intense follow-up care for patients treated for non-metastatic colorectal cancer,[1468] and short recall intervals for oral health check-ups and routine dental de-scaling and polishing.[1469] [1470]

The American Board of Internal Medicine launched its Choosing Wisely initiative in 2012 in cooperation with eight other specialty societies. It listed 45 interventions not backed by solid evidence. Examples multiplied through 2021, when the ABIM ceased maintaining lists of these low-value types of care.[1471]

Cliff and associates evaluated the effectiveness of the effort, reviewing 131 papers. They concluded that the guidelines, alone, did little to cut low-value care. Adding active interventions like utilization review by clinicians, clinical education, academic detailing for medications, modifying clinical pathways, and obliging clinicians to justify care deemed to be of low value by

removing them from EHR menus were effective in cutting low-value care. Interventions aimed at patients seemed to have no value.[1472]

Rourke assessed 10 years of Choosing Wisely and found it politically compromised and "toothless." She considers its aim to have been to "promote professionalism in medicine and to encourage conversations between doctors and patients."[1473] Choosing Wisely did not take cost of care or revenue generation into account. Zadro and others found that only 18 percent of recommendations involved income-generating treatments. Of these, only 16 percent targeted members of the specialty society preparing those recommendations while 40 percent targeted non-members.[1474]

Hawryluk describes efforts in Colorado, costing $134 million in 2022, to reduce delivery of low-value care along the lines pursued by Choosing Wisely. Results were disappointing. Reasons included doctors' reluctance to abandon traditional practices, financial incentives, and some patients' reluctance to give up care to which they were accustomed.[1475]

These criticisms of Choosing Wisely point to the value of crafting methods of paying doctors that liberate them to recognize and excise low-value care.

Fisher and Welch identified four ways "in which inadequate information and improper reasoning may allow harmful practices to be adopted—a constrained model of disease, excessive extrapolation, a missing level of analysis, and the assumption that more is better."[1476]

The quality of evidence on which drugs work for which problems is decidedly mixed. Drug makers sometimes push for accelerated approval of new drugs. Liu and colleagues found in 2024 that only 43 percent of cancer drugs receiving accelerated approval between 2013 and 2023 were subsequently confirmed to extend life or improve quality of life.[1477]

In 2024, Makary condemned physicians who urged patients to deny peanuts to young children for fear of allergic reactions. In 2000, the American Academy of Pediatrics (AAP) followed the U.K. health department in warning parents away from peanuts for children under age 3. Both were apparently reacting to well-publicized but very rare instances of bad—even fatal—reactions to peanuts. The result has been a massive, manufactured, and science-free rise in the number of children who are indeed allergic. Makary asserted that physicians and physician groups had no idea whether abstinence was a good idea but refused to admit their ignorance. After a natural experiment comparing Israeli and U.K. rates of peanut allergies showed that early consumption of peanut snacks was associated with near-zero rates of allergies, the tide of ignorance-generated behavior began gradually to recede. But only slowly. Makary wrote:[1478]

> The AAP should have originally said something like "We're not sure." At least that would have been honest. Even today, the WIC program does not cover peanut butter for children, a remnant of the AAP dogma.
>
> When modern medicine issues recommendations based on good scientific studies, it shines. Conversely, when doctors rule by opinion and edict, we have an embarrassing track record. Unfortunately, medical dogma may be more prevalent today than in the past because intolerance for different opinions is on the rise, in medicine as throughout society.
>
> We can enact reform, close health disparities and give every American gold-plated insurance, but if we continue to recklessly issue health recommendations based on an

illusion of consensus instead of proper science, we'll continue to struggle and waste billions.

Corruption of evidence

One reason for weak evidence is the corruption of science. It is, though, hard to measure the power of corruption to undermine validity of evidence.

Pressure from drug makers has led the FDA to approve some meds despite only indirect measures of efficacy—measures thought to be associated with a problem but actually separate from improved effectiveness (better outcome) in addressing a clinical problem.

The FDA sometimes fails to insist that drug makers conduct timely studies to measure safety or efficacy. Other bad behavior in the prescription drug realm is discussed in the section on theft later in this chapter.

Medical journals rely on peer reviewers to evaluate which submissions are worthy of publication. Editors and authors are supposed to disclose potential conflicts of interest, but reviewers do not consistently do so.[1479] [1480]

Non-adherence to good evidence

A second type of failure of care delivery is non-adherence to available good evidence. McGlynn and colleagues reported that patients received an average of only 55 percent of recommended care. Acute and chronic conditions fared equally well. But very wide variations were found among medical conditions.[1481]

Failure to use good evidence is unsurprising. Mosteller pointed to the gap of 264 years between obtaining conclusive evidence of the value of foods with Vitamin C in preventing or curing scurvy and the adoption of this remedy by the British merchant marine.[1482]

Brook examined coronary artery bypass grafts in southern California and one in the English Midlands. A high share of the surgery in southern California was deemed clinically inappropriate.

The bypass graft surgery rate in the English region was only one-seventh that of southern California. A number of English patients had to be placed on wait lists for surgery. Nonetheless, surgery was considered clinically inappropriate for about one-half of the English patients who received it. This is astonishing in light of U.K. hospitals' fixed budgets, payment of surgeons by salary, and "a small number of surgeons and cardiologists performing large volumes of procedures."[1483]

Similarly, a study of men with limited longevity owing to prostate cancer who were served at U.S. VA hospitals found that over-treatment had actually increased over time. Some forms of over-treatment, violating clinical guidelines, more than doubled between 2000 and 2019.[1484]

The UK/California and VA studies suggest that fixed hospital budgets and financially neutral doctors are not enough to guarantee that clinical waste will be squeezed out. Those macro-financial factors must, it seems, be accompanied by micro-clinical factors of developing

consensus on evidence-backed standards of practice, supported by ongoing clinical review and evaluation by teams of doctors—efforts like those undertaken by Brent James at Utah's InterMountain system.[1485]

Ebeling and colleagues assessed evidence on the efficacy of injecting bone cement to ease pain and speed recovery from spinal fractures. The found "no demonstrable clinical benefit over placebo." [1486] Despite this evidence, reported Kolata, one doctor at a major teaching hospital asked whether it is so bad to offer bone cement. A doctor at a different major teaching hospital said that, although he agreed with the findings of Ebeling and colleagues, he was willing to perform the procedure after trying to discourage the patient. "'If it's not done by me, it will get done by Joe down the road.'" [1487]

The Bone Health and Osteoporosis Foundation responded to Ebeling and colleagues' study. It highlighted the pain and disability associated with spine fractures, noted that both procedures criticized by Ebeling and colleagues were FDA-approved, and questioned the persuasiveness of the evidence on which Ebeling and colleague relied.[1488]

A report from IMS Health asserted that improper or unnecessary use of prescription drugs generated $200 billion in waste in 2012 or 8 percent of health spending.[1489] (Applying that figure to 2024 expected health spending indicates waste equal to $390 billion.) IMS estimated that almost one-half of the waste was associated with non-adherence to prescribed use. Delayed treatment owing to disregarding evidence, misuse of antibiotics, medication errors, suboptimal use of generics, and mistakes in polypharmacy for elders accounted for the rest.

In 2011, Pronovost and Goeschel wrote that results of some 18,000 clinical trials were published yearly, but that their findings were too seldom translated into better clinical practice. They urged much greater attention to disseminating evidence on ways to prevent harm. For example, they note that 200,000 Americans die yearly from nosocomial infections, deep vein thrombosis, or pulmonary embolisms, which they label preventable harms.[1490]

In May 2026, the DHHS Inspector General reported that the level of physician billing for in-office peripheral vascular procedures raises "questions about program integrity." In 2022, Medicare alone paid over $1 billion for angioplasty, stenting, and use of rotating blades to address leg pain owing to obstruction of arteries in the leg. The IG is troubled, in particular, by over-use of atherectomy (rotating blades) because it is often ineffective and even dangerous. Between 2019 and 2023 the rate of use and Medicare payment for these procedures did fall. But, at the same time, site of care shifted considerably from hospital outpatient departments to doctors' office-based laboratories. Only 26 physicians accounted for three-fifths of troubling payments of $105 million in 2022. The IG urged greater reliance on treatment with meds or with lifestyle changes.[1491]

Slow uptake of evidence-based innovations is one reason for failure to follow valid evidence. Berwick has analyzed reasons for slow dissemination of valuable innovations and has suggested 7 ways to accelerate the process. These include finding and supporting innovators, investing in early adopters, and relying on trusted experts to communicate innovations.[1492] Berwick emphasizes humanizing dissemination and resting it on professional relationships. Berwick's and James's styles of encouraging better care run in parallel.[1493]

Casalino and colleagues have found that higher levels of physician altruism were associated with lower rates of spending, hospital admissions, and ER visits.[1494]

Failures of care coordination

Segal and others found that over-use of care was greater when primary care doctors were in shorter supply.[1495] Ganguli and associates found that provision of low-value care was higher in health systems with fewer primary care doctors.[1496]

Since about 1 percent of Americans use 20-25 percent of health care in a given year, and 5 percent of Americans use about one-half of health care in a given year, opportunities for savings are highly concentrated. In a crisis, solid and sustained primary care for needy, complex, and costly patients will improve care and lower costs. Experienced primary care physicians can identify the patients whose medical problems are most amenable to better care that lowers cost—especially when they and other doctors are able to marshal finite budgets flexibly. The VA, for example, enables that.[1497]

This surprises no one. Weak primary care means week coordination and weak continuity of care. These, in turn, mean higher cost and lower appropriateness and quality of care. Bodenheimer brilliantly describes coordination problems and some of their causes and consequences.[1498]

The four C's of primary care are first-contact, continuity, coordination, and comprehensiveness. A good primary care doctor diagnoses more competently and refers difficulty cases for diagnosis and treatment by specialists. A good primary care doctor coordinates care by all those experts and tries to minimize duplication or gaps in care. A good primary care doctor maintains continuity of care—diagnosis, treatment, medications, rehab, and other services--from outpatient to inpatient and back to outpatient.

Hopes that EHRs could substitute for good primary care have been dashed by their orientation to support billing, coding, and quality documentation.

Over-treatment

Paradis wrote with fury about the explicitly undesired but repeated surgical and radiological over-treatment his hospitalized father suffered for late-stage pancreatic cancer. His father had sought only palliative care. Neither he (a physician) nor his brother (a lawyer) succeeded in forcing their father's doctors to cease aggressive, unwanted, and futile treatments.[1499]

Some observers suppose that U.S. health care is sometimes excessively aggressive in treating patients near the end of life. As discussed in chapters 8 and 11, high end-of-life spending has sometimes been associated with disproportionate spending patterns—the finding that small shares of Americans account for high shares of health spending. Shih and colleagues found that spending during the last year of life was 50 percent higher for those below age 65 than for over-65 Americans. They controlled for price differences between commercial insurance and Medicare, and also for co-variates.[1500] They suggest that younger patients may be treated more aggressively.

Uneven profitability of services can distort care patterns. As noted in chapter 4, the 6th requirement for free market competition is that prices track costs. In a free competitive market, then, prices of services with high costs would be higher than prices of services with low costs. Over time, generally, all care would be equally profitable. So caregivers' clinical decisions would not be distorted by differential profitability. The requirement that price track cost is widely violated in health care. The resulting financial temptations can distort patterns of treatment and help to magnify clinical waste.

Reddy and colleagues examined 12 cardiovascular procedures and found some were enormously profitable to hospitals while others were money-losers.[1501] In today's world, it would be unsurprising that hospitals sought, encouraged, or promoted higher volumes of profitable procedures. And some of those higher volumes might well be of low value to patients, or even inappropriate.

In 2005, Ginsburg and Grossman carefully described ways in which newer types of care have been made excessively profitable to hospitals.[1502] Medicare DRG payments for innovative care have been set initially to be close to early actual costs of that care. Over time, costs fall but DRG prices remain stuck at high levels. Ginsburg and Grossman therefore called for re-setting prices in proportion to actual costs. But this is a difficult job.

As early as 1981, Roe described a similar problem with usual, customary, and reasonable prices paid physicians. He noted that innovative surgery—like much heart surgery—initially took a great deal of time and required expensive support staff and services. Fees for heart surgeons were set accordingly. But when surgical methods improved and time, resources, and actual costs of care all fell, surgeons' fees did not fall. Just like DRG prices for innovative types of hospital care, the doctors' fees were stuck at their high initial levels.[1503] Financial incentives can be corrosive. If care is very well-paid, some physicians are likely to persuade themselves that more and more patients might benefit from it.

Under-treatment

Care that is unprofitable to hospitals and less remunerative to doctors may be under-provided.

Care that depends on adequate supplies of meds will be under-provided when those meds are in short supply, as discussed in chapter 15.

Similarly, when blood is in short supply, needed surgery can be delayed, sometimes harming patients. In mid-2026, the American Red Cross declared only its second national blood crisis. Type O blood was "critically scarce."[1504]

A shortage of general surgeons may reduce delivery of needed surgical care.

When bed, OR, or ER capacity of hospitals is low, doctors and patients may have to delay or deny care.

When patients are uninsured or under-insured, they receive less care.

Physician exploitation of clinical discretion

Weaver and Jones explain how small numbers of physicians harvest large and—very often—apparently undeserved revenues by performing tests and procedures in their offices. This entails using new and specialized equipment to test or treat high shares of patients for very rare conditions. Four such procedures are dermatologists' use of electronic brachytherapy for skin cancers, testing sweat responses, measuring tear saltiness, and electroretinography to test retina functioning.[1505]

These procedures were so profitable because Medicare had established high prices for them. Over-using them—testing many patients without clinically valid reasons—is clinical waste.

As mentioned in chapter 1, Kliff and Thomas reported that Medicare spending on skin substitutes exceeded $10 billion in 2024. Manufacturers sell these to doctors at deeply discounted prices but the doctors bill Medicare for them at much higher list prices. It is wrong for manufacturers to induce doctors to extract money from Medicare by dispensing a product that may be unnecessary. Few private insurers pay for it. Kliff and Thomas note that Medicare spent more on skin substitutes than on ambulances, anesthesia, or CT scans.[1506]

These tests, procedures, and use of skin substitutes might constitute theft, clinical waste, or some of each. They seem to rest on the border between the two.

Uneven insurance coverage and payments distort medical care

Patients who are uninsured or under-insured are more likely to fail to seek or obtain needed care. Caregivers may choose to offer only meager services or refuse to serve them entirely. Patients who are well-insured—especially when covered by high-paying private insurers—may seek care more frequently and, when they do, they may be vulnerable to caregivers who are financially motivated to recommend excessive care.

Uneven profitability of patients and weak financial coverage for some Americans could lead caregivers to over-serve well-insured people. If many potential patients—Americans in need of medical care—are unable to pay for it, doctors, dentists, hospitals, nursing homes, and other caregivers may be led to over-serve those patients who can pay—or who pay higher prices.

Uninsured Americans use less care. So do insured patients obliged to make high OOPs when they use care. Well-insured Americans use more care. So do higher-income people, who are less likely to be deterred by high OOPs. As well, lower-income patients are more likely to be covered by Medicare and Medicaid, public payers whose prices to caregivers are consistently lower than the prices paid by private companies that insure the half of Americans who are covered through the job.

When some patients receive more care, some (or many) of them are likely to receive excessive care. That's clinical waste. Again, much of the excessive care is not entirely wasted. It usually has at least some clinical value. But marginally useful care for well-covered patients with easy access to doctors, dentists, and hospitals sponges up money that could have been available to much more adequately diagnose and treat badly-covered patients.

When all people have equal financial coverage, patterns of treatment will more closely match patterns of clinical need. And clinical waste will shrink from today's levels.

It is also possible that uninsured or lower-income Americans, financially deterred from seeking timely care, may end up needing more costly care than would have been necessary if they had sought treatment earlier.

Low prices paid by most state Medicaid programs deter many doctors from seeing patients covered by the program. About one-third of physicians said they do not accept new Medicaid patients.[1507]

An important associated matter is that fewer doctors are available in many of the places where uninsured or lower-income Americans live. Also, hospitals located in heavily Black neighborhoods of 52 large and mid-size U.S. cities have been much likelier to close, decade after decade, and controlling for other predictors, than hospitals located in heavily White neighborhoods. Loss of less costly smaller and mid-size hospitals in heavily Black neighborhoods removes ERs. Closings also under-cut remaining doctors in private practice—leading many to retire to relocate. These factors are discussed shortly.

Subtraction of care disrupts many patients' long-established fabrics of care; it takes time to re-weave those fabrics. Doing so is often very difficult. Disruptions make for discontinuity of care, which can be both medically dangerous and costly.

Unbalanced caregiver configuration reinforces unbalanced financial coverage. Together, the two engender substantial but as-yet unquantified clinical waste.

The small area analyses by Wennberg, Fisher, and their colleagues point to wide variations in volumes and costs of care that were not associated with improved health outcomes or patient satisfaction. This strongly suggests high levels of over-treatment in many parts of the nation.

Over-treatment is often thought to be associated with higher hospital density or overall physician density, low primary care density, greater numbers of well-insured patients, and a payer mix leaning toward higher-paying private insurance.

More generally, Wennberg estimated, some "20 to 30 percent of health-care spending goes for procedures, office visits, drugs, hospitalizations, and treatments that do absolutely nothing to improve the quality or increase the length of our lives."[1508] Fisher and Welch analyzed complex ways in which more care could often mean inferior care.[1509]

Uneven profitability distorts clinical care. Some medical services are much more profitable to caregivers than others. Public and private payers generally pay higher prices to doctors who do—perform procedures—than to doctors who think. This helps to distort physician configuration and is a main reason for the widely-lamented shortage of primary care. That shortage—by undermining primary care's job of coordinating care and boosting its continuity and comprehensiveness—helps to weaken clinical appropriateness and strengthen clinical waste.

Among procedures themselves, some are much more profitable than others. Many of these are relatively new types of surgery that initially were risky, difficult, and time-consuming—but whose costs fell over time as techniques improved. Over 4 decades ago, Roe vividly described how this happened for heart surgery.[1510] But prices (payments) tend to be sticky. Two decades ago, Ginsberg and Grossman noted that Medicare often relies on charges—not actual costs—to update payments.[1511] This practice sustains persisting unfairness in pricing. In 2025, Reddy

and colleagues found wide variations in profitability of various cardiac procedures but that procedures growing in volume tended to be more profitable ones.[1512]

As discussed in chapter 4, one of the requirements of a competitive free market is that, over time, prices track underlying costs. In health care, sticky prices mean that some types of care is much more profitable and is over-provided while other types of care is much less profitable and is under-provided. This is an important but under-studied cause of clinical waste.

Excessive screening and testing. Halpern and colleagues estimated the 2011 cost of screening for 5 cancers at $43 billion.[1513]

Commenting on that study, Welch—who has long criticized excessive and badly-targeted efforts to screen for disease, particularly some cancers—asserted that the $43 billion figure under-estimated screening costs. It omitted subsequent diagnostic tests and futile follow-up biopsy and even surgery for false positives.

Welch was also concerned that many people are unnecessarily screened because, at their ages, the incidence of various cancers is very low. Even at appropriate ages, Welch cast doubts on the value of screening; he suggested that money for screening for many cancers would be better spent treating patients who are diagnosed but receive poor care currently.[1514]

Indeed, Daskivich and colleagues found that active surveillance of prostate cancer was associated with over-treatment of men whose life expectation was limited.[1515]

Method of payment. Schoenfeld and colleagues compared rates of surgery for low-value care by surgeons paid salary with rates for surgeons paid fee-for-service. Some 20 percent of salaried surgeons' operations were considered low-value; that rate was 35 percent for FFS-paid surgeons. A 41 percent difference in low-value surgery remained after adjusting for case mix. Moreover, salaried surgeons' share of low-value surgery fell substantially faster over time than did FFS-paid surgeons.[1516]

Other financial incentives. Some hospitals and doctors clearly give and bill for care that is not needed. These practices sometimes cross the line separating excessive care from outright theft. Examples include a Prime hospital in Redding, California that billed for extraordinarily high numbers of patients with kwashiorkor.[1517] Such instances will be discussed shortly.

One Instance of bad behavior was excessive stenting of coronary arteries in Baltimore. A doctor lost his license and was successfully sued for malpractice. The main hospital where he worked agreed to pay $22 million to settle allegations of illegal kickbacks to refer patients.

A second is the high rates of spinal fusion surgery, prostate surgery, and hysterectomies. Spinal fusion surgeries, apparently, pay far better than simpler laminectomies. By one estimate, some decades ago, only one-half of spinal fusions were clinically appropriate. They make money for doctors, hospitals, hardware manufacturers, and—increasingly—ambulatory surgical centers.[1518]

Ellis and others pointed to the role of seductive salespeople in pushing costly new equipment at surgeons, most of which is "languishing in a hospital basement."[1519]

Bach has described a policy at a Chicago-area hospital called “no round-trips on weekends,” meaning that a patient admitted over the weekend should not be discharged before Monday afternoon. This permitted many doctors to see the patient Monday morning and bill for services—typically of low value.[1520]

Brewer, a family practice physician in Illinois, described the financial incentives he faced to perform lab work or imagining studies in his office, and to perform surgery—doing—instead of thinking. What’s good for him financially might not be needed medically—and it certainly boosted health care spending.[1521]

Hollingsworth and colleagues found higher volumes for five common procedures at ambulatory surgery centers owned by surgeons.[1522] Kouri and associates examined doctors’ self-referral for imaging studies. They found that “Nonradiologists performing their own imaging are at least 1.7 - 7.7 times as likely to order imaging as non-self-referring physicians in the same specialty who see patients with the same problems.”[1523] A GAO study found a similar pattern of high rates of self-referrals for MRI and CT imagine.[1524]

Moseley and others found through a randomized clinical trial that the 650,000 surgical procedures performed yearly in the late-1990s to relieve pain from knee joints had no clinical value. Each cost roughly $5,000, for a total yearly cost of $3.25 billion.[1525] In 2024 dollars, which would be some $6.25 billion.

Kalske and colleagues completed a 10-year follow up of middle-aged and older patients with knee injuries who were randomized to receive a common surgical treatment, arthroscopic partial meniscectomy. The surgery was not beneficial. Patients who received the control, sham surgery, had better outcomes.[1526]

Swedlow and others reported that physician self-referral boosted costs of medical care for patients covered by workers’ compensation for each of three services examined—physical therapy, psychiatric evaluation, and MRI studies. Extra costs per 1,000 patients were $89,456 in the dollars of 1992, or $206,245 in CPI-adjusted 2024 dollars.[1527]

Rundle reported on the lobbying and other political efforts to seek approval from Medicare to cover photon emission tomography (PET) scans to diagnose some cancers and, perhaps, Alzheimer’s.[1528]

As discussed in chapter 1, Kliff and Thomas have reported on Medicare’s $10 billion in yearly payments for artificial skin, with prices set by manufacturers and doctors as high as $21,000 per square inch. Manufacturers sell the skin at deeply discounted prices to doctors, who then charge sky-high prices to Medicare. Private insurance companies apparently don’t pay for this product. It is clearly a high-price and low-value item. That makes it an example of solid waste of the clinical variety.[1529] [1530] Others might disagree and categorize it as theft, legalized theft.

Korenstein and colleagues asserted in 2012 that over-use has been under-studied. “The robust evidence about overuse in the United States is limited to a few services.” Examples included antibiotics for upper respiratory infections, coronary artery bypass grafts, and carotid endarterectomies. Their definition of overuse includes care whose harms exceed benefits. They called for broader and deeper investigation.[1531] Progress has been slow.

Kim and Fendrick evaluated 47 low-value services and estimated their combined yearly Medicare plus OOP cost at $4.4 billion. Five services accounted for three-fifths of the yearly total. Kim and Fendrick made two important observations about their findings.

First, they viewed the $4.4 billion as a marked under-estimate, noting that PSA tests—despite their low clinical value—generated $6 in cascaded waste for each $1 wasted on the tests themselves.

Second, they warned that, while payers could promulgate rules to deny payment for low-value care, doctors and hospitals could game those rules. If payers refused, for example, to pay for head imaging of patients reporting dizziness, doctors could claim they were following up after a fall or head trauma.[1532] This underlines caregivers' intimate ability to manipulate payers' rules—if caregivers are motivated to do so, and if payment methods permit manipulation.

A 2024 Lown Institute report asserted that 200,000 unnecessary back surgeries were performed on Medicare patients during 3 years at a cost of $2 billion.[1533]

Landro reported on a program to diagnose and treat back pain more conservatively. Sponsored by the National Committee for Quality Assurance, it aims to cut unnecessary or premature surgery, steroid use, and costly scans. It offers procedures to protect doctors against concerns that more cautious treatment could expose them to malpractice suits.[1534]

Do and colleagues found substantial variation across states in cost of some 23 low-value services. This was attributable more to price than quantity. They estimated that the national cost of this low-value care would be cut by one-fifth if its prices in the 10 top-spending states were cut to the national average.[1535]

Supply-sensitive care. Fisher and Wennberg examined non-emergency "physician visits, the use of hospitals or intensive care units for the care of patients with chronic medical conditions, and non-palliative treatments given at the end of life." All varied in rough proportion to available resources.[1536] They noted that Medicare cost per enrollee, across the nation's 306 hospital referral regions, did not correlate with rates of provision of evidence-based care or of care sensitive to patients' preferences. But it did vary with use of supply-sensitive services at the end of life--share of patients admitted to ICUs, days of inpatient care, and number of visits to specialist physicians in the last six months of life.

Sub-optimal care. Some instances of clinical waste are unambiguous, solid. The wrong diagnosis or treatment results from lack of good information, failure to use good information, low skills or impaired judgment, refusal to research a problem or seek consultation, excessive self-confidence, or disorganized care. Kassirer and colleagues sought to address many of these issues in a multi-year "clinical problem solving" series in the *New England Journal of Medicine.*[1537]

Duffy describes the sad case of one patient whose care was poor owing to doctors ignoring or misinterpreting a number of clinical and laboratory clues.[1538]

Some clinical failures manifest systems failures and others personal failures.

By one estimate, some 800,000 Americans die or become permanently disabled yearly owing to misdiagnosis of dangerous diseases—particularly heart and vascular disease, infections, and cancers.[1539] These diagnostic errors are also likely to engender a great deal of costly but wasted care.

An Institute of Medicine Report found that between 44,000 and 98,000 Americans die yearly from in-hospital medical errors in diagnosis or treatment.[1540]

Schuster and RAND colleagues evaluated evidence on U.S. health care quality in 1998. Taking averages of estimates from numbers of studies, they concluded that about half of patients received recommended preventive care, that "an average of 70 percent of patients received recommended acute care, and 20 percent received contraindicated acute care. For chronic conditions, 60 percent received recommended care and 20 percent received contraindicated care." [1541]

When the wrong care is given, appropriate care should follow. When dangerous or incompetent care is given, care to repair the harm inflicted on patients should again follow. Substantial costs are incurred.

But most clinical waste is a continuous variable, not a categorical one of waste versus not-waste. Costly sub-optimal care is one example. An expensive antibiotic might be prescribed for urinary tract infection in place of an effective but inexpensive one. Wang and colleagues examined Medicare payments (net of rebates) for 49 cancer drugs. Fully 9 were rated-low benefit in France or Germany and 1 was rated no-benefit. Fully $6.7 billion (one-fifth of total spending of $32.7 billion) went to the low- or no-value meds.[1542]

Cardiac bypass surgery might be performed in place of medical management of one blocked artery. Coronary arteries are often stented when evidence indicates no added benefit over medical management.[1543]

Pinsky has suggested ways to cut low-value biopsies and MRIs stemming from elevated PSA levels.[1544] Katz described his reluctance to devote much of a finite county budget to paying for PSA tests.

Daskivitch and Leppert reported that "overtreatment of men with limited life expectancy for clinically localized prostate cancer has been a long-standing problem in the US." [1545]

Clinical waste can entail provision of high-cost but low-value care. Examples include reckless use of expensive meds, surgery, or ICU time for patients with only a few days or weeks of life left, and who have instead chosen comforting care, not aggressive interventions.[1546] Inflicting care that is painful, ineffective, and undesired care is simply intolerably wrong. If that is done for financial gain, it is evil.

Clinical waste includes over-use of costly hospital resources. Three decades ago, Schapira and colleagues noted that ICU care consumed fully 7.5 percent of U.S. total health care costs. They found that "the majority of patients with solid tumors or hematologic tumors who are admitted to the ICU die before discharge." [1547] This signaled a great deal of very high-cost but low-value ICU care for patients with advanced solid tumors or cancers of the blood like leukemia or lymphoma.

Greenspan and others found that one-fifth of surgical implantation of permanent pacemakers was not indicated; another one-third was only possibly indicated.[1548]

And four decades ago, a powerful surgeon operated on a terminally ill person who was rapidly bleeding to death internally. The surgery cost one-quarter of a California county's yearly medical care budget for uninsured people and a large share of the available blood supply. Motives for providing unwanted and futile care might include a benign, powerful, but narrow-minded desire to act to prolong life, unawareness of the inevitability of trade-offs, egotism, and unbalanced empowerment.

The U.S., alone, entitles individuals to certain medical benefits, pays for them, and raises taxes and premiums when actual costs exceed expected sums. Doctors and hospitals give care and are paid for it. They typically face no financial constraint and no pressure to weed out care of marginal clinical value. Trade-offs and prioritization are generally unnecessary.

The lack of constraint that characterizes U.S. entitlement-based financing is revealed in the timing of data collection. In the U.S., adding up dollars actually spent often takes 1-2 years after the end of a given fiscal year.[1549]

Outside the U.S., spending is generally known in advance because payers' planned spending equals revenue available to caregivers. All other rich democracies impose caps of various sorts on annual heath spending. These ceilings help to hold down costs even if they are sometimes exceeded. They act by limiting available revenue and also by obliging caregivers to serve all citizens with an eye on finite available revenue. The two main methods of capping spending are single payer and coordinated all payer financing.

Single payer nations like Canada and the U.K. set annual spending levels for covered health services. Hospitals generally are given fixed budgets to finance care for patients. They must spend their entire budgets each year. Capital costs of new buildings, renovation, and equipment are generally paid separately. In single payer nations, increased spending on health care entails raising taxes or suffering greater budget deficits. Politicians who raise taxes are likelier to suffer defeat in the next election. So political and financial risks associated with raising taxes militate against higher health spending. Parallel efforts seek to cap spending on doctors or prescription drugs.

All payer nations employ a range of mechanisms. But all entail agreements among the various public and private payers to make available finite, specified sums to pay for health care each year. Generally, some citizens are covered by tax-financed public programs and others are covered through employer-level, wider industry-level, sickness fund, or other forms of assessments on income earned through a job. Higher health costs therefore mean a combination of higher taxes and higher assessments on earned income. Both result in lower take-home incomes and angry voters and workers.

Outside the U.S., individual hospitals typically have budgets. These must be spent each year. Usually, they can't be over-spent. In most rich democracies, these are adequate to finance expected volumes and types of patients. In a few nations—the U.K. and Canada stand out—budgets have not been adequate in recent years and hospitals respond by creating waiting lists.

These waiting lists are not caused by British or Canadian single payer itself. Rather, nations that are more serious, politically, about containing growth in health spending are likelier to adopt single payer as the containment mechanism.

Clinical care for one patient can be considered wasteful if it is more costly or less clinically valuable than other care for that patient—or than less costly or more valuable care for another patient. Suppose that a well-insured patient who lives in an area where many hospitals and doctors are located receives care of marginal clinical value while a Medicaid or uninsured patient who lives a few miles away, in an area with no hospitals and few doctors does not receive care of high clinical value. We should consider the cost of the first care to be largely (though not entirely) wasted.

A strategic question concerns the types of diagnostic and therapeutic interventions that investigators develop. Sometimes, medical researchers pursue therapies that could not be affordable for many or even most of the patients they might conceivably benefit. Five decades ago, NIH-financed researchers sought to develop an implantable nuclear-powered heart pump. Spending by 1972 was some $40 million. In CPI-adjusted 2024 dollars, that would total $312 million.[1550] This strongly illustrates Rosenthal's distinction between raising the ceiling for some versus raising the floor for all.[1551]

Because pathology is remorseless and resources are finite, opportunities to better marshal available resources are plentiful. This entails making trade-offs. Covering all people well, paying caregivers intelligently, and configuring those caregivers optimally will make it easier to improve clinical value.

Some doctors and others insist that doctors should focus on doing as much as possible for the patient they are now treating, and should intentionally wear blinders so they don't see other patients' needs. Levinsky believed that "physicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations."[1552] He called for higher revenue to make this possible. But it is unlikely that he would have supported the massive surgical care for the California patient bleeding to death internally.

Someday, revenue for health care will be capped in the U.S., as it has been everywhere else.

Then, with the safety valve of higher revenue plugged, how should doctors spend clearly finite dollars to do as much good as possible?

Then, how should doctors be organized and paid to inform and liberate and oblige them to spend the finite dollars to do as much good as possible?

Over 4 decades ago, Fuchs posited that perhaps 10 percent of medical care was actually harmful and that another 10 percent had very little value. Eliminating that 20 percent would do very little to harm health. But he noted that it was hard, with current medical knowledge, to identify which 20 percent to cut. So he called for much greater investment in learning which methods of diagnosing and treating patients are most effective.[1553]

Little such investment has materialized.

When the U.S. caps health care spending, doctors and politicians and managers will intensely desire evidence about which care works and who needs it. It would be useful to quickly compile as much of that evidence as possible.

In doing so, it would be valuable to prioritize the main areas of spending. Neumann and colleagues estimate that prescription drugs, which consume about 15 percent of health spending, are the subjects of 43 percent of cost-effectiveness analyses. So they are studied at nearly three times the level that spending on them would seem to warrant.

This makes a certain amount of sense. Thalidomide and Vioxx harmed thousands. So, probably, did Epogen. FDA rules therefore require—with considerable though incomplete success—that drug makers show that new meds are both effective and safe.

But new medical diagnostic or surgical methods do not undergo the same assessments. Neumann and colleagues estimate that services and procedures absorb 70 percent of health care spending but are the objects of only 42 percent of cost-effectiveness analyses.[1554]

Thurow writes that "Health-care costs are being treated as if they were largely an economic problem, but they are not. To be solved, they will have to be treated as an ethical problem."[1555]

Patient preferences. Some patients want more care than they need. This problem is more visible and troubling to payers than the reverse—patients who shy away from medical care even when it's demonstrably valuable and safe. Patients may become accustomed to certain types of care and some will worry that they might be deprived of it by new analyses or by payers' policies that financially reward doctors to withhold services.

Patients might prefer some care because it is more comfortable. Use of the fast-acting and strong anesthetic propofol markedly cuts pain during colonoscopies. But it also markedly boosts their cost. One reason is that it can require the presence of an anesthesiologist or nurse anesthetist during the colonoscopy.

Fuhrmans describes one insurer's effort to cease paying for an anesthesiologist. The payer cited "guidelines from three national societies of gastroenterologists—the physicians who primarily perform colonoscopties." But the propofol was widely thought to require presence of an anesthesiologist or nurse anesthetist.[1556] Two decades later, insurers continue to spar with doctors in some states about med use and role of anesthetists for colonoscopies.

Introducing matters of patient comfort or preference complicates the job of defining and squeezing out clinical waste.

Doctors' training. Kassirer is concerned that some physicians are unrealistic in their hopes for what he calls diagnostic certainty. He thinks doctors are taught to put patients in one category or another, not to think about probabilities. And this, he believes, is expensive.[1557]

Defensive medicine. Physicians report ordering substantial numbers of laboratory tests and imaging studies even though they are not clinically necessary, but rather to protect themselves against malpractice suits. Doctors' provision of clinically inappropriate care to protect themselves against malpractice suits is costly. In one widely-cited study, Mello and colleagues estimated the 2008 costs of defensive medicine at $45.6 billion, though they labelled the quality of the evidence on that number as "low."[1558]

Applying defensive medicine's share of 2008 NHE to the $4.9 trillion NHE of 2024 yields estimated defensive medicine spending of $93 billion in 2024. This applies to all health spending.

McClellan testified in 2005 that cutting defensive medicine "could lower overall hospital expenditures by between five and nine percent."[1559] Applying the mid-point of McClellan's estimate to projected 2024 U.S. hospital spending of $1.54 trillion yields a saving of $108 billion in 2024. This applies to hospital spending only.

How to cut the clinical waste associated with defensive medicine? Some have asserted that capping total malpractice awards or awards to compensate for economic damages or pain and suffering would substantially reduce defensive medicine costs.[1560] But a Congressional Budget Office regards the evidence supporting that assertion as "weak or inconclusive."[1561] Hyman and Silver classify the connection as a myth.[1562] And a report from Public Citizen found that limits on malpractice liability in Texas did not produce measurable savings.[1563]

Since current malpractice law fails to improve quality of care, fails to identify and either re-educate or extrude dangerous doctors, focuses narrowly on provable torts and therefore fails to fairly compensate the overwhelming share of victims of medical harm, but powerfully boosts clinical waste, it should be ripe for reform. But reforms have addressed symptoms of perceived dysfunction of malpractice rules—such as a few high jury awards or years of rapid rises in premiums. Causes are ignored. So are costs of defensive medicine itself.

Writing in 2009, about nine months before the ACA's passage, Mello and Brennan argued that malpractice reform should be included with health reform for three reasons. It would help contain cost by cutting defensive medicine. It would help persuade doctors to support federal legislation to cover more Americans. And it would attract Congressional Republicans to support a reform package by advancing their interest in tort reform. Mello and Brennan identify three possible malpractice reforms. One is disclosure-and-offer. Here, doctors would disclose unanticipated bad outcomes and offer compensation. A second is specialized tribunals relying on clinical guidelines, administered by experts. And a third is safe harbor from litigation for doctors who follow evidence.[1564]

An alternative would be to do away with lawsuits for medical malpractice. Litigation would cease to be a substantial tool purporting either to protect quality of care or to compensate victims of medical harm. Today's malpractice suits resemble a person who drinks too much at a party, tries to sit down, and falls on the floor between two chairs. Malpractice tries to do two jobs and fails miserably at each. It doesn't fairly compensate victims of harm. Nor does it identify, educate and upgrade, or extrude dangerous doctors and other caregivers.

In reformed health care, the small numbers of dangerous, exploitive, incompetent, reckless, or criminal doctors will be identified by their colleagues. Most will be supported, re-educated, and reformed; some others will have to find work outside medicine; and very small numbers will spend time in prison.

