# 1. How the U.S. won health security for all – A note from 2035

## A. You awaken in 2035

### 1. And you are astonished

One evening in August of 2025, you recall a headline from late in 2023, "The Era of Major U.S. Health Reform Is Over." [11] That pessimistic and unrealistic assertion angers and frustrates you. Adrenalin surges. But after it subsides, you sleep very well.

So well that you don't awaken until a decade has passed.

Family and friends visit you. Aware of your intense interest in health care, they recount a few things you missed.

***First, they describe the years of growing recognition*** that affordable health security for all Americans should be the easiest problem to fix in the U.S. Not easy—just easier than any of the others. That recognition rested on five insights.

One insight was that spending was very high and rising. How much? Even back in 2025, health spending was $5.3 trillion, over $15,000 per American. Over one-sixth of the economy. Six times defense spending and three times all education spending. And health spending was rising by $1 trillion every four years. It reached $6.2 trillion in 2028.

Still not enough to pay for all the services that all caregivers might conceivably want to offer all patients. Or that all patients might conceivably seek.

But enough to pay for just about all the care that works for all the people who need it. Enough to fully cover all people. Enough to secure the right numbers and types of doctors and hospitals and other caregivers in the right places. And enough to boost quality and appropriateness and equity of care.

Enough to finance health security for all Americans—as discussed in chapter 3.

A second insight was that growing problems inside health care made it harder for many people to obtain needed services. Refusal to contain health care costs in effective ways led to reliance on suppressing use of care. These included rising premiums and out-of-pocket (OOP) costs; higher medical debt; growing shortages of doctors, nurses, long-term care workers, and mental health professionals; closing of many hospitals and nursing homes and increased crowding and

wait times at surviving institutions; denial of payment or prior authorization by insurance companies; and massive and confusing paperwork that angered both patients and caregivers.

Third, up to one-half of health spending was wasted. On clinical services that didn't work or weren't needed, mindless and infuriating paperwork, high prices, and outright theft.

This probably helps explain why—despite much higher U.S. health care spending per person, survival chances here, even for the wealthiest quartile of Americans aged 50 to 85, were inferior to those of their counterparts in northern and western southern Europe. Indeed, ***the wealthiest quartile of Americans die at rates similar to the poorest quartile in northern and western Europe***.[12] This raises questions about the effects of social determinants of life (SDLs) on mortality. It suggests that high levels of waste in U.S. health care may be at fault.

***It may take a village to raise a child, but it certainly takes a crisis to spur fixing health care***. The potential to squeeze out some of this vast fat and recycle it as clinical bone and muscle helped inspire reform. But the four types of waste had become so deeply embedded in U.S. health care that only political and financial crises could uproot them. Hirschman described an "optimal crisis," one big enough to spur change but not too big to paralyze reform or leave reformers without adequate financial and political capital.[13]

The types and causes of waste are discussed in chapter 3, along with a few ways to recycle that waste.

A fourth insight was recognition that almost all of the various remedies touted in 2025 to fix health care problems were just empty words, snake oil. The panoplies of panaceas peddled by politicians and professors proved to be a portly Potemkin village. Free market competition, traditional regulation of care delivery by insurance companies and public payers, Medicare Advantage, Medicaid contracting, for-profit care, moral hazard and high out-of-pocket payments, value-based payments, payer micro-management of doctors, accountable care organizations, and all the rest were on the road to ill repute.

Centrally, this fourth insight entailed appreciating that none of the conditions for free market competition are present or attainable anywhere in health care (chapter 4). And that traditional government actions in health care have not been remotely competent (chapter 5) to sweep up the debris and waste left behind by market failure's circus parade.

Anarchy results when competitive markets are absent and government actions are incompetent.

Anarchy undermines financial and clinical accountability. It makes equilibrium impossible.

It leads health care to cry for more money while squandering up to one-half of what it obtains. It makes money the opiate of the managers.

Anarchy means health care poverty amid financial plenty.

It allows powerful parties to pursue profits without honor by financially pillaging and plundering.

It means chaos, waste, and unnecessary suffering.

Realistic alternatives are available. They start with strategic decisions by public and private payers to cap spending, pay caregivers in simpler and more trustworthy ways, assure financial coverage for all people, and identify and sustain the right numbers and types of doctors, hospitals, and other caregivers in the right places.

They continue with crafting an alternative to failed competition and failed financial incentives and micromanagement of caregivers.

Doing this entails shaping health care to be as self-regulating as possible. And that means relying mainly on doctors' and other caregivers' fiduciary duty, honor, professionalism, altruism, and other good motives—backed by good evidence—to marshal the nation's vast but finite health care dollars to serve all people as well as possible. It also means relying partly on caregivers' own intelligent awareness of their enlightened self-interest in taking accountability for spending money carefully and equitably.

Because the alternative is that payers will increasingly control these decisions. They will broaden their financial bribes and penalties for doctors, hospitals, and other caregivers. They will strengthen their administrative oversight of doctors' decisions about diagnosing and treating patients.

A fifth insight was that the focus of health care reform needed to be on health care itself, not on the social determinants of life (SDLs). Housing and transportation, food, education and job training, income, environment, personal and neighborhood security, and other social determinants of life are probably more powerful than health care in shaping health, disability, and longevity.

It is helpful to distinguish addressing SDLs wholesale, for millions of Americans, from ameliorating SDL-related sources of harm to individual patients. When SDLs impair medical treatment for people who are ill, injured, or disabled, they must be addressed. And today's health care dollars can be stretched to pay for many valuable SDL interventions to help individual patients.

But the money to address SDLs wholesale—on a large scale—is lacking today. One of the main reasons is that health care spending sponges up so much new money each year.

Further—as discussed in chapter 2—experts disagree about which of the social determinants are more important or strategic targets of intervention. Evidence on which remedies for individual SDL problems might actually work is surprisingly weak, so far.

Those who call for greater wholesale attention to SDLs often assert that doing so will save money now spent on health care. Sadly, the evidence that investing in SDLs actually cuts health care costs is very weak.[14] [15]

(That is not an argument against spending to mitigate social problems. After all, we don't spend money on health care to save money.)

As discussed in chapter 8, the powerful causes of high U.S. health spending are inside health care itself, so they can't be modulated even if we somehow obtained more money to address SDLs on a large scale—or even if those investments succeeded. Those investments will be

worth making on their own merits. When we have the money, when we figure out which SDLs are strategic, and when we know more about what works.

Today, demanding large-scale, wholesale attention to SDLs is futile.

Even worse, it has the unintended effect of letting health care off the hook. Which helps to enable health care to continue to feed its financial addiction to more money for business-as-usual—grabbing an added $250 billion yearly—at least for a few more years. And that, in turn, crowds out spending on all the good things sought by the proponents of wholesale investments in SDLs.

Fixing health care is much more likely to liberate money to address SDLs on a large scale than addressing SDLs on a large scale is to cut health care costs.

These five insights gradually but steadily entered the public's consciousness. And that delegitimized U.S. health care and helped motivate Americans to opt for substantial health care reforms—after attempts to cut the federal budget deficit sparked crises in health care financing, patient care, and caregiver survival.

Reform offered hope.

***Second, your family and friends continue by describing the forces outside health care that gave rise to the 2029 federal budget crisis***. Growing political, economic, and social problems in the U.S., coupled with international worries that demanded higher defense spending, led Congress to seek ways to lower the deficit's share of the federal budget. That would require a combination of tax increases and spending cuts. It was known that this combination would trigger an economic recession. But that was seen—correctly or not—as essential to wean the economy off its years of reliance on very high federal deficits to cope with Covid and, subsequently, to forestall recession.

***Searching for substantial spending reductions, Congress recognized that Social Security cuts were politically unacceptable, and asserted that health care spending should already be adequate to finance health security for all Americans. So Congress enacted a multi-year freeze in federal Medicare, Medicaid, and ACA spending.***

The initial, panicked response to the freeze by doctors, hospitals, and other caregivers was to seek higher prices from employer- and worker-financed private health insurance. Employers and workers declined to pay more—partly owing to their own financial worries amidst the national economic recession.[16]

Rebuffed, many caregivers feared bankruptcy or closings. Patients feared inability to obtain needed care. Both groups came to recognize that no option but reform was practical.

***Third, family and friends explain the shift toward reform***. Caregivers rejected the main alternative to reform: shoehorning health care to fit the requirements of an imaginary free market by cutting insurance coverage and boosting out-of-pocket payments.[17] Caregivers were terrified that a financial bloodbath of bankruptcies would result from market-worship, along with

soaring rates of denial of needed services. Patients and voters hated the medical and financial insecurity that de-insurance—and even greater suppression of care than already prevailed—would impose on anyone foolish enough to become ill or injured.

Congress, caregivers, and citizens coalesced on crafting cost containment, comprehensive coverage, and changed caregiver configuration.

The political, financial, and medical upshot was to find a way to address all stakeholders' needs, using the newly-capped—but still vast—sums already available. A consensus emerged on covering all Americans, respecting the ceiling on current revenue, configuring the right caregivers in the right places, boosting quality of care, and on financing all of these reforms by repurposing previously unproductive health care dollars and clinical resources—recycling waste.

***Fourth, they emphasize the value of getting ready***—of designing and testing ways to reshape health care well before the financial and political crises presented the opportunity to do better.

CMS (and other organizations) had *nominally* practiced contingency planning in 2025, but—to the extent this was actually done—focused on small operational or tactical matters, not large and strategic ones.[18]

As you knew early in 2025, Americans were spending enough money on health care to assure health security for all of us. We could have realized that potential even then. But political and financial pressures for reform were weak. Those benefiting from wasted health care dollars were unwilling to relax their grip on that money.

***Consequently, pressure to prepare to respond to crises was weak. And planning to seize the opportunities presented by crisis—to reform health care—did not exist.***

Happily, beginning in 2025, a number of complementary efforts were launched to anticipate and plan responses to the very sorts of crises mentioned in this chapter and analyzed subsequently in this book. Reformers were galvanized by the need to prepare for broad and deep responses to crisis.

One reason was that most politically feasible efforts to contain cost, improve access, or address caregiver configuration in recent decades had failed. A second reason was that the second Trump presidency demonstrated how politically and financially shaky even the more successful efforts had proven. A third was that only crisis appeared to offer opportunities to put U.S. health care on a durably affordable and equitable foundation.

Because health care coverage, cost control, methods of paying caregivers, caregivers configuration, and other elements of reform are all complicated individually, because they are intertwined, and because the reforms all relied substantially on shifting much money from where it was wasted to where it was vital, these plans sought conscientiously to identify and test key reform provisions, sequencing, allies, opponents, and methods of building both competence and confidence.

It was clear from the beginning crisis could permit or even impel reform—but also that the tangled and fraught medical, financial, and political depths of a health care crisis would be the worst possible time to start figuring out how to fix problems.

Of course, no one knew that a health care crisis was inevitable; no one could even estimate the chance that one might occur. But if a crisis did hit an unprepared nation, the harm would be enormous. Given the very low cost of preparation and the high potential for harm, it clearly would have been foolish to refuse to prepare.

Most health care experts were wedded to failed cost controls and failed methods of improving access. And most were deeply uninterested in doing anything serious to configure doctors, hospitals, and other caregivers where they were needed.

Nonetheless, the risk of harm from refusal to prepare persuaded one foundation to finance pre-emptive planning.

Nationally, a small foundation-financed Health Care Red Team began operating in 2025. Its aims were to anticipate deep threats to U.S. health care (such as a freeze in federal dollars), and to prepare positive, coordinated responses. ***Those responses aimed to offer immediate relief, speedy recovery, and durable reform.***

To protect care and caregivers, the Red Team recognized that compensating for the freeze required identifying money that was already available in health care but was badly used. And then mobilizing it to pay for needed health care, thereby preserving access for patients while avoiding bankruptcy for caregivers. Freeing up wasted dollars required addressing the causes of clinical waste, administrative waste, high prices, and theft.

The efforts of the Red Team and other reformers to anticipate and respond to the health care crisis are sketched at the end of this chapter.

***But first, your family and friends have more to say about what reformed health care now looks like. Then, they describe the origins—both outside health care and inside it—of the health care crisis.***

## 2. The shape of reformed health care in 2035

The U.S. now solidly protects all people against health costs, contains total spending, boosts appropriateness and quality of care, and sustains the right numbers and types of doctors, dentists, nurses, hospitals, social workers, and other caregivers in the right places.

The piecemeal reform proposals of the past—the ones that had been deemed politically acceptable because they were too feeble to threaten wasteful business-as-usual—have been rejected.

So, if we want more primary care, we must cease hoping that well-intentioned indirect, slick, cheap, badly-targeted, and ineffective remedies like medical school debt forgiveness will help. Instead, since drafting doctors is politically inexpedient, we must simply and directly pay primary care physicians enough money to get enough good doctors working wholeheartedly in primary

care in the places where they are needed. This entails both higher incomes and slashing the unproductive paperwork that payers had imposed on all doctors, especially those in primary care.

And if we want equitable care for all Americans, we must cease obliging sick people to make high out-of-pocket payments or wait for hours in the ER. Instead, OOPs are slashed, everyone who wants a primary caregiver has one they can reach by phone or text, and all payers pay the same price for the same care.

Many who abandon trying to retrofit free market competition into health care still want health care to become largely self-regulating. And also to pursue low-cost care. That would obviate intrusive private insurance company interference in decisions about care. Detailed government regulatory micro-management would also become unnecessary.

For years, free market ideologues seeking both lower costs and self-regulation in health care had pushed patients to shop for services by price and quality. High OOPs were intended to impel that. (They would also combat supposed moral hazard by suppressing use of care.) Data about price were supposed to make shopping practical.

Be real. Decades of work to promote price transparency failed utterly. Worse, even if accurate price data could be made available, few would use them. Comparing price with quality is impossible without good evidence on quality. Which is much harder to obtain and understand than the price data. And the main decision, in any case, concerns what care is needed, not where to get it.

It is a fool's game to ask the weakest and least knowledgeable party—patients and families who are worried about illness, injury, pain, disability, and fear of death—to become smart shoppers who will choose appropriate and lower-cost care. Who will become the instruments of cost control. Relieving the strong actors—public and private payers—with real power to contain costs from the obligation to do anything useful.

Only one group of candidates exists to better spend our vast but finite health care dollars. They are called doctors.

Their decisions about how to diagnose and treat us, patient-by-patient, determine how almost 90 cents on the health care dollar are spent.

Phased and interlocking reforms address cost, coverage, quality, and caregiver configuration. These have supported and built on one another. Their allied and mutually reinforcing successes discredited the hoary myth of the iron triangle—the myth that reforming any one area—boosting access, containing cost, or improving quality—would harm one or both of the other two.[19] [20]

**Coverage**

All people are equally covered financially. Medicare, Medicaid, private group insurance through the job, and the ACA's subsidized individual coverage persist on the surface. The plastic insurance cards still look different but all now have the same benefits and pay caregivers at the

same prices. How? By channeling all revenues from public programs and private insurers into one reservoir and then using that money to protect citizens and pay caregivers.

While covered benefits remain incomplete, they have become so solid that only about 5 percent of health spending is financed by individuals' out-of-pocket payments. These help pay for long-term care, mental health services, and other remaining areas of incomplete coverage and financing, or for voluntary personal payments for amenities or for care whose efficacy is unproven. That's one-half the share paid OOP in 2025.

**Costs**

Yearly spending on health care is capped. Successive reforms that cut waste make it possible to deliver needed care to all Americans without exceeding the cap.

All increases in yearly health care spending must be financed with federal tax dollars. This builds in a powerful political pressure to control health spending.

The second powerful motive to contain cost is to link each specific extraction of wasted spending to a specific and visible improvement in access.

Suppose that a cut in health care theft or in over-generous payments to drug makers would save $17 billion yearly, the equivalent of one day's U.S. health care spending. That would finance a $50,000 yearly boost in primary care physicians' incomes for all primary care docs practicing in 2029. Which translates into more available primary care—particularly in places where primary care had been least adequate.

**Revenues**

Medicare, Medicaid, private insurance, ACA subsidies, and similar money that had financed coverage of individuals is pooled in the single reservoir. Employer-employee payments are frozen at 2028 nominal dollars per worker or family. New private businesses pay premiums into the reservoir at the county-wide per-worker and per-family averages, again measured in 2028 nominal dollars. The same holds for health coverage paid for by federal, state, and local governments. State governments' Medicaid payments are also frozen at 2028 per-person levels. After considerable debate, Congress allowed the cap on revenue for health care to rise somewhat with age-adjusted population growth.

**Waste**

About ½ of U.S. health spending had been wasted. Squeezing out theft and also clinical, administrative, and financial fat has financed access to care for all Americans while containing health care costs and protecting caregivers' financial and clinical capacities to serve us all. Seizing this opportunity has boosted patients', voters', politicians', employers, and doctors'/nurses'/hospitals'/other caregivers' support for full coverage combined with cost containment.

An amendment to the False Claims Act channels a substantial share of recaptured stolen dollars to finance expanded coverage and delivery of needed care. Parallel federal legislation does the same for civil penalties and other theft-associated recoveries.

High drug prices have proven to be a second relatively easy type of waste to cut. Money saved is devoted to buying more meds from the drug makers. Given the low marginal (incremental) costs of making more pills, the recycled dollars pay to put large quantities of needed meds into patients' bodies while imposing only small cuts in drug makers' profit margins.

Gradually, physicians have learned to weed out wasted clinical services—unneeded care, ineffective care, inefficiently-organized care, and low-value but high-cost care. The dollars and clinical time saved by slashing those wasted services are used to deliver and pay for needed, effective, and high-value care to Americans previously denied it.

Physicians were spurred to build this knowledge when hospitals were switched over to fixed yearly budgets. Fixed budgets mean that waste kills—that dollars wasted on low-value/high-cost care were not available to finance high-value/low-cost care.

Physicians were liberated to use this knowledge because they are paid in financially neutral ways. Doctors working in hospitals are paid salaries, adequate and generous ones, that free them to stop thinking about their own financial well-being when considering how to diagnose and treat their patients. Their compasses seek magnetic north without distortions by financial magnets of self-interest. Or by profit pressures from practice owners or payers.

One of reform's most pressing challenges has been to cut waste quickly enough to liberate money and caregiver time to boost improvements in coverage and delivery of needed care. This is particularly important for administrative waste, both inside insurance companies and public payers, and inside hospitals and doctors' offices and other caregivers. It is helpful to simplify methods of payment. Fixed global budgets for hospitals and salaried payments for in-hospital doctors cut administrative costs. They build trust. Financially neutral doctors could be trusted to marshal scarce clinical time and dollars to do as much as possible for patients. Micro-management of payment withers as payers find they can almost always trust in-hospital physicians. Parallel steps are taken for physicians in ambulatory care.

**Compensation**

Payments to caregivers has to be sufficient to finance equal coverage and care for all Americans, but without exceeding the cost/spending ceiling. Caregivers are paid by methods that allow and induce all of them—particularly doctors and hospitals—to act in light of altruism, fiduciary duty, professionalism, and honor. Financial incentives and penalties are abandoned entirely because they corrupt judgment, undermine patients' and payers' trust in caregivers, and engender vast administrative waste and theft. Instead, with dollars capped and time scarce, caregivers devote both to doing as much clinical good as possible.

Caregivers become financially neutral but still have to wrestle with finite time and money. This means doing as much good as possible for patients with the money available. The only reason to deny care to one person is to reserve clinical time and money to deliver care to another person who will enjoy greater benefit.

This exemplifies what Koller calls ceasing to outsource "the 'no' in health care." [21] Paying caregivers in trustworthy ways both obviates and precludes insurers' intrusion into clinical decisions and into caregiver-patient relations. Health care becomes much more self-regulating, equilibrium-seeking. Indeed, insurers' functions and financially parasitical practices both wither away.

Importantly, this is the only safe and effective way to contain cost. Insurers' past attempts to privately regulate physician and hospital behavior magnified paperwork waste, constrained access, and still failed to contain cost. In the past, mistrust spawned costly but ineffective bureaucratic micromanagement of doctors' decisions and of hospital coding of patient condition and services. Unchaining health care entails building payment methods, attitudes, and behaviors that engender trust.

Salaries or target incomes are set to achieve the right numbers and types of doctors in the right places. For example, primary care (PC) doctors' incomes are boosted to an average of $400,000 plus fringe benefits. This attracts more physicians to primary care, boosting access and cutting panel size toward 1,000 patients. Primary docs have more time to diagnose, treat, and coordinate care for patients. Even so, costs of paying PCs rise to only 3.5 percent of national health spending.

At the same time, physician training is expanded to boost access by lifting the U.S. from the bottom tier across all rich democracies in doctor-to-citizen ratio. This also prevents the rise in PCs from crowding out specialist physicians—who have themselves been in short supply in many parts of the nation.

Target incomes and payment methods are negotiated between payers and doctors. This reflects Glaser's insight that payments must be negotiated politically.[22] The traditional U.S. method of manipulating doctors' (and hospitals) payments by regulatory formulas has been abandoned.

All this recognizes that affordable and universal access to high-quality care can't work unless doctors are positively engaged. Doctors' patient-by-patient decisions about diagnosis and treatment commit some 87 cents on the health care dollar.

And all this means that financial incentives are gone. Because they corrupt, distort, and waste money.

Instead, the hospitals and their doctors now face no financial risk but are accountable for living within each hospital's budget. Salaried physicians working at each hospital work with trustees and managers to allocate the yearly budget to do as much clinical good as possible—and as equitably as possible.

All needed hospitals have annual operating budgets financed by all payers in proportion to volumes of care and severity of illness of their patients. The entire budget must be spent each year. No surpluses need be generated to save for new buildings or equipment because capital projects are financed by separate public grants. At the same time, no hospital can suffer a deficit because it cannot spend money it does not have.

Need for hospitals—and for the types and volumes of their services—is assessed in each state in light of numbers, ages, health problems, locations of citizens, and other factors. Given the

number of rural and urban hospital closings in recent years, each surviving hospital is initially deemed to be needed until evidence demonstrating otherwise is adduced. Shortfalls in hospital bed capacity or services are also identified and factored into capital investment plans. Rebuilding needed hospital capacity in under-served rural or urban areas requires parallel action to ensure sufficient numbers of physicians locate nearby. Without enough doctors to admit and treat patients, hospitals close.

Care would be denied to one patient only when it would be too costly in light of its clinical value. The only motive to deny care is to reserve clinical time and money to serve other patients whose needs and clinical gains would be greater or whose care would be less costly.

Added work remains to convert all for-profit hospitals, ambulatory surgery centers, nursing homes, home health agencies, hospices, and others to non-profit operation by gradually buying out their owners' equity. Owners are compensated for their equity through 20-year bonds. Large chains are disassembled. For-profit provision of support services like food service and laundries—those separate from clinical decisions and clinical care—remains legal.

Why is this necessary? Because profits are illegitimate without a functioning competitive market in health care to justify them. Without such a market, profits are not outward signs of inner financial grace. They don't reward innovation or efficient satisfaction on human needs. Instead, they incentivize avoiding low-paying patients, making patients look sicker to boost revenue, and other unfortunate practices.

**Caregiver configuration**

We need the right numbers and types of doctors, hospitals and ERs, and other caregivers in the right places. No American's plastic insurance card has value unless the promise of financial coverage is redeemed by professional caregivers like doctors, nurses, social workers, and dentists; institutional caregivers like hospitals, nursing homes, home health agencies, and hospices; and the other individual clinical and non-clinical workers who deliver or support needed care. For decades, urban and rural hospital closings and physician departures had interacted to undermine access and boost cost in many places. They had been one of the main threats to medical security.

Each state government therefore assesses needed caregiver capacity and identifies both surpluses and shortfalls, statewide and in smaller areas. It identifies which existing caregivers are needed and pays them enough to continue serving patients efficiently. Where they are in short supply, state government acts to expand capacity to match need.

Action on primary care replaces decades of rhetoric. Primary care means better access, coordination, continuity, and comprehensiveness. And lower cost. Most patients—especially those with serious and costly medical problems, seek trusting and durable relations with a primary caregiver. Many more primary care physicians and nurse practitioners are trained and retained through a combination of raising incomes by 50-75 percent and lowering doctors' average panel size to 1,000 patients.

In parallel, since all Americans' teeth are now insured, states act to expand the supply of dentists and dental therapists.

**Reality overcomes fantasy**

Americans overwhelmingly recognize that providing effective care to everyone means ceasing to pay publicly for care that does not work at all. Or for care with very low value but very high cost. Citizens, doctors, hospital CEOs, nurses, and others see that waste kills. That pathology is remorseless but dollars are finite. So spending money on unneeded care or very costly low-value care for some patients inevitably sponges up resources that could have been used to deliver needed, effective, and affordable care to other patients.

Pretending goes out of fashion—pretending that the same dollar can be spent twice, that trade-offs are unnecessary.

So do the cults that have long clogged the arteries of health care reform. These include moral hazard and out-of-pocket costs, competitive markets and profit-making, reliance on incompetent and ineffective government regulation to curb the abuses resulting from market failure, reliance on health insurance or insurance companies, financial incentives and penalties, incremental band-aids that don't begin to cover open wounds, pay-for-value, population health, social determinants, and prevention. (Of course, population health, social determinants, and prevention are all vital. They have little to do, though, with fixing health care itself.)

Ceasing to rely on imaginary remedies is possible only because health care has itself become much more trustworthy. Doctors, hospitals, and other caregivers no longer face distorting financial incentives to give more care, less care, or different care. Our money is in the hands of the people with the best knowledge about how to spend it to care for us as well as possible.

Trust is human; it is rarely abstract. It rests heavily on the foundation of durable and trusting relations between patients and their primary care doctors. These are particularly important for the small share of Americans who benefit from most of our health care spending in a given year.

More and more doctors are recruited who have altruistic values and behavior. Casalino and colleagues had found that patients of doctors who'd been identified as altruistic had three-fifths the chance of a potentially preventable hospital admission, two-thirds the chance of a potentially preventable ER visit, and 9 percent lower health care spending.[23]

To reinforce altruism, professionals like doctors, dentists, and social workers are paid in financially neutral ways, liberating them to spend their time to do as much clinical good as possible for their patients. These payment methods make it possible to cut regulatory micromanagement substantially, freeing up time and money to give better care to more Americans.

Organizations like hospitals or nursing homes have static global budgets. They must spend all that money yearly and can't exceed their budgets. So their trustees and managers need to support physicians acting as fiduciaries. They must decide how to do the most clinical good as equitably as possible with the vast but finite dollars available.

These changes render unnecessary most of health care's vast administrative waste. Clinical waste is squeezed out more gradually as doctors learn more and more about which patients need which types of care. Malpractice reforms eliminate costly defensive medicine by making

medical harms no-fault, by covering costs of medical care for all patients, and by disability insurance that replaces earnings lost owing to illness, injury, disability, or medical misadventure.

One of the most important human foundations for trust is the relation between patients and primary care doctors.