Patients injured medically will be compensated. Since all will be insured after health care is reformed, and since remaining OOPs will be tiny, there will be no need to sue to cover costs of medical care. Disability insurance should replace lost earnings of people unable to work owing to medical misadventure. Injured patients will receive apologies and explanations of steps to be taken to prevent recurrence.

Possibly, patients harmed by medical errors seek apologies, repair of medical damage—when possible—at no charge, compensation for lost earnings, and confidence that effective steps are being taken to protect other patients from similar harms. Full coverage of health costs would address the first. Disability insurance could address the second. A systems outlook—like the one prevailing for airplane safety—could help address the third.[1565] [1566]

In isolation, this approach might not accomplish much. But it might well do a great deal of good if accompanied by improved clinical guidelines and other forms of better evidence, financial neutrality in physician payment, more adequate primary care, and less time wasted on administration.[1567]

Sirovich and others surveyed primary care physicians. Over two-fifths said their own patients were receiving too much care. Reasons included malpractice worries (76%), weak measures of clinical performance (52%), and inadequate time with patients (40%).[1568]

Shortage of doctors and uneven supply of caregivers across specialties and locations

In the U.S., no one is accountable for learning the right number of doctors or hospitals, what skills or services they should offer, or where they should be located. Medical schools decide how many students to admit each year. Hospitals, mainly, decide which types of residencies to offer.

Doctors. After the Second World War, scarred by doctors' low incomes during the Depression, organized medicine in the U.S. sought to hold down the numbers of new doctors trained here.[1569] Fewer doctors meant higher incomes. In subsequent decades, as U.S. commissions and researchers debated whether the U.S. had a surplus of doctors, a shortage, or just the right number,[1570] the AMA occasionally argued that we suffered a surplus.[1571]

More recently, the AMA has unambiguously acknowledged a substantial shortage of doctors,[1572] citing AAMC estimates of a projected shortage of between 38,000 and 124,000 doctors by 2034.[1573]

This is one reason the U.S. ranked 31st among 33 rich democracies in doctors per 1,000 people in 2020. The U.S. had 2.6 doctors per 1,000 people, only two-thirds as many as the mean of 3.8 for the other 32 rich democracies. Only Canada, the U.S., Japan, and Korea had fewer than 3.0 doctors per 1,000 people.[1574]

Even this low ranking would be far worse without the multi-decade practice of relying on foreign-trained doctors to fill a high share of U.S. residencies. For most years since the Second World War, U.S. medical and osteopathic schools graduated far fewer students than the number of first-year residency positions offered by the nation's teaching hospitals. This was labeled evidence of a doctor shortage. Consequently, the U.S. allowed non-citizen physicians graduating from medical schools outside the U.S. to assume residency positions here.

This was rationalized by many as a way to offer advanced training to doctors who would return to their countries able to offer better care. In reality, a very high share of foreign-trained medical graduates trained in U.S. residencies stayed in the U.S. Instead of giving to other nations, the U.S. relied on other nations to shoulder the cost of medical school for many of the doctors delivering care in the U.S.

New graduates from medical and osteopathic schools are free to compete for residencies in the specialties of their choice. But teaching hospitals, usually in cooperation with medical schools, decide which residencies they establish to train new doctors, and the number of residents in each specialty. They do so mainly in light of their own needs for low-cost residents to give inpatient and outpatient care at the hospital.[1575] Unfortunately, they pay little attention to the nation's subsequent needs for doctors.

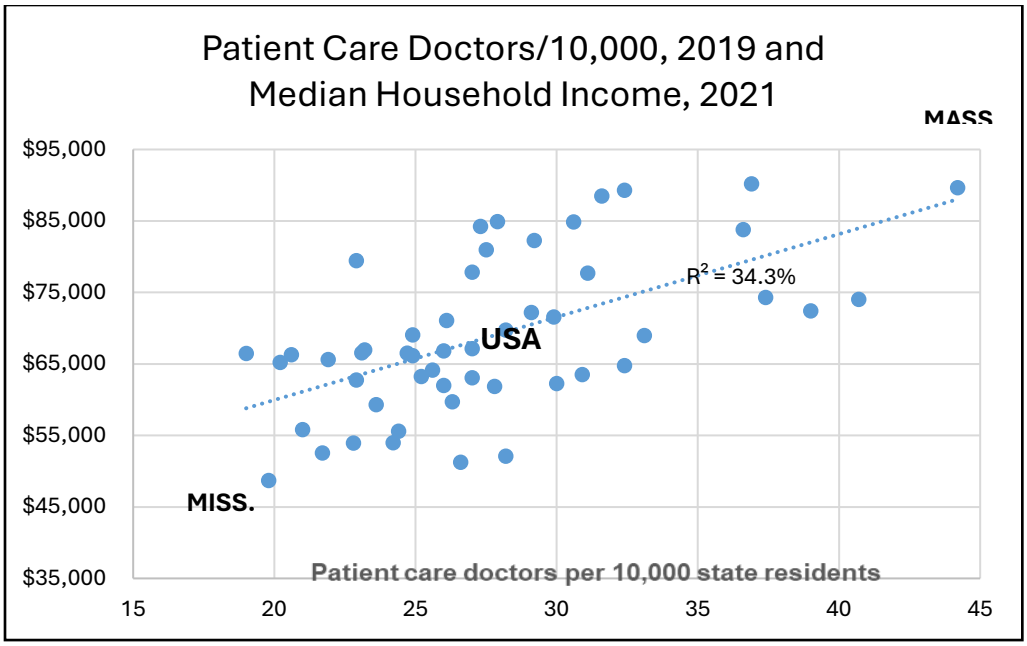
And this is one reason U.S. physicians are the most specialized in the world. A second reason is that specialists dominated early U.S. Blue Shield plans when those plans adopted a method of payment that boosted the incomes of specialist procedure-performing doctors emerging from expanding residency programs after the Second World War.

(That method paid doctors' charges. Most specialists had previously set fees on a sliding scale, with greater discounts from charges for patients with less money. When Blue Shield plans and other insurance companies paid charges, discounts disappeared and specialists' incomes soared.)

Unsurprisingly, the correlation between a state's patient care doctor-to-population ratio and its median household income is fairly high. The R^2 between the two is 34.3%. (See Exhibit 3 – 6.)

No one decides how many doctors should or will practice in each state. Doctors are free to locate where they wish, just as they are free to apply to residencies in the specialty in which they seek to become certified. Some state governments imagine that building medical schools and subsidizing tuition will help add doctors subsequently. But doctors are likelier to practice where they did their residency than where they went to medical school. Almost three-fifths of doctors completing residencies between 2013 and 2022 were practicing in the state where they were residents.[1576] Few state governments take any accountability or any effective action to influence their overall ratio of doctors to people, doctors' locations, or the mix of doctors by specialty.

Exhibit 3 - 6



Sources

Patient care physicians per 10,000 citizens for 2019 is reported in Centers for Disease Control, *Health, United States, 2020-2021,* Table DocSt. Active Physicians and Physicians in Patient Care, by State: United States, Selected Years, 1975-2019, https://www.cdc.gov/nchs/data/hus/2020-2021/DocSt.pdf.

Median annual household income for 2021 is from the U.S. Census Bureau, American Community Survey, and is reported by Kaiser Family Foundation, State Health Facts, https://www.kff.org/other/state-indicator/median-annual-income/.

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Primary care. The shortage of primary caregivers to serve as points of first contact and to advance coordinated, comprehensive, and continuous care. Good primary caregivers help patients secure needed care and avoid unneeded care. They can also help integrate and coordinate care, cutting cost and boosting appropriateness.

U.S. health care is fragmented and disorganized. Electronic health records, touted as one way to better integrate care, have disappointed sponsors. Investments in EHRs have been exploited to substantiate higher billed charges and revenue.

Rebuilding primary care is one of the most vital foundations for improving access, containing cost, and improving appropriateness and quality of care. The substantial shortage of primary care in the U.S. is a main cause of clinical waste.

The U.S. suffers a shortage of doctors, a shortage of primary care doctors, and a shortage of good, clinically proficient primary care doctors with enough time to do their jobs. As shown in chapter 11, the U.S. has the third-lowest ratio of doctors to citizens across rich democracies, behind only South Korea and Japan. A low share of those doctors work in primary care.

And too low a share of today's primary care doctors we do have are good enough at their jobs. Garibaldi and Russell summarize the forces that tend to suppress good care generally:[1577]

> Medical trainees today spend as little as 13% of their time in direct contact with patients. As physicians spend less time with patients, fundamental bedside skills decline. This decline contributes to diagnostic error, poor clinical outcomes, and increased health care costs. More than half of outpatient diagnostic errors have been attributed to poor history taking and mistakes in the physical examination. An overreliance on technology, due in part to declining clinical skills, leads to overinvestigation and rising costs.

Primary care means first-contact care, continuity over time, coordination of care, and comprehensive care. These save money by better targeting care and weeding out much unnecessary or duplicative care.[1578] [1579] The importance of primary care and serious, practical paths to rebuilding it are taken up in chapter 11.

Some doctors might think that demanding patients seek and get substantial amounts of clinically inappropriate but costly care. Against their clinical judgment, some physicians accede to those demands by prescribing meds requested by patients, ordering labs or imaging studies, making specialist referrals, or performing surgery. Reasons for doing so might include aversion to confrontation and conflict, a desire to cut short an encounter that could delay care of other patients, or a wish to minimize risk of being sued for malpractice.

It may be, though, that only very small shares of clinical waste stem from patient demands for care they don't need, combined with doctors' compliance with those demands. Gogineni and colleagues found that only 7 of 5,050 clinical encounters studied saw caregivers complying with demands for clinically inappropriate care.[1580]

Segal and others analyzed predictors of over-use of care by Medicare patients. They found that for-profit operators and those with fewer primary care doctors tended to suffer higher levels of over-use.[1581] Unfortunately, Pham and colleagues found high levels of fragmentation in primary care for Medicare patients.[1582] The shortage of primary caregivers is one reason. Another is the movement of patients from one insurer to another—or their insurer's own changes in which doctors are in-network. Either will force patients to switch primaries or pay substantially more OOP.

Ganguli and associates measured delivery of 41 low-value services by 556 health systems. Average use of low-value services ranged between 0 and 28 percent. Pre-operative lab tests, PSA tests for men over age 70, and use of anti-psychotic meds for patients with dementia were the most frequently provided. Predictors of higher provision of low-value care included lower shares of primary care doctors, absence of a teaching hospital in the system, a larger share of non-White patients, and higher health care spending.[1583]

Hospitals

A more balanced configuration of hospitals could reduce over-use of costly care. When care is given in the wrong setting, it can be wasteful and costly. Routine hospital care for ordinary medical problems requiring hospitalization can and should be given in ordinary small- and mid-size community hospitals. For decades, though, care has been shifting toward major teaching hospitals.

Why does this matter? One reason is that lower-income urban U.S. residents who obtain inpatient hospital care—or are seen in hospital ERs and outpatient departments—are being served disproportionately in the world's costliest hospitals. This boosts cost to Medicaid—and also cost to public hospitals with open door policies. Higher Medicaid costs make that program less popular to state legislators.

A second reason is that patients with ordinary medical problems may be seen as less of a priority at a major teaching hospital.

Third, patients with ordinary problems may be treated with excessive intensity and unnecessary labs, imaging, specialist referrals, and other care when they are admitted to major teaching hospitals. In 1990, the cost per admission, adjusted for severity of illness, was one-sixth higher at major teaching hospitals than at non-teaching hospitals in 52 cities studied.[1584] This probably results in part from greater patient needs—needs not captured by DRG or other case mix measures. Size-related inefficiency—sometimes called diseconomies of scale—is another possibility. Larger hospitals are probably harder to manage efficiently. Also, teaching hospitals' residents and med school faculty may be oriented to delivering more complex packages of services, some of which may be of marginal clinical value.

Hospitals sometimes over-build or add unnecessary or duplicative services and equipment to try to compete with nearby hospitals.[1585] One reporter compiled a set of photos of new hospitals and luxury hotels and invited readers to say which was which.[1586]

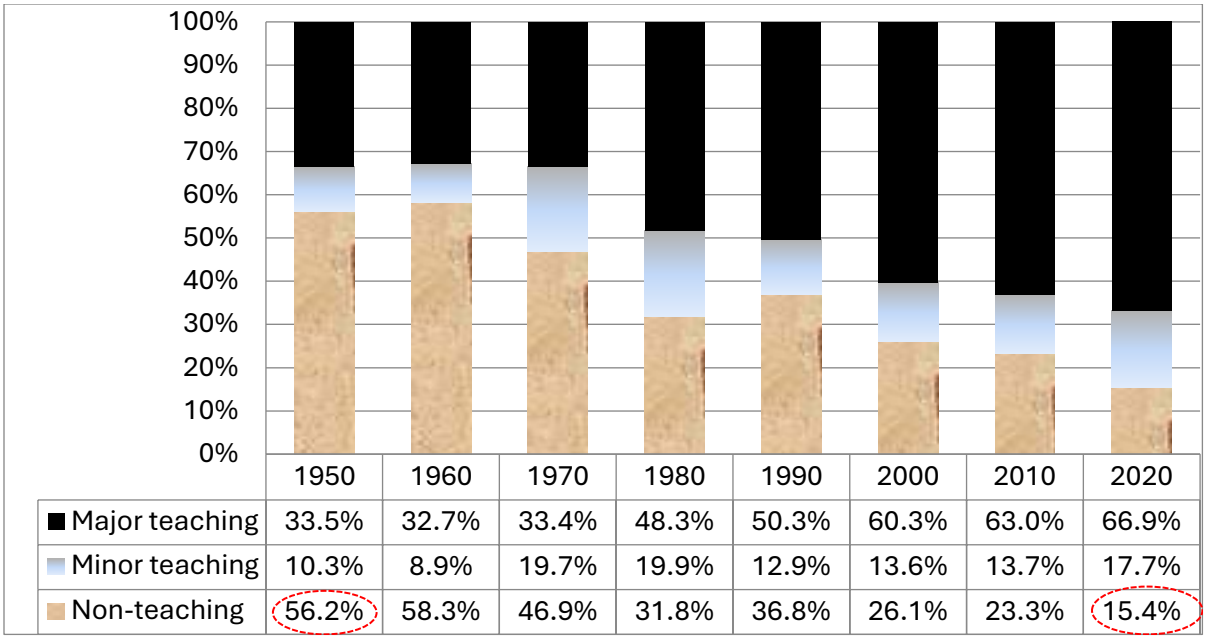
More salient is the growing concentration of urban hospital beds in large teaching hospitals. In 1950, 56 percent of the acute hospital beds in 52 U.S. cities were in ordinary community non-teaching hospitals. As shown in Exhibit 3 – 7, that share fell to 15 percent in 2020.[1587]

As will be discussed in chapter 12, this happened partly because smaller and mid-size community hospitals were more likely to close or relocate from cities; because teaching hospitals employed many resident physicians, medical school faculty, and other doctors; and because new medical schools were built in cities that had not had one. A consequence is that the average patient in these cities was much more likely to be served in a teaching hospital in 2020 than in 1950.

In a large teaching hospital, the average patient is likely to receive a richer mix of services than in a community hospital, raising the chance of inappropriate care. One reason is that inexperienced residents might lean toward doing more. Another is that greater availability of specialized services or physicians might spur greater use of them.

Exhibit 3 – 7

Percent of Beds by Medical School Affiliation, 1950 – 2020, 52 U.S. Cities



	1950	1960	1970	1980	1990	2000	2010	2020
Major teaching	33.5%	32.7%	33.4%	48.3%	50.3%	60.3%	63.0%	66.9%
Minor teaching	10.3%	8.9%	19.7%	19.9%	12.9%	13.6%	13.7%	17.7%
Non-teaching	56.2%	58.3%	46.9%	31.8%	36.8%	26.1%	23.3%	15.4%

Some hospitals are badly run and under-financed. A disproportionately high share of their doctors and nurses are less-well-trained and less proficient. Medical errors are more common. But bad care occurs at good hospitals, also. Many teaching hospitals rely excessively on weakly-supervised residents.

In most other rich democracies, physicians caring for patients in hospitals are typically employed by them and are paid salaries. These doctors must deliver care with an eye toward the budget that's available to finance the hospital's care that year. They must make trade-offs. This usually means avoiding high-cost care of low value. Salaries make doctors financially neutral, so they are not motivated to make more money for themselves by boosting overall volumes of care or by skewing care toward more profitable services.

In those other nations, physicians in ambulatory care practices, working outside hospitals—like primary care doctors, psychiatrists, rheumatologists, endocrinologists, and the like—are usually paid fee-for-service (FFS). But fees are typically set so that an energetic doctor who sees an expected number and mix of patients will earn a target income.

Remedies for clinical waste

Neumann and colleagues call for taking four approaches to prioritizing cost-effectiveness analyses of medical services and procedures. One is horizon scanning to identify new medical interventions—early in their use—that have the potential to be widely employed and costly.[1588]

A second is examining current spending patterns. Neumann and others identified spinal fusions, percutaneous coronary artery angioplasties and other interventions, and caesarian

deliveries and the three costliest in-hospital procedures. That makes them natural targets for assessments.

Gilmer and others examined the value of ethics consultations in reducing non-beneficial ICU use. They deemed this important partly because ICU care absorbs about one-fifth of inpatient hospital costs.[1589] More important, they suspected that over-use stemmed in part from inadequate understanding of when to aggressively treat in the ICU and when to make the patient comfortable, instead. Conflicts within the family, among physicians, and between family and physicians impaired efforts to respect patients' prognoses or preferences.[1590] A randomized trial of an ethics consultation was associated with a cut in ICU days by one-fifth, and of total cost by one-sixth.

This highlights more than one specific opportunity to cut clinical waste: It also points to the value of improving communication between clinicians and patients and their families to support shared decision-making. A better process won better outcomes and, also, very probably enhanced trust between families and caregivers. That trust is vital to sustaining patient, family, and citizen comfort with health care—especially when care is stressed by crisis and is undergoing reform.

A third is to examine variations in rates of procedures or other types of care in different places. This could be extended to study rates of care for different groups of people—especially those vulnerable to deprivation of needed services or over-provision of care.

And a fourth is to prioritize assessments when the value of information gained would be high.

Specific remedies must address each of the main causes of clinical waste. These are discussed in chapters 7 through 16.

It will be particularly valuable to seek ways to improve information on the value and incremental cost of various types of health care. And equally valuable to put that information in the hands of physicians—the million or so Americans who diagnose and treat our illnesses and injuries—under arrangements that allow us to trust them to spend our money carefully.

Multiplying outsiders' microscopic scrutiny of doctors' decisions can't be the main tool. In 2025, Liu and colleagues reported on CMS's decision to introduce prior authorization into traditional Medicare. This stemmed from mistrust of many physicians' clinical decisions and fear of over-delivery of low-value but profitable care. CMS identified 17 specific services that, it believed, were subject to fraud or waste or delivery of services found to be of low clinical value. CMS also included services subject to PA by MA plans.

These reviews, called WISeR, will be conducted by private companies and will rely on AI. It is said that the companies "clinical staff" will review AI decisions for PA submitted by doctors. The companies will retain a share of the money they save by denying PA.[1591]

This is a foolishly-designed and dangerous arrangement. It magnifies mistrust instead of mitigating it. Therefore, it creates new opportunities for payers and caregivers to fight, wasting still more scarce health care dollars.

It is not surprising to witness adoption of this foolish remedy. It builds on years of bad behavior by for-profit MA plans. It builds on beliefs that micro-regulation of doctors is both feasible and worthwhile. It applies yet another toxic band-aid to health care's wounds.

The alternative is to create a structure of care and payment that we can trust with out lives and our money. Other rich democracies have succeeded—more or less—in doing that.

2. Administrative waste: Death by a thousand paper cuts – about $750 billion in 2024

DeBuvitz wrote in 1989 that:

> The heaviest element known to science was recently discovered by investigators at a major U.S. research university. The element, tentatively named administratium, has no protons or electrons and thus has an atomic number of 0. However, it does have one neutron, 125 assistant neutrons, 75 vice neutrons and 111 assistant vice neutrons, which gives it an atomic mass of 312. These 312 particles are held together by a force that involves the continuous exchange of meson-like particles called morons.
>
> Since it has no electrons, administratium is inert. However, it can be detected chemically as it impedes every reaction it comes in contact with. According to the discoverers, a minute amount of administratium causes one reaction to take over four days to complete when it would have normally occurred in less than a second.
>
> Administratium has a normal half-life of approximately three years, at which time it does not decay, but instead undergoes a reorganization in which assistant neutrons, vice neutrons and assistant vice neutrons exchange places. Some studies have shown that the atomic mass actually increases after each reorganization.
>
> Research at other laboratories indicates that administratium occurs naturally in the atmosphere. It tends to concentrate at certain points such as government agencies, large corporations, and universities. It can usually be found in the newest, best appointed, and best maintained buildings.
>
> Scientists point out that administratium is known to be toxic at any level of concentration and can easily destroy any productive reaction where it is allowed to accumulate. Attempts are being made to determine how administratium can be controlled to prevent irreversible damage, but results to date are not promising.[1592]

Types

Administrative waste takes many forms. Marketing entails advertising, commissions, and other substantial administrative costs. Prior approval of doctors' care decisions imposes heavy burdens on physicians and hospitals. Determining correct prices to pay caregivers, net of different patients' varying OOPs, is complex, confusing, and prone to error.

Indeed, much administrative waste stems from the great complexity of establishing and paying large numbers of different prices and net payments for different patients. Constructing narrow

networks of doctors and hospitals, and then paying different prices for in-network and out-of-network care is complicated to do correctly. Complexity invites mistakes.

It is likely that mistrust between payers and caregivers generates even more administrative waste than does complexity. Payers often fear that doctors or hospitals are upcoding patients to generate higher payments. Caregivers often fear that private insurers are downcoding patients in order to pay lower fees. Payers frequently deny payment retroactively.

Patients have described the complexity of medical bills. Some of those who face high bills and have enough money may hire a specialist to assist with claims. Those without enough money pay bills, some illegitimate, or face liens and legal fees.[1593] Some patients—older, living alone, or those suffering chronic illnesses that make many types of care essential—often suffer inability to understand the masses of bills they receive, challenge illegitimate ones, or secure redress.[1594]

Patients who could afford to set aside money in HSAs are able to pay many OOPs with before-tax dollars, but face complex paperwork.[1595] [1596]

In 2007, Pear reported that MA were condemned for deceptive and corrupt marketing since the program's inception.[1597] Many such criticisms came later—for both MA and ACA plans. Public regulations and criminal prosecutions apparently have had little effect. This waste straddles the fence between cumbersome administration and theft.

For-profit MA plans enrolled almost three-quarters of MA plan members in 2024, up from two-thirds in 2019.[1598] If patients, doctors, and hospitals fear that for-profit pans deny clinically legitimate prior authorization requests in order to boost profits, they will become suspicious and angry. They will probably also appeal more denials and complain publicly and politically. This will make for greater friction and also boost administrative waste.

Rooke-Ley and colleagues note that MA plans require prior authorization (PA) at a rate of once for every 1.5 members, while traditional Medicare requires it once for every 80 enrollees. They claim that MA plans make it hard for doctors to obtain PA by under-staffing and delaying approvals. This is one of the main reasons MA plans devote 13 percent of revenue to administration, versus 2 percent in CMS.[1599] (To the 2 percent must be added the administrative costs of the private insurers who serve as Medicare's own financial intermediaries.)

To reform MA, Rooke-Ley and colleagues urge removing the job of PA from MA plans. Instead, they propose that Congress create a distinct MA administrative contractor, which would use best available evidence to establish standardized rules by which to review all requests for PA. AI, they hope, would permit low-cost review. The contractor would be financed by fees paid by all MA plans. The MA plans would continue to pay caregivers' claims.

Remarkably, though, Medicare is launching a 6-state pilot program to test use of prior authorization in traditional Medicare. It would employ private contractors that would use AI and that would retain a percentage of the payments they avert. Trump's CMS head, Oz, said that the program's goal was to "root out fraud, waste, and abuse", reported Abelson and Rosenbluth.[1600] This program efficiently compresses into one activity the worst of paperwork waste, financial incentives, for-profit intrusion into health care, and generation of costly legal challenges. Its fate is uncertain.

Another difficulty with prior authorization is its unreliability—its inconsistency. Jabri and colleagues have found considerable variation in rules for prior authorization.[1601] Consistency is necessary for validity—though it is not alone sufficient.

Effective reform of prior authorization is probably not feasible. It would be better to cease "outsourcing the no." That would entail self-regulation by physicians.

Dorn describes federal health coverage tax credits that paid 65 percent of health insurance premiums for some workers who lose jobs owing to higher imports. Even after attempted streamlining, administrative costs still absorbed one-third of program spending.[1602]

Freudenheim reports on physicians' complaints that insurance companies that lose doctors' claims or refuse to pay them, obliging doctors to hire more office workers to re-file claims or appeal denials.[1603]

Hospitals sometimes focus their own complaints on burdens imposed by federal regulations. A consultants' report commissioned by the American Hospital Association identifies numerous forms Medicare patients must sign in the ER, a 30-item Medicare secondary payer form, detailed justifications care to document doctors' decision-making, and many forms that must be completed on nursing home patients.[1604] These burdens manifest mistrust.

At other times, hospitals broaden their criticism of administrative waste to include impositions by insurers and HMOs, and private sector attempts to measure quality, and demands of EHRs.[1605]

Zhou and colleagues measured the added administrative cost to hospitals of mandatory "value-based" programs. These were Hospital Value-based Purchasing, Hospital Readmissions Reduction, and Hospital-acquired Conditions Reduction. Zhou and colleagues found some $3 billion yearly in added administrative costs from these 3 programs, along with added cost of a non-mandatory Comprehensive Care for Joint Replacement program.[1606]

Barndollar reported on one small Massachusetts hospital that identified over 40 health plans, large and small, for which it was out-of-network.[1607]

The Medical Group Management Association (MGMA) reports yearly on regulatory burdens facing physicians. It ranks these by severity. Prior authorization was labeled very or extremely burdensome by 82 percent of respondents, surprise billing by 70 percent, Medicare Quality Payment Program (MIPS) by 65 percent, audits and appeals by 64 percent, MA chart reviews by 61 percent, and lack of EHR inter-operability by 50 percent.[1608]

Schweitzer and Mathur have pointed to administrative burdens that impair access to Medicaid and other programs designed to help low-income Americans.[1609]

Size

Administrative waste is the unnecessary diversion of people, money, and energy to non-clinical activities. Applying Berwick and Hackbarth's high estimate to projected 2024 NHE of $4.9 trillion gives us $705 billion in administrative waste in 2024, 14.4 percent of NHE. That's very close to Debbie Socolar's and my own estimate of 15 percent from 2005. Applying

Himmelstein's and others' 2017 estimate of administrative waste of 17.2 percent to U.S. 2024 NHE, discussed shortly, yields an estimate of $843 billion in administrative waste in 2024.

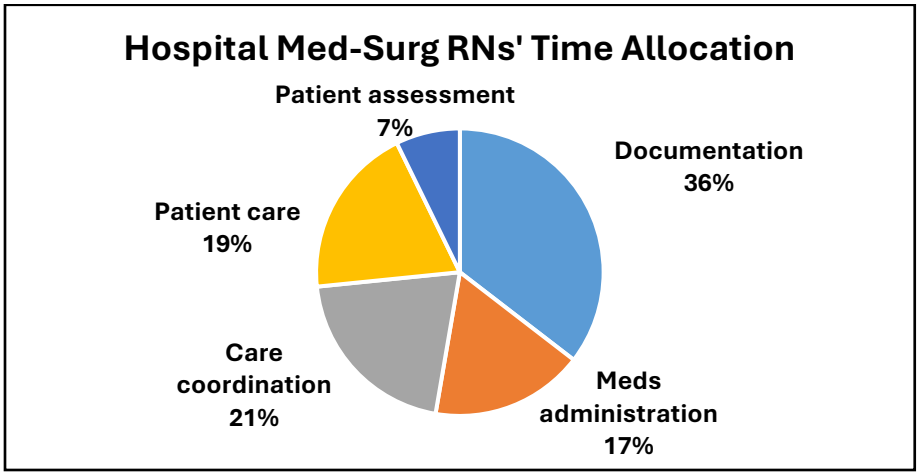
Sahni and colleagues estimated administrative spending at fully $950 billion in 2019, fully one-quarter of NHE of $3.8 trillion.[1610] In 2023, they described ways to cut $40 to $60 billion of the $200 billion spent in 2019 on financial transactions inside health care. They include those transactions' claims processing, payment, patient collections, and prior authorizations.[1611]

Hospitals have added administrative workers faster than clinical workers. Anderson and Kohn examined state-by-state changes in clinical and non-clinical staff at U.S. hospitals between 1981 and 1993. Nationally, the ratio of clinical staff per 1,000 patient-days, adjusted for case mix, rose by 6.3 percent over a dozen years. But the ratio for non-clinical staff rose by 21.2 percent. The ratio of clinical to non-clinical staff fell by 13 percent.[1612]

And clinical workers devote high shares of their time to administrative duties.

As displayed in Exhibit 1 – 8, one substantial study found that hospital nurses on adult medical-surgical units devoted about three-quarters of their time to documentation, care coordination, and administering medications—and only one-quarter of their time to patient care and patient assessment.[1613]

Exhibit 3 – 8



Source: Ann Hendrich, Marilyn P. Chow, Boguslaw A. Skierczynski, and Zenqiang Lu, "A 36-Hospital Time and Motion Study: How Do Medical-Surgical Nurses Spend Their Time?" *The Permanente Journal,* Vol. 12, No. 3 (Summer 2008), pp. 25-34, https://www.thepermanentejournal.org/doi/10.7812/tpp/08-021.

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A very different study tracked not clinicians' activities but their locations. RNs in an ICU spent only one-third of their time in patients' rooms.[1614]

One partial response to the shortage of hospital nurses at bedside would be to liberate more of nurses' time to care for patients. Reducing documentation time would be one way to do that. Some critics assert that nurses (and doctors) spend too much time learning about and caring for the e-patient than the corporeal one.[1615] [1616] Primary care doctors were found to spend 52 percent of their workday nurturing the electronic health record or EHR.[1617]

The problem seems not to be inherent in the EHR software, but rather in the uses to which it is put, uniquely, in the U.S. An examination of characters typed per ambulatory care progress note in EPIC in eight nations showed a range between 600 and 2,000 outside the U.S. The U.S. range was between 2,000 and 7,000 per note. U.S. clinical notes averaged almost four times longer than those in seven comparison nations.[1618]

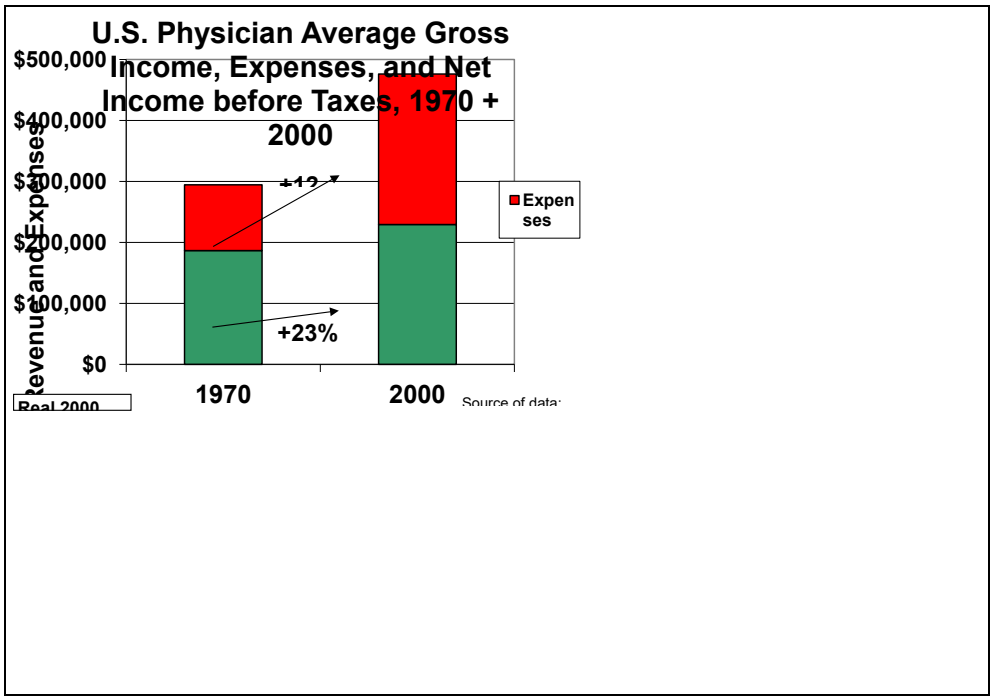
Excess typing in the U.S. was deemed to stem from documentation for reimbursement and compliance purposes.[1619] Also, much documentation aims to pre-empt malpractice claims. It is noteworthy that most of the seven comparison nations paid physicians in ambulatory care by fee-for-service. So fee-for-service payment, like the EHR, is not inherently culpable. Rather, U.S. problems stem from how EHRs and FFS are used in the U.S.

Rodwin and colleagues offered compelling evidence on the growth of administrative waste in physicians' practices. Analyzing AMA data, they compared the changes in physicians' average total (gross)0 actual incomes, expenses, and net incomes after expenses between 1970 and 2000.

As displayed in Exhibit 3 – 9, doctors' average net incomes before taxes rose by 23 percent from $186,000 to $229,000, adjusted for inflation.

But practice expenses rose by 129 percent from $108,000 to $246,600. Doctors' net incomes fell from 63 percent of total incomes to 48 percent.[1620]

Exhibit 3 – 9



Inter-nation comparisons. In 1992, Poullier reported on his efforts to compare reported administrative costs across 20 rich democracies in the OECD between 1975 and 1990. Unfortunately, data were available on only 7 nations. Total per-citizen spending for health administration in the U.S. was $149 in 1990. This was 3.0 times as much as the average for the 6 other reporting nations (Australia, Canada, France, Germany, Netherlands, and Sweden).[1621]

Himmelstein and colleagues compared U.S. and Canadian employment of administrative (non-clinical) workers in health care between 1971 and 1986. They found high ratios of administrative workers per thousand citizens in the U.S., an excess of 7 percent in 1971, rising to an excess of 42 percent in 1986. For 1986, their data show excess administrative workers per 1,000 citizens in the U.S. of 56 percent for hospital care and of 82 percent for outpatient care. Canada's excess for nursing home care was 133 percent.[1622]

Morra and colleagues compared U.S. doctors' costs of working with payers with those of Ontario doctors. They found that American practices spent 3.7 times as much per doctor. U.S. savings would have been $27.6 billion in 2006, had they incurred costs at the Ontario rate.[1623] That's $42.9 billion in January 2024 dollars.[1624]

The $42.9 billion in yearly savings would be enough money to recruit 82,500 added primary care physicians and pay them $400,000 per year plus $120,000 (30 percent) in fringe benefits, at a total yearly cost per added doctor of $520,000. If each added PC enrolled a panel of only 1,000 patients, they would together still be able to care for 82,500,000 Americans needing good primary care, or roughly one-quarter of all Americans.

Himmelstein and others compared hospital administrative costs across Canada, Netherlands, and the U.K. with those in the U.S. U.S. administrative costs per person were 3.0 times the average elsewhere.[1625] The per-person gap was $440 in 2010, or $626 in January 2024 dollars.[1626] For a projected U.S. population in July 2024 of 337 million, the dollar *savings on*

hospital administration would total about $211 billion, or roughly one-seventh of U.S. hospital spending in 2024.

Himmelstein and others compared all health care administrative costs in 2017 in the U.S. and Canada. In the U.S., administrative costs borne by payers and caregivers were 34.2 percent of NHE, compared with 17.0 percent in Canada.[1627] The gap is one clear definition of administrative waste. Applying the difference of 17.2 percent of NHE to expected U.S. NHE of $4.9 trillion in 2024 yields *estimated U.S. administrative waste of $843 billion.*

A *Health Affairs* Research Brief reviewed evidence on administrative waste, highlighted its salience, and concluded that one-half of U.S. administrative expense is wasted.[1628]

Critics. Supporters of business-as-usual in health care have been inclined to minimize the problem of administrative waste.[1629] [1630] They are wrong.

Also wrong—but much more interesting—are those who seem to justify administrative waste.

Chernew and Mintz seem to believe that a high level of administrative waste is the price Americans choose to pay so they can exercise choice of insurer.[1631] To make that choice possible, payers must be fragmented (and, therefore, often too weak to hold down caregivers' prices). Billing becomes complicated. So does marketing.

This serves to justify high levels of administrative waste. A market-oriented system, they write, relies on insurance to share risk. Since insurance is open-ended, insurance companies must try to hold down prices by bargaining with doctors and hospitals. And by boosting OOPs. Subsequent administrative costs include tracking and administering OOPs, creating narrow networks, finding in-network caregivers, and hiring advisors to guide choices.

This entire edifice rests on the asserted primacy of choice. Yet Chernew and Mintz adduce only one shallow citation in support—the opinions—not a consensus—or some members of *Health Affairs'* Council on Health Care Spending and Value.[1632]

Chernew and Mintz have asserted that Americans so value choice and, therefore, must accept or embrace reliance on market mechanisms to enable choice in coverage, mechanisms that are administratively expensive and that fail to contain health care costs. Chernew and Mintz seem to be balancing a large and costly structure of administrative waste on the point of a pin.

It is reasonable to wonder two things. The first is whether many Americans are aware of the choice, and how many would signal the primacy of choice of insurer if they knew both its cost and what they were giving up to enjoy choice. Do Americans worship so blindly at the altar of choice of insurer? Even if the right to choose an insurance company trumps the right to choose a doctor or hospital?

The second is whether Chernew and Mintz are actually writing with heavy irony in an above-ground samizdat journal article designed to enrage Americans by blandly listing the high prices we pay for the appearance of choice.

Actors and sites

Administrative waste, like fat in prime beef, is marbled throughout health care. It may be helpful to follow the money as it flows downhill from its source in premiums or taxes or OOPs to caregivers.

A number of parties dwell on the banks of the money river. Insurers are heavily involved if the patient is covered through the job. If the patient is covered by traditional Medicare, a contractor—usually an insurance company—administers coverage and payment on Medicare's behalf. If the patient is in MA, the MA plan acts much like an insurance company. Medicaid managed care plans typically do the same. All these may contract with various specialized companies that claim expertise in scrutinizing claims.

On the caregiving side, hospitals typically are large enough to bill for themselves. But some contract with highly specialized firms to handle initial billing or appeals. Doctor groups are more likely to contract for billing. Regardless of method employed, billing costs are a financial burden on doctors' practices.[1633] They are particularly crushing for primary care.[1634] That's because PCs see many patients per day and must bill for each.[1635]

Patients who question coverage decisions, denial of prior authorization, size of OOPs, or denial of claims sometimes receive help from employers; that help varies in competence and effectiveness. Small patient advocacy groups help a few patients.

The money flows past a number of distinct milestones. Most occasion substantial administrative waste.

1. Some waste is located in the insurance companies that set premiums for different employer groups and individuals. Insurers often construct narrow networks of hospitals and doctors, negotiate fees to be paid, and market plans to eligible citizens.
2. Some is associated with collecting premiums. More occurs before care is given.
3. Eligibility must be confirmed: is the patient indeed insured, covered for this care, and in-network for care by this doctor or hospital?
4. Often, a referral from a primary care doctor must be obtained, along with prior approval from the payer.
5. Once the patient receives care, the caregiver must decide how to code the service because that heavily influences the sum to be billed. Some caregivers work energetically to boost codes and garner more revenue; others are more relaxed.
6. The medical record must be prepared in detail to substantiate the code.
7. The medical record must also demonstrate that care of the patient followed appropriate protocols, measures of quality.
8. Once the bill is sent, the insurer must confirm steps 3 through 7.
9. The claim might be denied retroactively even if care was authorized.
10. Or the claim might be downcoded to a lower-paying sum.
11. The caregiver might appeal the denial or downcoding.
12. The patient might do the same—especially if the caregiver seeks payment from the patient for claims denied by an insurer or for elevated OOPs.

Administrative waste results, first, from the high—and growing—levels of mistrust among caregivers, payers, and patients. Second, complexity of raising money and paying caregivers contributes substantially to administrative waste.

Both mistrust and complexity stem, generally, from the anarchy characterizing U.S. health care, and specifically from the failure of both private market and public regulatory cost controls. Methods of payment and units of payment are often crafted to attain various objectives—mainly cost control but sometimes improved quality or, much more rarely, improved access to care.

Jain has pointed to the proliferation of middlepeople throughout health care.[1636] They breed in the dark and moist corners of complexity and mistrust. Their main overt or manifest aim is to contain cost. But when they fail to do so, still more middlepeople are added to run new cost containment efforts.

Istvan and colleagues recognized the heavy burden of administrative waste. But they suggested merely mechanical remedies.[1637] One is standardization of contracts between payers and caregivers. They liken this to the success of efforts by federal mortgage buyers, Fannie Mae and Freddie Mac, in standardizing mortgage contracts. It is hard to understand how this would address the sources of complex variety of prices, rules, quality measures, networks, and other aspects of increasingly privatized health insurance. Their second notion is reliance on AI, though they acknowledge that the nation's 317,987 health plans could each set their own rules for employing AI. Perhaps most important, it is not clear how routinizing or standardizing bill processing could actually cut complexity or, if it did, how that could modulate mistrust.

Reporting in 2006, Wessel and colleagues identified reasons for the proliferation and aggrandizement of middlepeople; they pointed to efforts by some employers to directly negotiate with doctors, hospitals, and drug manufacturers.[1638]

Certainly, administrators are essential. But they sometimes elevate themselves and their function by amassing substantial power and money. A big problem in health care, it arises in many sectors.

In the Union Army of the Civil War and more so in the forces liberating France 8 decades later, the U.S. has had relatively high ratios of rear-echelon tails to front-line soldiers. The power of some administrators to protect themselves and those who work for them is sometimes remarkable. Witness the ability of the logistic and administrative branches of the U.S. Army in 1944 to secure for themselves the better hotels and superior social comforts in Paris, thereby denying them to those recuperating or on leave from the fighting infantry divisions.[1639]

Outside the military, Teles describes complex and incoherent public programs and regulations. He contrasts the administrative simplicity of raising money for Social Security and receiving benefits with the complexity of IRAs, HSAs, and 529 college plans. He points to the remarkable complexity of the Internal Revenue Code, tangled flood control responsibilities in New Orleans, dozens of small and confusing federal programs to support both K-12 public schools and colleges and universities, and the federal government's own need to contract with private consulting firms to advise on how to administer its own public programs.[1640] He points to the widespread lack of accountability in public programs.

Leslie and Rhoades analyzed the rise in college and university administrative costs 30 years ago.[1641] Early in Covid, Randall called for emergency action to slice administrative costs.[1642] Kohli described administrative bloat at Massachusetts colleges before, during, and after Covid.[1643]

Administrators sometimes speak loudly on their own behalf or commission others to do speak for them. AHIP commissioned the PwC firm to rebut claims that private health insurance administrative costs were high. PwC concluded that "a significant portion of administrative costs go to services for consumers, purchasers, and providers." Improved IT holds down cost and improves care, PwC wrote. And PwC tried to discredit comparisons of public and private insurance administrative cost by pointing to differences in people served, care provided, and the private companies' "value-added services." [1644]

Mistrust

In 2004, after U.S. doctors sued 10 insurance companies for systematically cheating them on payments, Cigna and Aetna paid over $1 billion to settle.[1645]

Growing mistrust between caregivers and payers is the most powerful cause of administrative waste. It exceeds even complexity. Insurers complain that caregivers illegitimately upcode in hopes of winning unwarranted revenue. Insurers deny that a patient is covered at all, is covered for a given service, is in-network, or even needs that service. Payers embrace the twisted notion of moral hazard to rationalize imposing high OOPs on patients.

Mistrust between payers and caregivers is baked into U.S. health care owing to the absence of effective cost controls. That absence is explained in part by failures of competitive free markets in health care, as discussed in chapter 4, and of effective public action, as discussed in chapter 5. Detailed analyses of causes of failed cost controls and possible remedies are offered in chapter 8.

The result is that payers are obliged to work to restrain use of care. This is sometimes called "outsourcing the no."

Still, it is remarkable to read a headline that "'The Finger Pointing Isn't Working': Aetna's President Talks Rebuilding Payer-Provider Trust." [1646] He asserted "'My strong passion right now is to change the dialogue between payers and providers… We have got to create a different approach because the finger pointing isn't working, and it just leaves members in a bad place.'" At the same time, he recognized "'There's a constant tension between clinicians and payers…. We're in a tight funding environment with historically high year-over-year trends and high health care costs.'" It's impossible to see how that tension can be relieved—and the finger pointing cease—without effective cost controls that protect equitable patient access to care while relying on doctors to in-source (take on) the job of saying no.

Since U.S. health private insurance through the job was originally designed as an entitlement, it is financially uncapped, open-ended. Medicare and Medicaid were enacted on similar principles.

Absent effective controls on health care costs in the U.S., payers—particularly private insurers—have sought to contain their spending by suppressing use of care. This requires establishing adversarial relations with both caregivers and patients. Patients face high OOPs. Caregivers face prior authorization and retroactive denials of payment.

One of the few tools available to payers to contain cost of entitlements was to contract with narrow networks of doctors and hospitals—caregivers that agreed to accept lower prices in exchange for higher volumes of patients.

Patients who wander out-of-network pay much higher OOPs.

A second set of tools was to raise administrative barriers to care. Payers deny prior approval or make it hard to obtain. They deny claims for care given. They downcode many caregivers' requests for payment.

A third path to holding down spending was to promote various sorts of capitated payments to HMOs, MA plans, and Medicaid managed care plans. These capped money available to spend in various ways. To stay under revenue ceilings, capitated entities tried to hold down volumes of care and prices paid to caregivers.

Originally, capitated entities like Kaiser plans and other pre-paid group practices were operated as non-profits. A number of reformers pushed capitation of non-profit organizations as a way to hold down health care costs in a humane, safe, and trustworthy manner. The intent was to save money by squeezing out high-cost/low-value care in order to hold down costs to payers or to make more money available for low-cost/high-value care.

Over time, most HMOs, MA plans, and Medicaid managed care plans came to be operated for-profit. Money saved on care or obtained through higher capitation rates could be channeled to stockholders. Free market theorists and greedy owners applauded for-profit operation and supposed that actions to boost revenue or cut costs were sanctified by an invisible hand's applause for profit.

Potter, a former insurance company executive, testified that insurers seek boost the price of their stock. To do so, they hold down their care shares ("medical loss ratios"), the percentage of the premium dollar that actually pays for medical care.[1647] They do so by boosting revenue or cutting payments for care.

Insurers mistrust doctors and hospitals. Methods and units of payment fuel that suspicion.

Payers suppose that, since most doctors are paid FFS, they have a financial incentive to give more care. So insurers feel justified in refusing authorization for much care and in denying payment for other care. Brewer describes his increasing number of fights with insurers and his struggles, as a doctor, to try "to prove to a non-doctor that I know my patient and what I am talking about." [1648]

Kerr describes his futile efforts to persuade the Medi-Cal program to pay a hospital for two days' inpatient care of a young girl who faced substantial risk of dying from septicemia.[1649] The under-informed Medi-Cal clerk almost certainly did not recognize the severity of the patient's problem, clearly did not trust the doctor, and very probably suspected the doctor and hospital in colluding in admitting a low-cost patient to generate surplus revenue during a low-occupancy holiday weekend. Medi-Cal's method of paying for hospital care by the all-inclusive patient-day, established by competitive bidding, probably gave rise to the clerk's suspicion.

Private insurance companies' narrow networks, prior authorization requirements, rigid care protocols, and payment denials impair patients' access and undermine quality of care.[1650] In

one large study, one-quarter of respondents reported that care was delayed or abandoned owing to patient/family administrative tasks.[1651]

Van Gorder of Scripps Health criticizes MA plans' payments, saying "'It's become a game of delay, deny, and not pay.'"[1652]

Rescissions. One technique employed by some insurers has been to rescind coverage of patients who needed costly care.[1653] [1654] Particularly common in California, this practice helped to revitalize political support for the ACA at a time it seemed to be flagging shortly before ultimate passage. Radical premium increases also nourished the ACA's political progress. The ACA made it much harder for payers to rescind coverage.

Prior authorization. Prior authorization frustrates both patients and physicians. Their complaints are long-standing [1655] and widespread.[1656] [1657] [1658] [1659]

MA plans saw more than one prior authorization request per member in 2021.[1660] Insurers that choose to demand prior authorization—before care can be given—upset and inconvenience many physicians. Some 37 percent of doctors surveyed by the AMA reported rejection rates of 20 percent or more for tests and procedures; 57 percent reported rejection rates of 20 percent or higher for preauthorization of drugs.[1661] Some allege that patient care can be delayed dangerously. Many resent the time they and their office workers must devote to assembling information required to justify approval, insurers' delays in processing requests, and consequent extra efforts required to schedule and coordinate actual patient care.

Doctor groups have sought reform in prior authorization procedures. In the face of these complaints, federal and state governments' actions and proposals promised to constrain prior authorization.[1662] [1663] In December of 2022, CMS proposed a rule requiring caregivers and payers to submit and process prior authorizations electronically. This would apply only to tests and procedures, not meds, where denial rates are highest. Insurers would face time limits for deciding on requests.[1664]

A March 2024 interview with CMS's chief informatics officer, reveal a belief that "prior authorization has its necessary place in health care." It described efforts to expedite prior authorizations through "digitization and better data exchange," promising to save $1.5 billion yearly.[1665] If successful, that savings would amount to a tiny share of annual administrative waste.

Facing doctors' anger and regulatory movement, albeit at glacial speed, some insurers—Humana, United Health Care, and Cigna— said they would modestly ease their requirements for prior authorization.[1666] Not all doctors are impressed.[1667] Some journalistic coverage balanced doctors' own frustrations with prior approval with descriptions of harms to patients stemming from delayed care.[1668]

Unfortunately, this ritualized dance of complaint, regulation, and modest responses ignores the reasons insurers demand prior authorization: They do not trust caregivers and lack effective ways to contain cost.

Altman reluctantly concluded that the nation is "stuck" with prior authorization because eliminating it would boost health care spending.[1669] In doing so, he relied on studies that

supposed everything else would remain the same. This suggests that safely eliminating prior authorization would require making additional changes.

One study by Vabson and others asserted that 4 percent of Medicare Part D prescriptions were subjected to prior authorization, but these accounted for 20 percent of actual Part D spending. The study also found that the cost of administering this prior authorization was a small share of the money saved. It was, though, unable to say whether denials of authorization harmed or killed patients.[1670]

The finding of saving money is entirely predictable. Insurers would not require prior authorization if they did not expect to save money for themselves, net of added administrative costs. But this ignores administrative costs imposed on doctors and possible harms to patients.

It also ignores the many underlying sources of costly prescriptions, including drug makers' high prices on monopoly meds, their aggressive marketing to patients and doctors, and weak primary care coordination of drug use.

As mentioned in the section on clinical waste, Liu and colleagues reported in 2025 on CMS's decision to introduce prior authorization into traditional Medicare. This stemmed from mistrust of many physicians' clinical decisions and fear of over-delivery of low-value but profitable care. CMS identified 17 specific services that, it believed, were subject to fraud or waste or delivery of services found to be of low clinical value. CMS also included services subject to PA by MA plans.

These reviews, called WISeR, will be conducted by private companies and will rely on AI. It is said that the companies "clinical staff" will review AI decisions for PA submitted by doctors. The companies will retain a share of the money they save by denying PA.[1671]

This is a foolishly-designed and dangerous arrangement. It magnifies mistrust instead of mitigating it. Therefore, it creates new opportunities for payers and caregivers to fight, wasting still more scarce health care dollars.

Denials and downcoding of payment for care. Many caregivers, squeezed on price, believe that payers downcode their bills unjustifiably. The AMA has advised doctors on ways to respond to downcoding.[1672]

Caregivers suffer denial of legitimate claims [1673] [1674] and have been obliged to hire specialized consulting firms to harvest revenue they are due from payers.[1675] [1676] Payers hire specialized consulting firms to plow under claims they prefer not to pay.[1677] Payers' outright denials of some claims parallel downcoding of other claims.

Some caregivers respond defensively to payers' downcoding. The AMA sought to inform doctors about payers' methods of downcoding bills for evaluation and management care.[1678]

Other doctors feel that upcoding is their main tool for generating the revenue they deserve. Others improperly partition an episode of care and send bills for individual services that should be bundled.[1679] Still others find it hard, with the best of intentions, to code care accurately when billing. Even billing experts agreed on how to code doctor visits for evaluation and management—the most frequently commonly billed primary care codes—between 50 and 71 percent of the time.[1680]

Experian, which sells ways to improve claims submission, surveyed caregivers' experts in billing and collecting money due from payers. A large share of those experts asserted that some of the blame for denials rests on their own lack of resources. Some 42 percent of those surveyed thought the rate of denials was rising. They identified several specific shortcomings of caregivers: insufficient data and analytic capacity to spot flawed bills, failure to automate claims submissions, insufficiently trained staff, lack of expertise inside the organization, out-dated technology, and staff shortages.[1681] It is possible, though, that addressing these shortcomings would require substantial investments and ongoing spending to try to clean bills before submitting them to payers. This would be costly in itself and might spur payers to escalate their own efforts to find reasons to deny claims.

Insurers vary in caregivers' estimation. Some years ago, 41 percent of hospital executives rated the average large health insurance unfavorably, but United Health was viewed that way by 91 percent of executives.[1682]

State Medicaid programs often make it hard for caregivers to get paid.[1683] Gottlieb and colleagues found an 18 percent rate of Medicaid denial of payment for doctors' care, the highest of all payers.[1684] The military's Tricare program has been accused of low payments, very narrow networks of approved doctors and hospitals, and remarkably high levels of paperwork to get care approved.[1685]

Some payers deny many claims for in-network care. ACA insurers denied 17 percent of in-network claims in 2021. Some insurers denied only 2 percent of claims while others denied almost one-half. For almost three-quarters of denials, no specific reason was provided.[1686] Only a few tenths of one percent of patients appeal denials and, even then, insurers uphold most of the denials. These figures show little improvement from previous years. Unsurprisingly, Horny and colleagues found that low-income and disadvantaged Americans suffered disproportionately from denials.[1687]

The ACA statute obligated HHS to monitor denials of claims. This probably stemmed from a fear that the law's prohibition on medical underwriting, annual limits, lifetime limits, and rescinding coverage might lead insurers in the ACA marketplaces to take other steps to hold down their payments for care. HHS has not complied with the law's requirement.[1688]

Is this surprising? No. Federal regulation or scrutiny of millions of claims is very difficult. (A sample of claims could be pulled and examined, but even this has apparently not been done.) Regulations, simply, try to modulate the hurricane of financial incentives. The problem is the existence of those incentives—absent a functioning free market. Failure to regulate competently is unsurprising. Repeating this behavior, in one health care sector after another, and decade after decade, is pathetic. Governments' failures to make competent strategic decisions and to attempt regulatory clean-up instead, are discussed in chapter 5.

Refusal to pay one-sixth of all in-network claims—typically without a specific reason for refusing—undermines patients' confidence in their health insurance—and in the federal government that subsidizes it heavily. Worse, uncertainty about when claims will be paid inevitably discourages patients from seeking needed care. And caregivers from serving patients with ACA marketplace coverage.

Wide variations in denial rates across insurers suggests that payers' policies—not patients' or caregivers' behaviors—are largely responsible for denials. For years, the federal government

has been as lax in monitoring ACA marketplace insurers as it has been in 2023 in urging states not to throw patients off Medicaid for purely administrative reasons.

Patients in subsidized ACA plans are not the only victims of denials of payment. Baumel and Corrato wrote in 2003 that the Mercy system in eastern Pennsylvania saw a 25 percent denial or downgrade (downcoding) rate for its claims for managed care medical-surgical inpatient days.[1689] Pestaina and colleagues found that 21 percent of patients with private insurance reported claims denied during 2022, compared with 20 percent in ACA marketplace plans, 20 percent on Medicare, and 12 percent on Medicaid.[1690]

The American Hospital Association complained that MA plans' denial of payment rose by 56 percent between January 2022 and July 2023.[1691]

Miller and Fields report that health insurance companies have long been violating state laws prohibiting wrongful denial of payment. State enforcement action has been weak. Miller and Fields found only 45 instances of state agency action to address wrongful denial of payment across the nation in five recent years. Once again, regulators are overmatched politically and logistically.[1692] The core problem here is that insurers make more money when they deny more care. This financial incentive motivates denials. And the volume of claims and denials precludes effective regulatory response.

A technique more subtle than denial of a claim for payment or downcoding it is to delay payment. In response, as Flynn describes, doctors pressed state legislatures to enact prompt pay statutes. Michigan's was first in 1980; by 2007, all but one state had such a law. Speed of required payment of clean claims varied between 15 and 60 days.

Flynn reported decidedly mixed results. One problem was payer foot-dragging over what constituted a clean claim for payment. A second was some payers' practice of sending doctors letters saying their claim was pending. This could delay payment indefinitely. A third was some payers' willingness to pay interest and penalties for delayed payment because these cost less than paying promptly. Fourth, many doctor groups sued insurance companies for illegitimately delaying payment. Some won. Other suits were dismissed because some state statutes did not provide for right of private action to enforce the law's provisions.

On balance, Flynn concludes that stronger and unambiguous laws will be needed to provide predictable help to doctors.[1693] That may be true. Or it may be that insurers will find new grounds for delaying payment. The legislative and legal fights over prompt payment are one more manifestation of the mistrust and lack of accountability prevailing between payers and caregivers. They are one more source of administrative waste. They also reveal the weak value of traditional government regulatory and enforcement action in health care.

Causes of mistrust. Mistrust stems in part from failure to negotiate simple and comprehensive financial peace treaties. This failure makes both payers and caregivers excessively sensitive to financial details. It offers many opportunities to try to game and skirmish over the rules governing payment to boost revenue or shed costs.

Certainly, complexity magnifies this mistrust. Each payer pays different prices to similar doctors or hospitals for the same care. Some patients are covered for some services but not others. Some referrals are in-network and others are not. Some meds are covered but others are not.

Step therapy requirements vary also. So do quality measures and methods of calculating quality-related bonus payments.

Further, individual payers' rules for billing are, arguably, so complex that it is very difficult for caregivers to comply with them. The earlier-cited study of billing experts' disagreements about how to code care is one example. Another is Medicare's own detailed rules. Brubaker describes a realm of endless opportunities for finger-pointing between payers and doctors.[1694]

And failure to negotiate peace treaties, in turn, stems heavily from high reliance on putative competitive forces that appear to justify greedy self-enrichment. Caregivers try to garner greater revenue. Payers try to hold down their costs. Each insurance company seeks to squeeze hospitals and doctors on price by exerting power or by inducing some caregivers to lower prices to enter an insurer's narrow network.

This is not an effective substitute for levels of revenue and methods of payment that are acceptable to both payers and caregivers. It is a recipe for greater friction, anger, unaccountability, and mistrust.

Conflict-reducing methods of payment are more common in other rich democracies. There, budgeting of hospitals, reasonable fee regulation for doctors, or negotiations between organized payers and organized caregivers are some of the methods employed. Elsewhere, payers and caregivers generally jockey between relatively narrow boundaries—and these are established by the obligations to cover and care for all people, on one hand, and the constraints on revenue imposed by economic and political realities.

In the U.S., mistrust has the effect of making doctors, hospitals, and other caregivers highly sensitive to money. Am I being paid fairly? If payers are unfairly exploiting their power or rules of payment to deny me money I'm properly due, I'll take steps to recover that money in other ways.

Complexity and mistrust combine to create a warm, moist climate in which the mold of bad behavior grows freely. Caregivers that believe they are unfairly under-paid, that are losing money, or that simply want more money will sometimes upcode—make their patients look sicker than they really are. Crespin and colleagues found an extra $40.6 billion in payments to hospitals in 2019 that appeared to stem from upcoding of patients' diagnoses.[1695] This looks like theft; it is mentioned here as a product of mistrust and complexity of payment. Crespin and colleagues call for "design of payment models that limit distortions in payment and resource allocation." That challenge is among those taken up in chapter 9.

One example: In the fall of 2024, surgeons at the University of Virginia's main hospital, in Charlottesville, complained publicly about pressure from administrators to bill more aggressively. Some said they were already billing for inappropriately high-paying codes. Administrators said that other surgical groups bill for twice as much. Surgeons worried that they would be "'the ones that would get fined and go to jail.'" [1696]

A second example: Created in 1992, the 340B drug program offers drugs at discounted prices to hospitals, health centers, and other organizational designated "safety net" caregivers. Expanded over time, it now includes over one-half of the nation's hospitals. It functions as a partial response to the nation's political inability to make meds affordable by constraining drug makers' prices. It also has the effect of subsidizing designated caregivers, some of which badly need the added money (and much more) while others do not.

Unfortunately, in addition to being inefficient in the sense of badly-targeting its price discounts, the program is also complicated and administratively wasteful. Most work-arounds are.

Nikpay and Halvorson have described 340B's increasing administrative complexity and associated mistrust perceived by the federal government, the eligible caregivers, and drug makers. Seven special administrative functions are managing "drug discount cards, enrollment, auditing, revenue capture, referral management, inventory management, and 340B ESP assistance." [1697] (ESP in this instance might stand for "easy and secure platform" but this is not certain.) Drug makers established ESP in hopes of avoiding what they regard as paying unfair double discounts on meds (federal 340B discounts and either state Medicaid discounts or private insurers' PBM-negotiated discounts). Some institutions benefiting from 340B discounts regard ESP as an attempt by some drug makers to shrink their revenue loss by ceasing to extend some discounts they are legally or contractually obliged to offer.

Complexity

Early in 2025, the Mayo Clinic sued Sanford Health Plan for refusing to pay a $700,000 medical bill.

Snowbeck describes the controversy.[1698] Sanford authorized care for a patient hospitalized for over 50 days in 2022 and made some payments toward that care. But it asked Mayo to repay that money because Blue Cross Blue Shield of North Dakota was actually the patient's main insurer. Mayo did so and sought payment from BCBSND. But BCBSMD refused to pay because, it said, Mayo hadn't sought pre-authorization from BCBSMD. Mayo had faxed such a request but apparently used the wrong fax number.

Mayo is therefore suing Sanford, asserting Sanford had approved care and "'presented itself to Mayo Clinic as the patient's primary insurance plan…'"

It is hard to imagine this time- and money-wasting litigation arising in any other rich democracy.

Wang and colleagues reported that 317,987 unique health plans operated in the U.S. at the end of 2022. And they identified 57 billion different prices for fully 599,204 unique codes for services, or an average of 94,335 prices per code.[1699]

Financial chaos ensued after a February 2024 ransomware cyber-attack against Change Healthcare, a UnitedHealthcare subsidiary, closed down payments to many thousands of hospitals and doctors. Prior approval requests could not be processed. Bills for care could not be paid.[1700] U.S. health care depends too heavily on outside approval to give care and to pay individual claims. It is, therefore, all too easily disrupted.[1701]

Three weeks after the attack, Medicare responded by saying it would consider relaxing some prior authorization requirements and also advance cash to financially troubled caregivers.[1702] This constitutes a temporary work-around, one that will impose new administrative burdens on both Medicare and caregivers. It does nothing to address the chronic complexity of authorizing care, billing, and paying.

Calling for greater simplicity in 2013, Siegel and Etzkorn reckon that prospective Medicare Part D patients don't want to read 20,000 words to choose a plan. And dermatologists don't want to sign their names to forms 30,000 times a year. They blame lawyers and technologists. Government regulators demand full disclosure. Public and private bodies find it easier to add language than to re-write forms or requirements for simplicity and clarity.[1703]

Complexity, navigation costs, and primary care. Tellingly, free market economists' and gullible politicians seek to promote choice in U.S. health care as a substitute for straightforward and solid coverage for all citizens. Why does the ACA feature bronze, silver, gold, and platinum plans—covering 60 to 90 percent of health care costs? Perhaps to offer the illusion of choice. And certainly to channel people with less money into inferior low-premium plans that force them to pay more OOP—in hopes that their resulting choices to use less care will lower the cost of federal ACA premium subsidies.

One consequence of this sort of choice is that many patients need help "navigating" their coverage choices. In August of 2024, the Biden administration awarded $100 million to help citizens sign up for coverage.[1704] Some well-intentioned people doubtless applaud this award as essential to helping vulnerable people obtain insurance.

But the award is one manifestation of unnecessary complexity and associated waste, one triumph of incompetent policy, and—particularly—one manifestation of the failure to think about trade-offs in U.S. health care.

In no other nation does choosing a health plan require outsiders to navigate choices.

No one is asking, "What else might be done with $100 million?"

Suppose it would cost as much as $500,000 to pay one more primary care doctor to practice in under-served urban and rural areas of the nation. That means we could obtain 200 more primary care doctors with $100 million. Suppose they would each serve as few as 1,000 patients each—perhaps because they'd focus on patients with a number of chronic problems that demand substantial medical management.

Please consider that primary care panel size of 1,000 is not a fantasy. As discussed in chapter 11, Sweden has set a national standard of 1,100 patients per FTE primary care physician.[1705]

Even with these two conservative assumptions, 200,000 Americans would receive real primary care by the simple act of obviating navigation and substituting health care for bureaucracy.

If the incremental cost is $400,000 per primary care doctor and each serves 2,000 patients, then 500,000 Americans would get real primary care.

What would allow shifting the $100 million from administration to primary care? Simply rendering it unnecessary to need navigation to help people choose insurance options. One step would be simplifying choice by offering one plan with full coverage to each American. The second would be simplifying enrollment by offering lifetime enrollment to each person who lives in the U.S.A.

Sadly, it is no one's job to care about this trade-off—or even to think about it. Instead, most open-hearted people who think about the difficulty of choosing among health plans with different

premiums, OOPs, networks, and other elements quickly focus on the short-term and targeted remedy of navigation. Once multiple competing private plans were deemed politically necessary to pass the ACA, problems of complexity and unfairness were created, and the remedy of paying navigators seemed logical. How crazy is that?

The $100 million could easily be shifted from administrative waste (fat) to actual, needed health care (clinical bone and muscle) because it is money raised and appropriated by the federal government. It is, therefore, fungible. By contrast, it is much harder to grasp and shift fat money now wasted on physician directories to finance primary care bone and muscle. Simply eliminating need for those directories to exist would allow the money now spent on them to remain in doctors' practices.

Just as U.S. health care can be so complex that many patients require help navigating it, so many caregivers rely on consultants to obtain the revenue they believe they need and are entitled to receive. In 2025, Columbus Community Hospital, a 50-bed non-profit in central Nebraska, reported gaining $8 million in yearly revenue by using a consulting firm's coding system.[1706] Two decades earlier, Gawande described his conversation with a "financial-disaster specialist" who advised doctors on ways to obtain more money from both insurers and patients.[1707]

Complexity, physician directories, and primary care. Insurance companies believe that creating narrow networks of doctors and hospitals is one of their few tools for holding down employers' and MA plans' spending on health care. If patients go out of network, they face heavy financial penalties. Each network therefore requires an accurate directory. Payers face fines if they fail to maintain up-to-date directories.[1708] [1709] Inaccuracies seem to consistently involve over-stating the numbers of in-network caregivers. The problem is long-standing and seems to be a chronic source of pollution running downstream from use of narrow networks.

In October 2025, California settled its suit against Centene for inaccurate directory information for $40 million in penalties and remedies.[1710] But Centene's problems persisted. In 2026, Inaccurate Medicaid managed care plans' directories of caregivers were identified as a possible barrier to obtaining maternal health care.[1711] Over one-fifth of caregivers listed in Centene's directories, for example, were not in-network and 36 percent of caregivers actually in-network were omitted from on-line directories. Further, almost two-fifths of caregivers' contact information was inaccurate.

A 2019 survey of doctors estimated the cost to the doctors of maintaining physician directories at $2.76 billion in that year.[1712] [1713] Suppose that the total national costs—for federal and state regulators, and for the payers themselves, bring this total up to $4.0 billion yearly.

And suppose, further, that this sum could be captured and used to entice more physicians to enter and remain in primary care. Using the $500,000 per primary and the 1,000 panel size, we could obtain 8,000 more primary care doctors serving 8,000,000 million more patients.

Using the $400,000/2,000 estimates, we'd obtain 10,000 more primary care doctors serving 20,000,000 more patients.

Once again, no one in health care has practical accountability for addressing the opportunity costs associated with administrative waste of producing accurate and up-to-date directories of doctors, which are deemed essential to informing patients about who's in network, where to obtain care, and which doctors to avoid in hopes of dodging heavy out-of-network OOPs.

Interestingly, despite the high cost of maintaining up-to-date directories, they include many errors and omissions. Proposed legislation in California to create a single state directory operated by an outside party died in committee in the summer of 2024. The state's medical association and association of health plans both opposed the bill.[1714]

It is easy to over-state the value of accurate caregiver directories and to under-state the difficulties of preparing and maintaining accurate directories. Leaning in those directions, Zhu and Barnett cited a federal report to assert late in 2025 that California had begun to establish a single directory. Called Symphony, it purportedly "validates health care clinician and facility information, and facilitates reconciliation of data discrepancies."[1715] That may be. But the contractor that prepared that federal report actually wrote that "Although this solution has the potential to ensure greater accuracy of health plans' provider directories, the state agency that regulates health plans does not use Symphony in its monitoring of whether health plans' consumer-facing provider directories are accurate.[1716]

Inaccurate Medicaid managed care plans' directories of caregivers were identified as a possible barrier to maternal health care.[1717] Over one-fifth of caregivers listed in Centene's directories, for example, were not in-network and 36 percent of caregivers actually in-network were omitted from on-line directories. Further, almost two-fifths of caregivers' contact information was inaccurate.

Accurate directories would make it a little easier to swallow the large and distasteful pill of the narrow networks of doctors and hospitals that insurers have created to try to hold down their outlays. As discussed in chapter 8, no other nation relies on narrow networks to try to contain health care costs. It is generally ineffective; when it works in some instances, it tends to save money by suppressing access to care.

Kyle and Frakt found that one-quarter of patients surveyed "reported delayed or foregone care due to an administrative task." They opine that these delays or failures impede obtaining care as much as does lack of money.[1718]

Sable-Smith describes the plight of a patient who received a hospital bill that included costly care he didn't remember receiving. Some 17 months later, the hospital sent a much lower correct bill. It had billed for repairing a broken arm when all they had actually done was to splint it.

The correction was possible mainly because the patient's wife was a billing expert who managed her husband's physician practice. She obtained a detailed bill and matched it against the patient's medical record. Challenging the bill succeeded owing to her knowledge, self-confidence, and persistence. Few families have the resources that allowed her to prevail in the face of hospital (and insurance company) insistence that the original bill was correct. The hospital didn't apologize.[1719]

That's true but it isn't the main source of the heavy, complex administrative burdens in U.S. health care. Elevation of choice and reckless trust in non-existent competitive free markets

allow multiple private payers to sell insurance. Each has its own premium prices, covered services, caregiver payment rates, in-network caregivers, forms, procedures, and rules for prior authorization of care, quality reporting, formularies and step therapies for prescribing meds, and more. Medicare, MA, Medicaid, and Medicaid managed care add their own. And payer – caregiver mistrust magnifies complexity.

Caregivers, citizens, and patients must work with multiple payers, each with its own coverage rules, payment rates, out-of-pocket costs, and quality measures—and many with their own networks of preferred caregivers.

Narrow networks of doctors and hospitals, created by private insurers and MA plans that hoped thereby to contain expenses, treat patients as chips in their poker games. And when payers and caregivers can't agree on prices, they cease to contract with one another. It is the patients who must then find new doctors, hospitals, or other caregivers. This disrupts long-standing and trusting relationships. It undermines continuity of care.

And no other nation treats its citizen – patients in this insulting manner.

Variations in administrative cost across payers

The payers vary in their administrative costs. Exhibit 3 – 10 presents the administrative share of each of the main payers' costs in 2022. These are ***federal estimates of administrative costs borne only by payers. Doctors', hospitals', pharmacies', and other caregivers' own costs are not included. Nor are pharmacy benefits managers' costs of some $25 billion yearly. Nor are employers' or citizens' costs.***

Across all payers, $334 billion or 7.5 percent of health spending went to ***payers'*** administrative costs. Medicaid and CHIP had the highest share. This deserves close investigation—especially since managed care contracts cover ¾ of Medicaid patients[1720] and since CHIP's managed care share is even greater.[1721] They are followed by private insurance and Medicare. DoD and VA insurance had the lowest share. The tiny VA share stands out. The large, important, and heterogeneous "other" category had an average administrative share.

Exhibit 3 – 10

Administrative Costs by Payer, 2022, in millions of dollars

	Total spending	Administration	Admin % total
Private Health Insurance	1,289,806	$131,310	10.2%
Medicare	944,318	$71,043	7.5%
Medicaid (Title XIX)	805,732	$95,854	11.9%
Total CHIP (Titles XIX + XXI)	23,509	$4,534	19.3%
Department of Defense	46,156	$2,851	6.2%
Department of Veterans' Affairs	101,950	$1,828	1.8%
Other Third Party Payers + Programs	355,548	$26,208	7.4%
National Health Expenditures	$4,464,573	$333,627	7.5%

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, National Health Expenditures, 2022, Table 19, National Health Expenditures by Type of Expenditure and Program: Calendar Year 2022.

Note: Other third party payers and programs include federal and state workers' compensation for health costs, federal vocational rehabilitation health costs, federal-state-local governments' direct spending on hospitals, Substance Abuse and Mental Health Services Administration, Indian Health Service, general assistance health costs, school health, maternal and child health programs, medical spending by property and casualty insurance companies, employers' work site health services, private philanthropy, and non-patient revenue from hospital or nursing home gift shops, cafeterias, or parking garages. These are detailed in a methods paper from the CMS Office of the Actuary.[1722]

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Employer-sponsored insurance. Insurers face high costs of designing and marketing many competing forms of health insurance coverage. And of assembling competing networks of hospitals and doctors as "preferred providers" of care.

Often guided by health benefits advisors, employers must obtain bids from various insurance companies. Employers offering choice of plans to workers must prepare comparisons of benefits, coverage, and OOPs.

Operating on insurance principles, ESI entails paying individual claims to doctors, hospitals, or pharmacies. Lacking effective tools to curtail spending, insurance companies rely on narrow networks to try to suppress prices, prior authorization to block notionally unneeded care, downcoding, denial of claims, and other administration-intensive—and therefore costly—processes. Employers and insurers hope that pharmacy benefits managers will help them navigate use and cost of meds.

Morrison light-heartedly describes payers' numerous "explanation of benefits" forms mailed to patients, finding them confusing and devoid of value.[1723]

ACA exchange or marketplace plans. The ACA relied on private insurers to design and market plans through the ACA marketplaces. Four levels of plans (platinum, gold, silver, and bronze) could be sold, and plans at each level were not themselves standardized. This made it hard to choose the right plan.[1724] Dozens of thousands of "navigators" were paid by federal and state governments to inform or guide citizens' choices of plans. No other nation's methods of coverage require so much choice and so much help.

Worse, Americans often rely on insurance brokers to direct them to the ACA plan that they hope will best meet their clinical and financial needs. Sadly, brokers have been accused of betraying their fiduciary duties to clients by accepting bribes from insurers to steer patients. This evil practice straddles administrative waste and theft; it is discussed in the section on theft later in this chapter.

More broadly, it may be that many Americans' choices of ACA plans have been skewed toward low-premium plans that leave them financially vulnerable to high OOPs when they obtain health care. As discussed in this chapter's section on theft, Dorn and Jost explain that only two states—Texas and New Mexico—have passed their own statutes to oblige ACA plans to rate their premiums for a single risk pool—as federal law demands. The two did so, apparently, because Washington was not enforcing the relevant ACA provisions.

The ACA experience resembles that of Medicare and insurers' MA plans. Various types of bribery have been alleged there as well.