A second foundation is a steady re-orientation of doctors, hospitals, and other caregivers away from the corrupting influence of financial incentives and penalties, and toward the fiduciary role. Caregivers recognize that this is the only way to overthrow stultifying regulatory micromanagement by insurance companies, denials of prior approval, retroactive refusal to pay claims for needed care, and endless financial gaming and the equally endless paperwork that accompanies it. Incentives breed toxic mistrust. And that breeds payers' regulations, caregivers' efforts to navigate regulations to serve patients and garner revenue, and escalating administrative waste.

Enabling caregivers to think clinically about how to stretch dollars to best meet patients' needs liberates their best human instincts and also their professional training. It signals the end of alienation, of the poisonous acid drip of financial temptation and corruption and gaming, and of the guilt that caregivers formerly felt when they put their financial self-interest ahead of their patients' well-being.

Together, these reforms make health care much more self-regulating. Since we are human and imperfect, audits and whistle-blowing continue to turn up a few bad actors. A consistent criminal penalty of a year in a safe jail per $100,000 stolen helps to deter most of those who might be tempted to steal. No contest plea agreements, accompanied by dollar penalties, become rare. The motto "theft kills" helps remind everyone that medical resources are finite—that stolen dollars can't be replaced.

Since fully trustworthy and fully and automatically self-regulating payment mechanisms are impossible to craft, altruism, honesty, frugality, and other human traits matter enormously. Trustees and CEOs of non-profit caregiving organizations like hospitals, doctor groups, ambulatory surgery centers, and nursing homes have all been chosen to constantly pursue the aims of health care—equitable care for all Americans, delivering affordable services by marshaling finite resources of money and time as frugally and prudently as possible.

**Equilibrium, homeostasis, and self-regulation**

The decades of futile debates between market versus government roles in health care are finished. Both sides have lost.

Market advocates are recognized to be right that government can't regulate the details of health care delivery.[24] As described in chapter 5, the persisting general ineffectiveness of traditional government regulation in shaping resource allocation, deterring theft, enforcing regulations, and upholding standards of access or quality has surprised even supporters of public action.

Equally discredited are those who insist that competitive free markets in health care could contain cost or boost efficiency. It is now widely recognized that nothing close to a competitive free market functions—or can function—in health care. That's not a matter of theory, principle, or ideology. It's pragmatic. For reasons discussing chapter 4, not one of the 7 requirements for

a functioning competitive free market exists—or is attainable—in health care. The words "market" and "health care" are incompatible. Greedy pursuit of profit fails to cut cost, innovate, and give us the care that's needed. Dishonorable profit-seeking is thoroughly divorced from caregiving. And financial incentives (bribes) and greed corrode doctors' souls.

During the crisis, the federal and state governments' roles evolved upward.

Governments abandoned micromanagement of care via financial incentives, penalties, and administrative reporting. Pay-for-value/value-based payment, accountable care organizations, and other types of incentives were dismantled.

Instead, governments did the big jobs and then largely got out of the way. By statute, the federal government capped public program and private insurance revenues flowing into health care. It covered all people. It created a structure for budgeting hospitals and other organized caregivers. It established methods of paying doctors working in hospitals, in other organizations, and in private practice. It incentivized drug innovations but kept their cost out of the retail price of the pills.[25] Total spending on meds changed little but now all patients could afford all needed meds.

State governments also assessed which hospitals, doctors, and other caregivers were needed to protect the health of their citizens. State governments tailored flows of money to respect those realities.

Public and private payers, politicians, and citizen-voters recognized that doctors' decisions, patient-by-patient, govern the spending of almost 90 cents on the health dollar. That recognition meant it became essential to find ways to put the vast but finite money in doctors' hands under arrangements that allowed citizen-patients, politicians, and payers to trust those doctors to spend carefully. Effectively. Efficiently. And equitably.

Professionalism, honor, altruism, and fiduciary duty have supplanted greed and government as the engines that assure access, contain cost, and boost quality and appropriateness of care.

Promoting those good values requires crafting smart ways to pay doctors to make them financially neutral in their own clinical decisions. They would steer by a compass of efficacy and cost of patient care, not by one of their own greed and financial self-interest.

When doctors can be trusted to marshal capped dollars to serve all people equitably, administrative waste plummets. And doctors are liberated, at the same time, to slash clinical waste.

As White wrote, doctors will not immediately embrace the job of spending finite dollars carefully, but no other acceptable candidates are available.[26] Two measures to hearten doctors to take on that job were slashing administrative burdens and ending fears of malpractice suits and the alienating and costly defensive medicine they spur.

Governments were left with the jobs only they can perform accountably and competently: capping spending, marshaling money to cover everyone, identifying needed caregiving capacity, rectifying capacity shortages and excesses, and catching thieves.

## Remaining jobs

Although U.S. health care is much better, it isn't perfect. Overcoming unbalanced configuration of caregivers is a continuing challenge. It takes time to train more primary care physicians, dentists, and other skilled caregivers who had been in short supply. And to attract needed doctors and others to under-served areas. It takes time to identify and stabilize surviving hospitals and ERs in under-served urban and rural areas. To expand care where needed. And, particularly, to raise the floor under quality and appropriateness of care, particularly in regions where all care is in short supply or where less-well-trained caregivers work.

Even so, quality and appropriateness of care in under-served low-income urban and rural areas has improved markedly. Across the nation, though, overall improvements in quality and appropriateness of care are slower than expected or needed. Continued sharing of information on best ways to diagnose and treat different problems is helping. But new types of efforts are required.

Long-term care and mental health remain the two most difficult challenges. Each is costly because people in need often require lots of sustained help. Incremental hours of help are expensive. Goals are often unclear and effectiveness of care—existing or improved—is hard to measure. For these reasons, higher spending on LTC or mental health has won only moderate political support. Progress remains slow. The growing elderly population share means rising need for long-term care services. Congress recognizes that more spending on long-term care probably means less spending on acute care—especially on acute care of marginal value.[27]

Dental care has been challenging to deliver because only about one-half of Americans had previously been receiving regular dental services. Most states have moved quickly to license dental therapists. Training programs were greatly expanded. By the time all Americans were covered for dental care, capacity was almost sufficient. Waiting times rose moderately but then returned to acceptable levels. A number of hospitals added emergency dental care for citizens in pain.

Happily, reformed ways to generously reward drug makers with large prizes if they develop effective and safe and valuable new meds have begun to bear fruit. These prizes shift the cost of innovation, of measuring safety and efficacy, and of manufacturing the first pill out of meds' retail prices. Spending on meds has stabilized. Very low retail prices and negligible out-of-pocket burdens have made meds affordable for all. Drug makers have therefore ceased threatening the public that reform would stifle innovation.

Resetting patient and caregiver expectations to match what's medically possible and financially affordable has proceeded more quickly and smoothly than expected. One reason is steadily rising patient trust in primary caregivers. Another is the marked drop in OOP burdens. A third is patients' growing recognition that doctors, hospitals, and other caregivers are financially neutral, and that time and money are finite.

## Foundations for continued progress

Solid foundations for continued progress are in place. Reform is politically credible. The nation recognizes its victories for competence and compassion, for efficiency and equity, and

continues to build on them. These victories have magnified health care reform's political capital, not dissipated it.

Crisis sparked these reforms. Worry and unmet need were so great during the crisis—and expectations were so low—that the stabilization and reconstitution of health care were able to proceed with unexpectedly low levels of carping, complaining, and court cases. It helped that reformers did not need to over-promise. So each improvement was widely appreciated.

Different views about health care access and cost between the two political parties have narrowed greatly. A phrase, "politics ends at the edge of the hospital parking lot" becomes popular.

This pragmatic climate is vastly different from that of the prior decades of stalemate, inaction, recrimination, ideology, unaccountability, and incompetence in health policy and financing. One reason is that crisis shifted most people's default position from "more money for business-as-usual" to "win affordable health security for all Americans."

A second reason is that, in the past, most changes were successfully resisted by those who expected to lose something—usually income, profit, or prestige.

Opponents' power had previously been magnified by the asymmetry of pain and gain. Those who fear loss are usually much more vocal and powerful than those who would be better off. This is partly because negative emotions are usually stronger, and partly because those who might be helped by some reform rarely know it. Sharfstein describes the flip side, noting that positive news gets less attention than negative news.[28] This undermines confidence in our collective competence; pessimistic people may fail to push hard for remedies.

In a time of crisis, though, most people are worried and are much more willing to accept changes that promise better times—and better health care—ahead.

Inside health care, pragmatic, concrete, incremental, but substantial and coordinated actions boost human well-being more effectively than did decades of rhetoric, abstractions, ideologies, and fantasies.

Health reform lowers federal deficits. And it liberates dozens—and then hundreds—of billions of dollars to finance reindustrialization, job training and education, housing, environment, defense, infrastructure, and other sectors suffering under-investment in recent decades. Effective wholesale interventions to address social determinants of life become affordable—once experts learn which investments are actually both strategic and effective.

***Speedy implementation of coordinated medium-size substantial reforms*** has been largely successful. It has worked to cover all people, contain cost, pay caregivers in trustworthy ways, address caregiver supply and location, and boost appropriateness and quality of care. These reforms instill clinical and financial accountability.

They depart from decades of opportunistic posturing, disjointed incrementalism, or rhetorical fantasies offered by proponents of both traditional market competition and public regulation.

They abandon decades of theoretical or half-hearted reforms that had been advanced because they are politically convenient in assuaging aggrieved people but are not expected to disrupt wasteful business-as-usual inside health care. And they are equally different from the great single leap to single payer sought by others. Instead, they climb the steep but manageable paths taken decades ago in most rich democracies.

Before the crisis, most private insurance companies (and the employers they worked for) joined some caregivers in leading the opposition to covering all Americans, containing cost, and reforming caregiver payments. Both feared reform would harm them.

During the crisis, both forms of opposition melted away. Most caregivers became angry and frustrated by the old methods of payment, corrupt financial gaming, paralyzing paperwork, private regulatory controls, and malpractice threats. So they were willing to try new arrangements that promised assured income to productive and efficient caregivers and substituted fiduciary and professional thinking about what's best for patients for the soul-crushing old world of gaming financial incentives and defensive medicine.

The crises afflicting private health insurance companies and the employers who relied on them led most to retreat from health care.

Crises meant falling shares of citizens with solid financial coverage. And also high levels of caregiver financial distress. These combined to discredit traditional market or regulatory approaches. Most parties came to recognize that it is very hard to win affordable medical security for all Americans or contain costs without coordinating the two.

And that neither is feasible without reforming methods of paying caregivers. And shrinking clinical and administrative waste.

It is daunting to address these and many other interlocking problems and to implement coordinated medium-size reforms. Fortunately, the nation is blessed with millions of wonderful caregivers and thousands of knowledgeable, intelligent, and energetic reform experts. And it had been able to build on four years of preparation—of contingency planning by the Red Team and others—to anticipate what to do when politicians, voters, caregivers, and payers come to agree that U.S. health care is in crisis.

***Still, you are incredulous***. You question what your family and friends tell you.

Then, you ask yourself: why would they make up a story like this? And you recall the mess that was U.S. health care back in 2025. Even then, you could not understand how your nation could have been spending over one-sixth of a huge economy to give less health care to fewer people at double the rich democracy per-person cost, while dying younger.

You ask your family and friends: How did the crises outside and inside health care unfold politically and financially? And how did all the many and complicated individual parts of health care get fixed? They respond by putting the rest of this chapter in your hands. And by urging you to read the chapters that follow.

Fortunately, you are well-rested, so the narrative doesn't put you to sleep.

1. How the U.S. won health security for all – A note from 2035

## B. The nature and causes of the crisis outside health care

When you awaken in 2035, your family and friends describe how a number of international, economic, social, and political upheavals helped spur health care reform. They describe a succession of cascading crises that rendered traditional U.S. health care's recipe of more money for business-as-usual to be financially unbearable and politically inedible. In retrospect, they say, the meltdowns outside and inside U.S. health care that led to reform were inevitable. It was a matter of when, not whether.

> Around now, you start wondering whether your friends and family are just making up this story. You recall that most health care policy and finance people have long preferred fine-tuning remedies to small problems instead of preparing to identify big problems that might emerge and how to address them. And promoting remedies that look good and are politically feasible but ineffective. That is like preferring to answer e-mails instead of actually working. You then decide that this story—and this book—might help you either to understand ***changes that have actually occurred or to prepare to respond to crises that are likely to arise in the future***.

Most individuals and almost all organizations resist change. Even after they are able to acknowledge their own imperfections. But pressures for change accumulate when individuals or organizations fail those who rely on them—when they cease to function effectively. Demands for change grow louder as failures increase. Eventually, crises make change impossible to resist. Successful adaptation to crises rests on a combination of luck, adequate resources of time or money or goodwill, skill, and preparation.

***By 2028, crises outside and inside health care had reinforced one another. The outside crises led to pressure to cut federal deficits. With tax increases deemed politically impossible, the main alternative became a freeze in federal health care spending.***

***Early in 2029, the new Congress froze 2029 federal spending on health care at 2028 levels, measured in nominal dollars. This allowed no rise for inflation. Subsequently, Congress extended the freeze to total health care spending. Modest rises in spending, in line with the age-adjusted population growth were later permitted.***

***Crises outside health care*** interrupted the regular infusion of added public and private dollars on which doctors, hospitals, other caregivers, and drug makers had long relied.

***International, economic, social, and political challenges grew. Each made it harder to address any of the others.*** The cascading crises resembled those that tipped the world into the First World War,[29] those causing the Great Depression of the 1930s,[30] or those that led to industrial accidents like refinery explosions.[31]

International friction, U.S. economic difficulties, domestic social challenges, and inflamed U.S. politics all intensified. Together, they led to choking off the flow of added public and then of

private money into U.S. health care. Caregivers became increasingly alarmed. So did many patients. And voters.

***At the same time, the crises inside health care—unaffordable costs coupled with evidence of enormous waste, suppressed access, and loss of needed caregivers—worked to delegitimize U.S. health care. Health caregivers and payers became unable and unwilling to withstand pressures for change. They lost confidence that the old regime could or should be sustained.***

Crises inside health care were partly financial—associated with revenue increases that could not keep up with rising costs. Existing efforts to contain cost were badly designed. Some invited higher spending. None addressed the huge share—up to one-half—of health spending that was wasted.

Crises inside health care were partly owing to accumulating mistrust in health care's ability to serve Americans safely. Health care access—always uneven—was increasingly suppressed in hopes of containing costs. Under-insurance meant unaffordable care—even when physician, ER, or hospital capacity were available. And caregiver capacity was increasingly inadequate in many places as hospitals and nursing homes closed and primary care doctors retired. For many citizens, health care tipped from being a source of security to a source of insecurity.

## 1. Threats to world peace persist

Russia continued to occupy much of eastern and southern Ukraine. Delayed delivery of promised western armaments combined with mistaken reliance on western military doctrines handicapped Ukrainian counter-offensives. Putin's health, while uncertain, declined. His reservoir of grievance toward Western democracies' imagined role in dismantling his beloved KGB and Soviet Union remained full.

Pressure to boost U.S. defense spending grew because the war on Ukraine highlighted the value of new missile, drone, electronic, and other technology at the same time that it drained U.S. reserve supplies of both sophisticated and basic munitions.

More money might help. But, in some critics' view, it would also be essential to overcome the brittleness that afflicts the armed forces' procurement of hardware, their concepts of their missions (sending messages of shock and awe versus winning battles), and higher officers' training as managers who lacked combat experience or preparation.

The war on Ukraine exposed deep deficits in U.S. manufacturing capacity, supplies of sophisticated weapons, and technology. One noteworthy example of the hollowing out of U.S. manufacturing was reliance on a Turkish firm to help equip a new U.S. factory to make 155-millimeter artillery shells.[32] Wicker was among many who wrote about the value of preparing for war in order to avoid it. He complained that the U.S. military is simply unprepared.[33]

At the same time, the military suffered from very slow, rigid, top-down, and sometimes politicized and corrupt methods of procuring hardware. Only gradually did procurement encourage greater reliance on bottom-up and entrepreneurial designs.[34]

Some critics asserted that the U.S. military lacked a doctrine of fighting for victory over enemies—that it had become wedded to proportionality and to containing escalation.

North Korea's threats toward South Korea and Japan persisted. North Korean infantry supported Russia's war against Ukraine. Trump's appeasement of Russia invited further aggression in Europe and elsewhere.

China renewed its declared commitment to "resolving the Taiwan question." [35] A combination of ideology, growing military power, perceived weaknesses of adversaries, and domestic economic instability fueled risky and adventurous behavior by party leaders. Early in 2025, China began practicing a blockade of the island.[36]

Iran's pursuit of atom bombs and threats to destroy Israel magnified instability in the Middle East and heightened fears of large-scale war and resulting disruptions of oil and gas. History harshly judged the Obama-Biden appeasement of Iran. Attacks on Israel by Hamas and Hezbollah and Houthis resulted in their defeat or weakening. Syria fell to a Turkish-backed group with a history of dangerous violence. Harsh religious tensions inside Syria led to communal violence and violent repression. Turkey's own belligerence toward Kurds and Israel grew after Assad's fall in Syria.

China redoubled its support for Russia's attack on Ukraine and built pipelines to directly import Russian oil if Middle Eastern supplies were shut off. The EU remained vulnerable to that shut-off. So did Japan and South Korea.

Initially, rising costs of Social Security, Medicare, Medicaid, and other important entitlements—in combination with rising burdens of servicing the growing national debt—impeded increased preparation for defense.[37] Biden and Trump, in different ways, were confused about the need to protect ourselves and help protect our many allies.[38]

But clearer perception of growing threats steadily pushed U.S. defense spending's share of GDP upward during the 2025-2035 decade.[39] [40]

Most European nations faced similar choices between spending on defense and spending on health care, renewable energy, and other valuable objects.[41] They also faced pressures to raise taxes and cut spending to cut deficits. Governments fell on these issues.[42] [43] Political instability in much of Europe was heightened by the discrediting of the decades of elite pursuit of continental political and economic integration. And by growing social and economic divisions within many nations—including fights over immigration. And by high energy prices stemming from hasty switches to renewables, from some nations' incautious closing of nuclear generating capacity, and from discredited reliance on cheap Russian energy. As in the U.S., many European nations suffered economically from loss of manufacturing to China.

## 2. Economic stresses grow: demands on the U.S. economy exceed its capacity

The brittleness afflicting the armed forces found parallels in the economy itself. A striking indicator: the economy's reliance on high federal deficit spending during the ostensibly good economic years like 2023 through 2025. That was a signal of the growing disconnect between

the real economy of goods and services that underpin human well-being and the paper economy of Wall Street.

A U.S. economy that had been hollowed out was no longer able to produce enough of many goods and services needed and sought by Americans. Needs and demands for housing, infrastructure, defense, education and job training, clean energy and decarbonization, responding to climate change, health care, and child care exceeded the economy's capacity to deliver. Individual sectors like housing and transportation were beleaguered. Notably, these were all sectors that could not be offshored to low-paid foreign workers.

At the same time, largely because the U.S. had the least equal income distribution of all rich democracies, the federal government faced political pressure to financially protect low-income people.

To try to bridge the gap between human needs and the economy's capacity, the federal government ran big yearly deficits. Federal deficit spending also aimed to sustain purchasing power and avoid recession.

For example, the federal deficit's share of GDP rose to 6.3 percent in 2023 and then to 6.4 percent in 2024. These were unprecedented during good economic times and low unemployment rates.

The substantial U.S. trade deficit suppressed domestic employment and slowed economic growth. But efforts to repatriate jobs in manufacturing and other sectors were impeded by decades of erosion of domestic suppliers, managerial capacity, and skilled workers.[44] Tariffs, designed to bring back manufacturing, magnified inflation.

Many formerly productive industrial ecologies were wiped out. Simple lost knowledge, inexperience, diversion of managerial talent from factory to finance and of business school faculty from professional practice to theory,[45] and huge corporate and public bureaucracies all hindered efforts to restore manufacturing and boost its productivity.

Public education continued to suffer disruptions stemming from Covid and from fights over what could be taught or said. Schools' three related jobs—teaching skills and knowledge, socialization, and child care—continue to mix badly. Reading and math skills continue to decline. Fewer students emerged from schools with skills sought by employers. So labor shortages persisted.

Housing costs continued to rise. New building was constrained by high interest rates, high land costs owing to zoning policies and transportation congestion, rising wages for construction workers, more stringent energy-efficiency standards, and higher energy prices.

Growing demand—owing to immigration and to family formation in excess of new construction—put upward pressure on apartment rents and home purchase prices. Housing grabbed rising shares of family income, leaving less money to buy other goods and services. Real incomes and standards of living fell.

About 60 million Americans—almost one-fifth of our people—lived in Gulf and Atlantic coastal zones that are vulnerable to wind and flood damage from hurricanes.[46] Sixteen insurance companies, most recently including Farmers and AIG, ceased or curtailed writing homeowners'

policies in Florida. State government-financed reinsurance would probably prove inadequate if a powerful hurricane hit urban coastal areas. Pressure for federal bail-outs would be considerable. And very costly.[47] The same was true of recovery from the Los Angeles fires of 2025.

Early in 2023, Will recounted a joke, "The first law of economics is, scarcity is real; the first law of politics is, ignore the first law of economics." [48] He insisted that entitlements' high shares of federal spending made substantial program cuts impossible—that rising Medicare outlays, for example, would compel higher taxes. A few weeks later, Biden did propose substantial increases in Medicare taxes on high-income Americans.[49]

Only a few months later, though, came the 2023 installment of congressional Republicans' catch-and-release hostage-taking over raising the cap on the national debt. It revealed that both Will and Biden were only partly right. Social Security was untouchable. But most non-defense discretionary federal spending proved touchable or potentially vulnerable.

The three 2023 fights over the federal government's yearly deficits and accumulated debt manifested deep political divisions about the role of the federal government in protecting both the economy (jobs and profits) and vulnerable people.

***More fundamentally, this fight manifested the widening gap between our nation's economic resources and our citizens' needs and appetites.[50] Little noticed at the time, the three 2023 fights signaled the start of a reckoning with reality by both Democrats and Republicans. That reckoning would take very different forms, including Trump's 2025 radical efforts to slash federal spending to finance renewed tax cuts.***

In 2023, Republicans demanded deep cuts in federal deficit spending in exchange for voting to raise the cap on the national debt—thereby avoiding default on federal obligations. Republican Party dynamics in the House of Representatives temporarily rendered that body non-functional.

That apparent Republican intransigence stemmed from a combination of opportunistic political posturing, pre-Keynesian affection for balanced budgets, stunted empathy toward many beneficiaries of higher federal spending, and a possibly more realistic worry that the debt would absorb excessive shares of federal spending, crowd out private investment, push interest rates higher or, even, eventually, exceed the nation's capacity to repay it.

Interestingly, the Reagan and Trump tax cuts had added substantially to the federal debt (while disproportionately helping wealthy people). Only in 2008 did the national debt reach $10 trillion. But it tripled to over $30 trillion by 2022 owing to high spending to address the financial crisis of 2008 and the human and economic crises of Covid in 2020-2022.

The federal debt doubled from just over 30 percent of GDP when Reagan took office to just over 60 percent when he departed. It stayed roughly at that level until 2008. Then it jumped to over 100 percent of GDP by 2012, flattened, but then spiked to 135 percent of GDP in 2020. In 2023 and 2024, it remained close to 123 percent of GDP.[51]

Since the U.S. was at full employment, it was hard to understand why the FY2024 federal deficit was equal to a very high 6.4 percent of the economy. That share had been exceeded only 6 times since 1946—in 2009-2012 and in 2021-2022. The 5-decade average was 3.8 percent.[52]

While declaring their concern for the size of the federal debt, most Democrats had long been more comfortable with high annual deficits and growing debt than most Republicans. Some Democrats embraced deficit spending to boost overall employment, income, and profit. Others applauded higher federal spending on health care, education, and food.

Ritz argued, though, that Democrats should care about the deficit because rising interest payments would crowd out spending on Democrats' priorities. Both Social Security and Medicare faced automatic cuts if their trust funds were depleted, probably in the mid-2030s. Both programs spent more than they took in each year. At the same time, Ritz wrote, Republicans needed to endorse tax increases.[53]

Unsurprisingly, Democrats faulted those Congressional Republicans were apparently willing in 2023 to default on debt interest payments. That would have impaired the nation's credit rating, driven up costs of federal borrowing, sent the economy into a tailspin featuring business bankruptcies and rising unemployment, and impaired other nations' faith in our trustworthiness, in our competence to manage our affairs, and in our capacity to lead the world's democracies through perilous times.

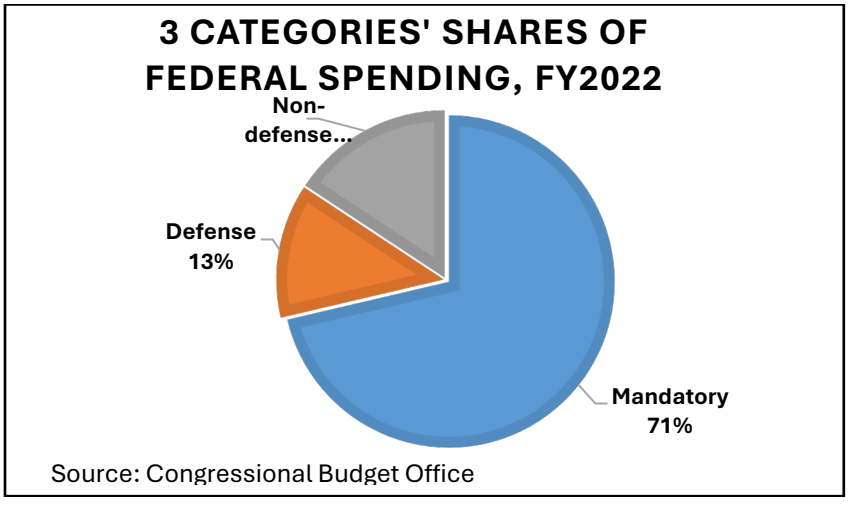
In the mid-2020s, politicians' subjective worries about deficits and debt become increasingly influential owing to increasing demands on a slowly growing real economy.

But in 2023, a combination of growing debt and rising interest rates meant that, as debt is refinanced—"three-quarters of Treasurys must be rolled over in five years"—interest payments rose substantially as a share of GDP.[54]

High deficits and interest payments during good economic times left little room for higher federal borrowing to prime the economy's pump to combat the next recession.

By one analysis, worldwide interest payments on national governments' debt reached $2 trillion in 2023 and were predicted to rise to $3 trillion in 2027. One-third of the interest payments were by the U.S. government.[55] The rise in public debt internationally obliged the U.S. to keep interest rates high to attract buyers of new and rolled-over U.S, debt. That, in turn, made for a stronger dollar, more imports, and fewer exports—thereby boosting joblessness.