Medicare. Medicare patients must choose between traditional Medicare and MA. If they chose MA, they should be informed that, in almost all states, they may not be able to purchase Medicare Supplement plans if they depart MA and for TM. And the choice of MA plans is complicated. In 1999, Medicare launched what the head of the Health Care Financing Administration—now re-named CMS—called "'the biggest peacetime education program the federal government has ever undertaken'" to explain MA choices to eligible citizens.[1725]

Sadly, a 2012 survey of elders found that one of four did not even know they could change their Medicare coverage.[1726] Low-income elders and those with less education were less likely to review coverage. Two-fifths found choices of MA plans confusing. Over three-fifths reported themselves overwhelmed by Medicare Advantage advertising.[1727]

Elders have the greatest difficulty choosing among free-standing Medicare Part D prescription drug plans. Zhou and Zhang found that only 5 percent of beneficiaries were in the lowest-cost plan covering the meds they used in 2009. The average person would have saved $368 in that year if they'd opted for the lowest-cost plan covering their meds.[1728]

This is not surprising. Elders typically face choices among some 40-50 Part D plans. Since cost of meds is the most predictable of all types of health care costs, making choices more complex and confusing has been intentionally designed into Part D as a safeguard against the adverse selection that would result from ease of identifying one's best plan. (The predictability of costs would make a freestanding Medicare drug benefit actuarially unsound. Greater confusion about choice of plan and greater public subsidies would offset this unsoundness.)

This problem goes well beyond Part D plans. The Medicare Rights Center found that WellCare's MA in Florida, which claimed a yearly OOP cap of $3,750, actually excluded chemotherapy drugs administered in doctors' office from the cap. But two of three WellCare customer service agents said these expenses did count toward the yearly cap, and that costs above the cap would be covered by the MA plan. Only by consulting the company's 155-page Evidence of Coverage report could patients or prospective enrollees learn that those chemo drugs were not covered.[1729]

Some academic economists assert that it is important to allow Americans choice of health plans. Providing greater choice appears to strengthen consumer sovereignty in health care, an important requirement for theoretical free market competition. A parallel assertion is that patients seek information on various caregivers' prices in order to shop by price. As discussed in chapter 4, I think these are deeply silly, ineffective, and time-wasting ideas. And both practices boost administrative costs.

Most politicians show affection for choice, posting prices, and competitive free markets. That is probably because those words relieve them of the obligation to make clear strategic decisions—to do something direct and effective—to control health costs control, to solidly protect access, to configure caregivers where needed, and other important matters. Choice is also warmly embraced by insurance company executives and brokers.

Medicare is the secondary payer for hospital care for most of its enrollees who are still working and also have private health insurance. This requires coordination of benefits, which often

proves to be complicated.[1730] Medicare provides a 20-page non-technical guide to this process.[1731]

Medicare contracts with financial intermediaries—mainly for-profit insurance companies—to actually administer benefits and pay caregivers. Payments for each type of care are complicated. Traditional Medicare pays individual claims for care by doctors, hospital inpatient care, Inpatient psychiatric hospital care, hospital outpatient care, community health centers, skilled nursing facilities, home health agencies, ambulance companies, ambulatory surgery centers, clinical laboratories, durable medical equipment, dialysis, Part B drugs administered by a doctor, and hospice care.[1732]

Medicare regulations are overwhelming in their breadth, depth, and detail. Exhibit 3 – 11 identifies the 10 most substantial final Medicare rules published by CMS in the *Federal Register* in calendar year 2023. The rules' 2,475 dense 3-column pages totaled about 2,600,000 words, or about 4 times as many words as this entire book. Most pertain to paying caregivers.

Exhibit 3 – 11

Ten Substantial Medicare Final Rules Published in Federal Register in 2023

Final rule title	Pages	Words
Calendar Year 2024 Home Health Prospective Payment System Rate Update; Quality Reporting Program Requirements; Value Based Purchasing Expanded Model Requirements; etc.	205	218,940
Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, 0Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly	226	241,368
End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choices Model	164	175,152
FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements	36	38,448
FY 2024 Inpatient Psychiatric Facilities Prospective Payment System - Rate Update	109	116,412
Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes, etc.	799	853,332
Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022	45	48,060
Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; etc.	646	689,928
Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program	97	103,596
Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2024	148	158,064
Ten rules	2,475	2,643,000
Average words per page: 1,068 * 2,475 pages = 2,643,000 words.		
The 23 May 2025 draft of this book contained 460,000 words, or 1/6th as many in the ten final Medicare rules listed in this exhibit.		

Source: Centers for Medicare and Medicaid Services, *Federal Register Index, 2023,* n.d., https://www.federalregister.gov/index/2023/centers-for-medicare-medicaid-services.

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Medicaid, ACA, and many other federal programs generate enormous quantities of regulations as well. Each year sees modifications and updates in rules to implement new legislation and to address unexpected complications in or opposition to previous rules.

It is daunting to think about the difficulty faced by individual caregiving clinicians and organizations in understanding these rules and complying with them. ACO, MA plans, private insurance companies, managed care plans, and other entities face similar difficulties.

These difficulties are compounded by the need to understand myriad private insurance companies, HMOs, MA plans, ACOs, and other entities that make rules for various doctors, hospitals, and other caregivers.

Caregivers therefore must rely heavily on advice from professional associations like the AMA, and from trade associations like the AHA or the Medical Group Management Association. Additionally, swarms of consultants, lawyers, and others offer their services to caregivers and other entities.

Medicaid. Medicaid finances one-sixth of U.S. health care spending. The Medicaid program's particular administrative complexities include difficulties in negotiating federal and state rules regarding eligibility, enrollment, and disenrollment; the adequacy of rates of payment to caregivers; the adequacy of Medicaid managed care organizations' networks of caregivers, scope of services, and rates of payment to caregivers; and the adequacy or care and quality of care in both ordinary Medicaid and managed care plans.

Federal and state costs of administering the Medicaid program are surprisingly high (Exhibit 3 – 8), given that, in FFY 2021, slightly over one-half of all Medicaid dollars were capitated payments to comprehensive managed care organizations.[1733] The federal and state governments, therefore, did not have to use this money to pay individual claims to doctors, hospitals, or nursing homes. But the MCOs did.

A college friend, now retired, volunteers with the New York Legal Assistance Group to help patients with Medicaid problems. He writes that:

> I used to be the senior bank regulatory lawyer for the largest bank in the country. Medicaid law is much more complicated than what I did in my earlier life. It is incredibly challenging to explain the basic rules, the loopholes, the bureaucratic barriers and the trade-offs associated with qualifying for Medicaid. Typically, I must do this with the concerned and stressed parent of a child whose physical condition is rapidly deteriorating.[1734]

In 2006, Pulos prepared a *MassHealth Advocacy Guide* for counselors, lawyers, and others working on behalf of Massachusetts Medicaid patients or applicants. It was very valuable but also 234 pages long.[1735] Ongoing waves of changes in Medicaid have made it difficult to keep the Guide current.

Many state Medicaid programs create lengthy and complicated application forms. They say this is necessary to prevent fraud and to comply with federal and state regulations,

Nonetheless, managed care plans that contract with state Medicaid programs were apparently over-paid by $4.3 billion over three years for patients who were enrolled simultaneously in two different states.[1736]

Friedman and Mendola described the rigidity and apparent incompetence they faced when trying to sign up their child for CHIP. Three lost applications, administrators' inability to follow byzantine rules, 86 phone calls, and 8 months later, they succeeded.[1737]

By contrast, Ontario's form to sign up for health insurance coverage, shown in Exhibit 3 – 12, is one page. It requires proof of eligibility and residence. Chapter 7 discusses this further.

Exhibit 3 – 12

Ontario's Form to Sign up for Health Insurance Coverage

Ontario ServiceOntario

Registration for Ontario Health Insurance Coverage

If you are a **new or returning to Ontario**, complete sections A, B and C.
If you are **renewing** your photo Health Card, complete sections A and C.
Refer to the Ontario Health Coverage Document List for the list of documents you will need to present with your application. **Please print and use a blue or black pen.**

Ministry use only
Facility Use Only
Number | Reference Number

A. Personal Information

Last Name | First Name | Middle Name | Sex ☐ Male ☐ Female
Date of Birth (year / month / day) | Official language preference? ☐ English ☐ French | Have you ever had an Ontario Health Number? ☐ Yes ☐ No | If yes, what was the number?
Home Telephone Number ( ) - ☐ No Telephone | Work or other Telephone Number ( ) - Extension -
Mailing Address | Apartment | Street Number and Name, R.R., P.O. Box or General Delivery
City | Province | Postal Code | Country
Residence Address (if different from above) | Apartment | Street Number and Name, or lot, concession and township
City | Province ON | Postal Code | Country CANADA | Date moved to this address

B. Section to be completed only by new or returning residents

Where did you move from? (Apartment number, street number and name) | City
Province/State | Country | When did you leave the above address?
When did you arrive to Ontario? | When did you take up permanent residence in Ontario? | How long do you plan to live in Ontario? ☐ permanently ☐ temporarily
If you moved from another part of Canada, were you covered by a government health plan? ☐ No ☐ Yes | If yes, what was your health number?
Are you a Canadian citizen returning to Canada? ☐ No ☐ Yes | Are you an immigrant returning to Canada? ☐ No ☐ Yes | Are you a new immigrant? ☐ No ☐ Yes
Have you recently left the Canadian Forces? ☐ No ☐ Yes (date of discharge) yyyy / mm / dd | Have you recently been released from a Federal penitentiary? ☐ No ☐ Yes (date of release) yyyy / mm / dd
Are you the spouse or dependant of a Regular Force member of the Canadian Forces? ☐ No ☐ Yes | Are you a reservist returning from an out-of-country posting? ☐ No ☐ Yes (date of return) yyyy / mm / dd | Are you the spouse or dependant of a reservist currently deployed by the Canadian Forces into active service? ☐ No ☐ Yes

Ascertaining Medicaid eligibility. Federal and state politicians sometimes seek to cut Medicaid eligibility through work requirements. As discussed elsewhere, administering work requirements apparently costs more than it saves, as the experience in Georgia testifies.

Kliff and colleagues reported on Equifax's apparent hope that the national work requirements to be imposed by Trump's July 2025 budget bill would prove "a 'just massive' new business opportunity." They noted that, starting in 2027, states will be obliged to recertify Medicaid beneficiaries' eligibility via monthly obligations to work, attend school, or volunteer.[1738]

Caregivers. Complexity plagues caregivers, also. One large hospital system deals with about 250 different payers (and their different rules and forms) yearly.[1739]

Complex methods of covering different groups of people by different rules, for different services, paid for at different prices, with different quality measures, and using different procedures and forms waste time and create frequent opportunities for mistakes.[1740] [1741] A result is very high cost of paying large numbers of individual claims.[1742] [1743]

Blanchfield and others are among the many writers who have called for simplification of billing by instituting one list of payment rules, one form, and clear requirements for submitting and processing claims.[1744] But decade after decade, little changes. Getting public and private

payers to cooperate is difficult. They have little to gain and would incur much legal, financial, and administrative pain from revamping their payment rules and forms.

Different forms of complexity plague patients, payers, and caregivers. Complicated rules govern coverage, assessing OOPs, and other clinical-financial matters. The ACA's requirement that preventive care be free to the patient is one common and visible example. Regular screenings for colon cancer by colonoscopies are free to the patient because they are preventive. But if a polyp is spotted and excised during the procedure, that is treatment and the patient faces OOPs—co-pay, co-insurance, or deductible.

Worse is an apparent effort by some caregivers to bill for ancillary services that are necessarily associated with colonoscopies. Liss describes "surgical trays" billed at $600 to accompany the free-to-the-patient screening.[1745] When payers decline to pay, the patient may be presented with the bill. Unless patients push back hard and loudly, they may be saddled with payment that seems to clearly violate the ACA. This speaks to the difficulty of enforcing regulations that define the complicated, often tortuous, and badly surveyed boundary between what the law allows and what some caregivers seek.

Brewer describes his struggles to persuade an insurer to cover a costly arthritis drug. In the background, one reason is drug manufacturers' ability to impose high prices in the U.S. Another is payers' high level of mistrust of doctors. He estimated that his number fights with insurance clerks had doubled from 2001 to 2008.[1746]

In 2007, the Medicare Rights Center, a smart and valuable patient advocacy organization, found it necessary to prepare a 24-page guide to the six levels of appealing denials of medication coverage under Part D.[1747] The Center has called this process "onerous and deeply flawed."[1748] Consider that patients appealed only about two-tenths of 1 percent of the many claims for in-network care that were denied by insurers operating the ACA's marketplace plans—and that three-fifths of the denials were upheld on appeal.[1749] Horny and colleagues found—unsurprisingly—that low-income and disadvantaged Americans suffered from denials more frequently.[1750]

A superior option would be to obviate or minimize appeals by creating a more trustworthy method of paying for meds. It would set prices at incremental manufacturing/distributing/dispensing costs. This would recognize actual costs of use of meds. In parallel, budgets to pay for meds would be in hands of non-profits that would have no financial motive to withhold payment for needed drugs—apart from the need to husband finite budgets by considering efficacy, safety, and cost of various meds. These approaches are discussed in chapter 15.

Doctors, hospitals, and other caregivers face similar problems in appealing denied claims.

They face the same sorts of problems from day to day in navigating payers' different rules for billing, prescribing, and making referrals to other doctors. Some years ago, Massachusetts Blue Cross Blue Shield prepared a 99-page manual guiding physicians seeking to refer HMO patients to specialists.[1751]

Advertising, Marketing, and Profits

If a competitive free market existed in health care, we might not laugh at assertions that costs of advertising and marketing were somehow legitimate functions, worth the money. And we would not laugh at assertions that profits signaled pure waste. Since no such market is remotely present in health care (chapter 4), advertising, marketing, and profits signal solid wastes of money.

Advertising and marketing. Schwartz and Woloshin estimated 2016 advertising and marketing costs in health care at $29.9 billion.[1752] Applying their share of 2016 NHE of $3.3 trillion to 2024 NHE of $4.9 trillion gives us an estimated 2024 advertising and marketing spending of $44.4 billion.

In 2013, Rosenthal presented a series of pictures of recent construction and asked, “Is this a hospital or a [luxury] hotel?” [1753] Some might try to justify added costs of large single rooms, waterfalls in lobbies, and gourmet food as promoting speedier recovery or avoiding infections in two-patient hospital rooms, but their core aim is to attract more wealthy patients who can be charged full price, and more privately insured patients who pay substantially more than Medicare or Medicaid. Newman [1754] and George [1755] describe hospitals’ campaigns to boost name recognition or enhance their reputations.

Worse than wasteful, some ads are misleading. Safdar and Fuller report on deceptive ads that boosted on-line mental health companies’ revenues during the years of deep harms from Covid. Higher levels of drug abuse may have ensued.[1756]

Misleading prescription drug ads—many of them dangerous—appear to be common.[1757] DiStefano and colleagues found that drugs with low clinical benefits were most heavily advertised.[1758] Misleading prescription drug marketing and advertising, variously directed at doctors and patients, can lead to wasteful and even dangerous use of meds. This is discussed briefly later in this chapter but mainly chapter 15.

Just as low-value meds are most heavily advertised, misleading advertising and marketing for MA plans lead a number of elderly and disabled Americans to enroll in low-value insurance. This is discussed in the section on theft later in this chapter.

Profits. Profits are dollars that are raised and spent to pay for health care but don’t. For-profit insurers and caregivers report high financial returns, but these understate true sums.

For example, when a company like HCA is taken private via a leveraged buy-out, and when the buyers compensate themselves in part by having HCA float bonds to buy back some of their investment, the share of HCA revenues (garnered by giving care) that is used to reward the new owners is considered a cost to HCA, not a diverted portion of a declared profit.

A report by Patel and Singhai at McKinley projected profits in health care at roughly $700 billion for 2024, or one-seventh of NHE.[1759]

This is a very high estimate. The main reason is that it calculates profits using EBITDA, earnings before interest, taxes, depreciation, and amortization. Some view this a measure of cash profit. Depreciation, for example, is usually an accrued accounting cost, not a cash cost.

EBITDA over-states actual profitability. "It is not a metric recognized under generally accepted accounting principles (GAAP)." [1760]

Still, the EBITDA data from McKinley, in Exhibit 3 – 13, does show a crude division of health care profits by sector.

Competitive free markets legitimize profit. In such markets, profits follow from efficiency and low cost, innovation, quality, and making what people want to buy. Chapter 4 discusses health care's failure to satisfy any of the 7 requirements for competitive free markets. That failure delegitimizes profit in health care. Chapter 10 discusses this in depth.

Exhibit 3 – 13

Profit Pool in Health Care by Sector (Using EBITDA Projections for 2024)

Sector	2024 Forecast, $B	% of Total
Caregivers	$198	33%
Pharma	170	28%
Payers	117	19%
Medtech	72	12%
IT	27	4%
Distribution + pharmacies	19	3%
Total	$603	100%

Totals may not sum owing to rounding

Sources

"Profit Pool of the U.S. Health Care Industry," Statistia, https://www.statista.com/statistics/1117974/healthcare-industry-profit-growth-by-sector/, accessed 22 February 2024.

Neha Patel and Shubham Singhal, "What to Expect in US Health Care in 2023 and Beyond," McKinsey & Company, 9 January 2023, https://www.mckinsey.com/industries/healthcare/our-insights/what-to-expect-in-us-healthcare-in-2023-and-beyond.

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Remedies for administrative waste

Streamlining administration. Sahni and colleagues identify administrative reforms that, they believe, would save $40 to $60 billion in 2019 dollars—about 5 percent of their estimate of administrative costs in that year. Half of the savings would involve payers' actions and the other half caregivers' actions. Payers might improve data quality and better train their claims processors. Caregivers might agree to create a central and automated claims processing clearinghouse, and to standardize policies regarding some prior authorizations. Each doctor might be able to obtain a single national physician license. [1761]

These proposed improvements are incremental and mainly technical. They ignore the high levels of mistrust between payers and caregivers.

The decades of rising administrative waste in U.S. health care also suggest that modest incremental reforms to improve efficiency of claims processing, standardization, automation, and training have saved little money and will probably continue to fail.

And what if these proposals—and similar suggestions—did actually cut administrative costs and save money? What would happen to those savings? Three results are possible. One is reduced spending on health care—savings to all of us who pay for care. The second is that the money saved would be used to finance additional needed care. And the third is that payers' or caregivers' own surpluses or profits would rise.

Various combinations of these three outcomes are possible. Unfortunately, under current arrangements for paying for care and delivering, it is likely that savings would typically fall to the bottom lines of payers or caregivers as windfall higher profit or surplus.

Setting minimum care shares. The ACA set minimum care shares (called MLR or medical loss ratio by insurers) for private insurance at 80 percent for individuals and small groups, and 85 percent for large groups. The 85 percent level signifies that insurers may spend no more than 15 percent of premium income on profit, advertising, administration, and marketing (PAAM).

If insurers spend less on paying caregivers than their minimum care share, they must rebate the excess. Federal regulators do permit spending to improve either quality or efficiency to be placed on the 85 percent side of the border.

This ACA provision was designed to push a greater share of premium dollars toward care and away from PAAM. Success would signal better value for money spent, and might even help to hold down costs of care. Insurers could respond by spending more on care, by cutting PAAM, or by cutting premiums.

Insurers have generally opposed care share provisions. Some argued that competition should push payers to get lean and give greater value in order to hold down premiums and attract more customers. Others resented regulation in principle.

My colleagues and I helped to craft and support legislation calling for 90 percent care shares in Massachusetts.[1762] One reason was that a number of the state's large non-profit plans were able to reach 90 percent.

The 5 percent gap between 85 percent and 90 percent care shares, applied to private insurance payments of some $1.4 trillion in 2024, equals $70 billion.

As a point of reference, that $70 billion would finance almost two-fifths of the cost of expanding dental coverage and care to Americans who lack it today.

Unfortunately, as a *Wall Street Journal* editorial reminds us, insurers can game a care share requirement. They can vertically integrate by buying or creating PBMs or by buying doctors' practices. Hospitals, also, can buy doctors' practices. Insurers can direct high payments to

PBMs or doctors' practices owned by the conglomerate of which they themselves are a part. Those inflated payments keep money in-house while formally complying with minimum care share requirements.[1763]

While accurate in identifying the opportunity to game the law, the *Journal* errs in blaming the ACA for insurers' or hospitals' behavior. The opportunity to keep money in-house existed prior to the ACA, and insurers didn't need the push of regulatory compliance to be spurred to make more money by owning doctors' practices and PBMs. For reasons discussed in chapter 4, the *Journal* also errs in claiming that, absent the ACA, competitive forces would have pushed down premiums, obviating care share requirements.

If public regulatory and competitive market forces aren't available to persuade payers or caregivers to behave well, an alternative must be found.

Electronic remedies? Some promised that EHRs would cut administrative waste. A widely-cited (2,533 citations in two decades) 2005 RAND study by Hillestad and others claimed that EHRs could save more than $81 billion yearly.[1764]

This work was financed by firms hoping to sell EHRs to doctors and hospitals.[1765]

Its assertions helped to push through the HITECH Act of 2009, a federal law providing dozens of billions of dollars to doctors and hospitals who adopted EHRs and made "meaningful use" of them. (In parallel, Massachusetts gave Athenahealth a $9.5 million tax break in exchange for promising to add 1,900 jobs in a Boston suburb.[1766])

A major shortcoming of the law was its failure to require grantees to purchase EHRs that were fully inter-operable—that could easily exchange data electronically. Another was that required meaningful use was not particularly meaningful.

Blumenthal suggested that a 2022 regulation would be "a potentially important step toward effective exchange of health information."[1767] But he was careful to note that both caregivers and EHR vendors had powerful reasons to oppose effective inter-operability. Both groups saw denial of information to others as a tool to enhance their power to leverage patients and revenue. Blumenthal makes it clear that coordination of information to enhance patient care is stymied in important ways by demands of competitors.

Goozner asserts that a large share of hospitals and other caregivers are reluctant to share data with states' hospital information exchanges. And that payers are equally reluctant to share claims data with state all-payer claims databases. Both groups hope to gain competitive advantage by holding on to patients' data. Or to make money by selling data to groups that hope to better market prescription drugs or medical devices.[1768]

One consequence of mistrust and complexity in U.S. health care is the proliferation of ways of using EHRs that require heavy inputs of data to substantiate coding of patients' illnesses and the services they receive, documenting quality measures, and attempting to forestall malpractice suits. *EHRs* ***became manifestations—and even servants—of mistrust and complexity rather than ways to overcome them.***

It is not surprising, therefore, that, a 2013 RAND study for the AMA found that although doctors liked the idea of EHRs, actual use "significantly worsened professional satisfaction" owing to difficulty using the EHRs, large amounts of time required to enter data, "interference with face-to-face patient care, inefficient and less fulfilling work content, inability to exchange health information, and degrading and obscuring of clinically-relevant documentation."[1769]

Perhaps surprisingly, as noted earlier, the problem seems not to be inherent in the EHR software itself, but rather in the uses to which it is put, uniquely, in the U.S. An examination of characters typed per ambulatory care progress note in EPIC showed a range between 600 and 2,000 outside the U.S. The U.S. range was between 2,000 and 7,000 per note. Clinical notes averaged almost four times longer than those in seven comparison nations.

Excess typing in the U.S. was deemed to stem from documentation for reimbursement and compliance purposes.[1770] It is noteworthy that most of the seven comparison nations paid physicians in ambulatory care by fee-for-service. So fee-for-service payment, like the EHR, is not inherently culpable. Rather, U.S. problems stem from how EHRs and FFS are used in the U.S. And that derives from the chronic mistrust between payers and caregivers—mistrust engendering demands for more and more data—from EHRs and other sources—in hopes that evidence will overcome mistrust and resolve conflicts.

It is more reasonable to suppose that conflicts are ended by negotiations. These are inevitably political and financial. Most rich democracies narrow the scope for conflict because their governments insist that patient access must be protected and that spending ceilings cannot be breached.

Brown has posed the choice for nurses between "Caring for the Chart or the Patient."[1771] Chen reported in 2010 that resident doctors typically spent more time with EHRs than with corporeal patients.[1772] And Chaiyachati and colleagues found that first-year internal medicine residents devoted 66 percent of their day to interacting with EHRs or documenting, and only 13 percent to direct patient care.[1773]

One proposal to use AI to integrate data in EHRs and highlight important information for clinicians seems to make sense.[1774] If successful, it might do more to improve quality of care—and cut time doctors need to devote to diagnosing patients and choosing treatments than save time or money now devoted to administrative work. That follows from the causes of the extra keystrokes associated with EHRs in the U.S. Shulman and colleagues argue powerfully that AI, by itself, won't cut administrative waste in U.S. health care.[1775]

It is hard enough to diagnose and treat patients in effective and affordable ways. It is doubly hard when different payers have different ideas about what's clinically appropriate, and also different rules about both care and paperwork. Different payers' very different administrative requirements and clinical rules impose heavy burdens. One practice reported on doctors' and administrative staff's difficulties in complying with each payer's complex demands and rules for covered services, billing procedures, quality measures and reporting, formularies and step therapies for meds, and financial rewards and penalties.[1776]

Gates wrote trenchantly that "'The first rule of any technology used in a business is that automation applied to an efficient operation will magnify the efficiency. The second is that *automation applied to an inefficient operation will magnify the inefficiency*."[1777]

For at least three decades, well-intentioned reformers have suggested narrow technical remedies for administrative waste, like automating billing for care and paying claims. These leave U.S. health care otherwise unchanged. At best, they have helped a bit. Consistently, they have run aground on Gates's second rule.

Eastaugh wrote in 1995 that he believed a national electronic data interchange would cut more than one-third of administrative costs.[1778] (But Holmgren and colleagues found in 2024 that "electronic health record documentation burden crowds out health information exchange use by primary care physicians."[1779] Primary care doctors lacked time to use health information exchanges to learn about patients' diagnoses or services from previous caregivers.)

Rundle suggested in 2000 that technology was beginning to smooth eligibility determinations, learning if a med was on a payer's formulary, and determining how much patients must pay OOP.[1780] Much more incrementally, Collins and colleagues suggested that a national insurance exchange for individuals and small groups could cut marketing and administration by simplifying the job of negotiating prices with caregivers and by standardizing payment of claims.[1781] Blanchfield and others claimed in 2010 that one "transparent set of payment rules for multiple payers, a single claim form, and standard rules of submission" would go far to cut doctors' billing costs. Cutler and colleagues wrote in 2012 that converting to electronic transactions and other automation, integrating administrative and clinical systems, national caregiver enrollment and certification, standardized quality measures and reporting, and stabilizing eligibility for Medicaid would save substantial sums.[1782] [1783] Sahni and others asserted in 2021 that some 30 interventions could cut administrative costs by one-third "within the structure of today's US health care system in order to preserve its market nature (eg, multipayer, multiclinician, multi-health care center)…."[1784]

Some MA plans have used AI to try to set limits on length-of-stay. Mello and Rose think that the complex decision-making and drudgery might make AI an effective tool for utilization review by payers. But they find that humans still need to backstop AI to prevent mistakes.[1785] They note that patients have sued UnitedHealth and Humana, claiming they pressure case managers to endorse AI-determined cuts in length-of-stay for post-acute care despite clinician and patient objections. AI decisions are never transparent and never indicate a reason for denial of care. They are not individualized but, instead, rely on learning from patterns. Early in 2024, CMS required that such decisions be made in light of the facts of each individual patient's case and must be reviewed by a doctor or other appropriately-trained professional. That would seem to preclude AI decisions to deny care.

Interestingly, some physicians have begun using AI to contest insurance companies' denial of authorization for treatments. And some have reported success in winning approval for needed care.[1786] Unfortunately, though, the high level of mistrust between payers and caregivers militates against durable improvement. Since the main function of prior authorization is to suppress use and cost of care, payers will ether find AI or other responses to doctors' use of AI to appeal denials, or adopt different methods of care/cost suppression.

Indeed, Wennberg and colleagues at the Blue Cross Blue Shield Association claimed in 2026 that hospitals' use of AI to enhance billing had succeeded in boosting their revenue—and insurers' costs—by some $2 billion over 3 years. Hospitals asserted that higher payments reflected more accurate coding and sicker patients.[1787] [1788]

Neither EHRs, AI, nor administrative simplification—nor other electronic counter-measures—will address the sources of administrative waste associated with payers' regulatory review and

micro-management of doctors' clinical decisions. They simply shift the payer – caregiver fights to fancier venues.

Cutting administrative waste requires addressing the sources of mistrust between payers and caregivers, simplifying the movement of money, and containing cost by methods that don't torture patients or caregivers.

And that liberates payers to trust doctors and hospitals.

It therefore means addressing financial incentives to make money by denying needed care or approving unneeded care. The only ethical reason to deny care to one patient is to liberate clinical time and money to care for another patient who will thereby derive greater benefit. Care would, then, be denied if it is harmful, ineffective, or of low value relative to its cost.

Neither is possible as long as failed competitive free markets, irresponsible public strategic inaction, untrustworthy payment methods, skimpy access protections, and ineffective cost controls persist in health care. The very high levels of administrative waste in U.S. health care are no accident.

Administrative waste has not been inserted into our health care by rogue elements of the former KGB. It is a natural product of failed cost controls, failed access protections, failed markets, failed government efforts, and failure to negotiate clinical-financial-ethical peace treaties between payers and caregivers.

Many of those failures arguably are associated with the notional primacy of "choice" in U.S. health care—as something to be valued more than affordability, simplicity, trustworthiness, and health security. Or so some would have us believe.

Large reforms in raising money and covering Americans that enable substantial cuts in administrative costs. As noted earlier, Himmelstein and Woolhandler have long argued that single payer financing would permit very substantial administrative simplification and resulting cost cuts.

A 1994 GAO report analyzed health reform proposals that had "potential to reduce administrative costs." [1789] One was to cover all people, which would lower the costs of regulating eligibility. A second was to standardize covered services. A third, to require caregivers and payers to use single standard forms to bill and pay claims. A fourth, to reduce the number of paid claims by developing alternative methods of compensating doctors, hospitals, and other caregivers.

Broader reforms that more fundamentally address mistrust and complexity. As long as the U.S. fails to contain health care costs, payers will confront caregivers. If a payment method—such as FFS for doctors or DRG payment by the discharge for hospital inpatient care—financially incentivizes boosting volume of care, payers will try to hold down volume by denying prior approval, downcoding, trying to cut prices by forming narrow caregiver networks, and similar measures. They will do so even though U.S. volumes of doctor visits or hospital admissions are well below the rich democracy average, as shown earlier in this chapter.

Conversely, if a payment method—such as capitating for-profit HMOs, MA plans, ACOs, or Medicaid managed care contractors—financially incentivizes cutting volume of care, payers or patient advocates will seek ways to protect adequacy of care by trying to ensure network adequacy, requiring detailed reports on quality of care or waiting times for appointments, and the like. And, since the for-profit operators (and many non-profits as well) make their patients look sicker and more costly in order to generate enormous amounts of undeserved revenue, payers will constantly fight with operators about fair payments.

The alternative is to begin by recognizing the central role of high costs in generating mistrust and complexity of administration. And then to response by capping spending at the top. That will have to rest on a shared understanding between caregivers and payers, one that is unlikely to emerge before a financing crisis threatens health care revenue and care delivery. Cost control is discussed in chapter 8.

And then to cover all Americans. See chapter 7.

And then, finally, to pay caregivers in ways that are as financially neutral as possible. Examples include hard budgets for hospitals, salaries for physicians working in hospitals, and negotiated fees and incomes and levels of effort (productivity) for doctors in ambulatory practices. These are discussed in chapter 9.

3. High prices – some $500 billion in waste in 2024

Many caregivers and administrators are paid high prices for their services. So are MA plans. Drug companies and medical device manufacturers are paid high prices for their goods. Manipulation of payment methods and economic concentrations are the two main explanations for most high prices.

As shown in Exhibit 3 – 2, U.S. doctor visits per capita are 60 percent of the rich democracy average. Hospital admissions are 80 percent of the rich democracy average.

At the same time, spending per person in the U.S. is about 2.1 times as great as the rich democracy average.

Since higher rates of use of care cannot account for any part of the cost difference, higher U.S. prices must be responsible. Writing in 2003 and again in 2019, Anderson and others made this case effectively and dramatically; they asserted “it’s the prices, stupid”. [1790] [1791]

Nonetheless, stupidity persistently conquers.

Pay-for-value, alternative payment methods for doctors, ACOs, and other fantasy remedies largely target use of care, not price,

Still, claiming that “it is well-known that high prices are the main reason health care spending in the US is well above levels in other countries,” Glied and Chandra do urge harder work to bring down prices.[1792] Papaniolas and colleagues believe that “excessive price growth” must be restrained if health care is to be affordable.[1793] Davenport and Pitsor inventory a few state actions that aim—ineffectively—to hold down private insurers’ prices: enforcing price

transparency rules, fighting facility fees, premium rate review, and trying to set reference prices.[1794] Ho and colleagues found that price increases explained more than one-half of the rise in ER spending per visit between 2012 and 2019. Upcoding and greater patient severity accounted for the remainder.[1795]

Turner and colleagues pointed to high incomes paid to doctors and nurses, and high prices paid for drugs and medical equipment, as important causes of high U.S. health costs.[1796]

Rosenthal highlighted efforts of some hospitals to woo wealthy privately-paying patients with elegant architecture, fine dining, plentiful amenities, and luxurious rooms and furnishings. This is not price competition.[1797]

Why, then are U.S. prices so high? A first reason is that our various cost controls have failed. Chapter 8 analyzes why this has happened. Weak restrictions on revenue to pay for health care—owing to failure of competitive free markets and of competent government action alike—meant steady flows of dollars to pay for health care. Caregivers therefore faced relatively low barriers to raising their prices.

Second, as discussed in chapter 9, the early organized methods of paying hospitals and doctors gave those caregivers the power to raise prices during the quarter-century after the end of the Second World War.

Third, doctors and dentists are in shorter supply than in almost all other rich democracies. This enables them to keep their prices and incomes high.

Fourth, doctors', dentists, and hospitals' high prices are all buttressed by purchases, mergers, and other combinations. These are designed to boost prices.

Fifth, MA plans extract high prices—in the form of risk-adjusted capitation payments—by making their enrolled members look more costly to serve than they really are. Mathews and colleagues reported on MA plans' investments in sending nurses to interview members at home. The nurses harvested diagnoses that boosted payments even though identifying and noting those diagnoses did not entail increases in actual costs of care. They calculated than nurse visits averaging about one hour yielded over $1,800 in higher yearly capitation revenue for the MA plan.[1798]

Sixth, high U.S. prices persist because, from decade to decade, most putative reforms don't target them. Instead, they persistently address volumes of care. Boosting OOPs, a favorite cost control attempt, suppresses use of care, not prices.

Seventh, payers sometimes pay excessive sums for care. Weaver and colleagues documented the ability of some autism therapy centers to milk often-extravagant payments from state Medicaid programs for many years. States' direct Medicaid payments rose from $660 million in 2019 to $2.2 billion in 2023. Medicaid managed care plans contracting with states paid additional hundreds of millions of dollars.[1799] [1800]

Even a reform that was intended to protect patients from surprise bills, the No Surprises Act of 2020, ended up paying absurdly high prices to some caregivers. The NSA protected patients from high OOPs if they unintentionally wandered out of network or were forced out of network by a medical emergency. But the NSA failed to create a clear, simple, and affordable structure of prices for the caregivers who gave the out-of-network services.[1801] Instead, compromises

added to the NSA, coupled with manifestly silly court decisions, created a process for arbitrating caregivers' appeals that resulted in very high prices. Sanger-Katz and Kliff described some outrageous ones.[1802]

Some centers charged high prices for care that was often of dubious clinical value. So, both high prices and clinical waste are involved. But allegations of very widespread fraud by autism centers could mean theft that was greater than waste from high prices or ineffective care. Some autism centers bribed parents to enroll children and provided no or few care.[1803] That parallels the practices, discussed in the following section, of buying Philadelphia addicts to enroll in bogus drug treatment programs, or of enrolling healthy elders in hospice programs.

Doctor and nurse incomes. As shown in Exhibit 3 – 14, U.S. doctors and nurses earn far more than their counterparts in 10 rich OECD democracies. U.S. generalist physicians earned 111 percent more than their OECD counterparts; U.S. specialists, 87 percent more; and U.S. nurses, 50 percent more. As a standard of comparison, non-health workers in the U.S. earned 25 percent more than their counterparts elsewhere.

Lauglesen and Glied found that much higher U.S. payments to doctors—particularly procedure-performing specialists like orthopedic surgeons—"were the main drivers of higher U.S. spending, particularly in orthopedics." [1804]

Exhibit 3 – 14

U.S. Incomes versus those in 10 rich OECD democracies, 2016

Category	U.S.	10-OECD	US excess
Generalist physician	$218,173	$103,278	111%
Specialist physician	$316,000	$169,323	87%
Nurses	$74,160	$49,559	50%
Non-health-specific annual wage	$60,154	$48,014	25%

Calculated from Irene Papanicolas, Liana R. Woskie, and Ashish K. Jha, "Health Care Spending in the United States and Other High-income Countries," *Journal of the American Medical Association,* Vol. 319, No. 10 (13 March 2018) pp. 1024-1039, https://jamanetwork.com/journals/jama/article-abstract/2674671, Figure 5.

The other 10 OECD nations are Australia, Canada, Denmark, France, Germany, Japan, Netherlands, Sweden, Switzerland, and the U.K.

All currencies are converted into U.S. dollars using purchasing power parities. These .reflect buying power of each currency in its own nation. This puts the dollars on an equal footing across nations. This parallels using price indices to calculate constant dollars to put prices on an equal footing over time.

- - -

Hospital prices. Hospitals often combine to leverage higher prices from private insurance companies. In Boston, for example, the 1994 merger of the two largest hospitals in

Massachusetts was intended to make the combined organization a must-have caregiver. They promised the merger would save money and boost quality of care, but they have never adduced actual evidence of either. The merger did enhance the combined operation's ability to leverage higher prices from private insurance companies. In 2022, the two hospitals' case mix-adjusted commercial prices were 36 percent above the state average.[1805]

As discussed in chapter 4, lobbyists for hospitals steadily trumpet the value of hospital mergers and consolidations, claiming these boost efficiency or quality of care. Lawyers for the American Hospital Association applauded the FTC and the DoJ's Antitrust Division for "emphasizing their desire to detect 'anticompetitive mergers while imposing *no more burden than necessary* on competitively beneficial or neutral transactions'" [1806]

The AHA's customary claims about the virtues of hospital mergers rise to the level of hypocrisy when contrasted with the group's habitual attempts to discredit insurance company mergers. This is self-interested attempt to leverage price, not high-minded principle.

Drugs and devices. Drug makers long denied that U.S. prices for pharmaceuticals were the highest in the world. Today, they generally concede that they are highest, but insist on two new things. One is that high prices are the only way to pay for innovation. The other is that other rich nations unfairly obtain lower prices via regulation, leaving Americans exposed to paying much more.