***Exhibit 1 – 1***



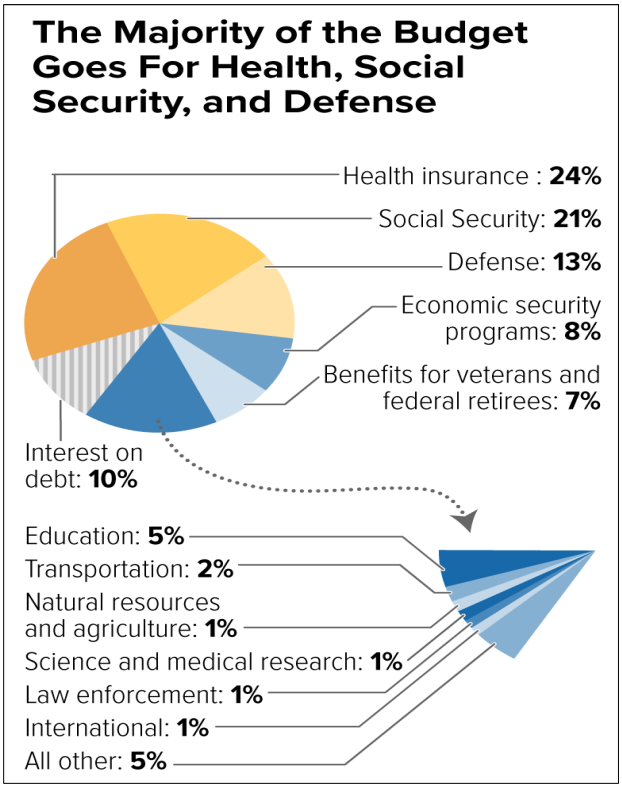
In May of 2023, Congress could not identify financially credible cuts because discretionary non-defense spending was only about one-sixth of federal spending. [56] See Exhibit 1 – 1. Exhibit 1 – 2 provides more detailed information for 2023 spending; it highlights health care's share.

The conservative Republican Study Committee, chaired by soon-to-be House Speaker Johnson, had published a FY2020 budget proposal that identified $10.7 trillion in spending cuts during 10 fiscal years. Fully $4.9 trillion (46 percent) were in Medicare, Medicaid, the ACA, and the Children's Health Insurance Program. Medicare would cease to be an entitlement. Instead, it would be transformed into fixed subsidies or vouchers to help elders and disabled Americans buy private insurance. Another $756 billion (7 percent) of the proposed cuts were in Social Security.[57] The RSC's motivation to cut was clear.

But cutting revenue for health care without cutting waste would harm patients and caregivers. Over the next few years, the new speaker and the RSC would learn to think harder about how to safely control federal health care spending—doing so in ways that protected patient care and also caregivers.

Rubin predicted that "exploding budget deficits" were here to stay. On the spending side, because non-defense discretionary spending was so small a share of the total. And on the revenue side, because Democrats would be unable or unwilling to refrain from extending Trump's 2017 income tax cuts. [58] Rubin also endorsed the conventional view that "both parties agree that Social Security and Medicare, the two biggest federal spending programs, must not be touched…."

***Exhibit 1 – 2***



Source: Center for Budget and Policy Priorities,
"Where Do Our Federal Tax Dollars Go? 18 July 2024,
https://www.cbpp.org/the-majority-of-the-budget-goes-for-health-social-security-and-defense

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Krugman was only a little more optimistic. He bemoaned the deficit "obsession" that had kept unemployment high for years after the 2008 fiscal crisis. And he hoped that health care spending increases had abated—at least Medicare spending per beneficiary. But he agreed that current deficit levels were excessive and that higher taxes were needed to tame them. But they were off the table, he wrote, owing to partisan disagreements.[59] [60]

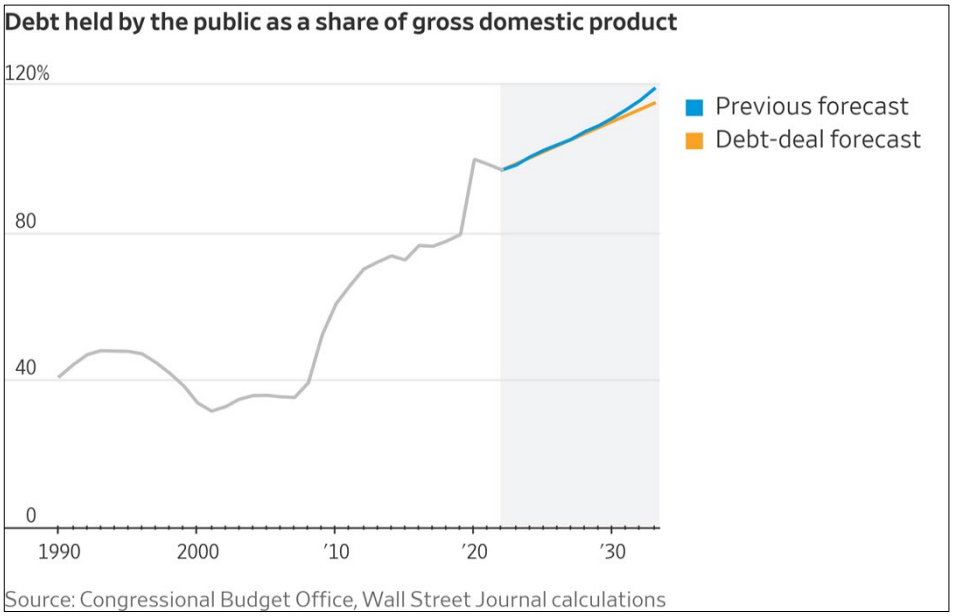
In 2023 and 2024, Democrats increasingly feared that redoubled efforts to limit federal spending would continue to fall disproportionately on important non-entitlement non-defense discretionary spending on food stamps (SNAP), housing, education, child care, or environment protection.

They saw signs of this in California in the spring of 2024. In 2023, the state enacted a tax on managed care organizations to raise $7 billion yearly to raise health workers' incomes, help hospitals cover costs of seismic compliance laws, boost some Medicaid payments, and address other health care priorities.[61] But less than a year later, Newsom sought to divert all of that tax revenue to help shrink the state's $28 billion budget deficit.[62]

During 2024, interest payments on the national debt surpassed defense spending for the first time.[63] Steil and Harding projected that interest payments would rise from one-seventh of federal spending in 2024 to one-sixth in 2034. Both were about 4 percentage points higher than projections made as recently as 2019.[64]

Exhibit 1 – 3 portrays a different measure, publicly-held debt as a share of the economy, before and after the May 2023 deal.

**Exhibit 1 – 3**



As shown in Exhibit 1-4, the Congressional Budget Office and Government Accountability Office project a substantial rise in interest payments' share of GDP.[65] This projection, though, antedated much of the rise in interest on the U.S. debt. Interest reached $1,126 billion in 2024, almost exactly double the $564 billion interest payment 5 years earlier in 2019.

Late in 2024, Treasury Secretary Yellen publicly regretted the Biden Administration's failure to slow growth in the national debt. She worried about the sustainability of the gap between federal revenue and spending.[66]

Looking backward, several consequences of the failed May 2023 budget compromise became clear.

First, it resolved nothing, as the subsequent September crisis and November temporizing quickly revealed.

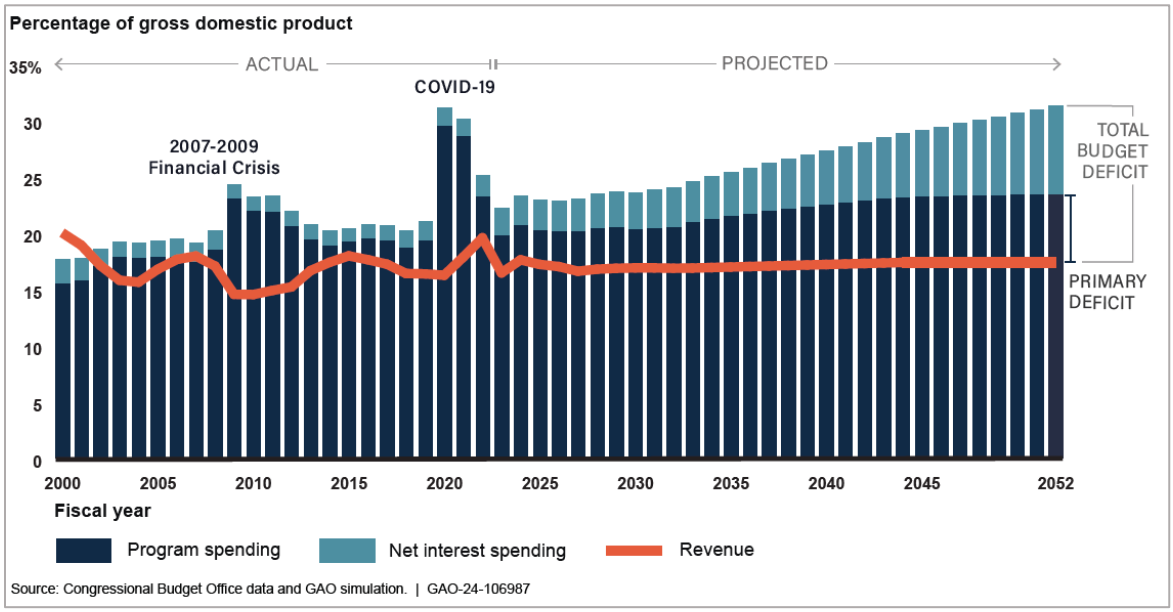
Second, non-defense "non-discretionary" federal spending—on Social Security retirement and disability payments, Medicare, and Medicaid—had been untouched.[67]

Federal health spending on Medicare, Medicaid, and ACA subsidies was projected to rise from about 3 percent of GDP in 2000 to about 7.5 percent in 2040.

Social Security spending was expected to rise from about 4 percent to over 6 percent of GDP in the same four decades.

***Exhibit 1 – 4***

***Primary Deficit and Total Budget Deficit, Actual and Projected***



Source: Government Accountability Office, *The Nation's Fiscal Health: Road Map to Address Projected Unsustainable Debt Levels,* GAO-24-106987, February 2024, https://www.gao.gov/assets/d24106987.pdf.

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Combined, federal health spending plus Social Security spending would rise from 7 percent of GDP to over 13.5 percent—nearly a doubling.[68]

And federal health spending would for the first time surpass spending on Social Security.

Both the Old Age and Survivors Insurance program (the heart of Social Security) and the Medicare Part A hospital insurance trust fund were projected to face shortfalls by the mid-2030s.[69]

In response, Congress considered cutting Social Security payments or raising payroll or other taxes. It had done so repeatedly in the past. Payroll taxes were raised from their initial levels of 1.0 percent from employer and 1.0 percent from employee to 7.65 percent each. The ceiling on earned income subject to the tax was hiked rapidly. Benefits were cut under Carter in 1977 and the age for full retirement benefits was raised from 65 to 67—a second cut in benefits—under Reagan in 1983.

None of these were popular. In 2019, two-thirds of Americans paid more in Social Security and Medicare payroll taxes than they did in federal income taxes,[70] a share that was poised to grow. Still, if either the Social Security and Medicare trust fund were exhausted, federal law required benefit cuts or immediate action to boost revenue.[71] [72]

Congress felt financial pressures to address Medicare and political pressures to address Medicaid spending. Financing Medicare became increasingly daunting over time, partly owing to rising health care costs and partly to the drop in the number of workers per Medicare beneficiary. At the program's inception, 4.5 workers paid in to the Part A hospital insurance trust fund for each beneficiary. This was predicted to fall to 2.5 workers per beneficiary by 2029.[73]

Maintaining the solvency of the Medicare Part A trust fund for the next 25 years would require either raising the Medicare payroll tax on all earned income by about one-quarter, to 3.6 percent, or cutting yearly Part A spending by 15.6 percent.[74]

By 2023, across all of Medicare, federal general revenues had become the largest source of financing. Before long, general revenues (almost four-fifths of which are raised by personal income taxation) would exceed all other sources combined—payroll taxes, premiums, and others.[75]

Pressure to cut Medicaid was political. In 2025, Trump sought cuts in federal Medicaid spending of almost $90 billion yearly to help meet the budget neutrality required to finance renewal of his expiring 2017 tax reductions. Many of his supporters disdained Medicaid as undeserved welfare. Some states declared that cuts in federal Medicaid payments would lead them to repeal their own voluntary Medicaid expansions under the ACA.

Third, economic pressure to shrink the deficit persisted. This boosted attention to Social Security benefits and to federal Medicare, Medicaid, and other health care spending.

A liberal view is that deficits and the national debt matters little: the U.S. is wealthy and borrowing allows us to do good things right now.[76] A moderately conservative view is that benefits must be cut or taxes raised.[77] A third view is that health care benefits can be sustained without increasing health care spending—but only by reforming health care coverage, delivery, cost control, methods of paying caregivers, and caregiver configuration.

It is remarkable that the high federal deficits and accumulating national debt were ignored during the 2024 presidential campaign. Rubin wrote that "The U.S. isn't fighting a war, a crisis, or a recession. Yet the federal government is borrowing as if it were." And "Both candidates were part of administrations that produced growing deficits. Neither is likely to reverse that trend if elected." [78]

Indeed, both were expected to accelerate debt growth. By one authoritative analysis made a month before the 2024 presidential vote:[79]

> The next president will face significant fiscal challenges upon taking office, including record debt levels, large structural deficits, surging interest payments, and the looming insolvency of critical trust fund programs. Our large and growing national debt threatens to slow economic growth, boost interest rates and payments, weaken national security, constrain policy choices, and increase the risk of an eventual fiscal crisis.
>
> However, neither major candidate running in the 2024 presidential election has put forward a plan to address this rising debt burden. In fact, our comprehensive analysis of the candidates' tax and spending plans finds that both Vice President Kamala Harris and former President Donald Trump would likely further *increase* deficits and debt above levels projected under current law.
>
> Under our central estimate, Vice President Harris's plan would increase the debt by $3.5 trillion through 2035, while President Trump's plan would increase the debt by $7.5 trillion.

Furman cautioned that Trump's tax and spending plans could boost the federal deficit from 6.4 percent of GDP in 2024 to 8 percent in 2028.[80]

Trump's December 2024 call to repeal the ceiling on the federal debt appeared to signal a desire to clear the way for reckless levels of chronic deficit spending.[81]

This would make for serious economic trouble. The higher interest rates spurred by a combination of continued inflation and the need to finance both rapidly growing new debt and re-finance old debt could force the federal government to cut spending and raise taxes.

Matthews recalled that Clinton was obliged to do this shortly after he took office in 1993.[82] One result was a rise in the unemployment rate to 7.7 percent. The second was a drubbing at the mid-term 1994 election.

High deficits and accumulating debt during good economic times handicapped the nation's capacity to borrow affordably during bad times. They forced interest rates on federal debt to levels higher than seen previously, leaving still more debt to be repaid. Economic and financial brittleness constrained responses to crises.

Some expected that the very narrow Republican House majority in the 2025 Congress would oblige a combination of compromise, discipline, and—when necessary—continued reliance on votes from Democrats to pass essential appropriations and other laws.

***But Trump's early actions belied this view. Soon after his 20 January 2025 inauguration, Trump's attacks on federal spending, the federal workforce, and entire federal agencies raised large questions about the motives, legality, and possible economic and political consequences of his spending cuts.***

Trump's tariffs increased risk of stagflation—rising prices in a weak economy, last seen during the two oil price crises of the 1970s.[83]

## 3. Social weaknesses and social splits

Social problems, heightened by Covid, were unabated. Rates of use of alcohol and other chemicals remained high. Death rates fell somewhat but were still catastrophic. Suicide rates remained steady at high levels.[84] [85] [86] So did rates of reported mental illness. All these both reflected and magnified personal and social troubles.

Another result of Covid was the drop in educational accomplishment: reading and math scores fell.

In many cities, personal insecurity, crime rates, and fear of crime remained high. Some local prosecutors ceased to prosecute some crimes. Some of those prosecutors were recalled or defeated in elections.

In some states, concerns about border security were also high. High levels of migration, both legal and illegal, pushed down housing vacancy rates, raised rents and home prices, and helped to propel higher levels of homelessness in many cities.

Almost one-quarter (23 percent) of American children lived in single-parent homes in 2019—the highest share in the world. We were followed by the U.K. at 21 percent and Russia at 18 percent. The share was 15 percent in Canada but only 7 percent in Mexico. By contrast, only 4-5 percent of children in India, Nigeria, and Israel lived in single-parent homes. Other family members were less available to help American single-parents because only 8 percent of U.S. children lived in extended families; the worldwide average was 38 percent.[87]

And two-fifths of births in the U.S. were covered by Medicaid.[88]

U.S. income inequality grew by 20 percent from 1980 to 2016.[89] It became the highest across rich democracies.[90]

Loss of well-paying jobs in manufacturing also contributed to income inequality. Many Americans were unable to afford adequate housing, food, child care, and other necessities.

One result of growing income inequality was that the U.S. economy depended increasingly on spending by wealthy people Ensign reported early in 2025 that the top tenth of households—

those make a quarter-million dollars or more yearly—accounted for one-half of consumer spending. That share was a little over one-third in 1995.[91]

Three-fifths of American adults said that "there is too much economic inequality in the U.S." A greater share rated it a top problem for the federal government to address than did those urging a reduction in illegal immigration. (Making health care more affordable was the top-rated problem.)[92]

In response, many Democrats pressed for higher federal government spending on food security, health insurance, education, job training, child care, earned income tax credits, public transit, environmental protection and clean energy generation, construction of affordable housing, and more.

Advocates variously saw this spending as matters of social justice, as protections for lower-income and vulnerable people, and as ways to save money on health care itself by addressing what they called the social determinants of health (here called social determinants of life).

Some who supported higher federal spending also advocated for criminal justice reform, affirmative action in hiring and education, reparations for slavery, greater diversity and equity, "anti-racism," abortion rights, LGBTQ+ rights, and more equal economic outcomes.

Unsurprisingly, many advocates of higher federal spending on various social programs appeared unconcerned about federal deficits or a growing national debt. Those who were concerned favored tax increases on high-income or wealthy Americans or more vigorous efforts to collect existing taxes.

But, for fiscal, economic, and political reasons, substantial new money to seriously address a wide range of social problems remained starkly unavailable. (See chapter 2.) Other demands were deemed more pressing. Those included rebuilding manufacturing, cutting taxes, boosting defense spending, and continuing—for a time—to spend even more public money on health care.

Other Americans had very different views of those demands.

Trump's second presidency featured attacks on federal government spending on education and other sectors. These were paralleled by highly visible actions on transgender sports participation, DEI, sanctuary cities and states, and immigration.

Many of those seeking cuts in federal spending on social programs declared they were motivated in part by worries about the debt. But their dislike of those programs—or the people they aimed to help—may have exceeded their concerns over the debt. Witness their willingness to deeply cut income tax rates even though that predictably boosted deficits under both Reagan and Trump.

A more detailed look may be helpful. Social Security and Medicare Part A have always been financed overwhelmingly by federal taxes on earned income—payroll taxes. These are regressive, meaning that lower-income people pay higher percentages of their incomes than do higher-income people. At household incomes below $200,000 in 2022, solid majorities of families paid more money in payroll taxes than in income taxes.[93]

But federal dollars that subsidized three-quarters of the premium costs for Medicare Part B and Part D, along with federal Medicaid costs were all financed by general taxation, almost four-fifths of which is raised by the income tax on individuals.[94] This tax was progressive, so higher-income households paid higher percentages of their incomes. The top 25 percent of taxpayers contributed almost 90 percent of all individual income taxes in 2020.[95]

Many who opposed social spending said they preferred less government generally. Was this consistent, a matter of principle? Some might have sought much less government regulation of business but greater public regulation of personal behavior.

Tensions between the two groups grew after the Supreme Court's June 2022 *Dobbs* decision, repudiating *Roe v. Wade,* and the 2023 decision overthrowing affirmative action in college admissions.

These tensions were magnified by Trump's multiple rapid actions early in his second presidency.

From 2025 through 2028, the nation suffered deepening disagreements about the federal government's role in the economy, the size of tolerable yearly deficits and accumulated debt, income and social inequalities—and whether and how to mitigate them, freedom and compulsion concerning vaccination and masking and other public health matters, abortion and sexuality, and tolerance for the ideas of others. These centrifugal forces worked to pull Americans apart.

The social split between the two groups meant reduced room for compromise on vital social questions: How could more housing be built to lower rents and prices? How could public education be re-shaped to equip Americans to be more self-aware, more skilled and adaptable workers, and better citizens? What social and job- and income-related changes might actually rebuild or strengthen family and social relationships, cut alcohol and drug dependence and suicide and mental health challenges? What changes might cut domestic abuse, street crime, and other sources of social insecurity? What changes might reduce rancor between groups of Americans who disliked one another?

And then, the Court's 2024 decision on *Loper v. Raimondo* modified [96] the 1984 *Chevron* decision, which had obliged courts to grant substantial deference to regulators' actions to implement federal statutes.[97] This had the effect, at least temporarily, of handicapping or even paralyzing enforcement of many federal regulations,[98] [99] including enforcement of Stark anti-kickback statutes.[100]

Consequences varied within health care. FDA regulations on drug safety or EPA regulations of air or water pollution usually rested on fairly firm foundations of evidence. They were less likely to be successfully challenged in court.

But CMS regulations of adequacy of networks of doctors or hospitals, prior approval or retroactive payment denial, methods of paying hospitals and doctors, and similar matters faced years of judicial scrutiny. A patchwork of legal doctrines emerged across different federal appellate courts.[101]

Some critics condemned the *Loper* decision as another judicial over-reach, disregarding precedent, and rewarding big business.[102] Others worried about how to rescue health care protections from the new regime of regulatory paralysis.

A third was to question the legal foundations of the majority opinion in *Loper* but to suggest that a high share of administrative agencies' actions in health care was clearly authorized by legislation.[103]

***Paradoxically, a fourth and more positive response was widespread realization that the panoply of incompetent political symbolism that characterized much—and perhaps most—federal efforts to regulate health care costs or payments to caregivers or care delivery should be abandoned. Crafting simpler, stronger, and strategic health care legislation on coverage, caregiver payment methods, and delivery of care—that encouraged and supported fuller insurance coverage of patients, caps on spending, and self-regulating caregivers—suddenly looked attractive.***

A fifth concerned the magnifying effects of *Loper* during the chaotic early months of Trump's return to the presidency. Wholesale downsizings, firings, program cuts, and contending decisions from different federal courts brought into question the federal government's capacity for competent action.

## 4. Political incompetence and crisis

In the 2020s—as in the years leading up the Civil War—American politicians were baffled. Most were unable to understand the international, economic, and social threats to the nation. Unsurprisingly, they were therefore not able to agree on effective responses to those threats.

The nation became politically brittle, seemingly lacking resilience, reserve capacity, and ability to adapt sufficiently to respond to the three threats.

Instead, the federal government took on more and more roles as shock absorber. It sought to avoid a 1930s-level financial melt-down and resulting depression by cushioning the effects of the financial misdeeds engendering the crisis of 2007-2009. The national debt rose by $4.5 trillion in the four years 1 October 2007—a jump of 51 percent.

It sought, also, to cushion Americans from the health, unemployment, and social disruption accompanying the Covid crisis of 2020-2022 and its aftermath. So the national debt rose by $12.7 trillion in the five years starting 1 October 2019—a further jump of 56 percent.

Persisting disagreement about the nature and gravity of international threats, the wisdom and safety of higher debt burdens on the economy and Treasury, and effective responses to social splits helped to paralyze effective public action.

Until 10 things happened.

1. Russia's continuing war on Ukraine threatened to spill over into Baltic states and Moldova.

2. Iran's announced construction of nuclear weapons led to air strikes, destruction of oil terminals, a spike in oil prices to $180 per barrel, and restricted flow of oil and gas to most of Europe, China, India, Japan, South Korea, Taiwan.

3. Congress and Trump agreed to boost defense spending from $850 billion in FY 2025 to $1.1 trillion in FY 2027.

4. Trump pushed through higher tariffs on China, Mexico, Canada, and other nations. These boosted prices on goods imported into the U.S., helping to fuel inflation here.

5. China suffered plummeting exports—along with soaring energy prices. These pushed China into recession. Top party officials sought to distract restive citizens by heightening confrontation over Taiwan.

6. Trump's cuts in corporate and personal income tax rates were enacted into law by narrow margins. So were cuts in federal spending on Medicaid, nutrition, and other programs. But the tax cuts totaled almost triple the reductions in spending, pushing up the yearly federal deficit to 8 percent of GDP. These, plus higher tariffs, raised the CPI by almost 8 percent in 2025 and by 11 percent in 2026.

7. This resulted in high boosts in mandatory cost-of-living adjustments to Social Security payments to retired and disabled Americans. The Social Security Trust Fund now seemed likely to be exhausted in 2030. If that happened, Social Security checks would, by law, have to be cut by about 17 percent, barring a hike in taxes to finance the Trust Fund.

8. At the same time, added federal borrowing pushed up interest rates. At Trump's behest, the Federal Reserve Bank was slow to fight inflation by raising interest rates even higher. When it finally acted in 2027, interest rates rose to 14 percent and a deep recession resulted, with unemployment rising above 10 percent. This resembled the stagflation following the 1973 and 1979 oil price shocks.

9. The recession was greatly magnified by a panic and crash resulting from a second collapse of a financial house of cards. Securitized debt—bonds and other debt converted into stocks and other financial instruments—had been resurrected from the shallow grave in which it had been buried after it nearly caused a world-wide depression in 2008.[104] Too much money chased too few legitimate investments. An inevitable liquidity crisis ensued. But this time, Congress refused to bail out lenders or borrowers. Trillions of dollars disappeared world-wide.

10. As old federal debt rolled over, requiring re-financing, the new interest rates on higher debt resulted in a doubling of the federal government's yearly interest payments to $2 trillion.

In 2028, as these problems became widely understood, citizens and politicians urged constraining yearly federal deficits, lowering interest payments on the national debt, and finding the money to pay for all the things Americans needed.

Health care was a focus of that political and public attention. Health care spending was both high and rapidly rising. The increasingly visible and frightening and costly failures inside health care undermined many citizens' confidence they would get needed, effective, and affordable care. Awareness rose that up to one-half of health care spending was wasted.

## C. Nature and causes of the crisis inside health care—delegitimization of more money for business-as-usual

Problems inside health care grew during the 2020s. Pressure for substantial reform rose. Public payers, employers, and rising shares of professional and institutional caregivers jumped ship. But they didn't jump into freezing waters without lifejackets. Rather, they jumped from a sinking ship to a safer one—one that, for each group, was better than the one they left.

Market competition, value-based payments, financial bribes, traditional government and private regulation, care suppression, and ineffective and oppressive administrative rules to contain spending all lost legitimacy. New ways were crafted to raise money, contain cost, assure medical security for all Americans, pay and configure caregivers, and boost quality of care and make it more equitable. These inter-locked, reinforcing one another. They were tested, modified, and found durable. They did require new financial and legal structures for health care.

U.S. health care suffered accumulating and highly visible, audible, and odorous organ failures. More money to finance business-as-usual became politically and financially unobtainable.

One reason was that health care did not productively use much of its yearly revenue. A second was the competing need for money to address other crises, international and domestic, facing the nation. Third, fixing U.S. health care was one of the key ways to liberate money to address those competing needs. Fourth, the waste, greed, and profits without honor plaguing U.S. health care enraged many.[105] Perception grew that "waste kills."

Growing coverage insecurity and access suppression, hospital distress and closings, doctors' distress, drug delegitimization, and long-term care and mental health shortages made patients and caregivers angry and insecure.

The politics of health care evolved as health care realities changed and became better understood. Even defenders of health care recognized the gravity of the high national debt and federal deficit. Most of those defenders joined most patients, voters, payers, and politicians in coming to recognize that more money for business-as-usual in health care was both unattainable and unnecessary.

The reasons for these recognitions are now discussed.

(Section D, which follows, takes up the ways in which the connections between the two crises—the one outside health care and the one within—were recognized and addressed successfully.)

From 2025 through 2028, the nation suffered deepening disagreements about the federal government's role in the economy, the size of tolerable yearly deficits and accumulated debt, income and social inequalities and whether and how to mitigate them, freedom and compulsion concerning vaccination and masking and other public health matters, abortion and sexuality, and tolerance for the ideas of others. These centrifugal forces worked to pull Americans apart.

In physics, centrifugal forces are exactly balanced by centripetal ones. Would that be true in politics, also?

After the 2026 mid-term elections, growing numbers of pragmatic politicians sought acceptable ways to contain federal government spending growth while doing more to address sources of economic and social discontents. Approaching one-fifth of the economy, health care became a prominent target. Rising numbers of desperate politicians argued that health care did not need ever more money.

One reason, sadly, was that cost and access problems had been worsening in tandem. High U.S. health spending led payers to spur or tolerate increasingly aggressive suppression of access to care.

This happened partly because effective caps on health spending had long been lacking, so suppressing access was accepted as one default method of holding down use of care and its cost. Even though it did little to actually stifle cost growth.

Long-touted cost controls were discredited. Medicare Advantage's sponsors had promised it would save money. But Medicare overpaid MA plans by 20 percent ($75 billion per year) in 2023.[106] MedPAC estimated overpayment at $80 billion yearly. To that should be added the $19 billion in spendthrift quality-related bonuses.[107]

Some had hoped that accountable care organizations could lower cost and raise quality, but ACOs made little visible difference.

Senate and House Republicans who disproportionately represented rural regions noted the continuing hospital closings, low rates of insurance coverage, high rates of medical debt, and worsening shortages of primary care back home.[108]

They contrasted U.S. health care's performance with that of the world's other rich democracies. Exhibit 1 – 5 compares life expectancy at birth with health spending per person across OECD nations. Generally, the two were positively moderately correlated at $R^2$ = 25 percent. But the U.S. was a marked outlier, with below-average longevity and double the cost per person.

They reviewed cost per person, rates of use of care, and health outcomes. They noted Papanicolas' and colleagues report that, between 2009 and 2019, avoidable mortality rose in each U.S. state while it fell in most rich democracies.[109]

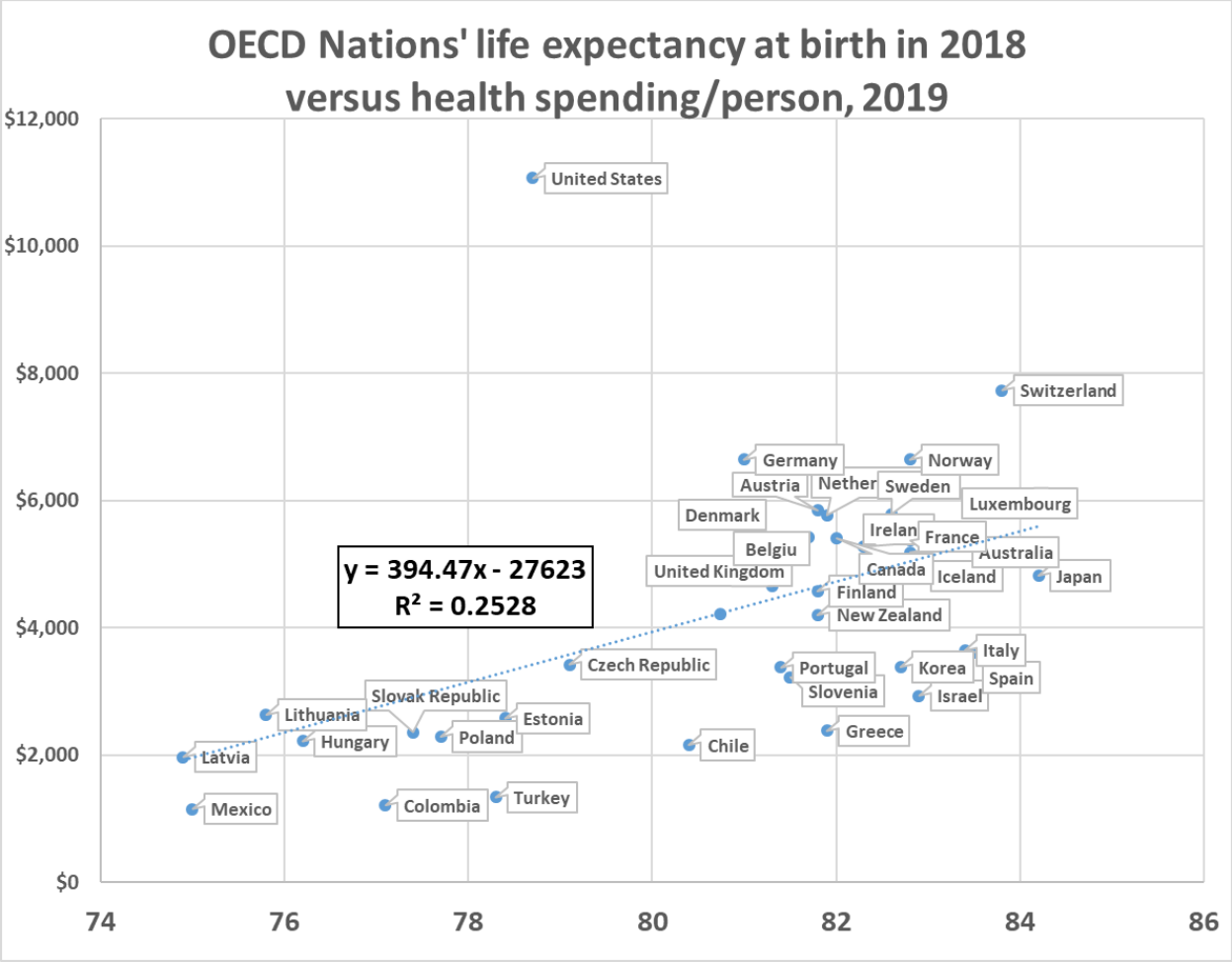
Further, that higher health care spending consistently was associated with lower avoidable mortality across nations but had no consistent relation across U.S. states.[110]

They recognized the hundreds of thousands of U.S. Covid deaths that would have been averted had our rates accorded with those in other rich democracies. Or even with those in the 10 U.S. states with the highest vaccination rates.[111] [112] [113]

Some recalled Milstein's 2013 warnings to doctors that rising health care shares of GDP were not sustainable, that much health care spending was unproductive, and that it crowded out spending on other needs.[114]

Growing evidence that up to one-half of health care spending was wasted led many caregivers and payers and patients to question the legitimacy of health care's organization, care delivery, and financing methods.

***Exhibit 1 – 5***




Some asked whether reasonable reforms could save money without cutting quality or volume of care. Hospitals and nursing homes—clinically and financially afflicted by Covid and its after-effects—saw this as the worst time to have to cope with threats to their revenue.

Nonetheless, the years of battles from 2025 to 2028 over the cap on federal indebtedness proved to be the spark that lit the fire that heated the crucible from which was forged a steamy sea change in political attitudes toward health care financing and delivery.

***A decade-long ban on metaphors also ensued.***

Biden's advisors had crafted his short-circuited 2024 re-election campaign to rely partly on efforts to hold down health care costs borne by citizens. Elements included negotiating lower

prices for 10 Medicare meds for 2026 and for more drugs subsequently, boosting federal subsidies for ACA marketplace plans (that may have cut 13 million covered citizens' premiums by an average of $800 yearly while doubling the number of Americans covered by those plans), and allowing hearing aids to be sold over-the-counter in drug stores.[115]

Those advisors had in mind lower costs perceived by voters. Even though lowering drug prices was very popular, citizens would not see any such benefits until 2026.[116] Worse, the negotiated prices for the first group of 10 Medicare drugs were three times as high as those already prevailing in western Europe.[117] And the lower ACA premiums, while real, were financed by higher federal subsidies, not by lower costs of care. They would expire at the end of 2025 unless extended.

It proved difficult to translate the advisors' hopes into votes—especially in the face of widely reported deep disenrollments in Medicaid. Even though state administrative actions—particularly in Republican states—were mainly responsible for those cuts.

At the same time, state Medicaid spending grew rapidly owing to the phase-out of Covid-related higher federal support for Medicaid. State Medicaid spending rose by 13 percent in fiscal year 2023 and by an added 17 percent in fiscal year 2024.[118] The result was a rise in Medicaid's share of states' tax revenue,[119] generating resentment and push-back from backers of education or infrastructure spending by states. That discouraged some states from working aggressively to restore eligibility for Medicaid patients disenrolled in 2023-2024 by expiration of Covid-emergency rules that had suspended semi-annual redeterminations of eligibility.

## 1. Amorphous worries

Repeated public opinion polls revealed Americans' deepening worries about health care costs, access, and quality. Gallup polls from 2001 through 2024 found that substantial majorities held consistently negative views of the health care industry.[120] [121] Four in five Americans reported either a great or fair amount of worry about the availability and affordability of health care.

Three-fifths of us asserted that the federal government should be responsible for assuring that all Americans have health care coverage. Only one-third had positive views of health insurance companies. And only about one person in five voiced much confidence in HMOs. Negative attitudes toward drug makers were even stronger.

Still, those attitudes and worries had long been politically irrelevant. Why?

First, as Blendon and colleagues asserted in 2006, most Americans disliked our methods of raising money, paying for care, or organizing and delivering medical services—but were fairly satisfied with their own medical care.[122] (One reason was that few Americans need much health care in a given year.) This parallels the common assertion that Americans' view of Congress was low—and falling—but were usually happy with their own representatives.[123]

Second, pollsters found that Americans agreed that health care problems were substantial but disagreed about how to address them. "[D]issatisfaction has not reached the point that they believe the system to be in crisis and that a completely new health care system is needed." [124]

Third, they noted that political analysts disagreed about whether politicians actually respected public opinion generally, across all issues—or even paid attention to it. They identified findings that public opinion could induce politicians to act, but other findings pointed to a growing gap between public opinion and political decisions.

Politicians had long been deaf to broad, episodic, and diffuse popular worries unless those concerns become intense, focused, durable, and organized. In health care, politicians had long listened to employers, insurance companies, hospital associations and medical societies, drug makers, and other focused stakeholders that lobbied and made campaign contributions.

In 2022, citizens' worries about health care rose substantially even as Covid death and hospitalization rates fell. Almost two-fifths of Americans—38 percent—said they delayed or refused to seek medical care owing to cost.[125] Subsequently, these worries were reinforced by alarming trends in the nation and world, and in U.S, health care itself.

By 2023, interestingly, the public came to form increasingly positive views of the Affordable Care Act's Medicaid expansions, subsidized individual coverage, and insurance reforms. Armour and Zitner attributed this to public financing of medical care and vaccines during Covid and to declining trust in markets or insurance companies.[126] Biden's markedly higher ACA premium subsidies may also have played a role.

A late-November 2023 poll found three-quarters of Americans dissatisfied with cost of U.S. health care.[127] And a late-2024 poll reported that only 44 percent rated health care quality at excellent or good levels, down from 54 percent in 2020 and as high as 62 percent at times between 2001 and 2020. Worse, satisfaction with coverage fell from 41 percent in 2012 to only 28 percent in 2024.[128]

Williams and others reviewed Democratic and Republican attitudes toward Medicaid.[129]
Late in the summer of 2024, Altman decried inattention to Medicaid during the presidential campaign. He warned of greater threats to Medicaid if Republicans won broad victories in November's election.[130] To pass a tax cut, they might seek some offsetting reductions in federal spending. With cuts in Medicare, Social Security, and defense deemed politically unlikely, Altman feared Medicaid would be a target. Republicans tended to view Medicaid as a welfare program, not as health insurance. Only about one-quarter of people on Medicaid were Republicans.

Against that, Altman cited evidence that Medicaid's broad popularity rivals that of Medicare and Social Security. It then covered some 80 million people—including two-fifths of children and three-fifths of nursing home residents. It was supported by advocates for elders and people with disabilities, and was the biggest federal aid program for states.

Altman therefore predicted that any cuts in Medicaid would be accomplished via waivers of current laws and regulations. While these might be consequential to some patients, they would be unlikely to save large sums quickly. If that proved correct, changes in Medicaid alone would do little to relieve increasingly intense political, economic, and fiscal pressure on the federal budget, deficit, and accumulating national debt.

A month before the 2024 election, Altman reported on the political party preferences of those covered by Medicare, Medicaid, and subsidized ACA plans. A narrow majority of

those on Medicare were Republicans and an equally narrow majority of those on Medicaid were Democrats. People covered by ACA plans were split almost equally. Altman further noted that individuals could be of two minds: some might politically favor "repealing the ACA" but also personally cling to the benefits it conferred on them.[131] This suggests that Republicans would need to think carefully before voting for Medicare cuts or letting enhanced federal ACA subsidies expire at the end of 2025. Galewitz reported that two-fifths of House Speaker Johnson's Louisiana constituents were on Medicaid.[132]

Indeed, poll results published early in 2025 showed that Americans were twice as likely to say that spending on Medicare and Medicaid was insufficient, as they were to say it was excessive.[133]

The confluence of rising premium and out-of-pocket costs, caregiver crises, and worries about federal deficits and ability to finance higher health spending meant that citizens' unhappiness and anger would become increasingly hard for politicians to ignore. But, in paying attention, politicians would need to take account of public support for higher Medicare and Medicaid spending.

In December of 2023, Markovich, CEO of Blue Cross of California, said that rising health care costs would mean "'There's going to be a reckoning about what to do about health care and it's going to happen in the face of most, if not all the players, in the health care value chain being deeply unpopular.'" [134]

## 2. A catalog of crises inside health care

Between 2025 and 2028, the international, economic, political and social stresses sketched in section B of this chapter continued to grow. These external forces all worked to constrict the annual infusions of added money to pay for health care.

Inside health care, access, cost, caregiver, and other problems also grew, but politically acceptable remedies failed consistently.

Problems of health care access, cost, caregiver configuration, caregiver frustration, and quality antedated Covid. Covid worsened all of them.

After the immediate Covid crises were stabilized, continuing increases in cost, constrained and suppressed access, caregiver malconfiguration and unhappiness, uneven quality, and more visible evidence of waste combined to delegitimize business-as-usual in U.S. health care.

External constrictions of revenue and internal delegitimization helped to persuade and prepare increasing numbers of caregivers, patients, citizens, payers, and politicians to accept reform.

**Market failure and government incompetence made for health care anarchy**

Competitive free markets have long been widely valued and accepted in the U.S.—usually for good reason. Greed for profit is the engine of the market. Adam Smith's invisible hand induces profit-seeking producers to innovate to keep cost as low as possible, and to deliver what people want to buy. It thereby converts greed into efficiency, productivity, and satisfaction of consumer demand.

Unfortunately, not one of the 7 requirements for a competitive free market is satisfied in health care (see chapter 4). Imagining a competitive free market to perform well in health care is like expecting sugar cane to thrive in the Arctic.

This means that, with rare exceptions, greed has generated profits without honor in health care—illegitimate and undeserved profits—not warranted by innovation, efficiency, low cost, or by delivering what people want to buy. Galbraith remarked that "The modern conservative is engaged in one of man's oldest exercises in moral philosophy; that is, the search for a superior moral justification for selfishness."

To applaud profit in health care—and the greed that powers its pursuit—when each of the requirements for a competitive free market is absent and unattainable, is to invert Adam Smith and pound his head into the ground.

This assessment applies to all for-profit caregiving, not only to the private equity-backed Steward and Prospect entities whose reckless pillaging of hospitals and subsequent bankruptcies made private equity the face of greed in health care in 2024 and 2025.

The problem is endemic. Narrow laws promising to prevent a recurrence of private equity scandals like Steward's and Prospect's do nothing to address the larger problem. Comprehensive market failure in health care means that no profit-seeking caregiving is legitimate or trustworthy in health care.

Nonetheless, many politicians long touted market remedies for health care problems. Some did so because they believed indiscriminately in markets. Others, because proponents of competition were powerful while opponents were politically weak and disorganized. Still others, because they knew little about health care and did not wish to learn. If they urged "letting the market work," they let themselves off the hook of accountability.

Others might have preferred markets because they sought profit. And market-friendly economists might have wished to conjure up market mirages or, more honestly, have sought ways to shoehorn health care realities to fit the some of the competitive free markets' 7 requirements.

Many chose to plug markets, despite their obvious flaws, because they had little confidence that federal, state, or local governments could do better—and many feared that governments could do worse.

Unfortunately, reasons for expecting little from government in health care were ample and valid. Governments do some jobs well. They are generally efficient at raising money. While they can be effective at financially covering citizens to make health care affordable, at capping spending

to contain health care costs, and at securing needed caregivers in the right places, they have rarely done these jobs very well in the U.S.

Owing partly to accidents of history, U.S. health care evolved to be very costly while failing to cover large shares of citizens very well—or at all. Governments here have failed to take accountability for any vital health care jobs, either alone or in alliance with private payers.

Uniquely across the world's rich democracies, governments in the U.S. have failed to recognize that health care for all was impossible without cost control—and that cost control efforts were unsafe and ineffective and politically untenable without assuring health care for all. Further, no government or private parties in the U.S. were accountable for identifying needed services, measuring current supply, or filling the gap between the two.

Because governments in the U.S. failed to do well at those big jobs—the ones that governments are actually competent to handle—they have been asked incessantly to undertake myriad small jobs. Most of these entail cleaning up after abuse or neglect or waste attendant on widely disseminated market failure. Even worse, governments generally have been unwilling or incompetent to succeed at these small but numerous and inherently difficult jobs.

Government actions in health care usually crudely paralleled those of the worker with shovel and barrel who follows the circus parade. Please refer to Exhibit 1 – 6.

***Exhibit 1 – 6***

***Following the Circus Parade***

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One such small job is to police network adequacy. Since government tolerates narrow networks of doctors and hospitals to serve Americans covered by MA or Medicaid managed care or ACA marketplace plans, it must promulgate regulations defining network adequacy. But does it have the means to measure adequacy of thousands of networks, compare it to standards, and enforce the rules? No. That job is impossible to perform competently or efficiently or effectively. It's the wrong job. This is one reason other rich democracies don't tolerate narrow networks. A second reason is that those nations actually strive by efficacious methods to contain costs, obviating reliance on the gimmick of narrow networks.

Other small jobs include protecting patients unable to afford needed care; clawing back dollars unjustifiably grabbed by MA plans; targeting section 340b drug subsidies to caregivers most needing the money; designing NSA provisions that can be competently, efficiently, and equitably administered; responding to bankruptcies of needed caregivers; and combatting horizontal or vertical mergers involving hospitals, doctors, insurance companies, long-term care, and others. (See chapter 5.)

Rising shares of doctors, nurses, other professionals, hospital trustees and managers, and others working in health care lost confidence in public and private payers' methods of covering Americans and serving patients, paying caregivers, and containing cost.

Increasingly, they recognized that competitive free markets did not exist in health care, and that traditional government action was rarely competent.

And that anarchy is the prime consequence of market and government failures.

Anarchy meant absence of built-in and effective cost controls, no effective protections for patient access to needed care, and no mechanisms to identify, protect and sustain, or secure needed caregivers.

This anarchy interfered dangerously with caregivers' abilities to act professionally and honorably to serve patients. Ensnared in payers' paperwork, and fighting for revenue by upcoding services, more and more doctors, non-profit hospitals, and other caregivers felt tainted, manipulated, alienated, and burned out.

In the years after 2025, business-as-usual in U.S. health care was delegitimized by the growing awareness of market failure, government incompetence, and the anarchy and waste resulting from both.

At the same time, public and private payers' flailing efforts to limit spending or boost quality lost credibility. Federal and state legislators and executives, and most large employers, finally saw that health care had become a costly, chaotic catastrophe. They acknowledged the failure of both competitive markets and traditional public regulation.

This recognition paralleled British and French politicians' realization, after the first three years of the First World War, that their generals were wrong to believe that humans could successfully charge through mud and barbed wire into entrenched machine gun and rifle fire.

***A third method was increasingly recognized and valued.***

Simpler and more trustworthy methods of payment were designed and tested. They entailed paying caregivers in financially neutral ways that liberated and obliged them to spend inevitably finite dollars carefully. As caregivers self-regulated financially and clinically, they experienced quick relief from the crushing dollar, time, paperwork, and alienation burdens that had long oppressed them. Those burdens had stemmed from mistrust-driven financial incentives, penalties, and payers' regulation of both payments and clinical decisions.

Caregivers increasingly recognized that escaping from invidious financial incentives and the paperwork that inevitably ensued from those incentives required financial neutrality, trust, and professionalism. Physicians saw that the first price of gaining autonomy and escaping paperwork was taking on accountability. The second was negotiating satisfactory incomes and then ceasing to think about their own revenue from day to day.

**Waste meant poverty amid plenty.** Delegitimization of business-as-usual was heightened by payers', politicians', patients', and the public's dismay over growing evidence of waste inside U.S. health care.

Provision of low-value/high-cost care and other clinical waste, administrative waste, high prices for meds and CEOs, and theft all weakened the case for added revenue for health care. Prominently visible among these were Medicare Advantage plans' gaming of capitation formulas to generate dozens of billions of dollars in undeserved revenue each year, failures of most pharmacy benefits managers to work assiduously on behalf of their clients, and financial manipulations by Steward, Prospect, HCA, Tenet, and others.

Dismay edged toward fury as more Americans became aware that costs rose and access was suppressed while up to one-half of health spending was wasted. One slogan was, "squander→ squalor." The extent and causes of waste—and some of its remedies—are addressed at length in chapter 3.

**Soaring costs.** By the mid-2020s, health spending in the U.S. was rising by $1 trillion every four years. That four-year sum equaled yearly spending on defense or yearly interest on the national debt.

In those years, payers, caregivers, and politicians could not agree on cost controls that were effective and also protected both patients and caregivers. Instead, they passively accepted or actively embraced cost controls that suppressed many patients' access and bankrupted some caregivers—but that did little to contain cost.

The politically acceptable cost controls did not work; many magnified waste. Mistrusting doctors and hospitals, insurers and other payers attempted to contain cost by scrutinizing caregivers' clinical decisions and their coding of patient care. Payers denied prior authorization, denied payment after care was given, and downcoded caregivers' bills. Caregivers appealed. Higher costs resulted. Mistrust magnified, fueling anger.

The extent of the cost problem is discussed briefly later in this section; remedies are analyzed in chapter 8.

**Suppression of access.** Even though the ACA slashed the share of Americans with no health insurance coverage, the years since its 2010 passage saw a proliferation of barriers that sought to contain cost by suppressing access to care.

Financial barriers included rising premiums and out-of-pocket costs for health insurance through the job, rising Medicare premiums, higher drug prices, facility fees, insurer denials of payment for care already given, and fear of surprise bills.

Non-financial barriers included narrow and shifting networks of doctors and hospitals, insurers' prior authorization barriers to care, the growing shortage of primary and behavioral care, and hospital closings and service cuts.

These barriers to access were put in place in hopes of restricting volumes of care and thereby containing cost. They failed. That was partly because high U.S. costs stem much more from higher prices than from volumes of care, partly because caregivers gamed payment rules to boost their revenues, and partly because so much of U.S. spending was wasted. Other rich democracies generally constrained health care spending directly, so they didn't need to resort to suppressing access.

High shares of Americans reported they had not obtained needed or recommended care because they could not afford it. Others did not obtain care because their doctor had retired or their hospital had closed.

Increases in health spending no longer financed improved access to care. Instead, high costs spurred suppression of access because that was intended or accepted as a way to slow cost increases.

Evidence on access problems is summarized later in this section; remedies are taken up in chapter 7.

**Caregiver meltdowns.** One sign of anarchy was that doctors and hospitals were becoming less and less available, especially to lower-income people.

The growing melt-down of primary care plagued both rich and poor. Inability to find a family doctor worked powerfully to delegitimize health care business-as-usual for many Americans.

Hardly anyone questioned the importance of primary care—to protect and enable access, to coordinate care and assure continuity, to contain cost, or to secure appropriate and high-quality care.

But no one acted effectively to protect and rebuild primary care. Most activities were indirect and, therefore, very weakly linked to actually putting more primary care doctors together with patients. These were promises, not guarantees.

Ineffective posturing included building more med schools, lowering or even eliminating medical school tuition, and forgiving debt. Some states set targets for higher share of health spending on primary care. But this indirect approach was hard to enforce effectively and did little good.

The three direct and simple remedies—assuring substantially higher incomes for primary care doctors, trustworthy payment methods that slashed useless paperwork, and smaller panel sizes were almost entirely ignored.

Urban and rural hospital closings persisted. Closings disrupted care patterns. They meant longer travel times for care. Surviving hospitals enjoyed greater leverage over payers, allowing them to win higher prices. Closings also undermined practices of many of the doctors remaining nearby. Federal and state governments papered over harm from closings, often choosing publicly to label them as legitimate judgments by a notional free market.[135]

Only one state government has a list of the hospitals needed to protect citizens' health. Only that one state, Maryland, has a legal obligation to ensure that needed hospitals are paid enough money to deliver needed care efficiently.

Elsewhere, states were unwilling to learn which hospitals were needed—often because they did not wish to take on responsibility for protecting them. Few state governments had the knowledge, tools, or willingness to use them to put needed but distressed hospitals back on their financial and clinical feet. Hospitals were increasingly split between money-making and money-losing institutions. Those expecting to survive usually opposed government action to identify and stabilize their perceived competitors.

In 2020-2021, nursing home residents and staff suffered high rates of Covid infections and deaths. Nursing home closing rates accelerated. Many beds could not be used owing to worker shortages. Bankruptcies and shortages often stemmed from many states' low Medicaid prices for nursing home care. Post-Covid, higher numbers of hospital patients ready for discharge were forced to wait in hospitals until nursing home beds opened up. Shortages of staffed hospital beds forced ERs to board patients in hallways until beds became available on inpatient units.

Physicians, nurses, other hospital workers, and nursing home workers reported substantial rates of burnout, frustration, and alienation.[136]

Caregiver configuration and related problems are discussed briefly later in this section. Causes and remedies are taken up in chapters 11, 12, 13, and 14.

**Reasons to hope for something better.** Growing shares of physicians, dentists, hospital trustees and CEOs, nursing homeowners, social workers, and even owners and managers of big drug companies worried that established ways to finance and deliver health care were unsustainable.