Indeed, Mulcahey and others found that U.S. prices for meds average 2.5 times as high as those in some 30 other nations.[1807] The Canadian Patent Medicines Price Review Board found U.S. prices so consistently high across the rich nations compared that it dropped the U.S. from the list of nations across which the Board compared prices.[1808]

As discussed in chapter 15, when Medicare was finally authorized to negotiate prices for its costliest meds after two passive decades, the negotiated prices were still 275 percent of the average of those prevailing in other rich democracies.

Ledley and colleagues found that profits of large drug makers are much higher than those in other industries.[1809] This was after they accounted for dry holes—investments in meds that don't come to market.

U.S. drug prices could be cut by leveraging payer power. As discussed in chapter 15, leverage could take the form of establishing a single U.S. buyer for drugs, refusing to cover drugs whose prices are deemed excessive relative to their clinical value, and establishing a prize system to encourage and reward effective and safe innovative meds. The last method aims to take the cost of innovation out of the price of the pill. A number of mechanisms could work; political will to create them is indispensable.

Even the 340B program, ostensibly aimed at making meds more affordable to low-income patients by lowering prices their caregivers paid for them, actually had the effect of enabling hospitals to obtain high prices from payers. Hospitals' price mark-ups for physician-administered meds for patients covered by private insurance were 6.6 times as high as mark-ups by independent doctors' practices.[1810]

Setser described ways in which drug makers garner disproportionate shares of their worldwide revenue by charging high prices in the U.S. Insultingly, they manage to pay very low U.S.

corporate income taxes on the high U.S. profits resulting from those high U.S. prices by paying contrived fees to foreign subsidiaries endowed by those drug makers with ownership of patent and other rights.[1811] This parallels the corrupt practice of some nursing home chains, described in the section on theft in this chapter, which entail excessive payments to captive subsidiaries (tunneling), designed to make nursing home profits look artificially low.

U.S. prices for standard items like hip or knee implants have long been notoriously above levels in other rich democracies. [1812] Wenzl and Mossialos found high levels of intra- and inter-nation price differences for various types of cardiac hardware—stents and pacemakers—between 2006 and 2014. But U.S. prices were almost always higher than those in France, Italy, the U.K., and Germany.[1813]

Duhigg reported on Medicare's effusively high payments to oxygen suppliers.[1814] CMS trumpeted 2008 regulations to implement the 2003 Medicare Modernization Act's provisions to cut prices for durable medical equipment, prosthetics, orthotics, and supplies.[1815] Subsequent press releases asserted lower prices via competitive bidding and other mechanisms.[1816]

CEO salaries and bonuses. U.S. hospital, HMO, and insurance company CEOs make much more than their counterparts in other rich democracies. The data are sparse but their meaning seems clear. .

In 2024, the CEO of Mass General Brigham was paid $9.2 million.[1817] It is useful to think of this in nurse-equivalents. If RNs made, say, $125,000 yearly, including fringes, that CEO was paid enough to add 73 RNs.

Starkman compared the salaries of the Ontario physician-CEOs who ran the two of the largest and most complicated systems in Canada (University Health Network and Sunnybrook Health Sciences Centre) with salaries of U.S. CEOs who ran six large U.S. systems (Christus Health in Texas, New York Presbyterian, Banner Health, Ascension Health, Beaumont Health, and Advocate Aurora). The salaries of the two Canadians averaged US$650,000 in 2020. The six U.S. CEOs' salaries averaged $10.1 million.[1818] The U.S.-to-Canadian salary ratio was 15.5 to 1.0.

In the U.K., the average 2022 hospital CEO salary plus added compensation was $228,400.[1819] U.S. data for 2021 show an average non-profit hospital CEO compensation of $620,000.[1820] The U.S. level was 2.7 times that in the U.K.

Within the U.S., the gap between non-profit hospital CEO salaries and pediatricians rose from 7:1 in 2005 to 12:1 in 2015. The gap between those CEOs and RNs rose from 23:1 to 44:1.[1821] Pay differentials have continued to grow. Fang and colleagues found that the income gap between non-profit hospital CEOs and employees widened from 2009 to 2023.[1822]

Jenkins found that the pay gap between CEOs and direct patient care workers widened most at the biggest 20 percent of non-profit hospitals. Size was measured by number of beds. At the biggest 20 percent, the gap rose from a multiple of 29.1 in 2015 to 39.7 in 2022. By contrast, the gap at the smallest 80 percent of hospitals rose only from 10.8 in 2015 to 11.3 in 2022.[1823]

Saini and colleagues reported that, larger U.S. hospitals paid their CEOs more money and also that the ratio of CEO pay to average worker pay rose from 6:1 at smaller hospitals to 14:1 at very large hospitals.[1824]

Galbraith said that “The salary of the chief executive of a large corporation is not a market award for achievement. It is frequently in the nature of a warm personal gesture by the individual to himself.” [1825] That is, the CEO is generally able to secure high remuneration from a friendly board of directors.

Unsurprisingly, U.S. hospital CEO salaries have been criticized frequently for at least the past quarter-century. [1826] [1827] [1828] [1829] [1830] No reforms have ensued.

U.S. hospital executives insist their job is difficult, that excellent CEOs are scarce, that paying more attracts the best talent, and that high pay is in line with—and justified by—the compensation packages enjoyed by CEOs at peer hospitals. At non-profit hospitals, boards of trustees must go through elaborate formal procedures to make—or appear to make—compensation decisions independently, and to pay CEOs in line with those at comparable institutions. A small industry of consultants has arisen to provide information purporting to justify hospital CEOs’ pay levels.

Both non-profit and for-profit hospitals offer CEOs incentive pay. Over 9 in 10 report that executive compensation rests in part on financial results. [1831] Mintzberg sets out cogent reasons for ending CEO bonuses. One is that one CEO’s success often rests on good decisions made by predecessors. A second is that non-financial measures like goodwill, reputation, depth of culture and workers’ commitment to doing good jobs are immensely valuable. [1832] That is probably particularly true in health care.

One possible reason why hospital trustees rely heavily on financial and other performance measures is that they lack the time, knowledge, or motivation to learn how well their organizations are being run. A second is that they suppose financial results measure efficient delivery of the right care. Absent a competitive free market, that supposition is groundless.

It is true that U.S. hospital CEOs’ job is, in some respects, more challenging than the jobs of their counterparts in other rich democracies. U.S. health care is more complicated, confusing, and riven by mistrust among payers, governing boards, high managers, doctors, and other workers. But the work of hospital CEOs, while different in each nation, is difficult everywhere.

It is likely that U.S. hospital CEOs’ high salaries float on money and hope. On high U.S. hospital revenues. And on non-profit hospitals’ trustees’ hope that paying more means hiring or retaining a CEO who is more competent and far-sighted than others. Just as usual, customary, and reasonable fees for doctors invited gaming and leap-frogging to boost doctors’ incomes, so each jump in one CEO’s pay serves as legal justification for others to surge forward.

Ten causes of endemic high U.S. health care prices

One is the focus of purported reforms like value-based payments, high OOPs, ACOs, MA, and Medicaid managed care, on cutting volume of care. But, in the face of the evidence that high prices are a much bigger problem than volumes of care, why the focus on volume?

A second, then, is that high hospital prices often result from closings, mergers, and purchases that consolidate care and give hospitals greater leverage over private insurers. But neither governments nor private payers have been willing to identify needed hospitals or act to pay

them enough money to stay open. Similarly, federal and state anti-trust efforts have been episodic and weak, lacking force.

Third, a reason for this is credulous faith in non-existent competitive free markets' capacity to identify and stabilize needed and efficient hospitals.

Fourth, a belief that the nation has too many hospitals and that a closed hospital is a good hospital helps to legitimize hospital closings even though their main effects are to boost surviving hospitals' prices and, often, to undermine patients' access to care and also many doctors in private practice who had formerly relied on the closed hospitals.

Fifth, similarly, the very low doctor-to-population ratio in the U.S. helps allow physicians to charge high prices to privately insured patients. The shortage of primary care doctors means greater reliance on high-priced procedure-performing doctors and other specialists.

Sixth, high U.S. prices for prescription drugs, implants and other hardware, and pacemakers and other medical devices stems from blind faith in competition and payers' unwillingness and inability to unite to win lower prices.

Seventh, the high numbers of uninsured and—especially—under-insured Americans means that patients with effective purchasing power are a relatively low share of our people. Caregivers therefore try to charge high prices when possible to garner the revenues they seek.

Eighth, failure to cap spending, assure full coverage for each American, and pay caregivers in trustworthy ways liberates doctors, hospitals, and drug makers to charge high prices.

Ninth, absence of either a competitive free market or competent government action makes all this possible.

Tenth, unwillingness and inability to competently rein in high prices leaves payers and governments with the weak option to try to hold down volumes of care.

4. Theft: U.S. health care has become the infirmary of kleptocracy – accounting for some $250 billion in waste in 2024

In December 1940, Roosevelt proclaimed the U.S. would be the arsenal of democracy.[1833] The nation then had factories full of idle machine tools, 8 million unemployed workers (one-seventh of the workforce) who knew how to use them, and managers who were competent to organize and produce hardware.

None of this remains true today.[1834] [1835]

The National Health Care Antifraud Association has estimated health care theft and fraud at 3 percent of spending.[1836] Sparrow places theft's share between 3 and 10 percent of health care spending.[1837]

The U.S. Department of Justice's Criminal Division compiled a summary of cases of theft. It identified 189 federal cases filed in 50 districts and 91 state cases filed in 12 states.[1838]

U.S. health care should now be seen as the infirmary of kleptocracy.

Gladwell asserts that theft from Medicare alone amounts to some $100 billion yearly—over one-tenth of the program's annual spending.[1839]

He succinctly describes the three elements of one of the main common types of theft—fraudulent billing of Medicare and other payers. First, fake patients are needed. They can be recruited; their need for care can be falsified; and their identities can be stolen or fabricated. Second, fake medical authorizations are needed. Doctors and other clinicians can be lured into falsely certifying need and provision of care. They are paid kickbacks. Third, false medical records must be created to appear to substantiate need for care and its provision. Gladwell illustrates the application of these three elements to widespread fraudulent billing in Miami.[1840]

In 2026, Zweig raised concerns about the growth of federal government lawlessness in general, and the ways in which this can erode trust in in markets and across the citizens. He pointed to instances of insider trading in stocks, abandoning prosecutions of alleged fraud, and pardoning people convicted of fraud. All this can weaken the public's belief that the world is just—that good things happen to people who play by the rules and bad things happen to people who don't. Zweig cited a stock analyst who said "'that the rules no longer seem to matter.'" [1841]

Anarchy in financial markets undermines the economy, just as anarchy in health care harms access and quality, boosts cost, and malconfigures caregivers.

Spectrum of shame

Theft can be categorized by its scale. Retail theft is unsystematic and typically costs hundreds of thousands to tens of millions of dollars per episode per year. Wholesale theft is systematic, organized, prolonged, and typically costs hundreds of millions to billions of dollars per episode.

Remarkably, retail health care theft is apparently more likely to result in jail time. One former NBA player was sentenced to 10 years in jail for stealing $300,000 and another to 40 months in jail for stealing $132,000.[1842]

By contrast, no corporate leaders at Tenet, Columbia/HCA, Pfizer, Merck, Lilly, or Abbott went to jail for thefts at the billion-dollar level, many of which involved off-label marketing or provision of unnecessary and dangerous medical care to human patients.

A rare but telling exception is the sentencing to jail for up to 30 years for 9 of the thieves at National Century Financial Capital who stole about $2 billion—mainly from bond-holders and other investors who invested in a company that factored accounts receivable, principally from health insurers.[1843] [1844]

It may be that bond-holders and investors enjoy more practical rights than do employers or citizens who finance health insurance or the patients who are harmed by inappropriately prescribed meds. Phillips wrote that they enjoy greater rights to accurate information than do voters.[1845]

Most theft is illegal. It entails civil financial penalties or criminal penalties of fines, imprisonment, or both. A criminal defendant can plead *no contendere*, which means passively accepting a judgment of guilt without requiring an active plea of guilty. A judge may then impose fines, sometimes massive ones. In banking, accounting, and investing, large theft was once punished harshly.

Accounting and other frauds revealed in the dot.com scandal of 2000 resulted in serious jail time for many. The savings and loan scandals of the 1980s cost the federal government some $200 billion to repair.[1846] Some 1,200 were jailed. Massive federal bail-outs replaced pillaged money. But only one person went to jail after even trillions of dollars vanished in the 2008-2009 financial meltdown.[1847] It may be that Obama's Justice Department had other priorities. Or it may be that in the years since the S+L scandals, the Justice Department gradually reduced its professional capacity to prosecute individuals and the political support it required to do so. Eisinger details this deterioration.[1848]

I suggest that some currently legal activities might be considered as theft or close to theft—and that the line between legal and illegal behavior may not be a bright one. Those activities might not yet be deemed to violate a law, but it may be widely agreed that they are improper, immoral, or harmful.

United Health's, Humana's, and other insurers' pillaging of the Medicare Advantage program by manipulating data on enrollee risk was for years deemed legal but that understanding is being challenged in 2025.[1849]

Steward and Prospect financially manipulated their hospitals, extracting substantial profits and but leaving needed caregivers bankrupt. Some patients were harmed by bad care. Both companies' owners had smart lawyers who surely tried to guide them toward away from law-breaking. Still, some politicians called for investigations to learn whether any of the companies' behaviors were illegal.

Plunkitt of Tammany Hall made a parallel distinction between honest graft and dishonest graft.[1850]

Theft can also be viewed by its financial motivation. Here, it is reasonable to suppose a continuum. When doctors are financially incentivized to give more care, they sometimes respond by energetically diagnosing and treating pathology they genuinely believe to be present. Some of this will be clinically inappropriate care but that is not theft. As financial incentives grow, some doctors go further and try to make money by billing for care that they know patients do not need or, sometimes, don't even receive. Or worse, that harms them. All that is theft.

Doctors can be frustrated by payer arrangements they regard as inappropriate or unfair. If a diagnosis or treatment is downcoded to pay less, or if payment is denied, a doctor may try to recoup revenue they feel was unjustly withheld. Is that theft? A payer will probably think so. But the doctor's motivation might be to obtain the revenue believed to be fair and commensurate with the value of care given. If a doctor, over time, feels it necessary to violate the rules of payment to obtain that level of revenue, the doctor may lose faith in the fairness of the payment system and begin to break the rules energetically and chronically.

Some managers, trustees, and owners of hospitals, ambulatory surgery centers, nursing homes, home health agencies and hospices, drug companies, manufacturers of durable medical equipment, and other organized caregivers steal money. So do some insurance companies and their agents, HMOs and ACOs, MA plans, and Medicaid managed care plans.

Some theft is purely financial and is usually seen as a victimless crime. That's because stolen money is typically replaced by new dollars financed through open-ended public and private entitlements. Less often, patients are clearly and badly harmed by thieves who aim to make money by recklessly delivering dangerous and unnecessary care. Or by stealing some of the finite dollars available to capitated HMOs, MA plans, or Medicaid managed care plans.

Finally, theft can be categorized by the laws broken by thieves. The HHS Office of the Inspector General notes five main laws that apply to doctors.[1851] One is the False Claims Act that imposes both civil and criminal penalties on those who submit illegal bills to the federal government. Civil penalties entail treble damages for each claim (or individual bill). It is not necessary to prove intent to defraud.

A second is the Anti-kickback Statute, which prohibits remuneration for referrals or other business. Hospital group purchasing organizations were congressionally exempted from compliance.

A third is the Physician Self-referral Law, sometimes called the Stark Law. It prohibits a doctor from referring patients to him- or herself or to family members for designated types of care.

A fourth is the Exclusion Statute, which obliges the Office of the Inspector General of DHHS to prohibit those convicted of certain criminal offenses from participating in all federal health programs.

And a fifth is the Civil Monetary Penalty law, which allows the Office of the Inspector General to impose substantial fines and assessments for violation of the preceding four laws and also a variety of other federal health statutes.

Hinton and colleagues have prepared a useful inventory and analysis of fraud, waste, abuse, and improper payments in health care programs.[1852]

Types of theft

Some 20 different types of health care theft merit consideration.

1. Billing for unneeded care or care not given

As early as 1989, Rundle detailed methods of inappropriately boosting revenue by unbundling treatments.[1853]

A Michigan surgeon was charged with stealing $60 million by submitting false claims for placing stents and for billing for multiple procedures that should have been billed as single procedures.[1854]

A Maryland cardiologist lost his medical license for implanting stents unnecessarily. The hospital at which he worked settled one class action suit for $37 million. Plus dozens of millions to repay public and private payers. Another Maryland cardiologist was sentenced to 8 years in jail for over-stenting, and one in Louisiana was sentenced to 10 years.[1855] A Cleveland Clinic cardiologist called over-stenting a national problem costing a fortune.[1856]

A New Yorker stole $70 million by organizing doctors to order tens of thousands of unnecessary brain scans from a diagnostic services company. He was sentenced to only 14 months in prison.[1857]

A Russian criminal organization fraudulently billed Medicare for $10.6 billion in medical equipment. It bought dozens of medical equipment companies with Medicare billing numbers. Using stolen personal information on over one million Americans, it submitted bills for equipment that was not prescribed or delivered.[1858]

In June 2025, the Justice Department summarized recent frauds summing to $4 billion, on top of the $10.6 billion Russian theft. It included charges against 324 defendants. Among them were 96 doctors and other licensed professionals. Among the crimes were fraudulent wound care, opioid trafficking, genetic testing, and billing for meds or medical services that were never provided.[1859]

In February of 2026, a Russia-linked owner of a medical supply company in Texas was indicted for stealing some $90 million by billing both Medicare and Medi-gap insurers for urinary catheters that patients neither needed nor received.[1860]

Georgia's former insurance commissioner has pled guilty to conspiring to commit health care fraud by advising a doctor's employees on ways to submit bills totaling $2.5 million for medically unnecessary tests.[1861]

A New Yorker was sentenced to 14 months in jail for organizing a scheme to sell prescriptions and DME orders for unneeded care to drug makers, DME manufacturers and others. He was ordered to pay $55 million in restitution and forfeiture.

In 2025, an Arizona man was convicted of billing Medicare and other federal health programs for $1 billion in unnecessary durable medical equipment, meds, and other types of care. His company was actually paid $360 million. Medicare and other patients received misleading e-mails, phone calls, and ads that persuaded them to accept unneeded care.[1862]

The former COO/CFO at Chicago's Loretto Hospital, which served high shares of Medicaid and Medicare patients, was indicted for embezzling $15 million from the hospital. Working with at least two accomplices, he billed the hospital for Covid-related services that were not given to any patients.[1863] Subsequently, that individual and other members of his gang were indicted for a $390 million Covid fraud.[1864]

In 2011, California's insurance commissioner accused Sutter Health of fraudulently charging hundreds of millions of dollars over a decade for anesthesia services that were already covered under bills submitted by Sutter's hospitals or physicians—or that, in some instances, were never pro[1865]vided.[1866] Whistle-blowers sued Sutter under California's then-new Insurance Frauds Prevention Act covering false claims against private insurers. Sutter settled the heavily-litigated case by paying $46 million two years later, just before trial was to begin. [1867]

2. Small-scale retail theft

Initially, public and private payers aimed to be friendly to caregivers. They were oriented to paying claims that looked clean—if the data were internally consistent and if all required items were complete. They were not looking for fraud. Crooks took note.

A Texan kinesiologist fraudulently but easily obtained a federal National Provider Identifier that allowed him to bill insurers as if he were a physician. He billed large insurance companies for $25 million and was paid $4 million.[1868]

The head of operations for the fundraising foundation for Miami's safety net hospital was indicted for stealing $3.6 million to buy designer handbags, a golf cart, and other trash. Her salary had ranged between $185,000 and $290,000 yearly.[1869]

And a physician in Texas was sentenced to 10 years in jail for prescribing $54 million for genetic tests for cancer or durable medical equipment for patients he had never seen—and which often were not received by the patients. The physician received just under a half-million dollars from the scheme, with the rest going to organizers.[1870]

3. Massive theft by hospital chains

Tenet

Were Tenet a human felon living in a state with a three-strikes-and-you're-out law, it would be jailed for life.

Phase 1. National Medical Enterprises was founded in 1969. It first owned psychiatric hospitals and nursing homes, later adding general hospitals. By 1994, it had paid some $675 million in federal and state criminal and civil penalties for kickbacks, unnecessary medical treatments, forcing patients to undergo electric shock treatments against their will, and billing for care not provided.[1871] [1872] NME changed its name to Tenet, signaling adherence to principles or rules of behavior. It signed a corporate integrity agreement (CIA). Unfortunately, 8 of 12 senior managers at NME remained with the renamed company.

The company agreed to sell its psychiatric hospitals; had it not, they would probably have been banned from participation in Medicare and Medicaid. NME's general hospitals were not prosecuted then. But in 2003 the Justice Department did sue Tenet for $323 million for falsifying diagnoses at its general hospitals from 1992 to 1998. That would push total NME penalties over $1 billion.

Phase 2. In November of 2002, revelations of an outlier payment scandal caused Tenet's stock to plunge by 46 percent in 3 days and by 78 percent between October 2001 and July 2002, erasing $17 billion in investors' equity.[1873] The CEO had exercised stock options for $115 million before the drop.

The drop stemmed from evidence that Tenet was being investigated for wholesale illegal manipulation of Medicare outlier payments to hospitals. Separately, clinical practices at some of its individual hospitals were condemned. Those included Alvarado Medical Center, where

doctors were paid kickbacks for referrals; Redding Medical Center, where doctors performed unnecessary cardiology and cardiac surgery procedures; Brotman Medical Center, where Tenet over-billed payers; and physician relocation agreements at many Tenet hospitals. Total penalties during this phase were some $1.45 billion.

In 2003, a new CEO was named; this person was a carry-over from the former regime. Tenet signed a new CIA in 2006.

Phase 3. From 2009 to 2023, Tenet settled 10 penalties for illegal behavior summing to $860 million.[1874] The largest was a case of bribes and kickbacks in which 2 of Tenet's Atlanta-area hospitals paid prenatal clinics for referrals for OB services—services for which Medicaid paid at high prices.[1875] Other claims involved false claims for rehab services, price-fixing and false claims by Detroit Medical Center after Tenet bought DMC from Vanguard, and wage and hour violations.

Individual hospitals, factories, universities, retail stores, and other organizations have their own cultures. How to explain Tenet's chronic criminal culture? NME's founders put profit and stockholders' interest first,[1876] and justified doing so by free market theories discussed in chapter 4. While CEOs changed, they had long been associated with Tenet. CIAs were signed, but the profit-first culture persisted. This was clearly signaled by incentivizing managers by promises of bonuses that could exceed their salaries—a departure from practices at other chains.[1877]

Tenet engaged in decades of illicitly making money by milking federal formulas, by upcoding patients, by providing unneeded and unwanted care. These practices violated ordinary medical and ethical standards. These behaviors suggested that Tenet cared more about money than medical care. That may help to explain Tenet's tragically weak preparedness of its Memorial Medical Center in New Orleans when Hurricane Katrina stuck in 2005.[1878] In 2011, Tenet agreed to pay $25 million to settle a class-action suit alleging failures to prepare adequately.[1879]

HCA

HCA's New Orleans hospital seems to have coped with Katrina somewhat more professionally.[1880] This may signal stronger managerial competence and a greater commitment to patients than Tenet has done. While HCA committed massive financial fraud decades ago, and has lapsed into bad behavior from time to time subsequently, its record of theft is less persistent than Tenet's. It has, however, engaged in repeated financial manipulations that showered vast profits on insiders and their allies. HCA has found legal paths to enrichment.

Between December of 2000 and June of 2003, Hospital Corporation of America agreed to pay $1.7 billion to settle at least 9 separate False Claims Act allegations. Those concerned paying kickbacks to doctors for referring patients, systematically upcoding severity of patient illness, billing for unallowable costs, inflating costs of transferring patients from one site to another, and illegally offering free rent and meds to doctors.

Investigations into these claims, which mainly involved activities of Columbia/HCA while Rick Scott headed the company, lasted for some 9 years before the concluding settlements.[1881] [1882]

Scott headed the merged company from the time shortly after Columbia and HCA combined in February of 1994 until he was pressured by board members to resign in 1997 in the face of serious allegations of theft against the company. Scott had wished to remain in charge and to fight those allegations. After his departure, the Frist family regained power to shape HCA practices. They took a less overtly confrontational stance—an apparently more cooperative one—toward federal investigators during the 6 years until allegations were resolved.

Tenet's financially aggressive leadership by a succession of insiders continued for decades. At HCA, by contrast, smooth control by the Frists and their allies from 1968 to 1994 was, at least apparently, interrupted by Scott's behavior as CEO. As with heads of Tenet, Scott was never charged with criminal behavior. He went on to election as governor of Florida and as a U.S. senator.

Just as at Tenet, some HCA insiders sold stock at high prices right before financial reports led to a sharp price drop on at least one occasion.[1883]

It is worth asking whether Scott's aggressive style could subvert a previously well-behaved company and transform it into an enterprise that stole $1.7 billion during the less than 4 years of Scott's control. Many who worked at a well-behaved, ethical company would resist illegal acts like inflated billing and paying kickbacks. One possible indication that HCA's culture differed from Tenet's was the substantial number of whistle-blowers who launched False Claims Act suits against HCA. Alternatively, some insiders may have seen opportunities for 7- and 8-figure payouts if their suits were successful.

During Scott's run for governor in 2010, a Florida reporter asked a speaker for the campaign about HCA's troubles. The speaker said "'Rick didn't do anything wrong. If Rick had known what was going on, he would have corrected the problem immediately.'" She said that Scott accepted responsibility for the theft but did not know about it as it was happening.[1884]

Viewed over decades, HCA's behavior has generally been more legal and smooth than Tenet's. But, below surface appearances, HCA may have been just as aggressive financially. Tenet's culture blatantly sanctified bottom-line profits and followed a straight and greedy path of regularly acting illegally to maximize profit.

HCA's path instead followed hairpin turns as insiders twice made money by taking it private and then public. At each turn, HCA took on high debts to finance leveraged buy-outs. Management then pushed hospitals and doctors to generate extraordinary sums to pay off those intentionally acquired debts and also to boost the company's value in anticipation of a new public stock offering. HCA garnered higher revenue by generating higher payments from Medicare, Medicaid, and employer-sponsored private insurance. Sometimes, this was done by legal gaming; other times, by theft. It's helpful to review HCA's corporate timeline.

> First, HCA began as a *private* company in 1968.[1885]
>
> Second, it made its first *public* offering on the New York Stock Exchange only one year later.
>
> Third, in 1988, HCA management leveraged a $5.1 billion buy-out of the company, taking it *private* again.[1886]
>
> Fourth, HCA re-emerged as a *public*ly-traded company in 1992. After paying $1.7 billion to address financial misbehavior on Scott's watch, and after the subsequent signing of a

> corporate integrity agreement, insiders believed or asserted that HCA's stock price was low enough to allow them to profit by taking the company private again.
>
> Fifth, in 2006, Bain, KKR, and Merrill Lynch took HCA *private* in a second leveraged buy-out, this time for $33 billion.[1887] This was the largest private equity LBO up to that time. Some stockholders in HCA and other companies sued Bain and others, claiming the bids for various LBOs were rigged.[1888] HCA's buyers put up only a small share of this money, $1.5 billion each. They borrowed $16 billion. A few years later, high profits allowed HCA to sell billions of dollars in bonds, paying each of the three main buyers $1 billion. By 2011, higher dividends alone had repaid the buyers fully.[1889]
>
> Sixth, in 2011, HCA began again to issue stock on the NYSE. This was the biggest IP backed by private equity in U.S. history up to that time. But HCA has remained under the control of a private investor group that include Bain, KKF, and the Frist family. By May of 2014, Bain and KKR had sold stock work $6.8 billion.[1890] Adding the value of stock they held in HCA, KKR's and Bain's gains were estimated at 3.5 times their original investments.[1891] [1892]

Leveraged buy-outs oblige a company to, in effect, take on debt to finance most of its own purchase by private parties, often insiders. The company's business activities generate revenue to pay back that debt. When privatized companies go public again, they sell stock to new investors. The latter require promises of high profits and rising stock prices. Those, in turn, require maximizing revenue from both publicly- and privately-insured patients.

As Zuckerman points out, leveraged buy-outs mean that buyers own an entire company after investing only a relatively small sum. If profits rise, they enjoy the full benefit. They can pay themselves substantial dividends. And, if they choose to take the company public again, high profits would allow them to sell off portions of their stock at high prices.[1893]

In one view, captured by Livingston, HCA has enjoyed decades of financial success by "sticking with the basics". These included buying many hospitals in growing metro areas in order to .leverage higher prices from private insurance companies and—particularly—from small payers like auto insurance or workers compensation insurance companies, aggressively collecting revenue due from each payer, conducting back-office work more efficiently, and using bulk buying to win lower prices from suppliers.[1894]

In another view, HCA has faced supercharged pressure to keep profits high. One way to do so is to buy a high share of hospital capacity in a given region, allowing it to squeeze higher prices from local employers' insurance companies. High profits go to repaying buyers with high dividends while they own lots of HCA stock, and with high prices when they sell off their stock.

If, for example, you spend $5 billion to own a company worth $20 billion, your return—in dividends—on your investment is multiplied by 4. Additionally, you can sell stock at high prices.

It is fair to note that leverage can also multiply losses.

A first instance of possible bad behavior is the suit by investors in HCA and other companies alleging that Bain and other LBO firms paid low rigged prices for the businesses they bought, harming existing stockholders. The HCA stockholders alleged they were illegally deprived of $1.6 billion.

A second is, simply, what a report by Zuckerman calls “windfall” profits for Bain, KKR, Bank of America, and members of the Frist family.[1895] Windfalls are branches that a storm accidentally knocks down on your property, so you enjoy firewood without great effort. But HCA’s exceptional profits were engineered, not accidental.

Bain had done the same elsewhere. Healy reported on Bain’s 1988 LBO of Domino’s Pizza. Bain generated very substantial profits but the Domino’s resulting interest costs absorbed one-half of yearly profits. Bain’s playbook at Domino’s resembled the one it and other investors employed at HCA. It included offering stock to the public and also paying a special dividend that, alone, was more than double the initial investment.[1896]

A third is upcoding of severity of patient illness and performing unnecessary care to boost revenue from payers. A former nurse wrote HCA’s chief ethics office in 2010 about his concern that cardiologists at some HCA Florida hospitals had performed unnecessary procedures. An internal HCA investigation verified the allegations. It is hard to know how pervasive these behaviors have been. HCA investigated some internally, sometimes reported to regulators, but sometimes worked to keep problems under wraps.[1897] Clearly, a number of doctors and hospitals were boosting volumes of cardiac services. Did they do so to enrich themselves? Or were they responding to pressures from HCA management to act to hike profits?

A fourth is payment of kickbacks and making false claims for payment to Medicare and Medicaid. Along with upcoding, these are behaviors that generated Columbia/HCA’s $1.7 billion payment to settle false claims allegations. In 2017, 4 Houston HCA hospitals paid $8 million to settle False Claims Act suits alleging they received kickbacks from ambulance companies in exchange for arranging referrals for well-paid transport for Medicare and Medicaid patients.[1898] Other settlements involved minimally invasive spine surgery in 2013, implanted cardiac devices in 2015, and a sleep center in 2013.

A fifth is alleged refusal to adhere to agreements signed with sellers of hospitals or other parties that require HCA to sustain certain services. In 2013, a Missouri court ordered HCA to pay $162 million for failing to keep promises to improve Kansas City hospitals it had bought.[1899]

In December of 2023, the North Carolina attorney-general sued HCA for failing to keep binding promises it had made when buying a formerly non-profit hospital in Asheville. He said that HCA had discontinued certain emergency and trauma services, and had inadequately staffed the ER and ICU. And that it had weakened medical transport services and failed to adequately staff oncology services.[1900]

The attorney-general’s complaint alleged under-staffing of nurses and other clinicians in Asheville. A union study asserted that HCA’s staffing levels were below average levels for other hospitals in 19 of the 20 states where it operated.[1901]

A sixth is remarkably high prices charged to auto accident victims and their insurers. In 2018, HCA settled for $220 million a potential class-action suit alleging remarkably high prices for imaging studies at Florida HCA hospitals—37 times Medicare’s price for a brain CT scan and 29 times Medicare’s price for a spine scan.[1902]

Prospect Medical

A 2020 history of Prospect Medical by Elkind and Burke detailed both profiteering and neglect of patients.[1903] It describes broken promises to keep hospitals open, to invest in buildings and equipment, and to refrain from paying extravagant dividends to owners. Supplies at some hospitals were short. Bills were paid late. In one dramatic instance, ambulance drivers could not purchase fuel for their vehicles because their Prospect credit cards were not accepted. Physically run down and financially loaded with debt, buyers for Prospect's hospitals have not been forthcoming.[1904]

O'Grady described methods used by Prospect's owners to extract money. In 2018, after taking on $1.1 billion in new debt, Prospect gave a $457 million cash dividend to its owners. She called this "dividend recapitalization." Prospect paid off the $1.1 billion by selling most of its real estate—buildings and land—to Medical Properties Trust. Prospect was then obliged to pay rent on that lost real estate.[1905]

Cass has noted that Prospect has faced remarkable difficulty in selling many of its distressed hospitals.[1906] This appears to be attributable to aggressive efforts to squeeze money from them.

Prospect Medical financially hollowed out two Providence, R.I. hospitals and then sought to sell them in 2024. A few months before the deadline for the sale, no buyer with a solid business plan has come forward.[1907] The state had to promise to stand behind a small non-profit buyer—one that had never run acute care hospitals. A state judge condemned Prospect's dangerous under-financing of its two Rhode Island hospitals.[1908]

In Connecticut, Prospect bought hospitals in Waterbury, Rockville, and Manchester. It seemed for a time that a sale to Yale-New Haven Health could save them.[1909] But this fell through after Yale-New Haven became aware of financial and other problems at the hospitals.

Prospect closed 2 of its 4 hospitals—Springfield and Delaware County Memorial—outside Philadelphia after taking control of them in 2016. A sale of the 2 remaining hospitals, Crozer-Chester and Taylor, to Christiana Health fell through, and both hospitals were shut in the spring of 2025.[1910]

As a parting gift, Prospect failed to redeem its promise to buy malpractice insurance for its hospitals and doctors, leaving injured patients without recourse.[1911]

In 2026, Davenport and Watts reviewed Prospect's actions over many years that destabilized hospitals in Pennsylvania, Connecticut, and Rhode Island.[1912]

Prospect's chronic, variegated, and widely disseminated activities prompt the question: What could hospitals and officials in various states have been thinking when they permitted Prospect to buy hospitals, extract cash, and run away? Were hospitals and state officials desperate because they saw no alternative to Prospect? Did they simply want to kick the problem down the road so someone else would have to address it sometime later? Did they not care? Were they bribed legally with campaign contributions or paid off less legally? Or were they out-maneuvered and outlasted by Prospect's lawyers?

Steward

Steward's bad behavior was sketched in chapter 1. It is discussed in detail in chapter 5. This short section will focus on Steward's financial pillaging and plundering, privatizing profits and leaving state government to pay many hundreds of millions of dollars to replace money extracted from Steward's Massachusetts hospitals.

In 2010, the Boston Archdiocese was beset by financial challenges. It sought to sell its 6 Caritas Christi hospitals because they were seen as burdens. The pension funds for retirees were substantially under-financed. Needed capital investments in buildings and equipment had been delayed.

Coakley, the Massachusetts attorney-general, permitted Cerberus Capital to buy the 6 hospitals from the archdiocese. The hospitals were renamed Steward Health Care. Cerberus retained the Caritas CEO to run them. Even though the hospitals relied heavily on lower-paying Medicare and Medicaid patients, the CEO promised to save and restore them by competing as a low-cost hospital to boost volume.

I asserted in 2010 that it would not be possible for Steward to make the profits demanded by private equity by ordinary methods of boosting volume and becoming more efficient.[1913] Steward bought a few more money-losing Massachusetts hospitals. Leveraging the newly-acquired Massachusetts hospitals, Steward subsequently bought hospitals in Texas, Florida, Arizona, Utah, Arkansas, Louisiana, Ohio, and Pennsylvania.

Between 2016 and 2018, Medical Properties Trust paid Steward $1.3 billion for the land and buildings owned by its 8 Massachusetts hospitals. Much of this money went to Cerberus. Steward leased back the land and buildings at rents that approached $400 million for 2020. This extraction of money from hospitals via sale-leaseback closely resembles Prospect's.

In 2020, in a complicated series of transactions, Steward came under ownership of its CEO and others. Cerberus departed after netting an added $335 million. Steward paid $111 million to its new owners.[1914] MPT sold one-half of its interest to Macquarrie, an Australian manager of pension funds for public employees.

Cerberus made money. Steward's CEO and fellow-owners made money. MPT and Macquarrie made investments that seem reckless. Episodes of dangerous and even fatal shortcomings in quality of care became visible.

In May of 2024, Steward declared bankruptcy. It owed about $9 billion. Of this, $1 billion was owed to secured lenders who had received collateral, $7 billion was owed to MPT, and $1 billion was owed to various suppliers and contractors.[1915] Utah hospitals had been sold off. Two in Texas and 2 in Massachusetts had been closed.

The bankruptcy filing put the fate of the 8 surviving Massachusetts hospitals in the hands of its creditors and of a Texas federal judge who formerly worked as a lawyer for Steward.

Steward's Massachusetts hospitals held 7 percent of the state's staffed acute inpatient beds in 2022; they delivered almost one-tenth of all ER visits statewide. More consequentially, Steward hospitals were major sources of emergency and inpatient care in substantial regions of the state—disproportionately in areas where citizens' incomes are below-average. A number of nearby hospitals, already crowded, would be inundated by patients displaced by closing of Steward facilities—or by bankruptcy-related disruptions of care at those facilities owing to loss of doctors and other clinicians, or by supply shortages.

The state's governor and attorney-general promised they would try to intervene in the bankruptcy proceedings. The AG said she'd petition the court to appoint an ombuds to advance patients' interests in court. But these were flimsy face-saving gestures. The state could have very little effective influence over bankruptcy proceedings. Unless it put up cash.

When Steward declared bankruptcy, the state could do little more than send a lawyer to watch the bankruptcy judge referee claims of creditors against Steward. The remaining Steward hospitals were treated like chips in a poker game.