They came to believe that the alternative to reform would be less and less money for business-as-usual.

Many—perhaps most—recognized that they could no longer count on the steadily rising stream of revenue on which they had depended. They were ready for reform. But still apprehensive about what it might mean. Would its design and implementation be sound? Would reform make things better or just different?

Most doctors, hospitals, and other caregivers, along with some patients, were alarmed by the financial crisis and anarchy afflicting health care. Caregivers' addiction to more money for business-as-usual could no longer be fed.

Profoundly, they came to accept the need for cost control as the **first** of three elements of a new formula for financial stability.

That need was reinforced by looming obligation—and political pressure—to better serve the growing number of very elderly Americans.[137]

The **second** element was the growing need to cover everyone well, and the opportunity to do so. After 2023, rising numbers of uninsured and under-insured Americans and rising costs gradually discredited liberal reformers' belief that they could afford—financially and politically—to buy full tickets of admission for all Americans into unreformed U.S. health care.[138] Worse, many caregivers' own financial crises and looming bankruptcies frightened more and more patients—and voters. They demanded that their own care crisis and the caregivers' financial crisis be addressed together.

The **third** element was the real opportunity to save vast sums by cutting wasteful misuse of existing health care revenues—and to use the money saved to protect both patients and caregivers. This was the main financial lubricant that allowed caregiver stabilization, care for all, and cost control to move forward together.

It was reinforced by the opportunity to shove overboard most of the private and public payment bureaucracies that plagued both caregivers and patients, and that failed to contain cost or protect either access or quality.

Still, a non-trivial minority of physicians, hospital trustees and CEOs, and other caregivers were not ready for change. Unable or unwilling to look forward, they clung to fantasies of returns to various good old days. Would these caregivers be forced to go along with reforms? Or could a few generate enough revenue from privately paying patients? What latitude might these caregivers enjoy to remain outside the reformed world of contained cost, assured access, and reconfigured caregivers?

## 3. Cost crisis

By the mid-2020s, health care spending was rising by about $1 trillion every four years.

As shown in Exhibit 1 – 7 – A , U.S. health spending passed $1 trillion in 1995, $2 trillion in 2005, $3 trillion in 2014, $4 trillion in 2020, and $5 trillion in 2024. It was expected to reach $6 trillion in 2027 and $7 trillion in 2030.[139] These demarcations are impressive. Chapter 8 discusses causes of cost increases and remedies for them—both puerile and sound.

Spending increases compounded yearly. Health care spending had become so high that it visibly snowballed at unaffordable rates. In 2024, for example, when health spending reached $5 trillion, a 5 percent rise added a quarter-trillion dollars yearly.

In 2025, health costs were over 6 times defense spending. Costs per person were more than double the rich democracy average. But Americans were not getting our money's worth: We benefitted from substantially fewer hospital admissions and doctor visits, and suffered inferior health outcomes. Chapters 2 and 3 explore these topics.

***Exhibit 1 – 7 – A***

***National Health Expenditures, 1960 – 2032 (Projected from 2024 Forward)***

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 1960 | $27 | | 1978 | $194 | | 1996 | $1,074 | | **2014** | **$3,002** |
| 1961 | $29 | | 1979 | $220 | | 1997 | $1,133 | | 2015 | $3,164 |
| 1962 | $32 | | 1980 | $253 | | 1998 | $1,198 | | 2016 | $3,305 |
| 1963 | $35 | | 1981 | $294 | | 1999 | $1,273 | | 2017 | $3,444 |
| 1964 | $38 | | 1982 | $331 | | 2000 | $1,366 | | 2018 | $3,601 |
| 1965 | $42 | | 1983 | $365 | | 2001 | $1,483 | | 2019 | $3,756 |
| 1966 | $46 | | 1984 | $402 | | 2002 | $1,631 | | **2020** | **$4,156** |
| 1967 | $51 | | 1985 | $440 | | 2003 | $1,770 | | 2021 | $4,289 |
| 1968 | $58 | | 1986 | $472 | | 2004 | $1,895 | | 2022 | $4,465 |
| 1969 | $65 | | 1987 | $514 | | **2005** | **$2,027** | | 2023 | $4,867 |
| 1970 | $74 | | 1988 | $577 | | 2006 | $2,165 | | **2024** | **$5,120** |
| 1971 | $82 | | 1989 | $642 | | 2007 | $2,306 | | 2025 | $5,369 |
| 1972 | $92 | | 1990 | $719 | | 2008 | $2,402 | | 2026 | $5,638 |
| 1973 | $103 | | 1991 | $786 | | 2009 | $2,493 | | **2027** | **$5,973** |
| 1974 | $116 | | 1992 | $852 | | 2010 | $2,590 | | 2028 | $6,303 |
| 1975 | $133 | | 1993 | $915 | | 2011 | $2,677 | | 2029 | $6,667 |
| 1976 | $152 | | 1994 | $966 | | 2012 | $2,783 | | **2030** | **$7,029** |
| 1977 | $173 | | **1995** | **$1,020** | | 2013 | $2,856 | | 2031 | $7,410 |
| | | | | | | | | | 2032 | $7,813 |

Source: Office of the Actuary, CMS, NHE Historical and Projections, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected. The 2023 spending is provided in Anne B. Martin, Micah Hartman, Benjamin Washington, and others, "National Health Expenditures in 2023: Faster Growth as Insurance Coverage and Utilization Increased," *Health Affairs,* Vol. 44, No. 1 (January 2025), pp. 1-11, https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2024.01375. Projections for 2024 and subsequently rested on the reported NHE for 2023.

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**Dwindling optimism about costs**. Rates of rise in spending sometimes slow; they even plateau for as long as a decade.[140] At these times, some experts chose to believe that continuing to provide more money each year to sustain business-as-usual was a real option. Journalists sometimes seized on these slowdowns to trumpet genuine change. Lowrey had been prominent in such reporting.[141] [142]

Sanger-Katz and others noted that growth in Medicare spending per beneficiary was slower than projected during the years since 2010.[143] They explained this slowdown in part by noting that Congress enacted markedly slower payment increases for doctors and hospitals. And by the finding that incidence of heart attacks and strokes declined.

The decline in the average age of Medicare beneficiaries between 2010 and 2021 doubtless played an important role. But those demographics shifted subsequently as baby boomers aged and needed costlier care. Sanger-Katz and others reported that the upward spike in cost per beneficiary was projected to resume soon.

Emanuel long supposed that pay for value and accountable care and MA plans have been and would be effective in slowing health costs.[144]

But the sanguine group shrank steadily. One reason was growing evidence that pay-for-value and accountable care and MA had done little—or nothing—or worse—to hold down health care costs.[145] [146]

A second reason was the rapid growth in health care employment—and costs of employment—post-Covid. McCall estimated that caregivers added 1 million health care jobs from Covid's onset in March of 2020 through March of 2024. That's an 8.2 percent growth, more than double the 3.8 percent rise in all other jobs. All major health care sectors—except nursing home care—more than recovered the immediate loss of jobs they suffered in the spring and early summer of 2020.[147] Even so, many jobs remained unfilled, pushing pay upward. More workers plus higher pay per worker combined to mean substantial growth in caregivers' own costs.

Each pause in spending engendered announcements that costs have been contained. But these were brief. Soon, high wages, prices, worker shortages, and utilization rates accelerated spending increases.[148] Post-Covid, spending in Massachusetts grew by 8.6 percent in 2023, more than double the state's desired benchmark rate.[149] [150] Even assuming sustained economic growth, some forecasted that health care costs nationally would return to one-fifth of GDP.[151]

After 2020, the $250 billion average yearly rise in spending had two profound effects. First, it crowded out spending on other valuable things—like housing, transportation, infrastructure, education and job training, or personal/neighborhood/ national security. Those seeking more money to address these things began organizing to oppose higher spending on health care. Some even hoped that focusing on these SDLs would cut health spending.

Second, the chronic failure of both market competition and public regulation to slow the rise in costs undermined both many patients' access and many caregivers' finances. Cost control failures made it much harder to find the money to finance Medicare, Medicaid, ACA subsidies, or private insurance. Consequently, cost controls defaulted in two directions—toward suppressing access to care via under-insurance and over-bureaucratization, and toward squeezing caregivers and fighting with them about payments.

**Growing evidence of enormous waste.** Worse, competitive and regulatory failures propagated even more of each of the four types of waste. The four are discussed and documented in chapter 3.

Up to one-fifth (20 percent) of health care spending ($1 trillion in 2024) was wasted by provision of care that never was appropriate, was not needed by a particular patient, was not sought or wanted by a particular patient, was incompetently provided, was provided inefficiently, or was of very low value to a particular patient owing to its high cost and small clinical value.

Lack of solid evidence on efficacy of much care or when it was needed, defensive medicine, financial incentives built into some payment methods, excessive care for patients covered by high-paying insurers, shortages of primary care to coordinate services and match them to patient needs or requests, and over-provision of care in costly surviving hospitals helped explain clinical waste.

Up to 15 percent was wasted on administration, or $750 billion in 2024. Vast private and public bureaucracies were required to shift money from payers to caregivers or to block those shifts. The money flowed through pipes that were—often deliberately—convoluted, constricted, or choked with waste.

Complexity was the most commonly cited cause of administrative waste—the large numbers of payers, each with its own varying prices for different caregivers, rules of payment, quality reporting, other data requirements, forms, and procedures. Payment for individual services—visits to doctors or surgery, hospital admissions, and the like—required processing of billions of bills yearly.

Although waste from complexity was great, waste from mistrust between payers and caregivers was probably substantially greater. Payers and caregivers fought about what care was needed, what care was billed for, what care was actually given, and what price was warranted. Caregivers frequently upcoded, billing for higher-paying care than they actually gave. This was either corrupt or caregivers' effort to garner money they honestly believed they were due. Many might have upcoded and over-billed in hopes of generating fair incomes, net of anticipated downcoding and denials by payers.

Excess prices accounted for at least one-tenth (10 percent) of health care spending in 2024. That was $250 billion yearly. High prices for hospital care, doctors' services, and prescription drugs were mainly responsible.

High incomes for hospitals' and insurance companies' CEOs and other managers, though visible and usually politically embarrassing, were relatively small overall contributors. As Galbraith said, "The salary of the chief executive of a large corporation is not a market reward for achievement. It is frequently in the nature of a warm personal gesture by the individual to himself."

Early U.S. health insurers gave doctors and hospitals remarkable latitude to set their own prices. Hospital closings and mergers of many survivors, mergers and purchases of doctors' practices, and vertical integration of caregivers all endowed caregivers with greater leverage over the insurance companies paying for MA, employer-sponsored, or ACA-subsidized care. Higher prices resulted. With relatively few hospital beds or physicians per 1,000 Americans—compared with other rich democracies—these caregivers were well-positioned to demand higher prices.[152]

Remarkably, those seeking to contain cost gave radically excessive attention to volumes of care when prices were much more culpable. Those aiming to contain cost were beguiled by the simple financial analyses that have long shown that paying for care by the unit of care—fee-for-service payments for doctors' services or payment per discharge—builds in a strong financial incentive to boost volumes of care. When volume of care rises, revenue rises faster than cost. That's mainly because so many costs are fixed; that is, they don't vary with volume or severity of illness. This led cost-controllers to try to craft methods of offsetting these financial incentives.

But those cost-controllers ignored the reality that U.S. rates of hospital discharges were only about four-fifths of the rich democracy average. And that U.S. rates of doctor visits were only about three-fifths of the rich democracy average.

If you shoot five yards to the right of your target, you are likely to miss it. Since U.S. health spending per person is roughly double the rich democracy average, and since higher rates of use of care cannot account for any part of the U.S. excess, 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".[153] [154]

Excess prices for prescription drugs are probably the most dramatic. As discussed in chapter 15, other rich democracies negotiate or regulate drug prices far more effectively than do fragmented U.S. payers. Remarkably, even after Medicare concluded its 2024 negotiations on the prices of the 10 meds for which it paid the most money, Medicare prices remained about 275 percent of those obtained by western European nations.

And a final one-twentieth or 5 percent ($250 billion in 2024) of health care spending was simply stolen in dozens of different ways—large and small, recurring and one-time.

Very weak financial and clinical accountability, along with administrative complexity and mistrust, enabled much of the theft of some $250 billion in 2024. Also implicated were the widespread legal financial bribes and penalties facing caregivers, inducing them to think about money too often, too stridently, too self-interestedly, and in excessive detail.

One example, reported by Kliff and Thomas: 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.

It might be argued that this is theft, clinical waste, or some of each—on the border between the two.

Kliff and Thomas note that Medicare spent more on skin substitutes than on ambulances, anesthesia, or CT scans.[155]

Financial complexity, mistrust, and generated the moist environment in which the mold of theft grew.

Open-ended financing of most health care allowed thieves to imagine that their crimes were victimless because stolen money was replaced by new money. That had never been true because high costs spurred efforts to suppress access. Still, this perception might help explain inadequate criminal prosecution of thieves.

Those whose thefts are in 6 or 7 figures are likelier to go to jail than those who grab 8, 9, or 10 figures of undeserved money. The largest thefts very rarely result in jail time. Since health care theft is calculated, not impulsive, failure to jail helped encourage further criminality.

Beginning in the mid-2020s, growing awareness of unnecessary care and other clinical waste, administrative waste, high prices, and theft combined to delegitimize calls for providing more and more money to finance health care. So did notionally legal misappropriations like Medicare Advantage plans' gaming of capitation formulas to generate scores of billions of dollars in undeserved revenue yearly, failures of most pharmacy benefits managers to work assiduously on behalf of their clients, and financial manipulations by Steward and Prospect and others that bankrupted hospitals needed by citizens who were already vulnerable to inadequate care.

In addition to undermining appeals for higher revenues, these and other bad behaviors led many payers to question reliance on competition in health care generally or profit-making specifically.

**Reliance on ineffective remedies**. Some critics noted that health care coverage was usually open-ended. One long-standing but still discussed Republican response was converting Medicaid from an open-ended entitlement to a block grant to individual states.[156]

A second was to end Medicare as an entitlement and instead provide vouchers to subsidize individual purchase of private insurance.[157]

Some Republicans and others also urged continued efforts to push health care toward a competitive market by requiring price transparency, by boosting patient OOPs, and by expanding use of health savings accounts (HSAs) for patients with chronic health problems. Others call for "giving control back to individual patients working with their providers, not government agencies or programs."[158]

Another proposal was to pay caregivers by capitating individual patients. A widely held belief was that payment by the unit of care—the doctor visit or the hospital admission—incentivized giving more care. Critics disparagingly called this "pay-for-volume." So they sought to push patients into managed care arrangements like accountable care organizations (ACOs) or Medicare Advantage (MA) plans. And they generally approve of eff0orts to force Medicaid patients to obtain care from similar organizations—managed care run by insurance companies.

These arrangements won support from many Democrats because they seemed to establish budgets to pay for care for groups of people. And they attracted Republican support because they looked like competition and also because they came to be run overwhelmingly by for-profit insurance companies.

This proved to be bi-partisan folly.

These capitated managed care plans and their caregivers were to be "paid for value," not for volume. Their revenue was to be adjusted for the expected costs of care of their patients. The Medicare ACOs faced some financial risk: If costs of care prove to be higher than predicted, they shouldered some of the loss. If costs were lower than predicted, they shared in the gain—as long as quality measures were satisfied.

Although these efforts were pushed for decades, they did very little to contain cost, improve equity, or boost quality and appropriateness of care.[159] [160] Because MA plans' capitation revenue depended on the perceived medical needs of their patients, the plans became skilled at

gaming or manipulating capitation payments upward by making their enrollees look more sick, fragile, and costly to serve than they really were. Some MA plans learned to game Medicare's star ratings of quality to win added undeserved income.

Because MA plans, Medicaid managed care, and other managed care arrangements' revenues were capped in various ways, they were financially incentivized to hold down costs. Because they lacked effective clinical mechanisms to hold down costs safely, they relied heavily on refusing to authorize some patients' care, denying payment for care given, squeezing caregivers during price negotiations, forming narrow networks of doctors and hospitals, or downcoding caregivers' bills.

These alternative payment mechanisms—pay for performance or pay for value—were unable to contain cost. But because many of their proponents seemed to believe that no other options were available, they called for more of the same. Others sought incremental improvements in capitation formulas, quality measures, and the like. Unsurprisingly, those notions were never commensurate with the size of the cost problem.

Even many very smart and dedicated people fell into this trap. The "Better Care Plan" was one example.[161][162] Its main nominal, ostensible, or hypothetical elements were team-based primary care, continuous quality improvement, combating inequities, risk-adjusted capitation paid to caregivers, and competition by quality, safety, access, and price.

Unfortunately, the actual efforts proposed by the plan were small. Only weak reforms were sought in primary care, patient safety and outcomes, and risk-adjusted prospective payment. Proposed improvements were so modest that this might be called the "not much better care plan" or "a little more of the same plan." If ACOs cut cost by only 1.5 percent in the study cited [163]—and it isn't clear if this figure is net of gain-sharing payments or of administrative costs inside the MA plans or Medicare itself—how could heavier reliance on ACOs save much more money?

Indeed, Parashuram and colleagues studied the Next Generation ACOs, operated from 2016 to 2021, and found that they increased spending per beneficiary by just over $50 per year when gain sharing payments to caregivers were factored in.[164]

It is hard to pay for value if value is hard to gauge. Berenson and colleagues concluded that decades of efforts to measure clinical processes and outcomes, and patient experience, "may have actually compromised care delivery—at a high cost."[165]

One reason is that the various financial incentives touted by some reformers made doctors and hospitals even more sensitive to money—but in the wrong ways. In ways that could corrupt clinical judgment. That wasted clinicians' time. And that alienated conscientious doctors, nurses, and hospital administrators.

Gain-sharing was a subtle bribe. Better to liberate doctors to spend large but finite sums as carefully as possible, thinking only of patients—not of themselves.

The sound alternative was to pay caregivers by methods that make them financially neutral, thereby freeing them to marshal large but finite budgets to do as much clinical good as possible. That eliminates need for the wasteful, burdensome, but incompetent private and public regulatory oversight that plagues caregivers today.

But this alternative would require that physicians be recruited, trained, and enabled to act professionally and even altruistically. That, in turn, entails paying them well enough—and by sensible methods—so they put their own incomes in the background and focus instead on doing as much good as possible for their patients with the money and time available. Similarly, it would oblige hospitals to act not as profit-maximizers but rather as fiduciaries, devoting their own finite resources to doing as much good as possible for patients.

**Medicare**. Congress had sought to tighten basic Medicare payments to doctors and hospitals for several years before 2026 by setting annual price updates for doctor visits or hospital admissions below the rate of increase in costs of giving care. The American Hospital Association asserted that overall hospital costs rose more than twice as quickly between 2019 and 2022 as did Medicare payments for inpatient care.[166] And the American Medical Association complained that Medicare's conversion factor for doctor payments fell from $36.09 in 2020 to $33.29 in 2024, a cut of almost 8 percent at a time when the all-item consumer price index rose by 20 percent.[167] (The conversion factor translated codes for types of care into dollar payments.) Many doctors appeared to have responded by billing for better-paying care codes.

Any remaining savings to traditional Medicare stemming from tightening the conversion factor was more than offset by Medicare Advantage plans' aggressive manipulations of both the risk adjustment for their members' capitation payments from Medicare and of Medicare's misguided quality bonuses. And also by MA plans' rising share of Medicare patients—surpassing one-half by 2023. A detailed *Wall Street Journal* investigation of MA plans in 2024 was headlined "Insurers Pocketed $50 Billion from Medicare for Diseases No Doctor Treated."[168] This work repeated years of frequent assertions that MA plans garnered profits dishonorably—by making their enrollees look more medically needy than they actually were.[169]

Interestingly, Wainer reported that investors expected Trump would be financially kind to big MA plans if elected again.[170] If so, this open-spigot financial policy would boost unjustified health spending at a time of high federal deficits, endemic health care waste, and great competing needs. This raised the height from which health spending would inevitably fall.

MA plans were not the only discredited remedy for high cost. The Congressional Budget Office's September 2023 report found that the Center for Medicare & Medicaid Innovation had consistently failed for over a decade to save money. This heightened readiness to consider new approaches to slowing cost increases.[171] That report sharply questioned the cost-cutting value of "pay for value," ACOs, and their cousins. In reaction, many realists paid greater attention to effective cost control methods successfully employed in the world's other rich democracies.

High deficits and high inflation impaired capacity and willingness to sustain real, inflation-adjusted, increases in federal spending on Medicare, Medicaid, and ACA subsidies.

Importantly, by 2028, Congress and the administration saw the looming exhaustion of the money in Medicare Part A's trust fund. Unless something changed, exhaustion would oblige either a cut in payments to hospitals or a rise in the Part A Medicare tax rate on employees and employers.

The odious manipulation of MA capitation rates by for-profit insurance companies, led by United Health,[172] pushed Congress to radically slice federal MA payments. Most insurers' stock prices fell substantially from the inflated levels to which they had been pushed by profits stemming from inordinate federal MA subsidies. (Indeed, as early as February of 2025, announcement of a Justice Department investigation into manipulation of payments to MA plans had caused stock in United Health, Humana, and other insurers heavily involved in MA to plummet.[173] [174] Shortly thereafter, though, Trump proposed boosting MA plans' rates by more than twice as fast as the Biden administration had recommended. Insurers stocks' soared.[175])

More states recognized MA to be an unstable sham. Fearing that more of their citizens would wish to flee MA, more states enacted mandatory community rating for Medi-gap plans to make it easier for Americans leaving MA to find financial security in traditional Medicare. Previously, only Massachusetts, Maine, Connecticut, and New York had legislated that requirement.

The patients in MA plans in 2028—then over three-fifths of those on Medicare—had reason to fear they could be forced to switch to a less desirable plan and worried they would lose both their extra benefits like modest payments for dental or hearing care, and their caps on yearly out-of-pocket obligations.

The effects on care of slow growth in Medicare payments were compounded by the rising numbers of patients covered by Medicare, and their steady climbs in average age and need for medical services. Medicare beneficiaries numbered some 63 million in 2022; CBO and CMS projected a rise to 74 – 76 million by 2031. The long-standing U.S. population pyramid—with many children and few older people—would soon more closely resemble a cylinder, with many more people over age 75 and, especially, over age 85 than in past decades.[176]

Slow growth in spending, coupled with rapid growth in need, made for clinical, financial, and political financial stress.

**Medicaid**. Threats to Medicaid patients were more serious still. Trump persuaded a sympathetic Congress to slice federal support for Medicaid soon after his 2025 inauguration. These cuts continued for two years and then leveled off at a level one-sixth below their 2023 peak. A querulous op-ed complained about Biden rules that had expanded coverage and spending, rules that Trump could simply nullify. The op-ed urged over $800 billion in Medicaid cuts in the coming decade to help finance an extension of Trump's 2017 tax cuts.[177]

State governments' finances were assailed by high interest rates and inflation. A number of red states were initially happy politically to cut Medicaid support for the same reason Trump urged federal cuts.

In responses, some states simply repealed their Medicaid expansions under the ACA, slashing the number of patients covered by Medicaid. Many states that did not repeal expansion cut their spending in other ways. With income eligibility for Medicaid protected by the ACA, those states leaned toward cutting payments for physician, hospital, and nursing home care—and for Medicaid managed care plans. The latter were obliged to cut their own payments to caregivers.

Importantly, state and local governments, as employers dependent on tax revenue, feared burdens of financing rising health insurance premiums for their own workers, dependents, and

retirees.[178] In 2023, state and local governments employed some 20 million workers,[179] fully one job in eight nationally.[180]

**ACA plans**. Ortaliza and colleagues reported that ACA marketplace premiums were expected to rise by about 7 percent in 2025, following a 6 percent rise in 2024.[181] That meant substantial increases in the cost of ACA federal premium subsidies.

No one was surprised when Trump and Congress refused to extend the enhanced subsidies for Americans covered under ACA plans that Biden had pushed through early in his term. After they expired at the end of 2025, enrollment quickly dropped from its 2024 peak of 24 million to 18 million in 2026, with slower falls to follow.

**Private insurance**. When American companies tried to sell abroad, high health costs boosted the prices they charged. This is why Buffett said that "medical costs are the tapeworm of American economic competitiveness." [182]

Early in 2024, Cuban worried that "CEOs are indifferent to health care outcomes because they are not viewed as a core business competency. 'As a result, they waste a sh-tload of money on less than quality care for their employees….'" [183] He also believed that corporate CEOs simply do not understand health care or health insurance.[184]

In this spirit, McCord asserted that rebuilding manufacturing required cuts in corporate health care costs. And that establishing a competent buyer of health care in each large business was essential to making those cuts.[185]

Maybe not. A reasonable alternative would be to relieve individual businesses of the job of buying health insurance for their workers. Disunited, they lack capacity to negotiate effectively with caregivers; they often are handicapped by lack of expert knowledge.

Business efforts to restrain their health care costs have generally failed. From time to time, rising premiums did lead some employers to begin to take to heart the evidence that higher health care prices push employers' health insurance premiums upward, leading them to cut jobs.[186] They saw health insurance as—effectively—a tax on employment, a tax that distorts decisions about how to produce goods or deliver services.

During the 1970s, 1980s, and 1990s, business coalitions in Massachusetts, California, and other states had occasionally sought to confront hospitals and hold down their prices. Some even embraced health planning and certificate of need regulations to constrain hospital capital projects. Others supported laws to mandate that all employers offer health insurance. The last aimed to shrink the free rider problem—employers that obtained competitive advantages by not offering health insurance.

Manufacturers were especially sensitive to health insurance premiums because they faced both domestic and international competition for their products. As manufacturing withered in many parts of the country, many business coalitions weakened. A number of employer groups even allowed hospitals and health insurance companies to join, thereby inviting fifth columnists inside the gates.

In the mid-2020s, a few employer coalitions tried to re-energize employer action on health costs.[187] If Cuban was right in asserting that employers did not understand health care or health insurance—particularly the unattainability of free market competition in health care—the new coalitions were no more likely than their predecessors to make a dent in health care costs.

Health care's burden on employers grew. In 2020, private health insurance premiums equaled 39 percent—almost two-fifths—of after-tax corporate profits.[188] In 2024, the average private insurance premium for families was $25,600. It had risen by one-quarter in the previous 5 years.[189] The average worker/family paid one-quarter of that total,[190] a substantial regressive imposition. A continued rise at that rate would bring the average premium to over $31,000 by 2029—even if employers continued to hike the highly regressive co-pays, co-insurance, and annual OOP maximum payments they imposed on workers.

Choudhury described five ways in which employers might try to limit their own financial obligations.[191] They could push OOPs even higher, rely even more heavily on narrow networks of doctors and hospitals, institute reference pricing—a fancy way to describe an employer's declaration of how much it will pay for the main types of care, substitute ICHRAs (individual contribution health reimbursement arrangement), a posh acronym for ending employer sponsored insurance—giving employees money (vouchers) to buy their own health insurance from exchanges or elsewhere, or simply drop insurance.