In the end, state government arranged take-overs of 6 of the 8 Steward hospitals remaining open early in 2024. For a total payment of $343 million, the 6 were bought out of bankruptcy.

Steward hospitals required substantial financial infusions to restore them to good health. Only promises of state subsidies to the buyers made these sales possible. The cost to the state has been rumored by some to be in the high nine figures.[1916]

It can be hoped that state government will perform better in the future. But there's little sign of that so far. Indeed, closing of inpatient care at 1 of the 6 ostensibly rescued hospitals was announced late in the spring of 2025.[1917]

The state's three main responses to Steward have been continued finger-pointing, promising protections against future private equity abuses in new legislation, and blaming imaginary market forces for the state's inability and unwillingness to protect 2 of the 8 Steward hospitals.[1918]

That seems remarkably backward-looking—resembling the French Army's preparations to fight the last war.

State government may, someday, choose to cope with the anarchy that results from profit-seeking in the absence of a functioning competitive free market, combined with lack of competent and strategic state government action. These themes are taken up in chapters 4 and 5.

Community First Medical Center

Chicago's Resurrection Hospital was about to close in 2014. Instead, it was bought by few investors. It was re-named.

Ramos reported in 2025 that the hospital has failed safety inspections, is under-staffed, and has delivered dangerously low-quality for a number years.[1919] This single hospital's problems reveal vividly the danger of relying on for-profits to save and revitalize failing non-profit institutions. As discussed in chapter 12, this remedy is not remotely adequate to address the causes of a hospital's failure.

HealthSouth

Since 2000, HealthSouth has paid $978 million in penalties. Some $545 million was for accounting fraud and deficiencies and $404 million was for violations of the False Claims

Act.[1920] In 2006, the company paid investors very substantial sums to settle a class-action suit.[1921] Investors also sued HealthSouth's investment banker, UBS, and its auditor, Ernst & Young, for being knowing participants in the fraud and for failing to report fraud while earning substantial fees.[1922] Further, in 2009, an Alabama state judge ordered Richard Scrushy, former CEO, to pay $2.9 billion to stockholders who were harmed by his overstating the company's income and assets from 1996 to 2002.[1923]

Notably, in 2005, Scrushy was found not guilty by a Birmingham jury on all 36 remaining counts (out of 85 original counts) of running a multi-billion-dollar and multi-year accounting fraud, and of violating the Sarbanes-Oxley law.[1924] But he was sentenced in 2007 to 82 months in federal prison for bribing Alabama's former governor.[1925] Previously, 15 former HealthSouth executives had pled guilty to various charges of fraud, with one sentenced to 5 years in jail; another went to trial and was sentenced to 8 years.

A possible lesson. The pattern of prosecution of so many high-level HealthSouth executives differs dramatically from that of Tenet and HCA, companies that also defrauded Medicare and Medicaid—but where no one was jailed. Speculatively, this might reflect the harm suffered by HealthSouth's investors. If so, this would parallel the heavy jail sentences imposed on officers of National Century Financial Capital, whose behaviors harmed bond-holders badly. If that is true, it signals that large-scale theft from Medicare and Medicaid may result in financial penalties and corporate integrity agreements, but that stealing from private investors warrants imprisonment.

4. Pharma fraud

Lying about safety or efficacy

Suppression or falsification of evidence about Zyprexa and Vioxx is discussed later in this section. Overt falsification of evidence is dangerous; it seems to be rare. But it does arise from time to time.

In April of 2026, the FDA moved to withdraw approval of Taveneos (avacopan) because new evidence indicated lack of effectiveness, and because untrue statements of material fact were made in the original application by ChemoCentryx, the drug's developer. ChemoCentryx was subsequently bought by Amgen.[1926]

Illegal marketing for off-label uses

Drug makers frequently violate prohibitions against marketing their FDA-approved meds for unapproved uses. They do so because their extra profits are expected to exceed the cost of the[1927] fines they pay if caught. They view those fines as a cost of doing business. Other forms of drug maker theft include bribing doctors to prescribe their meds, illegally over-charging public and private payers for meds,[1928] and failing to fully report or respect evidence on their products' safety or efficacy.

Liu and colleagues reviewed settlements of anti-kickback allegations against drug makers from 2000 to 2025. They found that drug makers' penalties for giving kickbacks to doctors amounted to only 2.2 percent of U.S. revenue garnered by selling:

> implicated drugs during years of alleged violations. Alleged conduct commonly involved direct payments to physicians intended to induce prescriptions of federally reimbursed drugs. Criminal AKS [Anti-kickback Statute] cases were uncommon, likely because they are more difficulty to prove. Moreover, all cases were resolved through negotiated settlements, likely due to resource constraints and uncertainty of judicial judgment, which also makes settlement more predictable for manufacturers. Thus, our findings suggest that AKS settlements may be economically tolerable for some manufacturers and function as a cost of doing business.

For these reasons, Liu and colleagues urged higher penalties for AKS violations and placing stronger sanctions on individuals, not organizations. The authors' reference to "resource constraints" reinforces worries about shortages of DoJ prosecutors to investigate the validity of whistleblowers' False Claims Act filings. The federal government could join valid filings. This would strongly reinforce pressure for a recovery of stolen money.

Many drug makers sign corporate integrity agreements that are intended to constrain future bad behavior. But, as Outterson notes, they appear to have been ineffective.[1929]

Lilly paid $1.4 billion in 2009 for illegally marketing an anti-psychotic med. Lilly had promoted the drug for off-label use—use not approved by the FDA.[1930]

In September of 2009, Pfizer paid fines totaling $2.3 billion for illegally marketing several drugs.[1931] And in 2016, it paid $785 million for hiding discounts it gave hospitals for drugs to treat acid reflux.[1932]

In 2012, Abbott paid $1.6 billion to settle civil and criminal complaints of promoting an anti-seizure med for off-label use.[1933]

In 2003, Abbott Labs had pled guilty to obstructing a federal investigation and paid $600 million in criminal penalties and civil fines involving nutrition supplements for people who must be fed by tube.[1934]

In 2019, Novartis set aside $700 million in anticipation of a settlement of a federal suit alleging systematic bribery of doctors with expensive food. It also anticipated addressing a possible criminal manipulation of data by a company it had acquired.[1935] The drug, just approved by the FDA, bore the highest price of all meds at the time.

Amgen and Johnson & Johnson aggressively marketed Epogen/Procrit/Aranesp to combat anemia in dialysis patients. And then in cancer patients. The two companies garnered $8 billion yearly in revenue. But neither company ever complied with lax and persistently delayed FDA deadlines for substantiating claims of safety and efficacy. (Some suggest that revolving door FDA officials were excessively sympathetic toward drug manufacturers.) Those claims were not proven. The companies richly rewarded doctors to inject heavy doses of the med. It did the same for salespeople who persuaded the doctors to do so. The FDA intervened to cut dosages and cease use of the drug for some purposes only after independent researchers cast doubt on its safety.[1936] [1937] Apparently, no criminal prosecutions or effective civil actions resulted.

Separately, in 2013, J & J agreed to pay $2.2 billion for off-label marketing of Risperdal, making false statements about its safety, paying kickbacks to induce greater use of the drug in nursing homes, and related illegal acts.[1938]

Then, in 2025, a judge ordered J & J to pay $1.6 billion for illegally marketing 2 HIV drugs, falsely claiming—in violation of their FDA-approved label—that they would not raise cholesterol or triglyceride levels.[1939]

In 2009, Glaxo announced it would pay $400 million to settle a 5-year investigation into illegal marketing several drugs for off-label uses.[1940] Glaxo also agreed to pay $750 million to settle criminal and civil complaints that it manufactured contaminated baby formula and meds at a plant contaminated for many years. Glaxo's quality manager alerted the company, was fired, and sued under the False Claims Act.[1941]

In 2010, Allergan paid $600 million to settle allegations it illegally marketed Botox for unapproved uses.[1942]

A whistle-blower at Serano pursued a False Claims Act case against the company, claiming it bribed doctors to prescribe an unnecessary weight gain med for patients with AIDS. The company also sought to manipulate and market unapproved diagnostic software. Serano agreed to pay $704 million in criminal and civil penalties.[1943]

A Takeda – Abbott joint venture paid $875 million in 2001 to settle criminal and civil charges of bribing doctors to prescribe a med to treat prostate cancer and infertility.[1944]

In 2003, Astra Zeneca paid $355 million in criminal and civil penalties to settle charges of fraud and of inducing doctors to illegally bill federal programs for free samples AZ gave them.[1945]

Schering-Plough paid three sets of penalties between 2002 and 2006 for marketing drugs for off-label uses, bribes to doctors, and illegal kickbacks.[1946] [1947]

In 2007, Bristol-Myers-Squibb paid $515 million to settle allegations of illegally marketing off-label prescribing, bribing doctors to prescribe BMS meds, and illegally failing to give Medicaid its lowest price.[1948]

Also in 2007, Cephalon booked a $425 million charge to pay for illegally marketing cancer drugs for off-label use.[1949]

Drug manufacturers differed enormously in their bad behavior. Exhibit 3 – 15 calculates non-safety legal penalties since 2000 as a percentage of market capitalization in October 2023. Pfizer's accumulated penalties equaled almost 3 percent of market capitalization; so were AbbVie's. J & J and Merck were not far behind.

Exhibit 3 – 15

Twelve Largest Drug Makers by Market Capitalization, Their Non-safety Penalties from 2000 to 2023, and the Penalties' Percentage of Capitalization

Company	Market cap. Oct. 2023, $M	Non-safety penalties from 2000 to 2023, $M	Non-safety penalties / Market cap
Pfizer	$181,300	$5,311	2.93%
AbbVie	$261,200	$7,560	2.89%
J & J	$377,700	$9,312	2.47%

Merck	$263,900	$5,282	2.00%
Bristol-Myers-Squibb	$118,000	$2,159	1.83%
Novartis	$201,100	2,449	1.22%
Sanofi	$138,000	$891	0.65%
AstraZeneca	$212,200	$1,341	0.63%
Amgen	$152,000	$932	0.61%
Eli Lilly	$578,300	$1,641	0.28%
Roche	$222,400	$433	0.19%
Novo Nordisk	$452,800	$130	0.03%

Note: The non-safety-related violations are for health care theft, violations of anti-trust laws or government contracting rules or environmental rules.

Sources: Market cap data - Panav Ganali, "The World's 50 Biggest Pharmaceutical Companies, 25 January 2024, https://www.visualcapitalist.com/cp/worlds-50-largest-pharmaceutical-companies/.

Penalties since 2000 - Good Jobs First, "Violation Tracker Current Parent Company Summary, accessed 9 May 2024, https://violationtracker.goodjobsfirst.org/.

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Omnicare's bad behavior

CVS bought Omnicare, a long-term care pharmacy business, for $15 billion in 2015. That year, a whistleblower filed a False Claims Act suit alleging that Omnicare had filled millions of bogus prescriptions. Four years later, the United States sued Omnicare for billing Medicare, Medicaid, and Tricare for meds lacking a genuine prescription.

In 2025, a jury awarded a $949 judgment against Omnicare, holding it liable for over 3 million claims that were not backed by physician prescriptions.

CVS agreed to sell Omnicare for $250 million in 2026, taking a loss equal to 98 percent of its purchase price.[1950]

Legally offshoring revenue—and profits. Not all bad behavior by drug makers is illegal. Setser described ways in which drug makers garner disproportionate shares of their worldwide revenue by charging high prices in the U.S. Insultingly, they machinate to pay very low U.S. corporate income taxes on the high U.S. profits resulting from those high U.S. prices by paying contrived fees to foreign subsidiaries endowed by those drug makers with ownership of patent and other rights.[1951]

Drug makers have long acted through politics and law to keep their prices high. And then, to keep the resulting profits, drug makers like Pfizer, AbbVie, Merck, and Amgen used their political influence to legally dodge U.S. corporate income taxes by claiming that their revenue was garnered outside the U.S. Indeed, Pfizer claimed no taxable U.S. profits for 2019, asserting all profit on high-price drugs sold in the U.S. was earned by offshore subsidiaries. A

provision of Trump's 2017 tax cut law made this possible.[1952] While different in legal form, this crudely parallels the practice of tunneling nursing home profits, discussed shortly.

Buying evidence. Another large area of legal but dubious behavior is drug makers' practices that undermine the integrity of the research evidence on their products' safety and efficacy. Bogdanich and colleagues reported on Novo Nordisk's part-ownership investment in a company serving as an institutional review board. Such boards are ostensibly independent entities designed to examine drug researchers' ethics and steps to protect safety of patients participating in clinical trials. But NoNo has relied on this partly-owned subsidiary to review 46 clinical trials in 6 years after investing in that company.[1953]

Opioids. A massive form of theft has been the illegal manufacturing, wholesaling, and retailing of opioids. This comprehensive theft began with aggressive marketing and over-selling of opioids' safety and under-stating their addictiveness. It continued with massive, organized distribution. Arguably, it peaked in 2016 with drug makers' success in persuading Congress to pass a law—and persuading Obama to sign it—to strip the "Drug Enforcement Administration of its most potent weapon against large drug companies suspected of spilling prescription narcotics onto the nation's streets." [1954]

Shortly thereafter, Trump nominated the bill's lead House sponsor to head the DEA. Marino had represented a Pennsylvania district whose citizens suffered greatly from opioids.[1955]

Fernandez and McCoy reported on the successful efforts of Endo Pharma to dodge $7 billion in fines for massive illegal distribution of opioids—and taxes on profits. Endo paid 3 percent of the sums owed, while shoveling $95 million to executives just before seeking bankruptcy protection. Victims received an average of $1,000.[1956]

One set of suits by attorneys-general in New York, Vermont, and Washington State highlighted the power of three distributors—Cardinal Health, McKesson, and Amerisource Bergen—to move illegal drugs and to protect retailers against investigators.[1957]

McKinsey's double dealing by advising the VA on health care while also advising opioid makers on how to sell more product to the VA highlights drug money's power to corrupt. McKinsey agreed to pay a $650 million fine and make the usual promises to sin no more.[1958]

Drug makers are not the only bad actors on the pharmaceutical stage. PBMs and payers have behaved badly, also.

PBMs. Pharmacy benefits managers may engage in systematic theft. They do so if they violate their fiduciary duty to clients—typically insurers, employers, or unions—by making deals with drug makers that enrich the PBMs and drug makers at the expense of their clients. Those deals typically entail promoting more costly meds in place of less expensive ones. Some PBMs have paid to settle such allegations. The Department of Justice has investigated others.[1959]

By 2025, drug makers and others had enjoyed some success in implanting lightning rods on PBMs. That is, they sought to persuade politicians and others that PBMs were to blame for high U.S. drug prices.[1960] Additionally, the Federal Trade Commission sought in 2024 to move

against PBMs owing to concerns they boosted drug prices and also harmed independently-owned pharmacies.[1961] The FTC followed up later in 2024 by suing three PBMs.[1962] [1963]

A second area of theft is more traditional—changing doctors' prescriptions without their consent, under-filling pill bottles, and unjustifiably cancelling prescriptions. In 2006, Medco settled charges for doing this for $163 million.[1964]

Third, for some two decades, PBMs took payments from opioid manufacturers to facilitate free flows of opioids.[1965]

It is noteworthy that PBMs are rarely used outside the U.S. Most other rich democracies have found ways to win lower drug prices through concerted action by public and private payers.

Payers. In 2024, Humana agreed to pay $90 million to settle allegations of contracting fraud under Medicare's Part D benefit. In 2016, a former actuary at the company had sued Humana under the False Claims Act, claiming it deliberately inflated its estimates of the share of drug costs it would pay. When it actually paid a lower share, patients were left to pay substantially more money out-of-pocket.

Humana made the usual claim that it would win at trial but that it settled "'without admitting any wrongdoing to avoid the uncertainty, distraction, inconvenience, and expense of a lengthy jury trial.'" [1966]

Retail. Some pharma fraud has been retail. Late in the summer of 2024, Walgreens agreed to pay $107 million to settle allegations that it billed Medicare and Medicaid for imaginary prescriptions—those never dispensed to patients.[1967]

Potentially subverting peer review. Medical journals require authors to disclose conflicts of interest. But they do not require disclosure by the peer reviewers who evaluate papers submitted for publication. Nguyen and colleagues examined payments by drug and medical device manufacturers to peer reviewers at 4 well-known journals. More than one-half of physician peer reviewers received payments from manufacturers in 2020 through 2022. Nguyen and colleagues urge greater transparency.[1968]

Counterfeiting and theft. High U.S. drug prices make it especially profitable to mislabel or counterfeit prescription drugs.[1969] PhRMA has marshaled this as an argument against importing meds from other nations.[1970] Unfortunately, and Shulman and Kellerman reported that in 2022, three-fifths of foreign drug factories had not been inspected by the FDA in the past 5 years. When inspections occur, terrible problems are sometimes found.[1971]

Or to steal and sell them. A vice-president of a large drug company described to me his firm's effort to donate good-quality meds to an African nation. The meds were flown in and warehoused overnight. When trucks arrived the next morning to distribute the needed drugs throughout the nation, it was learned that they had been reloaded on to a plane and flown to Europe, where they were sold. Were drugs' prices low—set at marginal cost, as they would be in a competitive free market, counterfeiting and stealing would be entirely unprofitable.

5. Exploiting and harming vulnerable citizens in order to steal

Systematic exploitation of patients—particularly elderly patients—through unnecessary surgery, incompetent care, bribery, and theft—was committed at the for-profit Sacred Heart Hospital on Chicago's West Side before it was closed and malefactors were jailed.[1972] A high share of services there were unnecessary, ineffective, dangerous, and incompetent.[1973]

Similarly, a New York cardiologist was sentenced to 3 years in prison for organizing a long-running bribery and kickback arrangement that may have stolen $40 million over 7 years. Patients were referred for care they did not need and that was often dangerous to them. As in Chicago, lower-income citizens were most subject to these heartless abuses.[1974]

Chesapeake Regional Hospital in Virginia was indicted for stealing $18.5 million over 35 years by knowingly permitting a crooked doctor to perform many unnecessary surgical procedures on women. Including hysterectomies. That doctor was granted admitting privileges even though a nearby hospital had terminated his privileges because he had performed unnecessary surgery. And the hospital retained the doctor even after he was convicted of two federal felonies.[1975]

Arizona and Nevada medical professionals were charged with submitting $1.1 billion in fraudulent claims to Medicare and other payers. Vulnerable older patients—many on hospice care—were subjected to medically unnecessary amniotic allografts. Infections were not treated properly. These grafts were not coordinated with patients' own physicians.[1976]

Another heartless and chronic fraud was perpetrated for 8 years in Tennessee and adjacent states. Some 20 pain clinics operating as Pain MD billed federal health programs for $35 million and private insurers for over $40 million more. Patients addicted to opioids were told that unless they agreed to receive very painful—and medically useless—injections, they would be denied their opioid pills.[1977] [1978]

Hundreds of patients, often immigrants, were recruited from across the nation and paid to travel to southern California for surgery. Insurers paid some $500 million for this care. Paying patients is very illegal.[1979]

In 2017, Lubrano described a wide and long-lasting illegal exploitation of addicts in Philadelphia, one that treats them as objects.[1980] Addicts were transported in vans from notional "recovery boarding houses" to drug treatment centers where they were exposed to a type of group therapy of unproven efficacy. Groups of up to 60 addicts sat for three hours, three times a week, and talked about their experiences. Treatment centers were paid $75 per person for each session, or about $800 monthly. People unwilling to participate were threatened with eviction from their boarding homes. Owners of those homes were bribed with monthly payments of $100-$400 per person transported. It is difficult to estimate how much public money was stolen, but the total is probably in the hundreds of millions of dollars.[1981]

Publicly-financed patients have not been the only victims. In 2025, Elinson and Wernau depicted a prolonged and widely disseminated pattern of insurance fraud and exploitation of people addicted to meth or other chemicals. Body brokers enrolled people who were covered by private insurance—including ACA-subsidized protection. Although insurers were billed huge

sums, patients received only nominal treatment. Examples included watching videos. When their insurance ran out, patients were dumped to the street. State regulations were either weak or weakly enforced.[1982]

Walker wrote about the problem of crooked marketers who offered gifts to citizens covered under ACA plans, who were then switched to bogus plans or those with much higher OOPs. Even more aggressive were the practices of brokers who signed up previously uninsured citizens for plans that often had low value, or who switched them frequently from one plan to another, garnering commissions with each switch. Over 274,000 Americans complained to CMS about these bad behaviors in the first two-thirds of 2024 alone, signifying a very large problem.[1983]

Complexity is one of the main enablers of theft. Apparently, most people covered by ACA-subsidized plans rely on agents to choose plans.[1984] No other nation's method of enrolling patients is so complex as to require agent involvement. In April 2024, CMS changed ACA regulations to try to prevent agents or insurers from switching patients' plans, but these add administrative requirements, complexity, and time. Indeed, litigation prevented the new regulations from taking effect as scheduled in October 2024.[1985] This speaks to the practical difficulty of taking speedy action to address abuses. CMS also suspended 850 agents.

Sforza reported on similar behavior by parasitical operators in Orange and Los Angeles counties that allegedly stole $40 million from one insurance company.[1986]

Medicare Advantage plans have also been implicated in broker and enrollment fraud. Patil and others described a whistleblower False Claims Act lawsuit against MA plans and brokers. It alleged that the MA plans paid bribes to brokers to find them healthy enrollees and discouraged them from enrolling disabled Americans. The federal government joined the suit.[1987]

After Hurricane Sandy flooded adult care homes in Queens, New York, hundreds of dependent residents were housed in a crowded former hotel in Brooklyn. Medicaid paid high prices for low-quality housing, food, and support services.[1988]

Across 3 years, a New York ophthalmologist billed for 10,000 surgeries and other services that were "improper, unnecessary, or never conducted…." He victimized mentally ill residents of adult group homes.[1989]

Six Detroit-area doctors were charged in a $464 million fraud to prescribe opioids, addict patients, and force them to undergo unnecessary and painful injections.[1990]

A Los Angeles hospital CEO and a homeless services manager were indicted for recruiting homeless citizens to feign illness and obtain care—sometimes dangerous care.[1991]

A New York cardiologist was charged with a $100 million scheme of fraud and bribery by billing for unnecessary procedures and buying referrals from other doctors.[1992]

A Chicago doctor was indicted for stealing $9.5 million by improperly ordering cancer genetic testing for telemedicine patients.[1993]

A Florida doctor was convicted of helping to steal $23 million by providing medically unnecessary HIV injection and infusion treatment, and by billing for treatments not provided.[1994]

A New York lawyer and an orthopedic surgeon were convicted of stealing $31 million through a 5-year scheme to recruit homeless citizens to fake falls and undergo useless surgery.[1995]

Doctors at two Prime-owned California hospitals diagnosed extraordinarily high shares of Medicare patients for malnutrition and also for kwashiorkor, a wasting illness afflicting children in poor nations during times of famine.[1996]

Interestingly, Prime was also investigated for high reported rates of blood poisoning—did these manifest billing fraud or bad infection control or other medical care problems?[1997]

A Worcester owner of a home health agency was convicted of stealing $2.5 million from Medicaid by billing for services not authorized by a doctor.[1998]

Klamann described a plot by drivers who unnecessarily—and illegally—transported Colorado Medicaid patients hundreds of miles daily to receive methadone. Independent transportation contractors drove patients from Pueblo or other southern areas to Denver clinics. That's about 115 miles, one-way. Drivers were paid per person, per mile. They averaged 5-9 passengers in new, rented SUVs. Drivers could make $10,000 daily. Patients, often homeless, were illegally paid $50 to $100 to ride, depending on distance. The organizers billed the state separately for each patient.[1999] Hossain described a systematic response to illegal billing for non-medical transportation. It calls for paying only those claims verified by GPS, not assertions of trips made.[2000]

The manager of a New York medical billing company was convicted of stealing $600 million from insurers. Working with plastic and orthopedic surgeons across the nation, the manager inflated bills, induced doctors to inappropriately admit patients via the ER to win higher payments, and impersonated patients to appeal to insurers for higher payments.[2001]

A Texas rheumatologist falsely diagnosed patients with chronic illnesses and gave them toxic drugs that caused strokes, severe chronic pain, and disability as part of a $118 million fraud. He was sentenced to 10 years in prison.[2002]

6. Betrayals of trust

In 2019, the University of Maryland Medical System's CEO and 3 trustees resigned; 4 others took leaves of absence. Investigations had revealed patterns of inappropriate insider business transactions between trustees' companies and the system. UMMS paid one trustee, the mayor of Baltimore, $500,000 for copies of her book for children. The *Baltimore Sun* found similar patterns of board members' insider dealings at 5 other Maryland hospitals.[2003] [2004] [2005] [2006]

As early as 1972, Kessler documented a similar pattern of insider deals between the Washington Hospital Center and its trustees.[2007]

A non-profit Florida hospital was bankrupted by years of theft by its CEO, COO, CFO, and others. Some trustees colluded.[2008] At one Massachusetts non-profit hospital, the CEO and some trustees allegedly colluded in multi-year pillaging of the institution's finances. Another Massachusetts hospital's associate vice-president for support services allegedly received $500,000 in kick-backs from contractors.[2009]

CareFirst, the non-profit Blue Cross plan operating in Maryland, Delaware, and DC sought to sell itself to for-profit Wellpoint late in 2001. Early in 2003, the Maryland insurance commissioner refused to permit the conversion. Reasons for the refusal included CareFirst's board's and CEO's failure to adequately analyze the need to sell or whether selling was consonant with its mission, questions about whether they obtained full and impartial advice about a fair selling price, and a number of conflicts of interest.[2010]

CareFirst's CEO would be paid over $10 million in salary and incentive bonuses if the sale went through, plus a $19 million severance package. The bank advising CareFirst on a fair price also represented Wellpoint and would be paid well if the sale went through. A consulting firm advising on the sale identified Wellpoint as a buyer but it also worked for Wellpoint.

The insurance commission's decision was supported by the legislature, which unanimously passed a law to ban a for-profit conversion for at least 5 years, publicly control the choice of CareFirst board members, and give the insurance commissioner the power to approve executives' compensation.

New York-Presbyterian and Mt. Sinai hospitals were investigated for awarding high-priced contracts to rigged bidders. Contract officers at the hospitals were bribed by bidders.[2011]

In 2006, Connecticut's then-attorney-general criticized high-status hospital CEOs for accepting payments and free vacations in exchange for insidiously advising drug makers and other vendors on how to sell to hospitals.[2012] In 2007, the group signed an agreement with the AGs of Connecticut and Florida to cease accepting consulting fees, free vacations, and the like from companies selling to hospitals.[2013]

In 2014, a volunteer expert at Leapfrog resigned after the U.S. Department of Justice accused him of taking $11.6 million in bribes from the CareFusion company in return for influencing care guidelines.[2014]

The head of pharmacy at Omaha's children's hospital was sentenced to 4 years in jail for stealing $4 million from the hospital by billing for an imaginary drug.[2015]

In 2007, 9 of the 16 trustees of Boston's Partners Health Care—now named Mass General Brigham—worked for firms that did business with Partners. These relationships were disclosed. But the chair of Partners' board of trustees never disclosed his large ownership stake in a medical education company that enjoyed exclusive access to Harvard Medical School. Mass General and Brigham & Women's hospital were the two largest clinical affiliates of the School. This individual reportedly made some $200 million when the company was bought by Bain Capital.[2016] But when asked about high health care costs, this person pointed to diet and exercise problems—even though Massachusetts had the nation's second-lowest obesity rates and the highest health care costs.[2017] He seems to have inaccurately identified some of the causes of those high costs.

7. Exploiting public reforms

HITECH

In 2009, Congress enacted a $32 billion HITECH program to subsidize doctors and hospitals that installed new electronic health record (EHR) software and necessary hardware.

This law was inspired in part by reported failures in diagnosis and treatment that stemmed from reliance on paper records and unsystematic communication and coordination of medical information.

And in part by promises of substantial savings. Administrative costs would be cut by more efficient recording and retrieving patient information. Clinical costs would be cut by reducing the number of repeated tests, imaging studies, and doctor visits.

As discussed earlier, some promised that EHRs would cut administrative waste. A widely-cited (2,533 citations in two decades) 2005 RAND study by Hillestad and others claimed that EHRs could save more than $81 billion yearly.[2018] This work was financed by General Electric, Cerner, and other firms hoping to sell EHR hardware and software to doctors and hospitals.[2019]

That study's assertions helped to push through the HITECH Act of 2009, a federal law providing dozens of billions of dollars to doctors and hospitals who adopted EHRs and made "meaningful use" of them.

A 2013 RAND study blamed the failure of EHR to save money on slow adoption, HITECH's failure to require grantees to buy EHRs that were fully inter-operable, and caregivers' inability or unwillingness to capitalize on EHR. Also, the law's requirement of meaningful use was not particularly meaningful.[2020]

Unfortunately, theft may account for some of EHR's failure to redeem its boosters' hopes. Schulte and Fry summarize complaints that included a $155 million False Claims Act settlement with a company selling EHRs to doctors, failure of one-quarter of audited doctors to meet program requirements, and lying about adhering to certification requirements that led one company to pay $57 million to settle claims of illegal behavior.

The first systematic problem was that HITECH's legislative supporters were in too much of a hurry to push money, software, and hardware through suppliers who were not competent or ready. The second was that many doctors and hospitals were far from able to absorb the federal subsidies. The third was that program administrators lacked the knowledge or willingness to pause implementation to correct flaws in software, hardware, vendor and caregiver behavior, and weak inter-operability and meaningful use requirements. That was tantamount to tolerating theft.

Auditors concluded that one-eighth of the first $6 billion in HITECH pay-outs were improper.[2021]

Medicare Advantage theft

Opportunities to steal from Medicare grew substantially after passage of the 2003 Medicare Modernization Act, which increased public subsidies to MA plans. Some unscrupulous marketers inveigled Medicare patients to sign up for MA when the patients believed they were simply buying new Part D prescription drug plans.[2022] Pear reported on deceptive marking of MA plans just two years after the new benefit became available.[2023]

(As discussed earlier, in parallel corrupt practices, insurance agents or brokers have been found to enrich themselves by switching hundreds of thousands of patients from one ACA-subsidized plan to another.[2024])

These and other illegal activities are conceptually separate from the bad but legal MA plan behaviors described shortly. It's worth noting that illegal and legal behaviors are arrayed along a continuum, not sorted cleanly into two boxes. This makes it hard to draw a clean line between them.

In 2021, the Department of Justice identified MA as "one of its top areas of fraud recovery."[2025] Perceiving that some insurers crossed the line between ethically dubious but legal practices and illegal ones, the Department of Justice sued Kaiser Permanente and Anthem (now Elevance) for bribing doctors to identify diagnoses that would win higher payments for MA plans.

In 2021, DoJ joined a whistleblower who had filed a False Claims Act suit against both Group Health of Puget Sound (subsequently acquired by Kaiser Permanente) and a New York State MA plan and a diagnosis harvesting firm it employed, alleging they submitted thousands of inaccurate diagnoses over 7 years.[2026]

In 2022, DoJ filed civil fraud charges against Cigna, accusing it of illegally making many of its MA patients look sicker and costlier to serve than they actually were.[2027] A year later, Cigna settled with DoJ by paying $172 million. Reporting on the settlement, Emerson wrote that "Nearly everyone major insurance company has previously been accused of or settled allegations of Medicare Advantage fraud by the federal government."[2028]

In 2025, DoJ filed complaints against Aetna, Elevance, and Humana, alleging that they paid hundreds of millions of dollars of kickbacks over 5 years to 3 brokers to secure MA enrollees.[2029]

In January of 2026, the non-profit Kaiser Permanente group agreed to repay $556 million to settle False Claims Act suits that it had illegally upcoded its MA patients to win higher-than-deserved capitation payments.[2030] Other MA sponsors were expected to face similar obligations.

In May 2026, Elevance repaid $342 million to help settle allegations it over-charged Medicare over a number of years. CMS helped to persuade Elevance to make this concession by threatening to halt new enrolments in its MA plans. In 2020, the DoJ joined a False Claims Act suit against Elevance (then called Anthem). Elevance had estimated its potential exposure at over $900 million.[2031]

It remains to be seen whether this is an isolated victory or a start of strong and sustained efforts to fight over-billing.

If something can't go on forever, it will stop. Undeserved payments to MA plans elicited a response. Near the end of that month, Medicare announced its intention to raise MA payments by only 0.09 percent for 2027.[2032] This shocked MA plans—and their stockholders. MA plans lost about $96 billion in market capitalization the next day.[2033] MA plans do have a history of fighting off federal attempts to rein in their payments. They might win a raise for 2027 higher than the one Medicare announced. MA plans have in the past successfully mobilized members to urge Congress to enhance payments.[2034] Alternatively, this near-freeze might constitute

another early warning of an approaching federal freeze of health care revenue, one paralleling the July 2025 budget law's massive roll-back of federal Medicaid spending.

This problem is discussed in some detail in part 14 of this section.

Telemedicine

Evil-doers fraudulently billed for telemedical services on a large scale even before payers allowed expanded use of virtual visits during and after Covid. In 2019. The owner of several telemed companies that stole $424 million pled guilty to charges of conspiracy to defraud the United States, receiving kickbacks, and money laundering.[2035]

Medicaid managed care

Hoping to save money, improve access, and integrate care for patients, most state governments have contracted out high shares of their Medicaid patients to profit-making companies. In 2010, fewer than one-half of Medicaid patients were enrolled in full-risk managed care plans. In 2023, that share rose to nearly three-quarters. In 2010, less than one-quarter of Medicaid dollars went to full-risk managed care plans. That share rose to almost three-fifths in 2023.[2036] In dollars, 2023 payments to full-risk Medicaid managed care plans totaled some $560 billion. Equity, effectiveness, and efficiency of this spending is hard to evaluate; so is patient access to appropriate care.

A sign of this appears in the 2026 report to Congress from the Medicaid and CHIP Payment and Access Commission. The report devoted an entire chapter to compiling and reporting evidence on managed care plans' compliance with federal and state laws and regulations, accountability actions, and sanctions. The Commission appears concerned about state oversight of Medicaid managed care plans. The Commission recommended: [2037]

> The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to plan noncompliance, in the sanction section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii). 3.2
>
> The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to develop a publicly available database on managed care plan performance that links federally mandated reported data together to facilitate analysis. CMS should also issue guidance and toolkits to help states effectively use these data to assess past performance, improve beneficiary experience, and oversee managed care plans.

There is reason for concern.

WellCare. In the years after 2002, Wellcare in Florida inflated medical spending and falsified data on patients' medical problems.[2038] Wellcare paid a total of $217 million to avoid some legal charges and repay undeserved revenue. Gentry and Wells report that the company actually stole between $400 and $600 million in several states.

Worse, the company disenrolled hundreds of sick newborns and terminally ill patients from its prepaid managed care programs to avoid paying for their care.[2039]

Four executives were found guilty of fraud and some spent time in jail. They were later pardoned by Trump, who decried the convictions as "over-criminalization" despite clear findings of criminal behavior by the trial court and a federal appeals court panel.[2040]

Soros was the main early investor in WellCare, once holding 70 percent of WellCare's stock. He sold it before the frauds became public but earned $870 million on an investment of $220 million. A former Medicaid official sat on WellCare's board and earned almost $2 million on stock shares and options. About a year before the indictments of WellCare executives, he said "'You only do well in health care if you deliver value". [2041]

California. Medicaid managed care plans have a decades-long history of making money by giving less care. In 1971, California Gov. Reagan sought to cap the state's financial obligation to Medicaid. patients by began shifting large shares to capitated arrangements called prepaid health plans.

A stronger state statute followed but some officials in the state's own Department of Health Services and legislators developed ties to defective plans. A culture of theft had become institutionalized in many aspects of capitated health care.[2042]

Under Gov. Jerry Brown, a new regulatory apparatus was fashioned in 1975. The state actively promoted capitated care for privately insured patients as well as those covered by Medicaid.

That year, a U.S. Senate committee report reviewed 54 California Medicaid managed care plans and concluded that almost all were fraudulent non-profit shell companies that contracted with for-profits that were controlled by the non-profits' officers and directors. The for-profit entities were typically under-staffed and failed to deliver much-needed care. Some employed highly deceptive and coercive door-to-door marketing techniques.

In the HMO Amendments of 1976, Congress regularized and regulated Medicaid payment to HMOs bearing financial risk.[2043] Under the 50/50 rule, these HMOs' Medicaid plus Medicare shares of patients was capped at 50 percent. Plans, then, had to be attractive enough to enroll at least one-half of their members from private insurance plans. Congress also required the plans to meet all federal HMO requirements.

In the Omnibus Budget Reconciliation Act of 1981, Reagan persuaded Congress to modify the 50/50 rule to 75/25. And Medicaid managed care plans no longer needed to adhere to the requirements of federally-qualified HMOs. Worse, the secretary of HHS was allowed to waive the Medicaid statute's requirement that beneficiaries enjoy freedom of choice of caregiver. This has allowed states to force Medicaid patients into HMOs or other MCOs[2044].

In 1995, Clinton vetoed a bill that would have eliminated any requirement for a minimum HMO share of privately-insured patients. But in 1997, he acceded to a repeal of the requirement subject to theoretical beneficiary protections. One was network adequacy standards and the other was external quality review. In practice, these have proven to have very limited value. Perhaps none at all.

Current Medicaid managed care plans inherently ration care for low-income Americans. The managed care seduction – that "pay for volume" and disorganization are the problem, so capitating organizations and calling them accountable for delivering care and paying for it comprise the remedy.

This problem has afflicted Medicare Advantage plans also. Many Medicare Advantage plans constructed narrow networks of doctors and hospitals. Jaffe has reported that despite frequent patient complaints about inadequate MA networks, CMS has done little to require plans to improve.[2045]

New York. It is worth recalling that Medicaid programs suffered theft before managed care surfaced as a proposed remedy to control cost and integrate care. A 2005 report claimed that "New York Medicaid fraud may reach into billions."[2046] One apparent reason was that a tripling in spending was enabled in part by a 50 percent cut in the state's fraud investigators.[2047] At the same time the GAO criticized CMS's own commitment to help states fight theft.[2048] That fraud was widely disseminated across hospitals, doctors, dentists, and other caregivers. In 2009, New York City and State paid $540 million to settle federal charges of false billing.[2049]

Subsidized ACA plans

A peculiar aspect of the ACA's many subsidized plans is their complexity. The 4 metal tiers are one dimension of complexity. A second is that plans can differ in their benefits, premiums, and required OOPs. This complexity helped engender widespread use of brokers to help Americans find a plan. Brokers have been convicted of taking bribes to steer profitable patients to certain insurers.