In a tight labor market, employers found it hard to advance any of these. While the next recession would spur employers to revive them, they would neither be acceptable to workers nor do much to hold down employers' costs.

Employers increasingly lost confidence in the competence, power, and tools that their HR departments, benefits management firms, and health insurance companies could wield to contain spending on health insurance through the job. Ever-higher OOPs, narrower networks, more aggressive retroactive claims denials and refusals of prior approval, and prescription drug formularies and step therapies simply did little to stem higher health costs and premium increases.

They did anger workers and did spur unionization.

Many corporations re-evaluated their roles as buyers of health care. Growing numbers sought to cap or escape their obligations to pay for health care. In Indiana, employers sought legislation to hold down hospitals' prices. Some voiced support for single payer remedies. In 2025, a conservative governor appointed a leader of the employer coalition to a newly-created cabinet position supervising all health agencies. Liss reported that the new secretary did not trust market competition and limited government to rein in hospital or other health costs.[192] Similar employer efforts gained limited traction in Texas, Florida, and Maine.[193]

One state's attorney-general urged denial of any rate increases for insurers owing to unaffordability; another state's regulators trimmed requested hikes.[194] Most states saw rising opposition to higher insurance premiums. Two reports expected 2024 private insurance premium increases to be the highest in years.[195] [196] [197] Some of this reflected higher overall inflation. Higher prices and use rates for many diabetes and diet drugs were also implicated.

But one high share of private insurance premium hikes stemmed from hospital and doctor pressure for higher revenue to offset slow growth in Medicare and Medicaid and ACA plans'

rates paid hospitals and doctors. A second high share resulted from rapid increases in caregivers' own costs. Late in the summer of 2024, for example, the 4,000 RNs at Boston's Brigham and Women's Hospital won 20 to 30 percent salary increases over the following 2.5 years.[198] Unionized Kaiser workers won a 21 percent pay raise.[199]

During 2023, national health care employment rose by 654,000 jobs, fully one-quarter of total U.S. job growth.[200] Health care wage growth, slow in 2023, rose more rapidly in 2024. Even so, dangerous worker shortages persist in LTC and elsewhere.[201]

One review of possible state actions recognized that higher prices, not higher volumes of health services, were mainly responsible for increased health care spending. It identified several main tools states used to try to hold down prices: reviewing insurers' requests for premiums increases, addressing facility fees, and linking insurers' prices paid to doctors and hospitals more tightly to lower Medicare prices. It also mentioned improving price transparency, a cosmetically appealing but chronically and comically futile effort.[202]

When their health insurers denied coverage for workers' or dependents' claims and refused to provide justification, employers feared considerable legal exposure. That's because the 1974 ERISA statute obliged employers to act as fiduciaries to protect and advance their employees' financial interests when offering health insurance coverage. This led to fights over administration of benefits and claims denials.[203] These fights took place against backdrops of accusations that an insurer illegally denied claims without clinical review,[204] doctors' and hospitals' battles with insurers, and the many well-publicized surprise bills to patients covered through employer-provided insurance who had mistakenly believed they were well-protected.

**Weak political pressure for cost control**. One reason the U.S. had previously refused to do anything effective to contain health care costs was that few thought they would benefit by slowing cost growth. Most supposed that Medicare, Medicaid, and private employers would simply pay less.

Few expected that measurable savings would result. And if savings did materialize, few imagined that the money saved would be captured and put to better purposes—such as slashing OOPs, training more primary care doctors and paying them higher incomes, or better mental health or dental coverage. Money that paid for health care was not yet fungible.

By contrast, caregivers constituted organized and politically consequential stakeholders that sought higher revenue for themselves. And many patients feared that lower spending on health care would mean either lower-quality care or higher OOPs.

**Why not boost taxes or slash benefits instead?** One response to rising health care costs at a time of growing worry about deficits could have been higher taxation.

The 2023 reports of the trustees of Medicare and Social Security projected that the Medicare Part A hospital insurance trust fund was fully funded only until 2031, and would subsequently be able to pay about 89 percent of scheduled benefits. The combined Old Age and Survivors Insurance plus Disability Insurance Trust Funds were fully funded until 2034 and would subsequently be able to pay about 80 percent of scheduled benefits.[205]

To address the Medicare shortfall, a bill filed by Democrats Sen. Whitehouse and Rep. Boyle would have required those earning above $400,000 yearly to pay an added 5 percent of their income to finance Medicare. This would include earnings from certain hedge funds and private equity corporations that are not currently taxed for individuals.[206]

In 2024, presenting himself as an instrument of stability—and hoping to counter Trump's short-lived threats to cut Medicare and Social Security—Biden supported the Whitehouse-Boyle initiative.[207] But Republicans continually opposed this and other tax hikes.

Alternatively, as Altman wrote, as recently as 2024, congressional Republicans repeated their calls for converting Medicare into a voucher program, for weakening the ACA's protections for Americans with pre-existing health problems, for combining and then block-granting Medicaid and ACA premium subsidies, and ending Medicare's price negotiations with drug manufacturers.[208] It is hard to imagine why Republicans endorsed these ideas—none of them popular or likely to win votes—in an election year. Republicans gradually abandoned them.

One sign of strain emerged in 2024 in North Carolina. Despite a $1 billion budget surplus, the Republican legislature was accused by the Republican state treasurer of under-paying the state's health plan for employees, retirees, and dependents. The treasurer claimed that inadequate state revenue was combining with higher costs of new meds and other care to threaten the plan's ability to pay all bills in 2026.[209]

Some advocates of higher spending on social determinants of life (SDLs)—housing, food, education and job training, criminal justice reform, income subsidies, and others—embraced restraints on health care spending growth. They hoped that successful restraints would liberate dollars to address their agendas. Some believed that higher spending on SDLs would prevent health problems from developing or worsening, obviating higher health care spending.

But others demanded that health spending be restrained in ways that did not harm access to needed medical care—and, indeed, in ways that boosted equity of access and care.

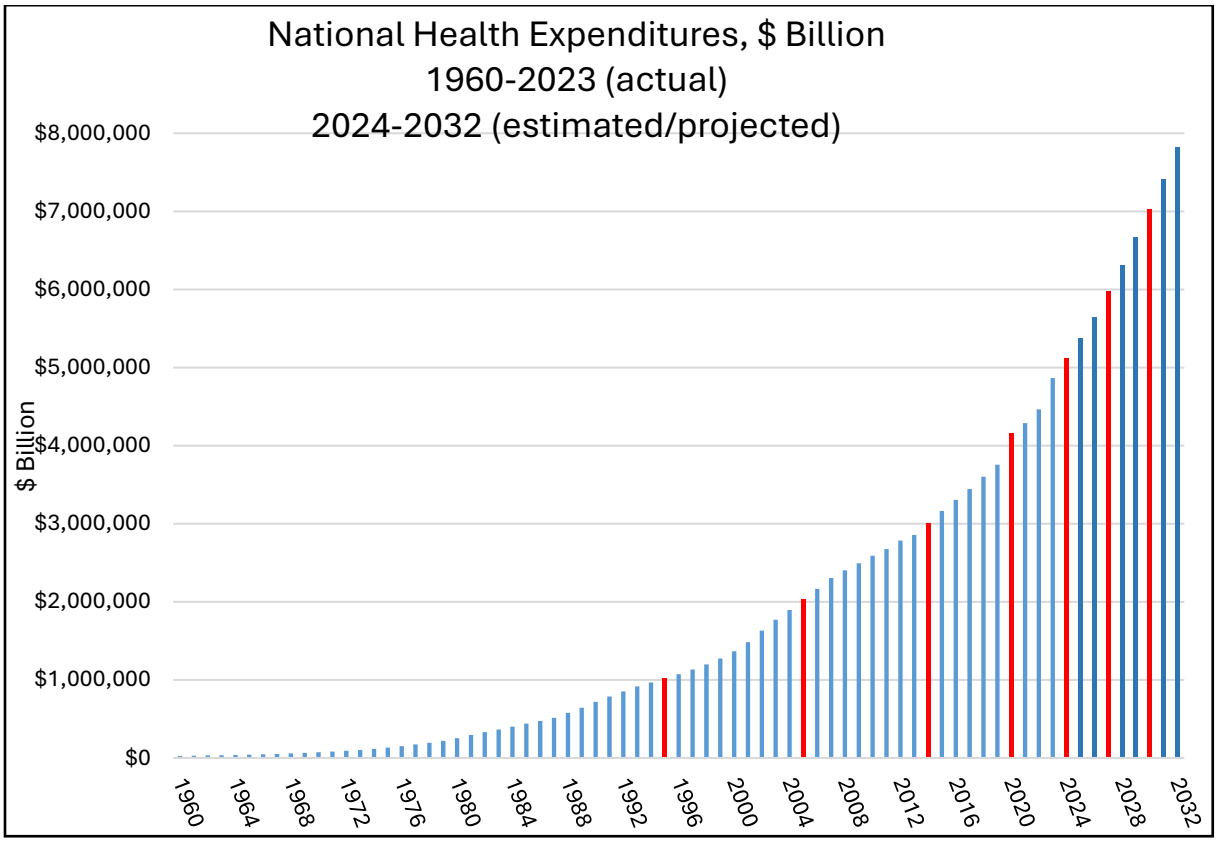
The increasingly loud public and private talk about reining in health care spending worried three groups particularly. One was doctors, hospitals, drug makers, and other caregivers who had been concerned that Covid had already weakened health care services, both clinically and financially. Years of slow Medicare payment increases angered many doctors—and also the hospitals, physician-owned groups, and businesses that increasingly employed doctors. Hospital financial distress, closings, and service cuts became more frequent owing to substantial cost growth (often caused by needs to boost pay to retain or attract workers) coupled with slower revenue growth and a greater share of patients covered by low-price payers.

The second group was made up of advocates for patients already uninsured, under-insured, lacking caregivers, or otherwise vulnerable to deprivation of needed medical care. The urban and rural hospital closings crisis, shuttering of maternity services, deepening primary care shortage, and cut and gaps in insurance coverage worried some patients. Persisting caregiver capacity and staffing shortages threatened quality of care.[210]

The third group was comprised of the businesses that paid for employer-sponsored health insurance that covered almost one-half of Americans. And also the insurance companies that piped money from employers to caregivers. Both feared that cuts in public spending would mean demands for higher payments by private employers and insurers.[211]

Exhibit 1 – 7 – B graphs rising U.S. health costs from 1960 to 2032, almost three-quarters of a century.

***Exhibit 1 – 7 – B***




## 4. Access crises: Eroding coverage, suppression of care, and rising patient insecurity

By 2025, three main threats to equitable health care access had taken shape. All worsened in the years that followed.

One was the rising cost of health care itself—owing to reliance on ineffective (and even on counter-productive) cost controls, the near-total absence of political support for effective cost controls, and growing waste of money going to U.S. health care.

The second was public and private payers' unwillingness and inability to boost health care revenue fast enough to improve or even sustain equitable access to health care for all Americans. Some stubbornly fought the old fight to finance better access by obtaining far more money for business-as-usual, combined with reform rhetoric and tinkering. This evolved—gradually at first, and then much faster—into somewhat more money but less care than usual. Spending continued to grow rapidly, but it was less and less sufficient to finance former levels of access.

Consequently, the third was quiet and widespread, though temporary—acceptance that greater suppression of access to care was the only politically feasible response to the first two threats.

Access advocates noted that fully 46 percent of lower- or average-income Americans reported skipping or delaying needed care in the past 12 months, double the average of 23 percent in 8 other rich democracies studied. Interestingly, 29 percent of higher income Americans reported skipping or delaying; that was more than double the average for their counterparts elsewhere.[212] One-half of Americans fail to take medications as prescribed; cost is one of the main reasons.[213]

***Over one-half of all insured adults reported problems in using their insurance coverage. These problems included denied claims, under-payment of legitimate claims, problems with caregiver networks, and pre-authorization of care. Two-thirds of people in fair or poor health reported such problems.[214]***

A Gallup survey found that 35 percent of adults said they could not afford high-quality care. And only one-half of adults could securely afford health care in 2024. The share was three-fifths for Whites, two-fifths for Blacks, and one-third for Hispanics.[215] [216]

During the two decades preceding the crises of the late-2020s that gave rise to real reform by 2035, the number of Americans with health insurance rose sharply but then fell. Many who retained insurance cards suffered increasing difficulty in obtaining or affording needed care.

The main reason was that American methods of covering people were nominally open-ended. In theory, citizens were entitled to benefits. Caregivers served patients and billed payers. And if costs were higher than expected, more public money was appropriated or insurance premiums were raised.

In practice, open-ended entitlements were closed off by a variety of methods, some overt and others sneaky. Having insurance coverage mattered greatly but was only part of the story. Other financial forces shaped actual coverage and ability to obtain medical care. Bernard and colleagues examined the combined effects of high OOPs, medical debt, and other financial impediments to care. They found that over one-quarter of non-seniors lived in families facing at least one of these barriers. And almost one-half faced a broader set of financial barriers.[217]

**Care capacity cuts.** Though not yet as grave as those in the U.K. or parts of Canada, stark shortages in capacity began to be reported. Ambulance response times lengthened in both cities and rural areas.[218] [219] [220] One important reason was hospital closings that lengthened trips to surviving ERs. Another was under-financing of emergency medical services and shortage of ambulances.

Indeed, the financial plight of many public and non-profit emergency ambulance agencies resulted in deliberately crafting the 2020 No Surprises Act to forego protecting patients from surprise bills from ground ambulance caregivers.

In the background, high U.S. health costs had, for decades, helped to propel or permit hospital closings, nursing home closings, physician shortages—particularly in primary care, and other capacity cuts.

This resulted, in part, from a focus on the ceiling—the very best care for some—and neglect of the floor—below which no citizen should be allowed to fall.

This medical prejudice paralleled a problem plaguing the U.S. military—short supplies of very good ships, planes, missiles, other equipment, and ammunition—good but complicated and very expensive to buy and maintain.

Another main cause was the thorough inability and unwillingness of public or private payers or other entities to identify needed capacity and work to conserve or secure it.

In the U.S., no one is accountable for learning which hospitals—with what capacity, offering which services, in what locations—are needed to protect the health of the public. The same for physicians, dentists, long-term care, mental health, and other caregivers.

And why is that so? Partly owing to payer fragmentation. Partly out of belief or hope that a competitive free market would identify and build or sustain needed capacity. Partly out of weak political support for competent government action. And partly out of fear that learning the need for primary care doctors, nursing home beds, or acute hospitals could impel someone to take accountability—to take actual action to remedy shortages and buttress failing caregivers.

And, for acute hospital inpatient care, partly owing to very weak information about actual hospital bed capacity and occupancy rates. Average U.S. acute hospital occupancy rates rose from about 64 percent pre-Covid to about 75 percent post-Covid. They varied greatly across the states, rising to the high-80's in parts of New England. Leuchter and colleagues projected a rise to 85 percent for adult beds by 2032 in light of projected age-adjusted rates of admissions.[221]

Even this useful analysis under-states the potential severity of tight hospital capacity. Hospitals cannot easily respond to increased need for care. Occupancy rates are calculated from hospitals' data on average daily census divided by hospital-reported beds "set up and staffed". But figures like 65 or 75 percent occupancy rates are, therefore, absurd. No hospital can afford to pay nurses to stand by and staff any substantial number of empty beds.

The low reported occupancy rates are an artifact of many hospitals' lazy convenience: many report licensed beds, which change slowly, not beds set up and staffed, which change by the season and day of the week.

Actual occupancy rates are as close to 100 percent as hospitals can make them. Immediate, short-term reserve capacity is, therefore, very low. Over time, capacity might be expanded, but that would entail hiring nurses and other caregivers who are today in short supply.

Few have criticized state and federal government unwillingness to scrutinize continuing hospital closings or to intervene to identify a needed but endangered hospital. Or, particularly, to learn either needed hospital capacity or the revenue required to finance efficient delivery of needed care.

One reason is that sustained ignorance of these matters liberates politicians and payers to continue to refuse accountability for knowing what's needed or paying for it. This is tied to a death-grip embrace of hospital closings as a way to save money. Politicians and public officials blame closings on market judgments, bad management, and low need. That rationalizes inaction. Reporting is often uncritical, and this helps to shield politicians and public officials from criticism.[222]

**ACA improvements in numbers covered**. In 2010, 48 million Americans lacked health insurance coverage.[223] That number fell to 28 million in 2015. Three very different ACA provisions combined to cover people. By 2015, almost 10 million people were covered under the ACA's Medicaid expansion, almost 8 million people through its subsidized individual mandate via marketplace plans, and about 2 million people under age 26 under their parents' private health insurance.[224]

In 2022, the number of uninsured Americans fell below 24 million, less than one-half the number prevailing pre-ACA, only a dozen years earlier.[225] This was mainly owing to rises in Medicaid coverage during Covid and to state expansions, and to Democrats' higher federal subsidies for marketplace plans. Those higher subsidies, enacted in 2021, helped propel marketplace plan enrollments from 12 million in 2021 to 21 million early in 2024. The share of uninsured Americans fell to an estimated 7.7 percent in the first quarter of 2023.[226]

Covid-related improvements in health insurance coverage made for substantial cuts in the share of Americans who said they were not able to afford medical care.[227]

Still, very serious problems persisted. Over one-half of working-age Americans reported in 2023 that it was very or somewhat difficult to afford to pay for health care.[228] Dorn and Jost wrote that one-half of ACA-subsidized Americans were in high-deductible bronze and sliver plans that left notionally covered enrollees badly protected.[229]

Indeed, Canham-Clyne asserted—citing Commonwealth Fund surveys—that the share of Americans insured all year (and not underinsured) rose from 56 percent in 2010 only to 57 percent in 2022. The underinsured group included those reporting they did not see a doctor for a medical problem, did not fill a prescription, skipped a test or treatment, and did not see a specialist.[230]

During 2025, the Trump administration and Republican Congress refused to reauthorize the Democrats' 2021 expanded ACA subsidies. Consequently, the numbers covered by subsidized insurance fell back from 21 million toward its pre-expansion 12 million. A small share of those displaced found substitute coverage under Medicaid and a slightly larger share found insurance through an employer. Premium costs rose substantially—and regressively—for all but those finding shelter in Medicaid.

Patients undergoing treatment, whose care was interrupted by loss of financial protection, were angry and frightened. Resulting medical and human harms were widely publicized. So was the loss of medical security for all losing coverage.

**Much health insurance isn't affordable**. Altman noted that financial insecurity afflicts a high share of people who are nominally insured against health care costs. He reported that workers in small firms—those with fewer than 200 workers—were obliged to pay an average of $8,334 in premiums toward family health insurance whose average total cost is $23,621 in 2023.[231]

Altman concluded that "family health insurance is no longer affordable through small employers". This assessment applied to nearly 50 million people working for 3.2 million businesses that employed fewer than 200 people. One reason was that incomes at smaller firms averaged only two-thirds of those at larger firms. A second was that workers at small firms paid a larger share of family premiums. To premium costs were added substantial OOPs.

In 2025, Averill and Kalison found that rising premiums left Americans increasingly dissatisfied with private insurance plans. By contrast, people covered by Medicare reported much higher satisfaction levels.[232]

Again, patient and political anger toward insurers grew.[233] Employers found themselves pinched between workers who could not afford rising and regressive premiums and OOPs on one side, and doctors, hospitals and other caregivers who viewed their own revenues as inadequate on the other side. More and more employers sought to extricate themselves from responsibility for buying health insurance for workers and their dependents.

**Medicare premiums and OOPs imposed heavy and regressive burdens on elders**. In 2024, the basic Part B Medicare premium was $2,096.40 per year (or almost $4,200 for a couple). The average expected Part D premium for 2024 was expected to be $666 per person. So the total Medicare premium for the two parts would be $2,762 per person.

The total per-person Medicare premium for the two parts of $2,762 in 2024 was 8.1 percent of estimated $34,235 median income in 2024, or about equal to one month's entire median income.[234]

Additionally, Medicare out-of-pocket burdens were substantial. Both premiums and OOP costs are regressive in that they are a higher percentage of income as income falls—unless elders are also eligible for Medicaid.

**Medicaid unwinding meant millions lost insurance.** Medicaid statute required yearly recertification of patient eligibility. This was suspended during the Covid public health emergency but came back into force in the spring of 2023.[235] States conducted recertifications. CMS was supposed to oversee state actions to ensure compliance with Medicaid rules.[236] That had always been a tough job—both politically and logistically. Some 90 million Americans—27 percent of us—were covered by Medicaid or CHIP in August of 2023.[237]

The size of the recertification job, the weak political support for strong federal action to protect enrollees from inappropriate decertification, and the states' varying political and financial

willingness and ability to spend on Medicaid led many states to inaccurately recertify eligibility. Many millions of Americans were disenrolled from Medicaid owing to state decisions that made it hard to re-certify them for eligibility, to administrative errors, to difficulty in tracking patients who moved, to complex Medicaid forms, and to patient failure to reapply on time. All this is discussed in detail in chapter 7.

Substitute coverage proved inadequate for many expelled from Medicaid. CBO analysts had projected that, if some 15 million people lost Medicaid eligibility owing to the unwinding, just over 6 million (two-fifths) would become uninsured while the remaining 60 percent would obtain alternative coverage.[238] Unfortunately, hopes like these for substitute marketplace enrollment were disappointed.[239] [240] By the end of summer 2023, few of the citizens terminated by state Medicaid programs obtained subsidized coverage in ACA individual insurance plans.

Massive unwarranted disenrollment from Medicaid testified to the complexity of U.S. health care's coverage provisions, to the consequent great difficulty of tailoring enrollment software to respect both that complexity and variations in patients' circumstances,[241] to the great variations in state government competence and commitment to protecting their citizens, to states' own financial incentives to push people off Medicaid, and to the inability or political unwillingness of the federal government to effectively address complexity and variation—or to require that states respect federal requirements for reviewing eligibility and disenrolling covered people.[242]

A complementary view is that securing health care coverage is the U.S. was usually and unnecessarily complex, confusing, adversarial, time-consuming to apply for and administer, and costly. (Ofri, a doctor, described her own challenges in re-enrolling her husband and children for coverage through her employer.[243])

Most of the trouble here stemmed from the awkward division of responsibilities for Medicaid between federal and state governments, to states' varying levels of commitment to coverage, to their varying competence to conduct accurate redeterminations of eligibility, and to the inherent administrative difficulty of reviewing Medicaid eligibility for one-quarter of all Americans.

Other rich democracies treat their citizens more respectfully. Not one compels large shares of citizens to jump through such complicated administrative hoops simply to retain their health insurance. No other rich democracy obliges so massive a redetermination of eligibility for coverage. None would tolerate so haphazard a process.

This is another way to say that the U.S. had not yet decided to durably and simply protect all citizens against the costs of health care. Altman writes that a slim majority of Americans who lean Republican view Medicaid as a welfare program. This aligns with the failure of 10 states to expand Medicaid under the ACA, with Republican interest in work requirements for some Medicaid recipients, and with proposals to slash federal Medicaid spending, block-grant the program, or time-limit Medicaid eligibility. Overall, though, three-fifths of Americans view Medicaid a health insurance, not as welfare.[244]

The disenrollment problems helped to build pressure to assure greater continuity of coverage—an important aspect of medical security.

And also to design mechanisms that can be administered feasibly, competently, and accurately—and without political interference—to financially protect Americans against health

care costs. Too much of the Biden administration's management of state recertifications resembled the local and state governments' and the Bush administration's response to Hurricane Katrina in New Orleans in 2005.[245] [246] [247]

Trump's re-election threatened deeper and less predictable cuts in Medicaid than those stemming from eligibility recertifications. Wolfson describes California's heavy dependence on Medicaid to insure its people. Some 14 million citizens were on Medicaid late in 2024—a number greater than the populations of all but three states, and including two-fifths of the state's children. The state might try to offset some cuts in federal dollars with new state tax money, but it was obliged to trim both eligibility and coverage of optional benefits like dental care for adults.[248] This also testified to the importance of designing secure, durable financing for coverage.

Financial protection against health care costs should be simple and speedy for citizens and also easily administered. Protection should be steady over time. No entity should have financial or political motives or legal or practical abilities to terminate or weaken coverage.

**Frustrations and complications**. U.S. health care was unnecessarily complicated. Challenges included retaining insurance coverage, judging among alternative insurance or MA or drug plans, maintaining durable relations with caregivers in the face of insurer – caregiver fights, shifting caregivers when payers choose or construct new networks, and preventing insurance agents from moving patients from a chosen marketplace plan to one not desired.

And simply making an appointment. Landro wrote that "at least half of patients report experiencing 'operational friction'—long hold times on the phone to reach a scheduler, difficulty getting a timely appointment, and trouble accessing follow-up information…." [249]

Three types of frustrations oppress many Americans who try to use their health coverage. One is inaccurate information from health plans about which caregivers are in-network. One clinician described letters sent to his patients by their health insurance company that stated he was no longer in-network, so they needed to find a new source of care. This was incorrect information but it badly disrupted patient care nonetheless. Especially because the insurer refused to simply provide corrected information to the patients or even apologize for its mistake.

A second is repeated incorrect payment decisions by insurers. I have heard many stories of patients who have been wrongly high by excessive co-pays, co-insurance, or deductibles by their health insurance company. Or charged for out-of-network care by caregivers who were actually in-network. This may be due to incompetent workers or to the complexity and multiplicity of coverage. Or worse: Sadly, the financial errors seem almost never to be in the patient's favor.

A third is repeated efforts by some caregivers to balance-bill their patients even though this sharply violates their contract with the patient's health insurance company. For example, a hospital charged $800 for a certain outpatient visit. Its contract with the insurer specified an agreed sum of $200 to be paid for that care. The insurer paid the $200 to the hospital. But the hospital then repeatedly balance-billed the patient for $600, ultimately threatened repercussions that would endanger the patient's credit rating. The state's attorney-general declined to investigate whether the hospital's practice violated the state's consumer protection law.

**Under-insured in practice.** A high share of Americans with plastic health insurance cards were under-insured in 2025. Indeed, under-insurance apparently rose as the number of uninsured Americans fell. One reason was reliance on under-insurance to suppress use and cost of health care. Under-insurance was arguably the main financial tool of U.S. health care cost controls. Much care suppression was intentional. The rest was widely tolerated.

Financial, bureaucratic, and caregiver barriers all contributed to under-insurance. High premiums, high OOPs, medical debt, bureaucratic barriers, surprise bills, refusal to pay legitimate claims, and unavailable doctors or hospitals were seven sources of under-insurance.

High premiums charged for solid insurance prompted many to opt for flimsier coverage. Inability to pay OOPs and uncertainty about the size of OOPs suppressed care-seeking.

So did accumulated medical debt.

Insurance companies' private regulations often denied prior authorization of care or denied payment after care was given. Owing to a mixture of insurance companies' policies, complex rules for what's covered and how much to pay for covered care, and incompetence of many employees, patients sometimes were unfairly under-paid for legitimate claims.

Caregiver shortages in many places and narrow networks of caregivers in many more places complemented financial barriers to care. Narrow networks generated surprise bills. The 2020 No Surprises Act sought to make affordable care more secure, at least in emergencies, but fear of surprise bills still deterred some care-seeking.

Other patients were forced to borrow. Gallup found that some 30 million Americans borrowed $74 billion to pay medical bills in 2024.[250] One reason was exhaustion of special pools of money to pay for care of uninsured or under-insured people.[251]

When patients switched coverage or when employers switched insurance companies, patients were often obliged to find new caregivers who were in their new payer's narrow network. This churn in coverage disrupted both care itself and caregiver-patient relationships.[252] Delayed care resulted.

In the absence of effective national controls on costs, Medicare Advantage plans, managed Medicaid plans, ACA marketplace plans, and ordinary insurance plans through the job tried to cut their own costs by forming networks of "preferred provider" doctors and hospitals that were sometimes so narrow and had so little capacity that care was often hard to obtain.

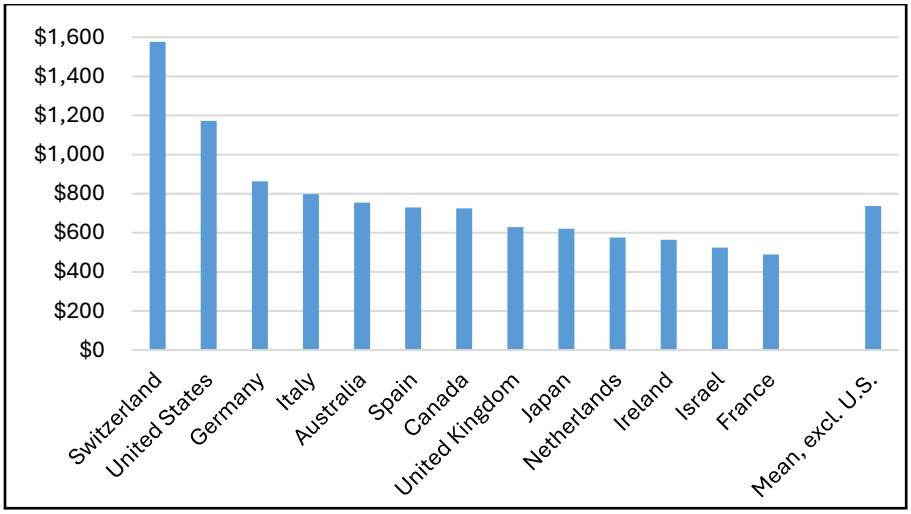
***The federal government showed itself to be politically unwilling and administratively incompetent to prevent unwarranted decertification of Medicaid eligibility. For years, it manifested its disinterest and incapacity to protect access for Americans unable to pay high OOPs or handle high medical debt. Or to protect patients against compromised access owing to prior authorization denials, inadequate networks, narrow networks, inadequate caregiver capacity owing to hospital closings or doctor maldistribution, or disruption of caregiving when employers' decisions or changes in source of coverage force patients to switch networks.***

No other rich democracy oppressed its citizens, patients, or caregivers in these ways.

OOPs. Americans paid the second-highest average yearly OOPs across rich democracies. Only the Swiss paid more—and their incomes were distributed far more equally than ours. As shown in Exhibit 1 – 8, U.S. per person OOP health spending in 2020 was three-fifths higher than the average of 12 other rich democracies. The spending was adjusted for purchasing power of each nation's currency.

***Exhibit 1 – 8***

***Per Capita OOP Health Spending, 13 Rich Democracies, 2020, Controlling for Purchasing Power***




Source: OECD, Frequently Requested Health Statistics, *OECD Health Statistics 2022,* http://stats.oecd.org/Index.aspx?DataSetCode=SHA.

Altman highlighted U.S. citizens' high concern over OOPs. He noted that 48 percent of polled registered voters identified "lowering out-of-pocket costs for people" as the most important health care cost problem. Only 7 percent identified lowering total health spending.[253]

Medicare had high OOPs for many services. One-third of Medicare beneficiaries said they could not afford Medicare's OOPs and more than one in five said they delayed or skipped needed care because they could not afford OOPs associated with it.[254] Two-fifths of Medicare beneficiaries with incomes below twice the federal poverty level (FPL) were deemed under-insured.[255]

The U.S. stands out in the share of politicians, backed by influential economists, who assert that high OOPs are good for us because people facing higher OOPs use less health care. They combat "moral hazard," the belief that patients will line up for unnecessary medical care if it is well-insured.[256]

Many who take those positions rely on the findings of the RAND Health Insurance Experiment. But they are probably wrong to do so. The HIE's three main findings were that, indeed, people paying more OOP used less care, that patients proportionately cut use of highly effective and

ineffective care, and that overall health was not affected—but that the sickest and poorest patients, and those with serious illnesses—fared better with free care.[257] [258] [259]

Also, proponents of OOPs have very rarely sought to inflict them equitably. A $30 co-pay for a doctor visit will not deter a high-income person. Those who would rely on OOPs to discourage unnecessary care and save money should have advocated equal-pain OOPs—setting OOPs that rise as a proportion of income as income goes up.

Facility fees. Some caregivers tried to boost revenue by foisting sneaky facility fees on patients. These were often not covered by insurance.[260] When not covered, the fees functioned as added OOPs. Other caregivers charged patients who posed questions to doctors via secure portals or by e-mail.[261]

Hospitals hounded patients. Low incomes or savings, lack of insurance, or high OOP costs left many patients unable to pay hospitals bills. Many non-profit hospitals became aggressive in collecting this money—even from patients entitled to free care. Some hospitals said they had to do this to remain solvent. Others seemed to imitate proprietary hospitals' pursuit of profit.[262] [263]

Some non-profit hospitals aggressively sued patients, placed liens on homes or cars, or garnisheed wages.[264] Some denied non-emergency care to patients with substantial accumulated debts[265] though they faced pressure to cease that practice.

The public University of Arkansas Medical Center sued some 8,000 patients between 2019 and 2023, including over 500 university employees. In 2016, pre-Covid, it sued only 35 patients.[266]

The public University of Colorado hospital sued patients almost 16,000 times between 2019 and 2024. Apparently ashamed, those suits were brought in the names of debt collectors working for the system, not in the name of the University.[267]

North Carolina hospitals sued thousands of patients, with one-third initiated by the formerly public Atrium Health in Charlotte.[268] [269]

Black and Levey described the high rate of debt collection suits against patients brought by McAlester, a financially distressed city-operated hospital in Oklahoma.[270]

A number of for-profit hospital chains aggressively sued patients for unpaid bills.[271] They often claimed this was essential to generate revenue to keep the hospital open, but hospitals involved were often much more profitable than they asserted.[272] Even very good reporters were sometimes fooled by such claims.[273]

Other hospitals embedded agents in emergency rooms to collect outstanding debts before new care was given.[274] [275] A firm supplying these services was expelled from Minnesota.[276] Shamefully, that firm was later bought by a non-profit hospital chain's investment fund.[277]

High medical debt inevitably resulted from public and private payers' reliance on out-of-pocket requirements, under-insurance, prior approval refusals, claims denials, and surprise bills. Such debt was close to $200 billion in 2022, with 17 percent of households facing some medical debt

and 6 percent of adults owing more than $1,000.[278] [279] One reporter suggested that medical debt led to patient anger toward doctors and hospitals.[280]

Debt anger generated political pressure for remedies.

Marketplace plans fell short. The 2021 improvement in federal premium subsidies for people insured through ACA marketplace plans resulted in a 50 percent rise in covered individuals by 2022 and a doubling by 2025.[281] The sunsetting of the improved subsidies in 2025 cut enrollment quickly.

Constrained coverage was designed into the original ACA in order to hold down the federal government's cost of subsidizing insurance.[282] One provision was the high yearly out-of-pocket costs legislated into the ACA. A silver plan, for example, covered only 70 percent of the care costs of enrollees whose family incomes exceeded 250 percent of the federal poverty level. Very high yearly out-of-pocket maximums--$9,450 for individuals and $18,900 for two or more people—for 2024 meant that the share of costs paid out-of-pocket by most people with silver plans and incomes above 250 percent of poverty substantially exceeded 30 percent. Why? Because most didn't receive much insurance coverage until they hit their out-of-pocket maximum payments.[283] Holahan and colleagues explained that ACA plans' premiums were low because their deductibles and other OOPs were so high.[284]

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 highly predictable and visible premium differentials and appear to have been less likely to consider risk of 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 helped make those silver plans very 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 follow federal law and rely on a single risk pool. In New Mexico, the result was that the share of enrollees in high-deductible bronze or silver plans fell from 49 to 23 percent in one year.[285]

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.

The ACA's second provision to hold down federal costs was allowing ACA insurers to form very narrow networks of doctors, hospitals, and other caregivers. Narrow networks impaired access and drove away patients with greater medical needs but saved little money. Premiums for ACA marketplace plans with an extra-narrow network plan—fewer than 10 percent of area physicians—were only 6.7 percent lower than for wider networks that included 40-59 percent of area physicians.[286] This apparent—and very modest—saving stemmed partly from patient self-

sorting: patients with chronic or severe health problems typically sought larger networks that included all of their trusted physicians and other caregivers.

A third method was high rates of denial of claims for payment—even for in-network care. ACA insurers denied 20 percent of in-network claims in 2023.[287] 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. [288] Only a few tenths of one percent of patients appeal denials and, even then, insurers upheld most of the denials.

The ACA statute obligated HHS to monitor denials of claims. HHS did not comply.[289]

Was this surprising? No. Federal regulation or scrutiny of millions of claims is very difficult. (A sample of claims could have been pulled and examined, but even this was apparently not done.) The problem was insurers' financial incentives to pay for less care.

Failure to regulate competently was unsurprising. Repeating this failure, year after year, exemplified governments' incapacity and unwillingness to regulate bad behavior that was spurred or tolerated by governments' own methods of covering Americans or paying caregivers.

Refusal to pay one-fifth of all in-network claims—typically without explanation—undermined patients' confidence in their health insurance—and in the federal government that subsidized it heavily. Worse, uncertainty about whether claims would be paid inevitably discouraged patients from seeking needed care. And caregivers from serving patients with ACA marketplace coverage.

Wide variations in denial rates across insurers suggest that payers' policies—not patients' or caregivers' behaviors—were largely responsible for denials. For years, the federal government was as lax in monitoring ACA marketplace insurers as it was in 2023 in timidly exhorting states not to throw patients off Medicaid for purely administrative reasons.

ACA patients were not the only victims of payment denials. Pestaina and colleagues found that 21 percent of patients with private insurance reported claims denied during 2022, along with 20 percent in ACA marketplace plans, 20 percent on Medicare, and 12 percent on Medicaid.[290]

The American Hospital Association complained that MA plans' denial of payment rose by 56 percent between January 2022 and July 2023.[291] Medicare patients were supposed to be able to appeal denials of payment by MA plans or by financial intermediaries that administered traditional Medicare. They were also supposed to be able to complain about MA plans' quality, delays in obtaining care, and the like—but, in practice, that required considerable knowledge about how Medicare worked, plus persistence.[292] [293]

After discussing these problems with federal staff, advocates, and caregivers, Skopec and colleagues recommended educating Medicare patients about how to file their grievances, making complaints public, refining Medicare "oversight and rulemaking to address abuses," and boost federal financing of "consumer assistance" to "resolve appeals, complaints, and grievances." [294] While doubtless well-intentioned, these recommendations read like a combination of a little more regulatory whac-a-mole and an almost invisible bow toward empowering fantasized health care consumers. Futile.

A more useful remedy would have motivated, enabled, and required MA plans and traditional Medicare's hospitals and doctors to take better care of their patients. That might have started by ending for-profit caregiving. And insuring. It might have continued by making sure that each patient had a primary care physician, one with time to run interference for them, to coordinate their care, and to seek remedies for abuses. It was a fool's game to imagine that patients could do these jobs.

Miller and Fields reported that private health insurance companies had long been violating state laws prohibiting wrongful denial of payment. State enforcement action was at least as weak as federal. Miller and Fields found only 45 instances of state agency action to address wrongful denial in five recent years. Regulators were overmatched politically and logistically.[295]

Insurers made more money when they denied more care. And the volume of claims and denials precluded effective regulatory response. Combined, these manifested the folly of "outsourcing the no." [296]

Insurers varied greatly in their shares of all-cause denial rates. Value Penguin reported in May of 2024 that United Health Care denied fully 32 percent of all claims; Medica, 27 percent; Anthem, 23 percent; Aetna, 20 percent; Blue Cross, 17 percent; and Kaiser, only 7 percent.[297]

Narrow networks: the unworkable meets the unenforceable. Networks of doctors and hospitals formed by insurance companies and other managed care operators were often not adequate to assure timely access to care. As discussed in chapter 5, the narrow networks formed by for-profit California Medicaid HMOs when Reagan was governor in the 1970s were so inadequate that they became a state and national scandal.

Many patients enrolled in Medicaid managed care plans, MA plans, ACA marketplace plans, and managed care plans through their employer-sponsored insurance suffered from inadequate access to doctors and hospitals owing to narrow networks. The Biden administration's response was to promulgate regulations to require state-run marketplaces to adhere to federal standards for network adequacy.[298]

But federal and state standards were neither adequate nor enforced. ("The food is terrible and, worse, the portions are so small.") It was probably impossible to enforce them effectively. Medicare and Medicaid did as little to protect their patients as marketplaces did to protect those covered by ACA plans. Private insurers' denials of claims for care of employees and dependents, discussed earlier, raised parallel upsets and frustrations.[299]

Narrow networks were one of the ways insurance companies and managed care operators tried to contain use and cost of care. Few other nations relied on them. Once they were allowed, it proved impossible—politically, logistically, or legally—to set and enforce standards that obliged insurers and managed care operators to behave. Insurers were sued for failure to perform the essential and seemingly simple task of maintaining up-to-date directories of participating caregivers, giving the appearance of having created "ghost networks." [300] But little changed.

***It is toxic to create unsolvable problems and then pretend to address them. This undermined health care equity, effectiveness, and efficiency. It employed talented lawyers and administrators in futile tasks. It undermined Americans' faith in our***

***competence and compassion.*** As chapters 4 and 5 describe, it was customary in U.S. health care. Kessler suggested this pair of behaviors was common here outside health care as well.[301]

***Entitling patients financially with one hand but incentivizing denial of care with the other was bound to upset patients and also frustrate doctors and hospitals.***

Built-in insecurity infuriated and frightened patients. Private insurance companies' narrow networks, prior authorization requirements, rigid care protocols, and payment denials impaired patients' access and undermined quality of care.[302] In one large study, one-quarter of respondents reported that care was delayed or abandoned owing to patient/family administrative tasks.[303]

When insurers had contractual fights with hospitals and doctors, many patients faced—or feared—disruption of care. Most contention concerned prices to be paid and whether caregivers would be in-network. If a valued physician or the nearest hospital ceased to be in network, patients were forced to choose among convenience, OOP costs, and sustaining important relationships with caregivers.[304] Even when resolved before contracts terminated, many patients feared that payer-caregiver fights would disrupt their care.[305] Rosenthal described "How your in-network health coverage can vanish before you know it."[306] Such fights were publicized for years.[307] They became common.[308] [309] [310] [311] [312] [313] [314] [315] [316] [317] And more visible to the public.[318]

More broadly, a survey of health system chief financial officers found that one in six had ceased accepting a Medicare Advantage plan and that an added 45 percent considered doing so fairly soon.[319]

In the spring of 2024, Texas announced plans to shift 1.8 million patients in six Medicaid plans to new health plans. Three large non-profit plans run by children's hospitals would lose contracts. For-profit entities would control care for a greater share of patients. Many patients could be obliged to change doctors and hospitals.[320]

This massive shift signaled treating patients as objects, with little agency or choice—like peasants moved to Soviet collective farms in the 1920s.

Prior authorization. In 2021, 6 percent of 35 million prior authorization requests were denied by Medicare Advantage plans. For some large insurers, the share was 12 percent.[321] Prior authorization frustrated both patients and physicians. Their complaints were long-standing[322] and widespread.[323] [324] [325] [326] In the face of these complaints, and of federal and state efforts to constrain prior authorization,[327] [328] some insurers promised to back off. Not all doctors were impressed.[329] Some journalistic coverage paired doctors' frustrations with prior approval with harms that delayed care imposed on patients.[330]

The burden of reviewing many millions of requests for prior authorization led payers to rely on predictive algorithms and, increasingly, on artificial intelligence.[331] But this mechanization meant many errors—including denial of authorization for essential care. In response, the federal DHHS required both that MA plans made prior authorization decisions in light of patients' individual circumstances, and that appropriate clinicians reviewed those decisions.[332]

It is hard to see how these new regulatory requirements could have been enforced.

Prior authorization programs couldn't be administered efficiently, fairly, and transparently. They existed because payers could not trust doctors' and hospitals' care decisions. Those programs' persistence manifested payment methods that magnified payers' mistrust of caregivers.

Since review of billions of individual claims couldn't be accomplished fairly and efficiently, it should have been abandoned. The alternative was to find different ways to pay doctors and hospitals—trustworthy ways that integrated effective caps on spending instead of retrofitting incompetent, secretive, unfair, time-consuming, often infuriating, and sometimes dangerous restraints on spending.

Unauthorized or predatory plan switching. Appleby reported that after Americans chose a marketplace plan, rogue licensed insurance brokers sometimes switched them to a different plan, sometimes leaving them out-of-network with preferred doctors or hospitals. Americans submitted some 275,000 complaints about unauthorized plan switching in the first 8 months of 2024.[333]

Plan-switched citizens were often forced to pay higher premiums or suffer reduced federal subsidies. Brokers engineered this to win added commissions. Data on frequency of unauthorized plan switching were kept secret. But one close observer called the practice "rampant." [334] [335]

Appleby's reports apparently led federal officials to discover that the systems used to enroll Americans in ACA marketplace plans "inadvertently" revealed social security numbers to brokers. CMS then sought to block brokers' access to those numbers.[336] More whac-a-mole.

McCormack and Trish discussed worries that dually-eligible Medicare-Medicaid patients would not be enrolled in plans that best met their high levels of needs. And that brokers might shift patients from one plan to another to boost their own commissions.[337]

Giovannelli and Pogue intelligently decried proposals to eliminate enhanced ACA subsidies in order to discourage broker bad behavior. But the ostensibly more targeted reforms they endorsed were of dubious value. Those were to oblige brokers to act in patients' interest, require patients to signal they want a change in coverage before a broker is paid a commission, boost federal resources to monitor bad behavior, and require 3rd party "lead generators" to register and adhere to standards.[338]

Though doubtless well-intentioned, their proposed reforms were a formula for a deeply ineffective whac-a-mole response. It would feebly copes\ with symptoms of corruption. It would not address the complex design of coverage that attracted thieves.

It would be far better to create one good method of health care coverage and obviate complex choices that invite crooked advisors to siphon off money.

Payments to brokers could be responsible for some of the high rates of enrollment in Medicare Advantage plans. Casalino and colleagues write that high commissions paid by insurance companies' MA plans to brokers could induce some to push Americans into MA plans.[339]

Shifting plans compelled finding new doctors. Good primary care rests in part on trust between patient and doctor. Building trust takes time. Uprooting trusting relationships can damage care and take added time to rebuild—if the patient is able to identify a new primary caregiver at all and, if so one with time and interest in forming relationships.

Crook and colleagues quantified overlap of primary care doctors between Medicaid networks and ACA networks. Average overlap was only 29 percent. That meant that a given patient forced out of Medicaid by administrative disenrollment or a rise in income—and randomly securing coverage in an ACA plan—had only a 29 percent average chance of being able to stay with the same doctor.[340] A patient might diligently seek a plan that boosted these odds, but might have to pay higher premiums to do so.

Evans reported on patients notified that they may lose their doctor owing to exclusion from a narrow network. Said one patient, "'Look at how much pain and suffering you are causing, look at how much distress you are causing, look at how little I am sleeping.'" [341]

***No other nation forced patients to find new doctors when they changed insurance coverage. Or when caregivers and payers fought financially. Elsewhere, freedom of choice of caregiver and continuity of patient-doctor relationships were rights of all patients in almost all circumstances. No other nation regarded harm to patients from insurer – caregiver fights as acceptable collateral damage.***

Strangely, though, Chernew and Mintz endorsed the view that choice among health plans was a primary value Americans sought from health care, and so they imagined Americans were willing to bear administrative and other costs to enjoy choice.[342] This fit with a free market view of health care, in which sovereign consumers and vigorous insurance companies were empowered to help discipline greedy caregivers or payers.

***They elevated the value of compelling Americans to choose a health plan and to choose whether care was worth the associated OOP cost.[343] They ignored the ways in which compelling citizens to make those choices impaired the same citizens' right to freely choose and retain their doctors.***

High administrative costs were not the only harmful result of touting choice.

Citizens often became victims of instability—of rogue insurance brokers, of divorces between large insurance companies and large groups of doctors or hospitals that forced patients to choose new doctors, of sales of hospitals and of doctor practices, and of closings of hospitals and doctor practices owing to bankruptcy or payer irresponsibility or corporate misdeeds.

Security and continuity of care were values that contended with choice. Americans became angry when their health care became an unnecessary source of insecurity—of sundering relationships with known and valued doctors and other caregivers.

Jaffe reported on federal rules that sometimes allowed patients whose doctors ceased to be in-network with their MA plan to switch to a different MA plan during special enrollment periods. It is not clear how many people knew of this option or took it when available. Jaffe noted, importantly, that some 6 million MA enrollees had no choice at all because their former

employer, which offered some retiree health benefits, was legally empowered to pick a MA plan for all of their retirees.[344] This could be called medical serfdom.

A March 2024 survey of citizens by Massachusetts Blue Cross found that 40 percent reported that cost of care led them to put off seeing a doctor or obtaining hospital care. Even though Massachusetts insured the highest share of its people—roughly 97 percent. At the same time, rising insurance premiums troubled small businesses. And the head of the hospital association complained that hospitals' needs for higher payments should trump efforts to contain cost.[345]

***A high share of nominally insured citizens couldn't afford care. Businesses and workers were burdened by higher insurance premiums, but those premiums were not high enough to cover hospitals' own rising costs.***

***Without reform, payers' success in constraining revenue to pay for care would further undermine or suppress access. This recognition empowered the search for safe ways to contain cost.***

***Fears that cost controls would accelerate the loss of needed doctors and hospitals sparked reformers to design protections for vulnerable patients and their caregivers.***

## 5. Caregiver crises

David Dunkle, CEO of Johnson Memorial Health in Franklin, Indiana, said:[346]

> I think everyone is nervous….I feel that, once again, we're not getting reimbursed for what we do. I feel it's almost criminal the way the system has gone towards denial and making it harder for hospitals to do what they need to do. Look at the rising costs of drugs, drug shortages….We continue to add people on the regulation side, on the side to try to help us get paid. Really, where we need more people is at the bedside.

Covid challenged the capacity and finances of many hospitals, doctors, nursing homes, home health and hospice agencies, mental health professionals and facilities, and other caregivers. Post-Covid, some bounced back while others recovered slowly. Many were plagued by revenue growth that lagged cost increases. ***Constrained revenue led many caregivers to re-evaluate the risks of clinging to business-as-usual and the risks of embracing thorough reform.***

***Institutional insecurity was mirrored in patient insecurity***—which had been heightened by use of the various tools for access suppression discussed in the previous section.

***Covid accelerated the pace of subtractions of caregivers***. These included departures of doctors from primary care and from underserved rural areas, closings of both urban and rural hospitals, cuts in individual services like maternity care, and shortages of long-term care and mental health care. Cumulatively, subtractions magnified harm from loss of needed caregivers pre-Covid.[347] [348] [349]

In different places, and at different speeds, caregiver capacity began collapsing even before the crisis of 2028-2029 hit.

***Financial and clinical crises afflicted caregivers and patients. They spurred caregivers and patient advocates to seek cost, revenue, and access reforms that protected both.***

Covid also highlighted the importance of identifying places already suffering deficits of caregivers. And of learning which surviving caregivers were needed but faced financial peril. Although these analyses should have been essential foundations for sensible, targeted, and efficient financial rescue plans, progress on these important tasks had been negligible until 2025.

Little had been attempted to remedy caregiver deficits; even less was effective. A 2023 study found that five decades of effort to identify health professional shortage areas and to establish programs to add primary caregivers had no visible effect on either doctor-to-population ratios or mortality rates.[350] Ambulance deserts in rural and exurban areas remained another serious source of unequal care.[351] [352]

***Failures to differentiate***. Typically, payers and politicians failed to see or treat different caregivers differently. Instead, they focused on measures like all-hospital median operating margins over time. Tracking changes in the median over time can be useful. But it points toward one-size-fits-all financial policies. It is more important to identify differences among hospitals at any one time. Doing so can identify institutions that are needed but financially troubled. But that supposes an orientation toward learning whether the troubles stem from high cost, low revenue, or both. It also supposes acting to help needed but endangered hospitals. The same is true for nursing homes and other institutional caregivers.[353]

Nationally, even after the fastest growth in hospital jobs in more than three decades during the first half of 2024, hospital employment per patient remained 10 percent below pre-Covid levels.[354] [355]

In some regions, high shares of caregivers—hospitals, their workers, doctors, nursing homes, and others—were doing well financially and their capacities were adequate to serve the people in those regions.

In other regions—some rural and others in low-income neighborhoods of large cities—high shares of most types of caregivers were financially distressed.

More broadly, elsewhere, some caregivers did well while others fared badly. In much of Mississippi, for example, hospitals were financially threatened while physicians' average incomes were highest in the nation. At the same time, the state had the nation's scantiest supply of doctors—the greatest number of citizens per physician.

In most states and most metropolitan areas, hospitals were increasingly split between financially healthy and chronically ill institutions.[356] [357] One credit rating agency predicted that hospitals would be increasingly sorted among the successful, the moderately successful, and the weak.[358]

Caregiver prosperity often varied with shares of citizens with insurance coverage, payer mixes, and prices paid by different payers,

## *a. Hospital financial distress and closings*

**Wide variation in finances, need to understand differences, and to pay differently when appropriate**

U.S. hospitals vary radically in their financial well-being across both space and time. The acute hospital financial data from Massachusetts for hospital fiscal year 2023, displayed in Exhibit 1 – 9, illustrate this dramatically. The 15 hospitals with the highest operating margins averaged 6.8 percent. The second quartile averaged 1.8 percent. The third, negative 1.9 percent. And the fourth, negative 7.2 percent.[359]

Hospitals elsewhere exhibit similar patterns.[360] [361]

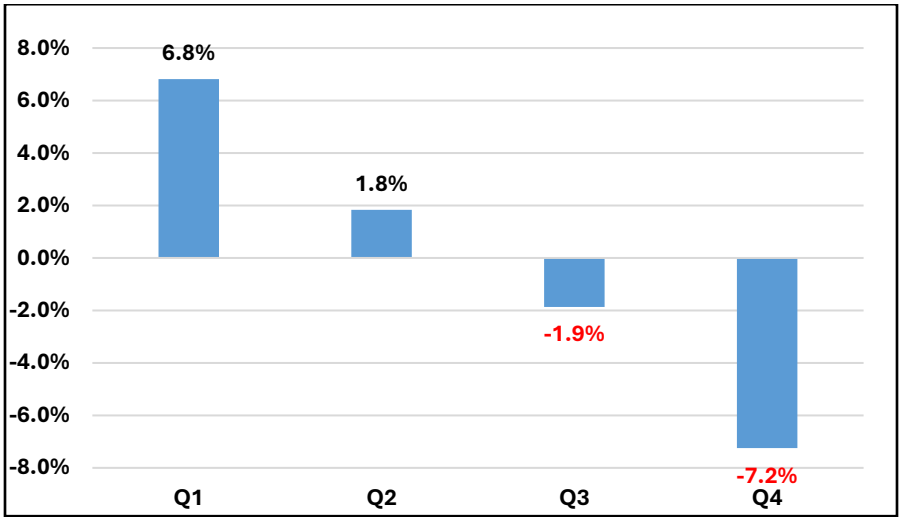
Also, mean hospital margins differ enormously across states, as shown in Exhibit 1 – 10.[362]

Within states, rural hospitals and those with higher shares of Medicaid patients generally suffered weaker financial results.[363]

Payers' inability and unwillingness to identify needed hospitals and pay them adequately heightened medical insecurity and frightened many citizen-voters, citizen-patients, and politicians.