One extreme form has been marketing companies that bribed brokers to enroll street homeless, mentally ill, and other people not eligible for ACA subsidies by deliberately claiming that their incomes exceeded 150 percent of the federal poverty level. In November, 2025, a Florida federal jury convicted heads of a marketing company and a brokerage of employing these practices to steal at least $180 million in fraudulently paid public subsidies.[2050] Americans who were legitimately eligible for ACA coverage increasingly complained that brokers enrolled them in plans without authorization or switched their plans without permission, a GAO study found. Complaints rose from 67,000 in 2023 to 300,000 in 2025.

Pathetically, CMS was considering tinkering with special passcodes and other gimmicks to try to prevent corrupt broker behavior.[2051] Such efforts closely parallel attempts by aeronautical engineers to improve the aerodynamics of a brick.

The ACA's complex design invited theft. Too many parties were invited to dip their beaks. As mentioned in chapter 1, Dorn and Jost explained that one-half of Americans whose premiums were subsidized by the ACA were in bronze and silver plans with very high deductibles. They claimed that insurance companies under-priced silver plans because they were highly profitable—even after Trump ended special federal payments to finance cost-sharing reductions for low-income silver plan enrollees.

Low-income patients have been acutely sensitive to premium differentials when choosing ACA plans. They appear to have been less likely to factor in the high OOPs associated with low premiums when choosing an ACA plan. But the high OOPs end up deterring low-income

enrollees from using much health care—which helps make those silver plans so profitable to the companies.

Dorn and Jost further asserted that insurers illegally set premiums to reflect risk. They contrast this with the experience in Texas and New Mexico, where state law requires ACA insurers to actually follow federal law and rely on a single risk pool. In New Mexico, the result was that the share of enrollees in high-destructible bronze or silver plans fell from 49 to 23 percent in one year.[2052]

This speaks to the difficulty of relying on traditional insurance in health care to fill gaps in coverage. The difficulty stems in part from the complications in setting premiums. And in part from insurance companies' willingness and ability to game—and even violate—federal law to make money for themselves.

Dialysis theft

In July of 2024, DaVita agreed to pay $34 million to settle False Claims allegations that it paid nephrologists and a related pharmacy company for referrals for dialysis services.[2053] This is the most recent case of theft from Medicare's End Stage Renal Disease, enacted in 1972.

In 2015, DaVita paid $450 million to settle a False Claims Act suit. Its conduct included coaching witnesses to present erroneous testimony and allowing false expert testimony to stand unrepudiated for a year.[2054]

In 2016, a fight arose between a big insurance company and a smaller dialysis chain. United Health Care sued American Renal Associates, asserting that it illegally pushed kidney patients out of Medicare and into United Health's private plans. The latter paid much higher prices for dialysis--$4,000 per session versus Medicare's $200.[2055] Interestingly, United did not take on either DaVita or Fresenius, the much bigger chains. Later in 2016, CMS issued an interim final rule intended to make it harder to steer Medicare-eligible kidney patients to either private insurance or subsidized ACA Marketplace plans.[2056]

In 2019, a whistleblower sued one of the nation's largest kidney charities, American Kidney Fund, claiming it illegally steered patients to DaVita and Fresenius, another large dialysis chain, while dodging smaller dialysis facilities. The two chains were major donors to the charity, which bought health insurance for patients needing dialysis.[2057] In 2022, AKF published a 30-page guide to its financial benefits. It included statements denying that AKF advises patients on plan selection or that it steers patients to insurance plans.[2058]

The crossroads between dialysis and pharma is a fertile site for theft. Dialysis centers have been sued for milking underserved money to pay for prescription drugs associated with kidney care. A nurse and doctor whistle blower team claimed in 2011 that DaVita had, in the past, deliberately used large vials of meds, throwing out some of their contents, and billing Medicare for the full quantity.[2059]

That year, Medicare bundled most meds into a total payment per dialysis treatment, removing the financial incentive to waste meds. This change addressed on source of concern. Bill Peckham, a patient advocate said, "'We should worry now about under use' of drugs 'because the incentives have flipped 180 degrees."[2060] [2061]

This problem plagues policies purporting to cut waste by bundling or by solely addressing payment methods and financial incentives—while ignoring factors like ownership, management, motivation, values, roles of physicians, and other institutional factors. Throughout, the core questions are: What happens to money saved by the new payment method? Does it go to companies' bottom lines or is it available to improve access, quality, or caregiver configuration?

Separately, DaVita settled for $55 million a FCA suit asserting the company used financially rewarding but clinically dangerous quantities of Epogen to combat what was believed to be dialysis patients' anemia.[2062] [2063] This broad and deep theft was discussed earlier under the heading of pharma fraud.

8. Kickbacks

A nationwide scheme of kickbacks involving orthopedic surgeons operated for 15 years. The investigation, called Operation Spinal Cap, identified more than $950 million in fraud—a figure that could rise to $2 billion.[2064]

Wheeling Hospital illegally paid huge sums to specialist physicians if they admitted more patients and thereby generated added revenue for the hospital. In the 7 years before this practice began, the hospital lost $55 million. It garnered a total surplus of $90 million in the subsequent 5 years. Quality of care was low, earning the hospital only one star from Medicare.[2065]

In December 2023, an Indiana hospital system agreed to pay $345 million for violating the False Claims Act and the Stark anti-kickback law. Those violations entailed paying doctors for referrals.[2066]

The University of Pittsburgh Medical Center agreed in May 2024 to pay $38 million to settle a 12-year-old whistleblower suit under the False Claims Act. The suit alleged that some surgeons did unnecessary or excessively complex operations. Surgeons were allegedly paid kickbacks in proportion to number of procedures performed.[2067]

In the same month, Cape Cod Hospital in Massachusetts agreed to pay $24 million for 7 years of failure to follow Medicare's required procedures for diagnosing certain cardiac problems.[2068]

Illinois and other states saw organized and widely disseminated falsification of MRI leases that were designed to disguise kickbacks to doctors in exchange for referrals.[2069]

Late in 2010, the proposed sale of the non-profit Detroit Medical Center to Vanguard was almost derailed when DMC's massive exposure to illegal financial relations with over 250 doctors over 6 years was revealed. Those included subsidized rents, free advertising, sports tickets, and free seminars. DMC could not have paid the resulting fines and would probably have been forced to close. That would have left the city with only 2 hospitals, Henry Ford in the center and St. John's on the eastern edge. Federal prosecutors therefore agreed to cap fines at $30 million, allowing the hospitals to survive that crisis and the sale to proceed.[2070] [2071] Remarkably, the

practice of illegally enticing doctors to admit patients to DMC hospitals persisted under new ownership between 2014 and 2017, resulting in another $30 million settlement in 2023.[2072]

Threats to the FCA

The federal False Claims Act was passed during the Civil War to combat crooks selling defective rifles or wagons to the Union Army. Private parties with inside knowledge of theft could sue to recover stolen money on behalf of the federal government. Insiders are best placed to spot theft. These whistleblowers can be paid some 15-30 percent of sums recovered.

The U.S. Department of Justice may intervene in suits initiated by private parties. But it often lacks the prosecutorial time to investigate and file. Some parties may prefer this so they can hide their bad behavior. (Similarly, parties that cheat on their taxes oppose adequate financing for the IRS.) But more adequate funding for the DOJ to intervene in FCA litigation would pre-empt challenges legal challenges to the FCA.

Howard suggests that this is becoming increasingly important because defendants sometimes claim that the FCA is unconstitutional.[2073] They allege that private parties can't sue on behalf of the federal government. These assertions crudely parallel claims in the Braidwood case against the U.S. Preventive Services Task Force. Although the Supreme Court ruled that the USPSTF was legally constituted, it may come to view the FCA's whistleblowers differently.

9. Broken Brokers

Broker malfeasance has been a chronic problem in ACA plans and also in MA. Early in 2026, a Florida insurance broker was sentenced to some 3 years in jail for fraudulently enrolling low-income people in an ACA subsidized insurance plans. (He faced decades in jail but chose to testify against co-conspirators and was rewarded with a much lighter sentence.) His company, Fiorella Insurance Agency, paid clients of homeless shelters or addiction clinics and people sitting at bus stops as little as $5 to enroll in ACA plans. These individuals were actually eligible for Medicaid and could never afford the substantial OOPs associated with ACA plans for which they were enrolled. This theft cost federal taxpayers some $133 million in subsidies and deprived the enrollees of free Medicaid care for which they were eligible.[2074] The broker and his fellow-thieves were paid commissions by the insurer backing the ACA plan for which these individuals were signed up.[2075]

Biden's 2024 ceilings on fees for MA brokers were largely nullified by a Texas federal judge.[2076]

In September of 2024, Oak Street Health, a primary care subsidiary of CVS, agreed to pay $60 million to settle allegations it paid kickbacks to insurance agents who arranged for patients to seek care from Oak Street doctors.[2077]

In August of 2025, two large marketing companies settled FTC complaints by agreeing to pay $145 million in penalties. The two had been deceptively selling short-term or limited benefit insurance policies.[2078]

Casalino and colleagues analyzed brokers' heavy financial commissions that reward them for steering patients to MA plans.[2079]

Meyers and others found that the share of MA enrollee renewals relying on brokers rose from 40 percent in 2014 to 70 percent in 2022.[2080] Reported payments were equal to 3 percent of MA spending. Additional secret payments were not reported.

Commenting on this finding, Casalino remarked that choices between MA and traditional Medicare can be consequential, as can the choice among MA plans. He therefore identified 4 ways to reform brokering, not abolish it. One was to make brokers financially indifferent to recommending MA versus traditional Medicare with Part D and medi-gap coverage. A second was to appeal the Texas decision that threw out Biden's ceilings on brokers' fees, or to pass strong legislation capping fees. Third, oblige brokers to explain to clients the incentives facing brokers. Four, increase federal financing of state health insurance assistance plans that counsel Medicare patients.[2081]

While Casalino's recommendations respect today's political realities and are both well-informed and well-intentioned, they would be difficult to enact, hard to enforce, and unlikely to clean up brokers' acts.

A better option would be to create one Medicare plan with one set of strong benefits, nullifying need for brokering. Choice confuses patients; choices can be consequential today; and too many brokers exploit that confusion.

Patil and colleagues describe a June 2025 DoJ complaint that MA "plans paid agents and brokers illegal kickbacks to drive… MA enrollment and discriminated against Medicare beneficiaries with disabilities."[2082]

The lesson here is establishing complicated arrangements that purport to make for greater choice end up as complicated opportunities for exploitation by badly-motivated Americans. It is easy to make clean, clear responses to the problem of plans bribing brokers or of brokers extorting fees from plans. One response is to standardize one plan that covers care that works for people who need it. The second response is to ban for-profit health insurance companies on the ground that no competitive free market legitimates profit-making.

Instead, we see bad, complicated programs engendering opportunities for corruption, which prompts regulation, which is enmeshed in the courts for years. Governments set themselves up for exhausting dissipation of purpose and energy, and for public perception of incompetence.

10. Tunneling profits to related companies

As early as 1983, the GAO analyzed hospital efforts to inflate their costs by doing collusive (non-arms-length) business with companies with which they shared ownership or other connections.[2083]

After the ACA set minimum care shares of 80 percent for employer groups with fewer than 100 workers and 85 percent for others—the shares of premium income that must be paid for medical care (not administration, marketing, or profit), it became clear that some payers could artificially elevate their care shares by paying high prices to captive companies for clinical services like traveling nurses or for meds, food, and the like.

As discussed under the heading of long-term care theft, some nursing home chains disguise profits by similar tunneling. Gandhi and Olenski estimated that, 63% of nursing home profits were hidden and tunneled to related parties through inflated transfer prices." [2084]

Similarly, Setser described ways in which drug makers dodge paying their fair shares of U.S. corporate income taxes. The drug makers garner disproportionate shares of their worldwide revenue by charging high prices in the U.S. Insultingly, they manage to pay very low U.S. corporate income taxes on the high U.S. profits resulting from those high U.S. prices by paying contrived fees to foreign subsidiaries endowed by those drug makers with ownership of patent and other rights. [2085]

Evading ACA rules. Another toxic practice parallels tunneling of profits. The ACA requires payers to devote 85 percent or more of premium revenue to care for groups of 100 or more workers. When payers like insurance companies have subsidiaries that own doctors or hospitals or hospices or other caregivers, the payers can evade this ACA requirement by boosting prices paid to those subsidiaries. [2086]

11. Stealing from employees

For 6 years, 5 Montana hospitals paid insurance companies $26 million in inflated premiums for their own workers' health insurance coverage. A substantial share of the extra payments was kicked back to the hospitals. [2087]

Tenet violated California law by lowering workers' hourly wages to dodge paying appropriately for over-time. Tenet agreed to pay $85 million to make employees whole. [2088]

Seattle's Providence Hospital has agreed to pay $200 million to 33,000 hourly workers harmed by illegal time-keeping practices over 5 years. [2089]

12. Organized and prolonged thefts by hospitals, doctors, others

U.S. hospitals have upcoded patients into higher-paying diagnoses, harvesting $14.6 billion in extra payments in 2019. [2090] That's in comparison to the coding practices prevailing in 2011. This upcoding looks like theft.

Hospitals would defend the legality of this practice. They'd call it something like more intense efforts to obtain revenue they need and deserve, revenue they had failed in the past to harvest owing to inability or unwillingness to bill for all they were due. This parallels MA plans defense of their own efforts to harvest diagnoses to make their enrollees look sicker and more needy—warranting higher capitation revenue—even though costs of care don't rise.

The Department of Justice indicted 35 people in 2019 for billing Medicare for $2.1 billion in unneeded genetic tests to screen for cancers. Recruiters frightened or persuaded elders to agree to be tested and bribed cooperating doctors to order the tests. [2091] [2092]

Empower HMS purchased over a dozen rural hospitals, promising to save them. But it generated hundreds of millions of dollars in extraordinarily high volumes of laboratory bills to

Medicare, Medicaid, and health insurance companies. (The added lab work was referred from other sites to exploit higher authorized payments at rural hospitals.) This money was siphoned through the hospitals to owners and agents of Empower. The hospitals themselves were left unable to pay for supplies or local property taxes. At least 8 hospitals were closed and others were bankrupted.[2093] Empower's head and nine others were indicted in 2020 for stealing $1.4 billion.[2094] Convictions followed in 2022.[2095]

Starting in 1981, the "rolling lab scheme" in California enlisted some 200 doctors in fraudulently billing up to $1 billion for unnecessary lab and other tests. A 6-year investigation yielded a dozen indictments but no financial recoveries.[2096]

New Jersey's St. Barnabas system agreed in 2006 to pay $265 million to end prosecution for theft of at least $630 million over 8 years by manipulating Medicare's outlier payment provisions.[2097] [2098]

Medicare and Congress have for decades warred with hospitals about upcoding or "DRG creep."[2099]

Medicare has also for decades fought to cut corrupt but profitable prescribing of durable medical equipment when it is not needed. A $1.2 billion long-running fraud was identified in 2019.[2100] In 2023, investigations in two states resulted in charging 11 doctors and others for stealing $2 billion by prescribing medically unnecessary braces and other items.[2101]

Pear reported on multi-state, multi-year raids on Medicare and Medicaid by organized criminal groups. Some 160 sham companies were identified in only 4 states. Physician clinics, labs, and durable medical equipment suppliers were all involved. Plundered money was sometimes laundered internationally.[2102]

Dorschner noted $122 million in illegal payments for artificial legs or arms—21,000 in 1 Florida county during only 4 months—and hundreds of millions of dollars for motorized wheelchairs in Texas.[2103]

One systemic cause of inappropriate bills was that crooks found it easy to obtain Medicare provider numbers to sell durable medical equipment.[2104] [2105]

The DHHS Inspector General's office found that Medicare over-paid chiropractors by $285 million in one year, and that fully two-thirds of all payments were questionable.[2106]

Elkind reported on illegal and abusive practices by Lincare, the main distributor of oxygen equipment. The company's bad acts included billing Medicare for ventilators it knew were not being used (2024), overcharging both patients and Medicare (2023), giving kickbacks (2018), charging Medicare for services to patients who had become late (2017), bribes for referrals (2006), falsifying claims of patient need for oxygen (2001). Medicare refused to enforce its own rules against recidivism by caregivers already on probation.[2107]

13. Organized and prolonged thefts by insurers and HMOs

Centene of St. Louis garnered $154 billion in revenue in CY 2023. One-half of its patients were enrolled in Medicaid.[2108] In 2023, it paid $281 million to settle allegations of over-billing 2 states'

Medicaid agencies for meds. It paid $308 million to 7 states in 2022. In 2021, Centene set aside $1.25 billion in reserves to pay back money it did not deserve to retain.[2109]

In the years after 2002, Wellcare in Florida inflated medical spending and falsified data on patients' medical problems.[2110] Wellcare paid a total of $217 million to avoid some charges as repay undeserved revenue. Four executives were found guilty of fraud and some spent time in jail. They were later pardoned by Trump, who decried the convictions as "over-criminalization" despite clear findings of criminal behavior by the trial court and a federal appeals court panel.[2111]

A Long Beach, California health plan paid $320 million to settle a quarter-century of fraudulent bills to the state's Medi-Cal program.[2112]

Multiple Employer Welfare Arrangements make it cheaper for smaller employers to buy health insurance. Many violated state laws that require MEWAs to maintain reserves adequate to pay claims. Two defaulted on $44 million in claims. These MEWAs and others were systematically drained by operators who bought homes, cars, jewelry, and other items. Other MEWAs promised deceptively low premiums—too low to pay claims.[2113] [2114]

14. Possibly legal gaming to grab undeserved revenue or profit

Medicare Advantage

A series of laws boosted enrollment—and spending—in capitated Medicare plans. Ostensibly aiming to save money, most of the laws increased spending. A half-century of accumulating failure testifies to a triumph of hope (or, worse, greed or ideology or stupidity) over experience and evidence. The program's various names—Medicare+Choice, Medicare managed care, Medicare Part C, and Medicare Advantage—resemble a series of aliases adopted by someone anxious to conceal their past.

Adrion has prepared a detailed and concise summary of the history of MA plans.[2115] The chronology that follows rests heavily on her valuable work.

The Social Security Amendments of 1972 authorized Medicare to make capitated payments to HMOs and other private managed care plans to cover costs of services under Medicare's parts A and B. At that time, most managed care plans were operated not-for-profit.

The 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) formalized capitation payments for Medicare patients. The aim was to save money, improve care, and increase citizen choice. Capitation payments were to be set 5 percent below traditional Medicare costs for comparable citizens. But, from the beginning, weak risk adjustment methods and entry of healthier people into the capitated plans hiked cost person to a level 5.7 percent higher than for traditional Medicare.

Enrollments in capitated plans grew from 3.5 percent of Medicare patients in 1990 to 13.5 percent in 1997. One reason was that higher-than-planned revenues allowed them to add modest but appealing benefits for eye care and hearing care or meds—and even health club memberships. This made them attractive to younger and healthier Medicare enrollees. These citizens were less likely to be deterred by the plans' narrow networks of doctors and hospitals

since they did not yet use much medical care and would not, therefore, face financial pressure to cut long-established ties with caregivers. By contrast, older and sicker Medicare enrollees were more likely to have come to rely on networks of doctors and other caregivers—with whom they were loath to cut ties.

The 1997 Balanced Budget Act substantially slowed yearly increases in capitation payments to the plans it renamed Medicare Advantage. The share of Medicare enrollees in MA plans rose to 18 percent in 1999 but fell back to 13 percent in 2003 as the slower increases took effect, resulting in fewer extra benefits to MA members.

MA plans fought back with claims they'd lose even more members if they could not provide extra benefits. Essentially, they argued that MA was inherently preferable to traditional Medicare so anything that deterred citizens from enrolling or that reduced the numbers of plans from which to choose was bad. MA was re-styled as *valuable in itself*, not as a means to containing cost of Medicare or improving its quality. This notion seems too silly to permit rational acceptance. But insurers' lobbying, campaign contributions, organized complaints from MA members angered by loss of extra benefits, and a belief that ostensibly competing MA plans had to be superior to government-run traditional Medicare helped persuade Congress to restore some of BBA's cuts in capitation payments.

Bush II included big boosts in MA payments in the 2003 Medicare Modernization Act. These provisions were attached to the bill whose highly visible purpose was to create the Medicare Part D prescription drug benefit. Bush hailed MA privatization, choice, and expanded benefits. Not cost containment or fair payment. Many more MA plans could afford to offer extra benefits. MA profits rose. Medicare paid. And those health care reformers still captivated by managed care and HMOs—or notional competition—went along.

The MMA's substantial increase in Medicare's subsidies and resulting extra benefits boosted MA's share of Medicare patients to one-quarter in 2010, one-third in 2017, and one-half in 2024.

The rising cost of those subsidies alarmed Congress. In 2008, in the midst of the financial crisis, it over-rode Bush's veto of a bill seeking to trim Medicare Advantage subsidies. The 2010 ACA did include a return to the 1982 provision that MA plans would be paid at 95 percent of traditional Medicare's cost of care. But it also added quality related bonuses, discussed shortly.

Insurance companies were desperate to keep the high subsidies that contributed heavily to their profit—some garnered one-quarter of their profits from MA and one as much as two-thirds of profits. So they lobbied aggressively to persuade Democratic and Republican legislators to successfully fight to overthrow the ACA's roll-back of Medicare subsidies to MA plans. Boosts in payment rates repeatedly replaced scheduled cuts in subsidies.[2116] [2117]

MA's risk adjustments and upcoding cost Medicare "up to $12 billion" yearly by one conservative estimate.[2118] MedPAC's own March 2025 report put overpayments at about 20 percent of MA income, or $84 billion for 2025.[2119] [2120]

Overpayments were defined as payments in excess of the sums MA enrollees would have cost Medicare, had they been enrolled in traditional Medicare.

Favorable selection—enrolling less costly-to-serve patients—accounted for about $44 billion of the excess.

Coding intensity accounted for about $40 billion of the excess. Coding varied greatly across plans. Some were conservative and honest while others were very aggressive.

In 2026, the Massachusetts attorney-general sued United Health Care for upcoding Medicaid patients enrolled in the state's Senior Care Options program.[2121] This behavior paralleled repeatedly alleged upcoding of MA patients across the nation.

Additionally, MA plans would be paid some $15 billion in quality bonuses in 2025 and $13 billion in 2026.[2122] Yet MedPAC reported that patients viewed the quality of MA and traditional Medicare as similar. Including the bonuses in the excess payment raises it to $99 billion in 2025.

In January of 2026, the non-profit Kaiser Permanente group agreed to repay $556 million to settle False Claims Act suits that it had illegally upcoded its MA patients to win higher-than-deserved capitation payments.[2123] This settlement undermined MA plans' claims that they had long been behaving legally in harvesting member diagnoses that did not correspond to provision of needed care. Other MA sponsors were expected to face similar obligations.

MA plans' high profits and extra benefits were financed by extra subsidies from Medicare. The extra benefits enticed more Medicare patients to enroll. Enrollees could be persuaded to lobby Congress to keep the extra money flowing.

Insurance company propaganda decried any cut in MA plan payments—including any effort to combat MA plans' manipulation of risk adjustment—as a threat to those extra benefits. Threats to profits were not highlighted. The original promise that Medicare+Choice, Part C, or MA would contain costs gradually evaporated. Choice, privatization, and competition supplanted cost control. This is taken up briefly in chapter 5 on government failure and is one of the substantial causes of high costs addressed in chapter 8.

Maremont and Weaver point to billions of dollars in yearly Veterans Administration over-payments to MA plans for coverage that is under-used because it heavily duplicates coverage and care that veterans already receive through the VA.[2124]

Illegal marketing, over-billing, and fraud associated with MA plans were discussed earlier. The mechanisms by which legal but excessive payments and subsidies to MA plans are now addressed. Some are retail. Brokers' bad behavior is one example. But the more consequential are unwarranted wholesale subsidies.

MA plans paid high $500 per patient commissions to insurance agents in 2008 (about $725 in 2023 dollars) to enroll Americans in those plans.[2125] Those inducements could easily lead to violations of citizen autonomy and freedom to choose traditional Medicare or a particular MA plan. Cunningham-Cook describes aggressive marketing of MA plans and the Biden administrations' refusal to rein them in.[2126]

A different and even more clear violation of citizen autonomy was created by the Balanced Budget Act of 1997. It allows insurance companies to automatically enroll people in MA plans if they had previously covered them through group insurance sponsored by employers or ACA plans. Insurers must write to people affected, giving them 60 days to opt out. But a number of people don't see or act on such letters.

Consequently, citizens may be placed in narrow networks that don't include doctors or hospitals or pharmacies on which they depend. This can leave them exposed to high surprise bills. Medicare must give the insurance company approval for this "seamless conversion," but that does little to help people harmed by it.[2127]

Instead, the Medicare Rights Center and other advocacy groups proposed that citizens opt in to MA when offered enrollment in MA plans instead of opting out. Neither Obama nor subsequent administrations acceded to this proposal.[2128]

Similarly, Appleby describes behavior of "rogue" insurance brokers who illegally made money by signing up citizens for ACA plans or by switching their plans. She perceives a tension between curbing those behaviors and sustaining ACA enrollments.[2129]

But this tension may be only partly real. ACA enrollments rose mainly because the 2021 Inflation Reduction Act strongly boosted federal subsidies, not because of newly aggressive efforts by brokers to sign up Americans.

One response would be to jail a few brokers who break laws. This would change the reward/risk ratios of any others inclined to abuse citizens seeking health insurance coverage.

Other responses would be to simplify ACA choices and also end competition among for-profit ACA plans. Opportunities for bad broker behavior originate with insurers that offer financial enticements. Multiple competing ACA plans mean unnecessary marketing costs. Competing plans create narrow networks of caregivers that fragment medical services and lead to discontinuities of care when patients switch plans.

One attractive alternative would be to allow no more than 3 competing ACA plans in each region. Each would offer the same benefits for the same premium, and each would enroll all eligible caregivers—with only low-quality doctors or hospitals excluded.

Cleaning up illegitimate broker behavior, marketing, and advertising would particularly help low-income elderly Americans, who say more frequently that they have been objects of fraudulent marketing.[2130] In mid-2025, the FTC settled with 2 health insurance brokers, Assurance IQ and MediaAlpha. They agreed to pay $145 million in penalties for misleading patients.[2131]

The complexity of choosing a plan led many Americans to rely on brokers to choose plans—something unnecessary in the world's other rich democracies. Worse, some brokers accepted bribes from insurers to steer patients, and other brokers even enrolled people not eligible for subsidized coverage in exchange for corrupt payments from insurers or their agents. The job of choosing a plan has remained daunting.[2132]

A June 2026 report from Nelson and colleagues at DHHS's planning office concluded that Trump policies cut 2.9 million ACA enrollees "who had previously been improperly receiving subsidies they did not quality for." They believed that an added 2.6 million enrollees remained covered improperly—including 1 million lacking Social Security numbers.[2133]

Separate from problems of bribery and illegal enrollments, reliance on brokers to choose among health plans is expensive.

Meyers and colleagues calculated the cost of payments to brokers for MA plans at $10.1 billion for 2022, up 159 percent from $3.9 billion in 2014.[2134] That's an average compound rate of rise

of some 13 percent yearly. Extrapolating that to 2026 would make for broker payments of $17 billion in 2026.

This accords with estimates from Congress's Joint Economic Committee, which reported in June of 2026 that payments to MA plan brokers accounted for most of the $25 billion then spent yearly on MA, ACA, and Part D plans.[2135] This problem is compounded by broker steering of Medicare patients to MA plans with higher over-payments owing to coding intensity.

Medicare Advantage plans have for decades—persistently and increasingly—grabbed undeserved higher payments by making their members look like they should need more care than they actually do need or do obtain.[2136] [2137] [2138] [2139]

CMS modified its risk adjustment formula to try to make it more accurate, but over-payments to MA plans may have risen owing to more successful gaming. Brown and colleagues found that MA over-pays for MA's healthier enrollees.[2140] Geruso and Layton found further evidence of up-coding.[2141]

Schulte and Hacker reported in 2022 that Kaiser Health News required three years of litigation to obtain summaries of 90 CMS audits of MA plans for 2011 through 2013. CMS had not yet sought to recoup extra payments identified in those audits, and had not even conducted any subsequent audits. They cite a former deputy director of the CMS Center for Program Integrity as saying "'I think CMS fell down on the job on this.'"[2142]

Abelson and Sanger-Katz reported that the Department of Justice considered MA fraud one of its top priorities but that CMS:

> has been less aggressive, even as the overpayments have been described in inspector general investigations, academic research, Government Accountability Office studies, MedPAC reports, and numerous news articles, over the course of four presidential administrations.[2143]

CMS has authority to cut payments to MA plans if they overbill but has never done so. Political popularity of higher MA benefits is one reason. A revolving door between regulators and insurers is another. Former CMS administrator Berwick said "'Even when they're playing the game legally, we are lining the pockets of very wealthy corporations that are not improving patient care.'"[2144]

A July 2023 review of evidence by the Committee for a Responsible Federal Budget concluded that the added costs of MA could range between $810 billion and $1.6 trillion ove the next decade.[2145] The MA plans claim they are simply and legally compiling evidence on patients' medical diagnoses, information that is used to risk-adjust payments to MA plans. But when the risk-adjustments enable the MA plans to game payment formulas to harvest revenue that isn't used to cover higher actual costs of care for the identified diagnoses, the activity reeks of inappropriate payment.

None of this is surprising. Study after study has found that MA does not save money. A quarter-century ago, the GAO found that MA boosted spending.[2146] The Medicare Modernization Act of 2003 hiked payments to MA plans. Biles and colleagues reported that extra spending on MA had passed $11 billion in 2009.[2147] The HHS Office of Inspector General

found in 2021 that MA plans improperly used chart reviews and health risk assessments to drive up their payments.[2148]

In 2026, a Congressional committee reported that MA plans' inappropriate efforts to make their members look more medically needy—and costly—caused most Medicare patients to pay higher Part B premiums—about 10 percent more than they otherwise would have paid each year.[2149]

Manipulation of risk adjustment is not the only path to undeserved enrichment. The ACA created a quality bonus program (QBP) for MA plans. This adds payments to plans but never subtracts. In 2022, the additional payments summed to $10 billion. It is likely that Medicare got little or nothing of value for this money. A substantial majority of MA plans earn the bonuses. Skopec and Berenson conclude that two-thirds of the weighting of the bonus payments reward beneficiary satisfaction and program administration, not clinical quality.[2150]

Fully 85 percent of MA enrollees are in plans earning bonuses. Indeed, many MA plans apparently work harder to earn the stars (in Medicare's 5-star ratings of plans) than they do to improve patient care. It is remarkable that Congress has long allowed the MA bonus money to be earned and spent with so little regard for actual quality of care. And in ways that invite gaming, manipulation, or corruption.

For example, MA plans boost their star ratings by combining contracts. But this does nothing to improve patient health. A dramatic instance of this practice is Wellcare's 2016 purchase of Universal American. This "drastically improves the quality of Wellcare's Medicare Advantage plans, which ultimately means more money." Some 70 percent of Universal American's MA enrollees were in bonus-earning plans with 4 or 5 stars, while Wellcare had no such plans.[2151] Although under new management when it bought Universal American, Wellcare—as discussed elsewhere—had previously been noted for a long history of corruption that included denial of needed care, possible insider trading, and cheating investors.

Consequently, MedPAC's June 2020 report to Congress urged eliminating the QBP and replacing it with a two-sided budget-neutral program that would equalize financial penalties and financial rewards.[2152]

Despite some shake-ups in scoring, MA quality bonus payment will approach $12 billion in 2024.[2153]

Group purchasing organizations

In Section 4 of Public Law 100-93, the Medicare and Medicaid Patient and Program Protection Act of 1987, Congress authorized hospital group purchasing organizations (GPOs) to legally receive payments from their suppliers—drug makers, medical hardware manufacturers, and the like. These payments, called "contract administration fees," would be capped at 3 percent of purchase prices. Notionally, those fees would cover the cost to the GPO of administering contracts.

Congress was led to hope that legalizing these fees—which would be illegal inducements or bribes absent PL 100-93—would help to give the GPOs greater leverage to win lower prices from companies supplying hospitals.

But a *New York Times* investigation in 2002 found that the tight financial relations between GPOs and vendors had the effect of stifling innovation by preventing hospitals from accessing new and valuable medical devices.[2154]

The source of that problem, reported the *Times,* is that the GPOs are beholden to the suppliers that finance them. The head of contracting at one hospital called this "'just like payola.'" In 2001, two GPOs, Premier and Novation, bought $34 billion in meds, supplies, and hardware. If suppliers paid the GPOs 3 percent of that sum, the GPOs would receive about $1 billion.

A preliminary GAO report found in 2002 that GPO price were often higher than those that hospitals negotiated directly with suppliers—sometimes one-quarter higher.[2155]

Sadly, some directors of GPOs were allowed to serve on the boards of suppliers and received stock options in those companies. This appears to be a clear conflict of interest. Some potential suppliers refused to work with GPOs because the latter sought financial favors in exchange for GPO promotion of their products.

After these press reports appeared and after the FTC, the CMS IG, and the GAO launched investigations, the Premier GPO promised to open up its contracting to more suppliers, stop investing in the very companies from which it bought, and cut payments from suppliers.[2156]

Unfortunately, two years later, the DoJ announced a "broad criminal investigation" into the practices of Novation, the largest GPO. Novation was alleged to have obtained payments from suppliers well in excess of the 3 percent safe harbor cap. A former Novation executive claimed that the GPO's relation with suppliers and hospitals resembles drug makers' payments to doctors to induce them to prescribe their meds.[2157]

The political influence of hospitals that suppose they benefit from GPOs, lack of substantial political support to tame GPOs, studies financed by GPOs that purport the organizations save huge sums,[2158] and Congress's and presidents' unwillingness to take on private parties have apparently allowed GPOs to continue legally to be paid to prefer some suppliers. It is likely that GPOs also continue to be unfriendly toward innovations that improve care or save money. Lastra illustrated that practice vividly.[2159]

15. Long-term care theft

Public dollars pay for a high share of long-term care services and supports. Medicaid alone finances a little over two-fifths of long-term care.[2160] Many nursing homes are owned and run by decent, honest, and competent people.

But care in many other nursing homes has long suffered from financial pillaging and neglect of patients. As discussed in chapter 13, the rapid expansion in nursing home capacity following passage of Medicaid, in part to accommodate the hundreds of thousands of elderly residents discharged from state mental hospitals, resulted in weak monitoring of nursing homes' quality and finances. Early cost-reimbursement of nursing homes by most state Medicaid programs invited thieves to sell nursing homes to one-another in non-arms-length transactions. These boosted the apparent costs of those homes, resulting in highly profitable over-payments for depreciation.

One owner of nursing homes and assisted living facilities was sentenced to 20 years in jail and fined $44 million for organizing a scheme of bribery, kickbacks, and money-laundering that stole $1.3 billion from Medicare and Medicaid over 18 years.[2161] Trump pardoned this criminal after serving 5 years in jail. Biden's Department of Justice sought to re-try him on those counts on which the jury had not reached a verdict.[2162]

Raghavan describes a practice of private loans to operators at 20 Wisconsin nursing homes that allowed them extract substantial sums from their properties until inability to repay the loans led to closure and unsafe rapid relocation of residents.[2163] The operators were charged with fraud for failing to maintain safe care that Medicare and Medicaid required, and with stealing from employees' paychecks, health insurance premiums, and retirement funds.[2164]

The federal government recovered $133 million paid for fraudulent rehabilitation services in four large nursing home chains. The rehab therapy company lied about the actual provision, duration, and need for care.[2165]

As noted earlier, the tunneling of nursing home profits to related parties evades corporate income taxes and also makes the homes look less profitable, which could boost political efforts to secure higher Medicaid and Medicare prices.

Medicaid sometimes pays for adult foster care in the belief that it is a lower-cost alternative to nursing home care. But cost comparisons are difficult because those served through adult foster care are generally less disabled—physically or cognitively—than nursing home residents.

In Massachusetts, a rapid rise in the number of newly-licensed foster caregivers was associated with much higher spending and also with questions about quality, program integrity, and fraud. The number of caregivers rose by one-third from 2023 to 2025.[2166]

Home health care has suffered similar problems. A Maryland company agreed to pay $150 million for home health billed to Medicaid and VA for work it did not perform over 11 years.[2167]

Owners of home health companies were convicted of $29 million in criminal Medicare fraud."[2168]

The nation's three largest home health care companies tailored the number of visits they required per-patient to maximize bonus payments from Medicare. The companies' visit patterns changed after Medicare altered its bonus payment formula.[2169]

After finding that a large number of licensed Medicare home health agencies and hospices shared one address, CMS acted in 2026 to suspend payments to 773 hospices and 23 home health agencies in Los Angeles County that were suspected of fraud. CMS promised to conduct site visits to hospices across the nation in an attempt to identify crooked operators. The agency declared a 6-month moratorium on new hospice and HHA registrations.[2170] Sadly, this looks more like a one-shot political performance than a serious, sustained commitment.

A good reason to think so is that chronic hospice and HHA fraud have persisted problems for decades. Much of the difficulty stemmed from Congress's decision in the 1980 Omnibus Reconciliation Act to permit for-profit HHAs to be paid by Medicare.[2171] For-profits are now almost 90 percent of HHAs. Home health care and also hospice are services delivered patient-by-patient in many individual settings, making fraud detection difficult.

A Texas doctor was charged with stealing $375 million from Medicare and Medicaid by billing for home health services that were either unnecessary or not delivered.[2172]

The owner of a Massachusetts home health company allegedly stole over $100 million from Medicare and Medicaid by offering bribes to obtain patient referrals, and by billing for services that were not provided.[2173]

Pennsylvania's Medicaid program pays for special transportation services that are designed to support efforts by disabled people to remain at home. But 4 companies billed Medicaid for $7.9 million for only 1,712 trips—or $4,614 per trip. At the authorized rate of $35 per trip, allowable cost was only $60,000. Executives were indicted.[2174]

The DHHS Office of Inspector General investigated Medicaid fraud by personal caregivers.[2175] Bailey has reported on the investigation's finding of widespread victimization of elderly Medicaid patients. Many suffered personal abuse, neglect, and fraud. These harms were sometimes fatal. Some of the victimizers were family members who were paid by Medicaid to care for disabled relatives. Since home care is given at so many different sites, it is hard to monitor what care is given or supervise workers.[2176]

Since 1985, Medicare has paid for hospice care for patients who are terminally ill. For many, the care is extremely valuable. But some patients do not receive needed services just when they may be most important. And others receive services they do not need.

Most hospice care is routine support designed to ease pain and make patients comfortable. Hospices are obligated to provide continuous 24-hour care during a patient's last days, times of great physical and emotional pain. But a number fail their legal and contractual duty to do so.[2177]

At the other extreme, some hospices systematically enroll patients who do not need their care. Their owners pocket considerable sums they do not deserve.[2178] [2179] This has become a greater problem over time as for-profit hospices grew from a small minority to about three-fourths of all hospices.[2180] Kofman described in detail the evolution of hospice from an idealistic non-profit reform to advance appropriate care for dying patients to a "for-profit hustle,"[2181] one increasingly dominated by large chains.

This appears to parallel the evolution of health maintenance organizations from non-profit reformers to aggressive profiteers.

A False Claims Act suit accused Texas hospices of enrolling patients who did not need care and then removing them when they came to require costly services.[2182] A similar suit decried a large multi-state hospice chain's practice of deliberately marketing to people too healthy to need its services.[2183]

In 2022, 13 defendants were sentenced to a total of 84 years in prison for stealing $27 million from Medicare's hospice program. A hospice paid for referrals and administrators decided which meds patients would receive under cover of orders illegally pre-signed by doctors.[2184]

A 2020 review of hospices by Christensen and Poston found that both theft and bad care were widespread.[2185]

The Trump administration's 2025 pause in hospice oversight was called a "reprieve" from a Biden program that sought to have corrupt hospices cleaned up. If they failed, they were to be expelled from Medicare participation.[2186] But in 2026, CMS Administrator Oz pledged to decertify hospices that over-bill dying Americans or that steal identities to enroll and bill for care of ghost patients.[2187]

Fraud in hospice care and in home and community-based services became politicized when Oz accused California state government, controlled by Democrats, of tolerating some $3.5 billion in fraud in Los Angeles County alone. The state's Democratic attorney-general complained that Republicans had weaponized fraud.[2188] Soon, he announced indictments against 21 individuals and claimed they had stolen identities from out-of-state Americans and fraudulently billed for $267 million in hospice services.[2189]

This evil multi-decade systematic pattern of abuse and neglect of dying patients, and of theft from Medicare, shows no sign of abating. The remedies that have been pursued have not been commensurate with the nature or severity of the causes of the pattern.

16. Theft by mental health caregivers

Exploitation of psychiatric patients by both Acadia Healthcare and one of its main competitors, UHS, has been a substantial problem. Silver-Greenberg and Thomas reported that on Acadia "lured patients into its facilities and held them against their will, even though detaining them was not medically necessary."[2190]

UHS paid $122 million in 2020 to settle False Claims Act suits alleging unnecessary behavioral health services and illegal kickbacks.[2191] UHS admitted no wrongdoing. Another probable instance of "fail to jail."

Cobb and Hotchkiss highlight the difference in jail time for Martha Stewart with the rarity of substantial—or any—jail time for most of those who steal from non-profit caregivers or who operate for-profit for-theft caregivers.[2192]

A number of individuals and state governments have accused many payers of listing caregivers as in-network when they are not. Other payers have simply been accused of failing to recruit enough caregivers to deliver promised benefits. This problems seems particularly acute in the mental health realm. Some payers have paid substantial fines and have promised to prepare accurate directories.[2193] [2194] [2195] [2196]

An analysis prepared by the DHHS Office of Inspector General found very widespread inaccuracies in directories of mental health caregivers. The OIG report noted that caregivers "cited administrative burden and low payment rates as factors affecting their willingness to work with managed care plans." But the report did not dig deeply into possible causes of payers' own systematic inaccuracies. So its three recommendations were to:[2197]

1. Use data to monitor provider networks and take additional steps to improve the accuracy of network directories in Medicare Advantage.
2. Work with states to improve the accuracy of network directories in Medicaid managed care.
3. Continue exploring how a nationwide directory could reduce inaccuracies and increase administrative efficiencies for providers and patients.

It is hard to imagine a more perfunctory, vacuous, and rhetorical set of responses to the human suffering created by insufficient caregiving capacity and chronically inflated and inaccurate directories.

Another bad behavior is heavy over-billing for services. An Indiana company providing autism therapy was declared ineligible for Medicaid payments after audits revealed it had been paid as much as $340,000 per patient.[2198] Private equity acquisitions of autism centers aggravated the problem of wrongful billing for care.[2199]

In 2026, Trump moved aggressively to publicize Medicaid fraud and, in states such as Minnesota and California, to delay payment of federal Medicaid matching funds.[2200] This may have been a well-intentioned effort to protect public dollars but it may also have been a political effort to discredit state governments dominated by Democrats. At the same time, though, the Massachusetts attorney-general sued United Health Care, alleging that it stole $100 million from the state's Medicaid program.[2201]

Since Medicaid finances about one-quarter of mental health and substance abuse care in the U.S.,[2202] and since diagnosis of need for mental health care is sometimes uncertain—as is efficacy of various remedies—financing for these services may be vulnerable to interruption while fraud claims are investigated. This parallels problems with Medicaid and Medicare payment for home health care and hospice care, discussed in the previous section.

17. Dental theft

Kelman and Werner reported on dental firms' promotion of extracting healthy teeth and replacing them with unneeded implants at great cost. Implants are sometimes performed wholesale and by dentists who have not received any special training. Private equity-owned chains are prominent in promoting substitution of implants. At some firms, patients meet with a salesperson and sign a financial agreement before meeting with a dentist.[2203]

18. Suppression and distortion of evidence

As discussed under the heading of clinical waste, many types of commonly-delivered medical care are unsupported by evidence or are supported only by weak evidence. That is understandable: many diseases afflict humans; causes of many are not well-understood; and many treatments have not yet been carefully evaluated.

But suppression of evidence or manipulation of research findings constitutes theft. Money is devoted to activities that are not as beneficial as promised, are not beneficial at all, or are actively dangerous.

A considerable literature documents payments to researchers from drug makers, medical device manufacturers, and others.[2204] [2205] [2206] [2207] [2208]

Drug research using actual clinical end-points that was financed by for-profits was twice as likely to report positive findings as was research financed by non-profits.[2209]

Zyprexa

By 2005, Zyprexa had become Lilly's best-selling drug worldwide. It generated sales of $4.2 billion to 2 million users. Unfortunately, the company hid evidence that Zyprexa caused many patients to suffer substantial weight gain or high blood sugar.[2210] [2211] Either raises risk of diabetes.

By 2007, Lilly had agreed to pay at least $1.2 billion to settle two large class-action suits by patients alleging harm.[2212] Two years later, it agreed to pay an added $1.4 billion in criminal and civil penalties for marketing Zyprexa for off-label uses. That marketing included efforts to promote the drug to primary care physicians—who would very rarely have reason to prescribe it for approved uses.[2213] Suppression of useful information and dissemination of harmful information hurt patients, wasted money, and allowed Lilly to illegally obtain revenue.

Vioxx

Merck touted its arthritis drug, Vioxx, as causing less stomach upset. A study published in the *New England Journal of* Medicine in 2000 [2214] was, for 4 years, influential in persuading doctors and patients that Vioxx was safe and effective. Some 20 million patients used it during those 4 years.

But the company suppressed and minimized evidence showing it caused patient to die from heart problems. In December of 2005, 5 years after the original study was published, 3 *New England Journal of Medicine* editors wrote an "Expression of Concern" that the authors of the original paper omitted data available to them on deaths from heart problems.[2215]

But Merck had stopped selling Vioxx in September of 2004.

So the expression of concern was published far too late to prevent harm from this drug.

Merck has paid some $4.85 billion to settle patient and survivor suits. It also paid $950 million to settle criminal charges brought by the Department of Justice. And another $830 million to settle a class action suit brought by investors. The total is $6.6 billion.

Merck had done more than omit data from the original published paper. It paid ghost writers to prepare dozens of journal articles touting Vioxx and paid actual researchers to publish them under their own names.[2216]

One sad aspect of the Vioxx catastrophe is the *New England Journal of Medicine*'s delay in following up on complaints about Vioxx. Armstrong describes several early warnings ignored by the *Journal*.[2217]

One was a 2001 plea from a pharmacist who had reviewed the same FDA data on added cardiac deaths from Vioxx on which the *Journal* editors later relied in their 2005 "Expression of Concern." She and a colleague wrote a letter to the *Journal* but it was not published. The *Journal*'s position has been that the authors of the original 2000 article were the ones who should correct it in light of new data.

A second was a report by Mukherjee and colleagues published in the *Journal of the American Medical Association* later in 2001. Those added data were available on the FDA web site before the original 2000 paper was published in the *New England Journal.*

Third, the *Journal* editors never challenged the original article's assertion that the lower heart deaths in the study's control group stemmed from a protective effect of the placebo drug given the control group. No evidence supporting that assertion was adduced.

Armstrong cites depositions and e-mails made public in the course of litigation on Vioxx to assert the *Journal's* editors' belated expressions of concern coincided with a crucial time in a court case and were designed to focus attention on Merck and away from the *Journal*'s own shortcomings in failing to challenge data and conclusions in the 2000 paper.

19. Ordinary old-fashioned theft

In 2025, a jury in Ohio awarded Medical Mutual of Ohio some $50 million in damages. It concluded that United Health subsidiaries conspired to manipulate bids for health insurance for Toledo municipal employees 7-8 years earlier. The conspiracy included using illegally obtained financial data from Medical Mutual to submit false bids.[2218]

In June of 2025, the former chief medical officer and head of emergency medicine at Brooklyn's SUNY Downstate admitted stealing $1.4 million. He used a business credit card for personal purchases.[2219]

20. Stupid stealing

Worcester's UMass-Memorial Medical Center spent $50,000 weekly for about 1.5 years "on young models in racy outfits to recruit potential bone marrow donors." Payments totaled about $4 million. The hospital's CEO subsequently apologized. The hospital charged patients' insurers $4,000 for subsequent lab work that usually costs about $100 per patient.[2220]

An employee of Boise's St. Alphonsus Hospital was sentenced to 41 months in jail for stealing $1 million over 14 years. Her theft from the hospital's annual Festival of Trees, sales of Christmas trees to finance cancer care, was particularly heartless.[2221] [2222]

Causes of theft

As early as 1992, a General Accounting Office report detailed a number of causes of fraud. The report identified 6 main reasons why health care is vulnerable to theft:

- ✓ Inherent difficulty of identifying fraud while processing billions of individual claims yearly;
- ✓ privacy concerns that preclude joint action by payers to spot and stop theft;
- ✓ private insurance companies' inability to exclude caregivers blocked from billing Medicare;
- ✓ disagreement about how to regulate new methods of payment; and
- ✓ the high costs identifying and prosecuting thieves.[2223]

At least 10 other factors help explain the high level of theft of health care dollars.

One is the perception—and, often, the reality—that health care theft is a victimless crime. So much financing is open-ended. When that prevails—in traditional Medicare, Medicaid not constrained by managed care contracts, and ordinary PPO-type insurance coverage, money stolen is simply replaced by new money. Theft—even massive theft—does not deprive patients of care. By contrast, the revenue available to MA plans, Medicaid managed care plans, and capitated private plans is finite, capped. Here, theft means less money is available to pay for medical care.

A second is the complexity of payment. Thousands of plans employ complicated methods to pay 5,000 hospitals, about 1 million physicians, about 14,000 nursing homes, and dozens of thousands of other caregivers. Each plan has its own rules for which services are covered, prices paid for covered services, quality measures to report, drug formularies and step therapies to follow, rules for obtaining prior approval for care, and more. Following rules demands considerable time and attention from caregivers. Failure to follow rules can result in denial of payment. Doctors must be paid for about 1.3 billion patient visits or other encounters yearly. Complexity of payment may permit doctors who wish to obtain higher revenue to upcode the care they give. Payers try to scrutinize claims and downcode when they wish or when they deem downcoding appropriate. Complexity is one source of mistrust between caregivers and payers.

A third is a deeper and more general mistrust between caregivers and payers. Each thinks the other is or may be cheating. Caregivers, close to patients, originate data about patients' diagnosis and treatment. When inclined, they may imagine or inflate both need for care and services provided. Payers, remote from care delivery, have few valid tools to question caregivers' reports. They develop software to try to match services with diagnosis, to identify patterns of care or cost that are out of line with that given to similar people elsewhere, and to demand prior approval before delivery of care they will pay for. Payers also try to squeeze caregivers on price, often by forming narrow networks. Many caregivers who feel under-paid or cheated owing to payers' behaviors will try to game payment rules to generate the revenue they feel they deserve.

It is far from clear whether caregivers have initiated financial fights by aggressively up-coding patients and otherwise manipulating prices to seek revenues they don't deserve—or whether payers initiated the fights by aggressively downcoding or denying claims or by squeezing caregivers on prices.

What is clear is that caregivers and payers harbor substantial and deep feelings of grievance toward one another. Grievance flourishes like mold in the humid, dank atmosphere of complexity, mistrust, market failure, governmental incompetence, and lack of shared understandings that characterize health care delivery and payment in the U.S.

Grievances can be multiplied by perceived widespread criminal or unethical behavior by executives high up in hospitals, insurance companies, drug companies, regulatory agencies, and legislatures.[2224] [2225] [2226]

And also by payer policies that violate many doctors' concepts of good medical care. Insurers long refused to pay hospitals and doctors for medical care to treat patients injured in car crashes while driving under the influence of alcohol or drugs. So emergency room doctors often refused to order a tox screen and omitted reference to chemical impairment in patients' charts. That, in turn, could delay referral to substance abuse counseling.[2227] When insurance companies make rules that doctors can't respect, many doctors break them. That behavior can spread to breaking payment rules when doctors come to believe these are also wrong or unfair.

Efforts to regulate hand-washing in hospitals can have similar effects. Muller and Detsky describe ways in which public reporting of handwashing compliance can lead to nominal compliance to protect reputation—a behavior that could undermine respect for professional norms.[2228] They therefore urge developing ways to encourage and support regular handwashing, and to measure it accurately, before requiring public reporting.

Failure to set and enforce clear and workable rules of payment may lead some caregivers and payers to cheat. When cheaters are not caught and punished, others behave badly.[2229]

A fourth is the failure to move toward a negotiated financial – political – clinical – legal – ethical peace treaty between payers and caregivers. Stable understandings, agreed by both parties, would drain poisonous motivations to cheat. Three understandings are that a) money and caregiver time are finite but pathology is remorseless; b) scarce money and time must be marshaled to do as much good as possible; and c) therefore, theft kills. Caregivers who think about their own financial self-interest will be tempted to act unethically, and will unnecessarily harm some patients with unnecessary care and deprive others of vital care. A fourth key understanding is that negotiated salaries or fees for doctors and payments to hospitals need to be as fair and adequate as possible, while respecting all the other demands on each nation's scarce resources. Then, no one is trying to cheat anyone else.

A fifth is the insinuation of competitive free market thinking throughout health care. Belief in a market justifies pursuit of financial gain. It undermines professionalism and honor. In a free market, profit signals efficiency, innovations that lower cost, and delivering what people want to buy. The market legitimates profit and the greedy behaviors that generate profit. For reasons set out in chapter 4, not one of the 7 seven requirements for a functioning competitive free market is—or ever can be—satisfied adequately in health care. But that does not matter to profit-seekers: they simply assert that a good-enough market does exist, must exist—to legitimate their profits and the often bad and often illegal actions by which they pursue profit.

Both caregivers and payers have long sought to build financial incentives into payment rules. Usual, customary, and reasonable FFS payment of doctors was supposed to liberate doctors to charge what they believed their services were worth but still enable all patients to afford to see all doctors. Cost reimbursement of hospitals was intended to be financially neutral when designed in the 1930s. And it was, then. But everything changed after the Second World War, and especially when Medicare adopted it in 1965. More recently, the belief that payment by the unit of care incentivizes unnecessary volumes of care caused many reformers to advocate capitated payments for groups of citizens or methods of paying doctors and hospitals that notionally rewarded "value," not volume. Value has been very badly measured and open to gaming. Many doctors and hospitals, increasingly sensitized to financial incentives, were motivated to game the value measures and soon learned how to do so. Crossing the border from cynical gaming to outright stealing can be easy.

Because doctors' decisions about how to diagnose and treat individual patients control almost 90 percent of health spending, doctors are subject to pressures—some legal and other illegal—to divert money. Drug makers and device manufacturers market and advertise to doctors.[2230] They underwrite research, offer speaking fees, sponsor seminar-vacations, and other inducements. It's a short step from accepting these payments to accepting payments from other doctors or from hospitals to refer patients, upcode care, and even bill for care not given.

A sixth is rooted in the very generous and open-ended early methods of paying U.S. doctors and hospitals—methods crafted by the doctors and hospitals themselves. Usual, customary, and reasonable FFS payment of doctors was a recipe for leap-frogging fees and revenue. Cost-reimbursement of hospitals invited them to boost their costs. These two methods prevailed during the quarter-century of economic growth from the end of the Second World War until the early 1970s. Their generosity led many doctors and hospitals to resent payers' subsequent financial restraints.

A seventh is most payers' desire to efficiently pay clean-looking claims submitted by legitimate-looking caregivers. In 2010, Medicare was paying some 4.8 million claims daily and 1.2 billion yearly.[2231] Clean claims contained all required information and that information was consistent. Treatments matched diagnoses. Payers were not oriented toward spotting theft by learning whether patients actually needed—or even received—the care specified in bills. Payers' desire stemmed partly from a belief that doctors and hospitals would rarely cheat and partly from a desire to hold down their costs of administering claim payment. The difficulty of curtailing this pattern of "pay and chase" caregivers submitted fraudulent claims was illustrated by the very slow start of Medicare's $77 million computer system to spot Medicare theft before bills were paid.[2232]

Just as important, payers did not wish to disrupt provision of needed medical care by scrutinizing and denying some individual claims, and thereby cause doctors to shy away from offering needed services.[2233] CMS could try to screen new applicants for Medicare Provider Numbers more carefully and work harder to extrude and prosecute bad actors. But each month, about 45,000 new applicants seek MPNs—a volume that is very difficult to monitor.[2234]

Over time, some cheaters made a great deal of easy money and that led others to cheat. Also, organized criminals found ways to steal health care dollars by creating rings of cooperating caregivers to prescribe unnecessary motorized wheelchairs, meds, or surgery. Outside investigations and suits by insiders using the False Claims Act had some value but they spotted only small fractions of theft.[2235] Insurers paying clean-looking claims were taken to the cleaners.

An eighth is that federal and state offices to prosecute cases of health care theft are typically under-staffed.[2236] Investigators are also in short supply.[2237]

This is no accident. Sometimes, governmental friends of thieves work to de-fund investigations. In one period when New York State's Medicaid spending tripled, the number of fraud investigators was cut in half.[2238] At other times, money given to the FBI from the Medicare Trust Fund, which was supposed to be used to investigate health care theft, was diverted to finance other important activities.[2239]

Prosecutors rely heavily on insiders to blow whistles on theft by suing privately under the False Claims Act. It is natural to do so, in one sense, because insiders are the people most likely to spot illegal behaviors. By law, no suits can proceed to trial until the federal government decides whether to intervene on the plaintiff's behalf. The tiny number of federal lawyers reviewing these suits meant a substantial backlog developed, causing years of delay.[2240]

(It is noteworthy that the various U.S. Attorney offices vary enormously in the resources they put into investigating and prosecuting health care theft.[2241] Greater investment in prosecutors would probably pay for itself many times over. And the resulting greater likelihood of getting caught would deter much bad behavior.)

This under-staffing means that exposing and punishing theft relies heavily on those with insider knowledge to come forward and file private suits under the False Claims Act. But the Department of Justice's short staffing has meant that it usually takes many years to decide whether to join the private plaintiff.

Worse, the DoJ has even moved to dismiss private suits, doing so in some 25 cases from 2017 to 2019. Still worse, Trump's then newly-appointed attorney general had (in 2001) called the False Claims Act "an unconstitutional 'abomination.'"[2242]

A number of Veterans Administration hospitals have worked to undermine and suppress whistleblowers who have spoken out against corrupt practices and dangerous patient care.[2243] Westervelt detailed problems of deep corruption, criminal behavior, cover-ups, and aggressive retaliation plus systemic efforts to discredit reformers. These amounted to a culture of theft, secrecy, and intimidation.

Bad behaviors included failure to read imaging studies, failure to repair wheelchairs, and long-term theft of food and other supplies meant for veterans. Retaliatory steps against whistleblowers included falsely accusing them of bad behavior, isolating them, and stealing their personal possessions.

Westervelt asked whether the VA is capable of correcting its problems.[2244] Congress sought to strengthen protections for VA whistleblowers by enacting the VA Accountability and Whistleblower Protection Act of 2017.[2245] But a 2018 GAO report found that whistleblowers were 10 times as likely to suffer disciplinary action as similar workers.[2246]

VA hospitals are far from alone. Corrupt behavior inside the VA is paralleled by non-profit and other hospitals' efforts to discredit whistleblowers and retaliate against them. Gamble details 8 instances. They included firing a surgeon who alleged substandard care, and firing a doctor and a nurse who claimed physicians billed Medicare for services not performed.[2247]

A ninth might be called the policy of "fail to jail." This summarizes most prosecutors' orientation toward getting some thieves to pay fines or agree to a financial settlement—often amounting to only a fraction of the dollars stolen—in place of criminal prosecutions of individuals that result in jail time. Several factors help explain this. One is a preference for obtaining at least a partial return of money. Settlements can be summed to yield impressive-looking reports of accomplishments. The DHHS OIG reported $3.44 billion in recoveries in FY2023, for example.[2248] But how does that measure up as a percentage of estimated dollars stolen?

Another factor is the difficulty, in many instances, of identifying individual actors who could be convicted of illegal behavior. This seems to have been particularly true in the instances of very large theft by Tenet, HCA, and many drug companies.

Two of the most visible exceptions, mentioned earlier, are the successful criminal prosecutions of many executives, including CEO Poulsen, at National Century Financial Corporation (who defrauded bond-buyers and others) and at HealthSouth (who defrauded stockholders as well as Medicare and other payers).

It may be that bond-buyers and stockholders are deemed more worthy of protection than are Medicare, Medicaid, or insurance companies. Certainly, as Phillips has compellingly written, bond buyers are legally and practically deemed to be entitled to much higher levels of truthfulness from bond sellers than are voters from politicians.[2249] Or it may be that those executives were simply easier to identify and successfully prosecute.

This pattern is far from unique to health care fraud. A review of financial crimes found relatively few individual prosecutions.[2250] Negotiating non-criminal financial penalties with corporations was common.[2251] Eisinger describes the multi-decade deterioration in the Justice Department's willingness and ability to prosecute individuals.[2252]

Possibly, federal prosecutors have, in recent years, become more aggressive in seeking and obtaining plea bargains or jury verdicts that result in jail time. Those prosecuted, though, have typically been closely involved with actual theft, not higher executives. They included clinicians who billed for care they did not give,[2253] or people who organized systematic upcoding.[2254] A D.C. doctor convicted of operating a pill mill for opioids was sentenced to 18 years in jail.[2255] No one at Columbia/HCA went to jail for stealing $1.7 billion.

And a tenth has been aggressive political pushes to preserve conditions permitting theft. After Medicare cut its prices for screening imaging studies for osteoporosis, a coalition of manufacturers, scanning companies, doctors, and women's groups inserted a provision in the ACA to double Medicare's prices.[2256] As discussed earlier, a parallel problem plagued the ACA's attempt to counter Medicare Advantage plans' years of illegitimate efforts to make their patients look sicker than they actually were.

These 10 groups of causes have persisted for decades.

In 1988, the DHHS Inspector General said "'We are sending a clear message to those who defraud and abuse the department's programs. The actions of abusers will be detected and they will bear the brunt of our punitive measures.'" [2257]

Kalb wrote in 1999 that "health care fraud and abuse have become major issues" [2258] and that the Department of Justice had declared "health care fraud to be the 'crime of the nineties.'" [2259]

A quarter-century later, the rhetoric about fighting fraud persists. So does the reality of thriving theft.

After Trump was re-elected, one analysis found that behind his tough rhetoric on crime, he had let fraudsters "walk" during his first administration. And the Biden administration's pursuit of health care miscreants was not much more vigorous.[2260]

A 2026 proposal illustrates payers' reluctance to replace rhetoric with effective action. That year, CMS sought strengthened power to extrude from Medicare corrupt home health agencies, hospices, hospitals, and other caregivers.[2261] [2262] But this was expected to save Medicare only $82 million yearly, or about $1 for every $16,200 to be spent in CY 2026.

The remedies adopted, so far, have not been remotely adequate to counter the causes' power. New approaches are touted [2263] but they consistently fall short. At best, they shift the problem.

Effective remedies are worth considering.

Remedies for theft

Deeper long-term remedies

Today, theft is widely disseminated and deeply embedded in U.S. health care. Serious combat against theft entails changing how we pay caregivers and how they think about money.

That should begin by delegitimizing greed and outlawing for-profit care, as discussed in chapter 10. Neither has a useful role in health care because—as analyzed in chapter 4—all 7 of the requirements for a functioning competitive free market are absent. Weakening greed and profit-seeking will knock out some of the props that support theft. This is important because legal gaming and other bad behaviors can gradually and easily shade into outright theft. Especially when mistrust and complexity color relations between payers and caregivers.

That should continue by instilling the need to carefully spend our vast but finite health care dollars, making the trade-offs that are necessary to contain cost and cover all Americans. Only then will it be clear to all that theft kills. Chapters 7, 8, and 9 describe ways in which reforms in insuring all people, containing cost, and paying caregivers can be expected to sharply cut theft.

At the same time, it will be essential to retain the False Claims Act's right of private action against health care theft. Insiders are best positioned to spot theft. Recent actions by conservative judges clearly contemplate making such private action illegal unless public litigators intervene in a private suit. As Kesselheim and Tu note, The underlying theory is that the private relators would be "exercising executive power presidential appointment or supervision…." [2264]

Taken alone, nullifying the False Claims Act would liberate thieves to pillage health care. That's because the great bulk of FCA suits are brought against those who steal federal health care dollars. In a more optimistic view, judicial nullification might force Congress to legislatively overthrow the court's decision—or to finance many more federal litigators to evaluate and then intervene in privately initiated actions.

Once all people are covered, annual spending is capped, and doctors and hospitals are paid in financially neutral ways, those caregivers will be liberated to think about how to stretch finite dollars to do as much as possible to protect Americans' health.

Capping health spending is the first key step to contain cost. Doing so means that each theft is seen to victimize Americans. "Theft kills" visibly by depriving citizens of needed care. Visibility is enhanced by translating dollars stolen into care lost.

For example, a theft of $2 million in supplies from a large hospital may mean a cut in FTE ambulance availability from 8 to 4, substantially increasing response times.[2265]

Or theft from a 100-bed nursing home of $1 million may force a cut in FTE certified nursing assistants from 70 to 45, assuming each CNA costs the nursing home a total of $40,000.

Or theft from a community health center of $500,000 obliges the CHC to trim next year's staffing by either a pediatrician or a nurse-midwife and 2 doulas, plus 3 community health workers.

And illegal marketing of a drug for off-label uses could mean there is no money this year to add an effective new med to the regional, state, or national formulary.

The next key step is to negotiate durable peace treaties between caregivers and payers. Those include a commitment to serving all people with finite dollars, and to shaping methods of paying caregivers that are financially neutral. These steps liberate caregivers to focus on the patient, within the budget, and to ignore the caregiver's own income or surplus. This shift in how caregivers think about money would address theft—and it would also serve as the foundation for slashing both clinical and administrative waste. While this change will be difficult to achieve, its importance and power are difficult to overstate.

It has proven impossible to honestly pay enormous numbers of small claims. This process has invited fraud so repeatedly that it is hard to believe that it has been allowed to persist.

One reason theft persists is weak accountability and financial control. One cause of that is the separation of payment from actual care delivery. This is true in both traditional payment of individual claims and in capitated arrangements like Medicare Advantage, Medicaid managed care, and HMOs.

One remedy would be to bring paying for all functions in-house by combining revenue with caregiving. When doctors gave or authorized care, they would trigger payment from a budget. Internal controls would include budget monitoring. Each caregiving organization would monitor and spot unduly rapid draw-downs on budgets. Failure to spot theft would deprive patients of needed care. Doctors who authorized care illegitimately in exchange for a kickback would go to jail for a long time. Those who paid the kickback would be treated similarly.

Another key step is to slash theft-adjacent behavior—the legal but corrupting bad behavior that can slide into theft. One example is the massive financial gaming that doctors, hospitals, nursing homes, hospices, and also capitated payers pursue to boost their revenue. These include horizontal and vertical mergers to gain leverage over commercial insurers' prices, boosting capitated revenue by making their capitated patients look sicker than they really are, avoiding low-paying Medicaid patients, and over-serving high-paying patients and patients with profitable diagnoses.

Another example is service on boards of trustees of non-profit caregivers by people who hope to profit by doing business with the caregiver. Yet another is the bad behavior by auditors who fail to closely scrutinize a caregiver's behavior when certifying a financial statement or the equally bad behavior by bond underwriting agencies.[2266] Often, both auditors and underwriters risk losing their client's business if they probe too deep or report too accurately.

Fundamentally, non-profit and public hospitals must be demonstrably accountable to the citizens and patients they serve. One foundation for accountability must be deep annual financial audits. Auditors are supposed to be independent but, in practice, are often reluctant to be fully objective for fear of losing a client. To cut the chance of either passive deference by auditors or active sweetheart deals between auditors and the organizations whose finances they audit (like that between Enron and Arthur Anderson [2267] [2268]), audits must be performed by qualified firms *chosen randomly and changed yearly*. Blinder recommended random selection as one option to elicit objective assessments of bond offerings;[2269] this mechanism is suitable for auditing, also.

A second—and even more important—foundation for accountability is to build trustworthy arrangements for spending the hospital's money to care for patients. As discussed in chapter 9, hospitals should have budgets. But to spend those budgets to do as much clinical good as possible with inevitably scarce dollars and clinical time, non-profit and public hospitals must negotiate strong, solid, and trustworthy relationships with the physicians who admit patients, care for them, help to generate revenue (or justify budgets), and incur costs. As discussed in chapters 9 and 12, each U.S. hospital should receive a budgeted sum that is adequate to finance efficient delivery of needed care. White has urged the view that physicians are best equipped to spend the money in this budget.[2270] This, in turn, reinforces the reality that dollars are finite so theft really does kill.

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Four things combine to substantiate the assertion that winning affordable high-quality health care for all Americans is the easiest problem to redress in the U.S.

- ✓ *The five-fold rise in real per-person health care spending in the U.S. from 1970 to 2020*
- ✓ *The ability of the other rich democracies to cover all citizens and provide more care at much lower cost while enjoying better health outcomes*
- ✓ *The high level of waste in U.S. health care, and*
- ✓ *The need to spend more to fix problems outside health care*

Further, seizing the opportunity to win affordable high-quality health care for all Americans will remind our citizens that we can be competent and compassionate, efficient and equitable. This lesson could serve us well in inspiring us to tackle the harder problems that plague us, both domestically and internationally.

Since health care problems persist even though they are easiest to redress, it is vital to analyze with care the deep origins of those problems and the reasons they persistence.

Chapters 4 and 5 do this. They provide the foundation for the subsequent discussions of remedies to the U.S.'s health care's problems of access, cost, caregiver configuration, and quality/ effectiveness.

Remedies can succeed only when they attack the actual, powerful causes of harm.

Short-term remedies

1. Raise the probability of getting caught. Substantially boost budgets and staff to monitor theft, investigate it, and prosecute it. The DHHS Office of Inspector General claims that it recoups $12.70 for every dollar it invests in fighting theft.[2271] That's a good RoI.

2. Elevate the consequences of getting caught. Seek more jail time for more of those who steal. A benchmark penalty of 1 year in jail per $100,000 stolen might be a good place to start. Penalties could be multiplied many-fold if vulnerable citizens were medically exploited, harmed, or killed in the course of health care theft.

3. Under current law, individuals may be barred from employment at companies doing business with the federal government if they have been convicted of felonious health care theft. Unfortunately, barred people resume work because their return is rarely spotted. That's because barred people are supposed to report their own exclusion when applying for new jobs.[2272]

Barring individuals could be extended by a law by barring organizations that have engaged in substantial theft for specified numbers of months or even years, depending on the sums stolen from a given payer as a proportion of total payments from that payer.

4. Tighten the design and monitoring and enforcement of corporate integrity agreements, extend their duration, and sharply hike penalties for their violation. These have been used with Tenet, HCA, many large drug manufacturers, and others.

5. Long-standing efforts to educate physicians and administrators about legal behavior might continue.[2273] [2274] [2275] [2276] By themselves, these do not seem to have been very effective. Why would that change?

6. Strengthen support for individual and private efforts to identify theft and punish thieves. These should include increasing the Department of Justice's legal staff to a number sufficient to eliminate within 2 years the backlog in assessing private False Claims Act suits. They should include vigorous efforts to investigate whistleblowers' complaints and identify and prosecute both thieves they identify and managers who illegally work to discredit or oppress whistleblowers. As with DHHS OIG investigations, mentioned above, investing in prosecutors and litigators will recover stolen money and discourage others from trying to steal.

The False Claims Act has long rewarded whistle-blowers who successfully identify theft from Medicare, Medicaid, and other federal programs. In 2024, the Department of Justice proposed

extending this method a wider range of criminal behaviors—notably including health care fraud perpetrated against private insurers and other parties.[2277] [2278]

Indeed, California and Illinois have enacted laws to permit that very extension to private health insurers.[2279]

Elberg and colleagues, though, have found reason for concern that a new Supreme Court majority might soon find the filing of private actions to be unconstitutional. They noted both a 2023 opinion supported by 3 Supremes and a 2024 U.S. District Court decision to that effect.[2280] This amounts to a radical rejection of precedent concerning a law in effect for over 160 years and an elevation of a right to grab and even steal over the right of government to protect itself. Elberg and colleagues worry that, were this view endorsed by a Supreme Court majority, "the most important protection against health care fraud will be lost."

The usefulness of a third type of private action is less clear. The 2003 Medicare Modernization Act created private Recovery Audit Contractors (RACs) to scrutinize Medicare claims. RACs are paid contingently: they receive a percentage of the sums recovered, one that varies with the size of the recoveries. Over 3 years, RAC auditors examined $317 billion in claims, identifying $1 billion in improper payments, or 0.3 percent. They were paid $187 million, so their fees approached one-fifth of recoveries. CMS has generally supported RACs while caregivers have opposed their work, sometimes calling them "bounty hunters."[2281]

It seems wasteful and peculiar to incentivize one group to make money through caregiving and incentivize another group to detect theft. Better to build trustworthy and honest payment to trustworthy caregivers.

7. Ramaswamy suggests a change in federal law that would allow state governments that identified theft in their Medicaid programs to keep part of the money saved. This would incentivize and reward state action. It roughly parallels the False Claims Act.[2282] States could use their share of the savings to finance needed health care that had previously been deemed unaffordable.

8. Cutler writes that "The goal of health innovators should be to do well by doing good—improving patients' health, saving them money, and making a profit along the way."[2283] That's how well-policed competitive free markets should induce all parties to behave.

But he then recognizes the rise of three problems of financial manipulation. To prevent asset-looting like Steward's, he calls for prohibiting payouts to private equity owners "until it is proven that patients are not harmed." But proving a negative is difficult. Since no free market is viable in health care, profits are never anointed as doing well by doing good.

To prevent doctors from merging their practices to boost prices, Cutler calls for anti-trust action. But such action in health care has proven weak and transitory. Why would that change?

When caregivers are too few in number to compete, he calls for price regulation. But could such regulation by exception prevail in the face of widespread continued faith that competitive markets work until proven otherwise?

Cutler demands regulatory action to prevent MA plans from manipulating risk adjustment to undeservedly boost revenue. But he then notes that better coding of patients could lead payers and caregivers to avoid unprofitable patients. After bemoaning a fraying of norms of ethical

behavior, he asserts that “willpower on the part of policymakers” will be required, “not just tough words.”

In light of the comprehensive failure to rein in health care theft in recent decades, it is not reasonable to expect Cutler’s well-intentioned suggestions to make a meaningful difference.

D. The 4 types of waste – Summary of causes and remedies

Some of the causes of waste are endemic—helping to generate all 4 types of waste. Many of these causes rest on market failure, as discussed in chapter 4, and on failure of governments to act competently in health care, as discussed in chapter 5. Other causes are more narrowly specific to one or more types of waste.

The same is true of the remedies. Some are general. These include reformed methods paying caregivers that are simple, that are financially neutral, and that build trust between payers and caregivers. They include equal financial coverage for all Americans, real cost control, improved configuration of caregivers, and establishing a higher and more solid floor under equitable appropriateness and quality of clinical services. Other remedies are specific to one or more of the causes of individual types of waste. Exhibit 3 – 16 summarizes the specific causes and remedies for the 4 types of waste.

Exhibit 3 – 16
Summary of Causes and Remedies for the 4 Types of Waste

	Type of Waste			
	Clinical	**Administrative**	**High prices**	**Theft**
Causes	- Lack of knowledge - Failure to use what's known - Financial incentives - Defensive medicine - Open-ended revenue - Weak care coordination - Malconfigured caregivers	- Caregiver-payer mistrust - Complexity - Financial incentives - Payment methods	- Failure to regulate drug, device prices - Shortages of doctors, dentists, nurses, others - Caregiver mergers	- Perception of victimless crime - Coddle white collar criminals - Too few prosecutors to investigate FCA qui tam claims
Remedies	- Learn what works - Financially neutral payment mechanisms - Promote MD/DO altruism - End malpractice suits - Cap revenue - Primary care for all - Full coverage for all - Sustain right caregivers in right places	- Financially neutral payment mechanisms - Liberate and oblige doctors to spend carefully - Simpler payments - Boost caregiver altruism - Boost solid primary care, trusting patient-doctor relationships	- Regulate prices - Consider floor for drug affordability as well as ceiling - Set budgets for meds, devices - Boost numbers trained	- Cap spending – theft then clearly kills - Boost DoJ and state prosecutorial budgets - 1 year in jail/$100K stolen

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