***Exhibit 1 – 9***

***Massachusetts Acute Hospitals' Operating Margins, by Quartile, HFY2023***




Source: Massachusetts Center for Health Information and Analysis, 2023 Hospital Databook.

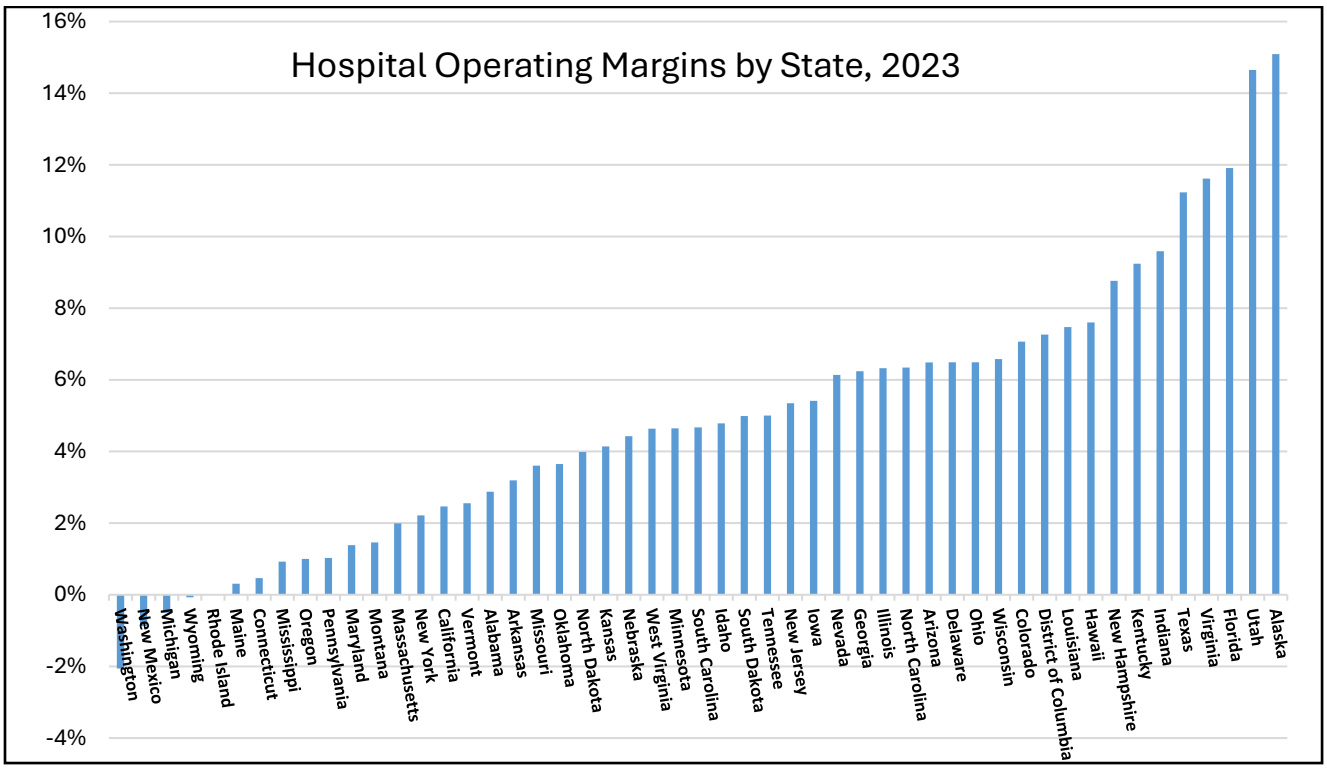
At the systems level, Ashley and Condon summarized Kaufman Hall findings that operating margins across 34 large non-profit and for-profit health systems ranged from 12.2 percent to negative 6.8 percent in 2023.[364] Report on some 1,300 U.S. hospitals found that about two-fifths suffered negative operating margins during 2024.[365] [366] Reed found that the gap between high- and low-margin hospitals widened nationally.[367] Lee reported similar findings across Massachusetts hospitals in 2022.[368]

All this highlights the ***importance of differentiation***—of constantly recognizing differences in finances of various hospitals and of crafting different ways to pay them. This requires identifying which hospitals are needed, which are in financial trouble, whether they require more money to efficiently deliver needed care, and the best ways to stabilize needed but troubled hospitals. Across-the-board remedies are bound to do too little for some impoverished hospitals while super-charging over-payment of prosperous hospitals.

Differentiation is not only financial. Some hospitals deliver safer and better care, as Leapfrog ratings and personal experiences show.[369] Some are fully occupied while others fill small shares of their beds.[370] Some hospitals suffer low occupancy rates because of population loss nearby, while others are located near patients and far from other hospitals—but lack enough physicians to admit and care for patients and generate revenue. Some successfully advance worker engagement and morale while others alienate workers. Some are well-managed. Some are focused on efficient delivery of needed care and on patient well-being while others are not.

Responding to appeals for across-the-board revenue boosts, the Purchaser Business Group on Health, a club of 40 large corporations, accused many hospitals of financial posturing. It acknowledged that "many smaller hospitals serving rural and disadvantaged populations are suffering post-pandemic financial hardship, and targeted policy solutions are essential to ensure their sustainability." But it also claimed that "for the country's larger health systems, the situation is hardly as bleak as advertised." [371]

***Exhibit 1 – 10***




Source: Zachary Levinson, Jamie Godwin, and Tricia Neuman, "Hospital Margins Rebounded in 2023, but Rural Hospitals and Those with High Medicaid Shares Were Struggling More than Others," Kaiser Family

Foundation, 18 December 2024, https://www.kff.org/report-section/hospital-margins-rebounded-in-2023-but-rural-hospitals-and-those-with-high-medicaid-shares-were-struggling-more-than-others-appendix/.
- - -

Until the U.S. or individual states learn which hospitals are needed, how much money they have, and how much money they require to deliver good patient care, debates about hospital revenues and payments will continue to rely on self-interested assertions, rhetoric, emotion, and political weight, not evidence.

**Revenue and cost threats change over time**

Between 2020 and 2023, Covid-related stresses on both revenues and costs threatened some urban and rural hospitals' finances. Some closed and others remain in peril.

Had we a functioning competitive free market for hospital care, operating margins might reveal useful information about efficiency, quality, and even need for a given hospital. For the reasons discussed in chapter 4, no such hospital market exists.

Some hospitals may be badly needed by their patients but suffer low operating margins and low occupancy rates owing to low revenues associated with payer mix, location in lower-income areas, or shortages of physicians to admit patients and generate revenue. High margins and occupancy rates, though, might result from supplier-induced demand or mergers to gain leverage over insurance companies or closing of nearby hospitals.

During and after Covid, hospital financial margins deteriorated owing to a combination of lower revenues and higher costs. Special federal financial aid helped many hospitals, but only temporarily.

Late in 2023, two hospital executives—one at InterMountain and the other at Providence—anticipated continued financial distress. Said one, "I think you're going to see massive destruction in the hospital space in the next few years." The other forecasts "a 'seismic shift' in margin compression," tighter financial margins in the years ahead.[372]

The data in Exhibit – 11 show that margins recovered across U.S. hospitals, taken together. One reason was that U.S. hospitals fought to hold down total expenditures.

***Exhibit 1 – 11***

***Hospital Total and Operating Margins, 2018 - 2023***

| | Total margin | Operating margin with Covid $s | Operating margin excluding Covid $s |
|---|---|---|---|
| 2018 | 6.54% | 5.83% | 5.83% |
| 2019 | 7.64% | 6.53% | 6.53% |
| 2020 | 6.46% | 5.34% | 1.93% |
| 2021 | 10.76% | 8.95% | 7.36% |
| 2022 | 2.34% | 2.66% | 1.87% |
| 2023 | 6.36% | 5.20% | 4.98% |

Source: KFF Analysis of RAND hospital data, cited in Zachary Levinson, Jamie Godwin, and Tricia Neuman, "Hospital Margins Rebounded in 2023, but Rural Hospitals and Those with High Medicaid Shares Were Struggling More than Others," Kaiser Family Foundation, 18 December 2023, https://www.kff.org/health-costs/issue-brief/hospital-margins-rebounded-in-2023-but-rural-hospitals-and-those-with-high-medicaid-shares-were-struggling-more-than-others.

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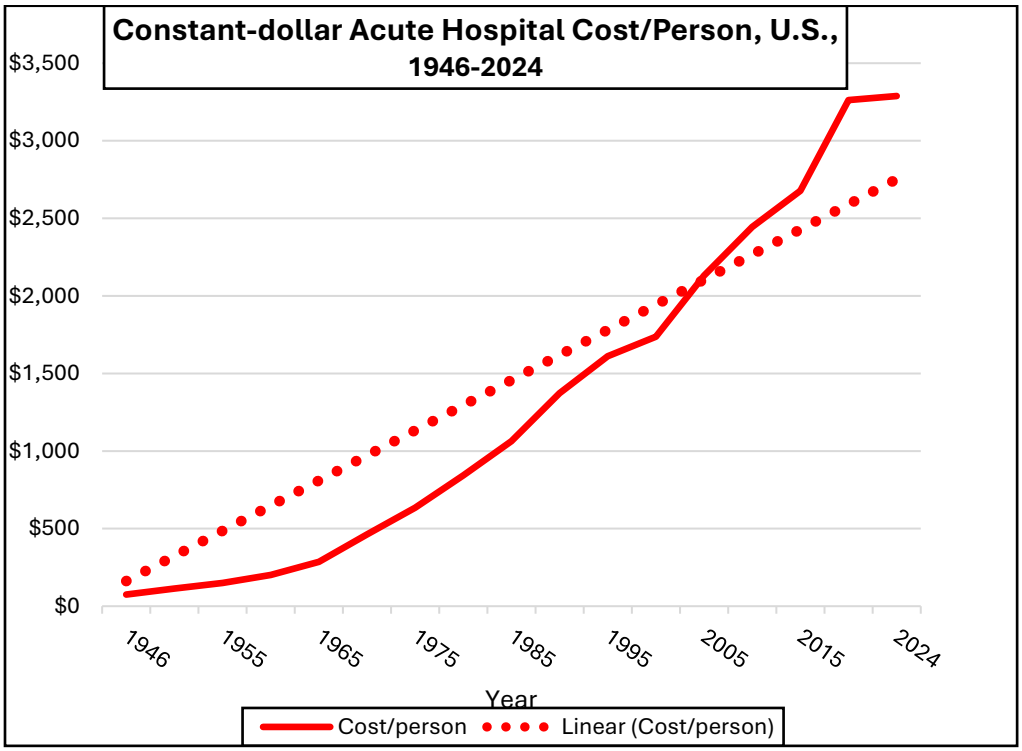
Exhibit 1 – 12 displays real (inflation-adjusted) expenditures by hospitals per person from 1946 to 2024. Generally, spending rose more rapidly over time, but it leveled off between 2020 and 2024. This might be an artifact of the measure of inflation used—the GDP deflator. More likely, it manifests hospitals' efforts to hold down their spending in hopes of avoiding continued deficits or fears of bankruptcy, or of rebuilding their endowments and operating margins post-Covid.

Regardless, hospitals feared they would be unable to hold down their expenditures in the years after 2024. That made them worry about payers' efforts to slow hospitals' revenue rises.

***Exhibit 1 – 12***




Sources: American Hospital Association, AHA *Guide Issue* and AHA *Hospital Statistics*, various years
Office of the Actuary, CMS, National Health Expenditures, 1960 – 2022, and projections to 2024
Bureau of Economic Analysis, GDP Deflator, 2017 base year.

Revenue threats. Beginning early in Covid, ordinary revenues from Medicare, Medicaid, and private health insurance plummeted because hospitals had to end or markedly chop volumes of often-profitable elective surgery. Higher Covid admissions were not enough to offset the drop in

elective surgery and other admissions. Lower volumes of care left many hospitals unable to cover their fixed costs. More hospitals suffered deficits.

Special federal subsidies helped many hospitals survive during Covid. To push money out quickly, Congress adopted a simple payment formula—special payments to all Medicare-enrolled hospitals equal to at least 2 percent of 2018 total revenue.

*Unfair*. Moving quickly required simplicity—and entailed unfairness—because Congress and DHHS lacked evidence on which hospitals were needed and on how much revenue they required to pay for efficient delivery of needed care.

Over many decades, political considerations had often magnified unfairness. Medicare's indirect medical education adjustment is one example of weak targeting. Medicaid's disproportionate share hospital program is a second. And the 340B drug purchase program, discussed in chapters 5 and 9, is a third. All failed to disburse more money to hospitals in greater need of it.

The simple formula adopted for distributing special federal Covid subsidies favored hospitals with higher revenue per discharge, which was strongly associated with greater private insurance shares of revenue.[373] One analysis found that the 10 percent of hospitals with the highest private insurance share of revenue received over twice as much special Covid revenue per bed as hospitals in the bottom 10 percent.[374] Many observers quickly labelled the formula as unfair, particularly to hospitals relying more heavily on Medicaid, the lowest-price large payer.[375] [376] [377]

Twenty large non-profit hospital systems, with combined net assets (wealth) of $100 billion, received $5 billion in special revenue under the CARES Act, signed by Trump in March of 2020.[378] Large for-profit chains also benefited financially—even as their executives continued to be highly-paid and as they laid off thousands of workers.[379] [380]

***Ill-targeted and inefficient federal subsidies to hospitals during Covid undermined public confidence—and also Congress's own confidence in its ability to understand and respond to health care problems.***

Threats to worker health, safety, staffing levels, and costs. Covid killed and sickened large numbers of hospital nurses and other workers. Nurse staffing shortages at many hospitals antedated Covid but were greatly worsened by it.

Overall hospital employment returned to pre-Covid levels by 2024. But nursing shortages persisted at many hospitals. Self and others projected a shortage of 100,000 health care workers by 2028.[381]

Employment in long-term care did not recover well. Substantial worker shortages persisted there despite the drop in number of nursing home residents and home health patients. In 2024, the main nursing home lobbying group estimated that nursing homes remained 130,000 workers (about 10 percent) short of needed or desired staffing.[382]

Spiro captured ways in which care by hospital nurses and doctors can become fragmented, stressed, hurried, and impersonal.[383] He wrote post-Covid. But Yeh described similar problems a decade earlier.[384]

Hospital RNs long complained that they lacked sufficient time to care for their patients. This resulted in demands—magnified by Covid-related worsening of RN shortages—for mandated minimum staffing ratios, a persistent source of contention between nurses and hospitals. Nurses fought successfully for minimum staffing ratios in California [385] but gains were slow elsewhere.[386]

Covid had imposed heavy emotional and other burdens on health care workers. Costs of living rose faster than income for many. Physical attacks on caregivers added to stress. Strikes by hospital workers increased.[387] [388] [389] In one view, strikes are only an example of "loud quitting."[390]

A complementary view is that strikes are an organized, visible manifestation of nurses' pressure for higher pay. That, in turn, will help boost the costs hospitals must bear.[391]

Nurses' strikes and threatened strikes during 2023 helped RNs win substantial pay increases. These rises were deemed likely to continue, especially if the projection (by the National Council of State Boards of Nursing and the National Forum of State Nursing Workforce Centers) that 800,000—about one-fifth—of U.S. RNs would cease working as nurses by 2027 proved accurate.[392] Higher health worker salaries meant either financial trouble for hospitals or stronger hospital pushes for higher revenue.[393]

Some hospitals sought ways to improve both nurses' job satisfaction and time allocation. Increasing the percentage of time RNs spend caring for patients and cutting documentation time would improve patient care, reduce cost, or both. Documentation too often aimed toward substantiating revenue claims, not supporting patient care. Brown posed the choice between "Caring for the Chart or the Patient." [394]

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.[395]

A very different study of clinicians tracked not activities but their locations. RNs in an ICU spent only one-third of their time in patients' rooms.[396]

Reducing documentation time would free up time to care for patients. Critics asserted that nurses (and doctors) spent too much time learning about and caring for the e-patient and too little time on the corporeal one.[397] [398]

Similarly, Arndt and colleagues reported that primary care doctors spent 52 percent of their workday nurturing the electronic health record or EHR. [399]

The problem seemed not to be inherent in the EHR software, but rather in the uses to which it is put, uniquely, in the U.S. Downing and colleagues examined characters typed per ambulatory care progress note in EPIC in eight nations. They found 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.[400]

***Excess typing in the U.S. was deemed to stem from documentation for payment and compliance purposes.[401] Also, much documentation aimed 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.***

To address nurses' complaints about excessive documentation, and to boost nursing time per patient without adding nurses who are both costly and—often—in very short supply, ***hospitals lobbied for simpler and more trustworthy methods of payment. Many hospital CEOs and trustees came to see that paying for hospital care in simpler and more trustworthy ways was the clearest path toward cutting documentation requirements.***

Financial margins. Bees concluded that "higher costs and stagnant revenue are the new normal for health care organizations."[402] The AHA asserted that overall hospital costs rose more than twice as quickly between 2019 and 2022 as did Medicare payments for inpatient care.[403]

In mid-2023, one bond rating company found hospital financial recovery "more sluggish than expected" owing to persisting inflation in hospitals' costs and to shortages of nurses and other workers.[404]

By mid-fall 2023, heads of two large hospital systems reported that one-eighth of U.S. hospital CEOs did not believe their institutions would ever recover to pre-Covid levels. Over one-half said their financial position was worse than it was pre-Covid.[405] [406]

Some observers anticipated a rise in hospital closings or bankruptcies in 2023.[407] [408] [409] Although the AHA continued to point to financial stresses, perhaps to build support for higher revenues, others were more optimistic, seeing a gradual recovery in hospitals' financial margins.

The Medicare Payment Advisory Commission's March 2023 Annual Report to Congress asserted that hospitals required a modest added 1 percent rise in prices—above those scheduling in existing law—to stay afloat. MedPAC did, though, highlight special needs of safety net hospitals with low private insurance shares of patients. Here, MedPAC urged special targeted increases in payment.[410] This was a rare bow toward differentiation of federal revenue support to align with different hospitals' actual financial needs.

***Hospitals with greater leverage over insurers won bigger payment increases. Weaker hospitals were more likely to seek ways trim costs. Some succeeded. Others suffered greater financial distress. Hospitals looked to Congress and state legislatures for higher prices. In vain. Friction between hospitals and both public and private payers grew.***

Hospital fears. One review of hospitals' political and revenue environment was titled "Hospital purgatory."[411] Covid sharpened fights between hospitals and payers. Becker's reported a 70 percent rise in publicly visible payer-caregiver fights between 2022 and 2023.[412] One long-time observer of hospitals wrote in February of 2023, "'I've never seen things more aligned to the detriment of hospitals than it is now.'" Gamble has described growing revenue losses suffered by hospitals—and doctors—owing to payer denials of claims.[413]

Interestingly, proposed legislation in California would impose penalties on insurers that repeatedly denied claims for legitimate care. Mai-Duc describes the case of a patient whose family incurred over $1 million in medical debt owing to denial of legitimate claims by United Health.[414]

But another insurer, Blue Cross Blue Shield of Michigan, announced that when hospitals appealed denied claims but lost, it would charge hospitals for the cost of professional reviews of the claims. The plan would shoulder costs only when the hospital won its claim.[415]

These two very different actions by insurers helped to build public and political anger and resentment toward payers, caregivers, and the administration of health care coverage. These episodes revealed the cost of controversy, the lack of accountability, and the ways in which health insurance failed to protect medical security.

The governor of Colorado and the state hospital association sparred over hospital finances. The University of Pittsburgh Medical Center faced criticism for financially exploiting its very high share of regional hospital care. The North Carolina state treasurer decried the growth in wealth of the state's seven large hospital networks during Covid. Montana won much lower hospital prices for state employees.[416]

Hospitals located in lower-income urban areas and in many rural areas have been likelier to suffer low operating margins and low financial reserves. Some observers predicted that academic medical centers' high costs and specialized physicians make it harder for them to "succeed in value-based care".[417]

This was not a new worry. The Clintons announced their health reform plan in September of 1993. It relied on HMOs to contain cost by squeezing hospitals and doctors' prices. That pushed some major teaching hospitals—that recognized their inability to compete with other hospitals on price—to defensively merge in order to leverage higher prices from payers.[418]

This persisting fear also helped to account for large systems' push to accumulate of wealth—in hopes of weathering new price storms—in the three subsequent decades. But the growth of pay-for-value, combined with the increasingly powerful scissors of rising costs but constrained revenue, frightened many large academic medical centers and led them to search for new financing methods. That made them friendlier toward reforms that promised to protect their core missions.

Public officials—and other payers—feared that hospitals' costs have been elevated by Covid, by inflation in prices hospitals pay for people, meds, and supplies, and by rising volumes of care. And that these impelled hospitals to ask for higher revenue. All payers worried about their own ability—financial or political—to find that money. Some payers criticized hospitals in order to delegitimize their revenue requests.

Financially stressed hospitals, their doctors, their patients, and local governments continued to seek special financial aid from state or federal governments.

State and federal governments tried in five ways to deflect accountability. First, they often claimed that closings were desirable because the nation is over-bedded and that closing hospitals would save money. Second, they asserted that bankruptcies are legitimate judgments

by a competitive free market. Third, they insisted that helping one hospital would lead others to recklessly bleed red ink in order to win special aid. Fourth, federal or state governments sometimes pled poverty and a need to fiscally retrench. And fifth, governments sometimes simply said they were not able to judge either which hospitals are actually needed or how much money they actually require to finance efficient delivery of needed care.

The last denial was the most credible. Only one state, Maryland, compiled a list of the hospitals and ERs that are essential to protecting the health of the public. Only Maryland had the experience, years of sound data, and analytic capacity (acquired over five decades) to competently weigh how much money each hospital required. These resulted from a state law requiring the state's Health Services Cost Review Commission to set prices or budgets for each hospital that generated revenue sufficient to give needed care if it operated efficiently.

Governments of the remaining 49 states, along with the federal government, never acknowledged accountability either for learning which hospitals are needed or assuring them adequate revenue. This was revealed with astonishing clarity in a 22 December 2022 letter to Secretary Becerra of HHS from the two Massachusetts U.S. senators and eight of nine representatives.[419] The letter posed seven questions concerning federal data on closings, effects of closings, and efforts to ensure access to hospital care.

Sadly, the secretary was not able to supply useful answers to any of these questions. Even though the secretary's inability was emblematic of decades of federal health policy, it frustrated the letter writers.

***In subsequent Senate and House hearings, witnesses' testimony criticized decades of federal neglect of hospital configuration and of need to support all needed hospitals financially. Pointing to market failure and government inaction, they decried the resulting hospital anarchy that cut access and boosted costs.***

The hearings galvanized many patients' and families' worries about hospital survival. After three years of Covid-related deaths and illnesses, loss of many hospital workers, and financial disruption, Americans had hoped for a return to more stable and dependable health care.

Well-publicized closings of numbers of rural and urban hospitals dashed those hopes. Patients displaced by closings were forced to find ways to reweave fabrics of their own medical care. Other patients feared they could be next.

Powerful elected officials and wealthy businesspeople or philanthropists have very rarely been patients at hospitals that closed. They tend to seek care at prestigious large teaching hospitals. It may be a noteworthy contrast that Pennsylvania Sen. Fetterman's first public office was as mayor of Braddock, a former steel town whose hospital was closed in 2010 by its owner, the University of Pittsburgh Medical Center.

Some doctors displaced by closings chose to retire. Others relocated their practices to be closer to surviving hospitals. Still others remained where they were and strove to care for patients and generate sufficient revenue.

Patients' fears of losing their hospital were reinforced by weakening of emergency services, [420] [421] [422] elimination of maternity care by many hospitals, [423] [424] [425] [426] [427] [428] [429] [430] along with cuts

in psych and substance abuse care.[431] [432] [433] [434] [435] All three problems were well-established before Covid and its aftermath worsened them.[436]

Longer patient waits for ER care—and extended provision of care in the ER—have long plagued U.S. hospitals, their patients, and families and friends. Wilper and colleagues found that average wait time to see an ER doctor rose by 4 percent per year between 1997 and 2004. Blacks, Latines, and women waited longer. Waits were twice as long at urban hospitals.[437] A rise in ER use rates, coupled with closings of hospitals and ERs, was partly responsible.

In San Jose, HCA's threatened August 2024 closing of the only trauma center in the area's east side would undermine emergency care. It also threatened the stability of the county's own hospitals.[438]

A 2022 study of rural hospitals by Kozhimannil and colleagues identified difficulties in adequately staffing maternity services. Numbers of births were below break-even, leading to at least the appearance of substantial dollar losses.[439] A February 2024 analysis from Kaufman Hall indicated that rural hospitals were particularly likely to cease offering maternity care, and did so in hopes of saving money.[440]

A problem facing all hospitals with maternity services—urban or rural, with high or low volumes of deliveries—is low revenue. Condon reported that a hospital CEO said that "'In Indiana, over half of babies…are covered by Medicaid, which pays 57 cents… of the cost of providing care.'"[441] Many hospitals' high reliance on low-paying Medicaid programs closely parallels' most nursing homes' heavy dependence on low Medicaid-set payments. (See chapter 13.)

The closing of maternity services was seen as the precursor of a wave of hospital closings.

Revenue problems plagued other services. In New York State, acute general hospitals closed over 1,000 psych beds during Covid and most were not re-opened. The governor said that neither added state money nor threat of fines for failure to operate licensed psych beds had proven sufficient to induce hospitals to reopen beds.[442]

**Inadequate capacity**

In many parts of the nation, post-Covid closings of both rural and urban acute general hospitals, along with low bed-to-population ratios and high occupancy rates in many regions, helped to heighten medical insecurity and thereby magnify pressure toward comprehensive health reform.

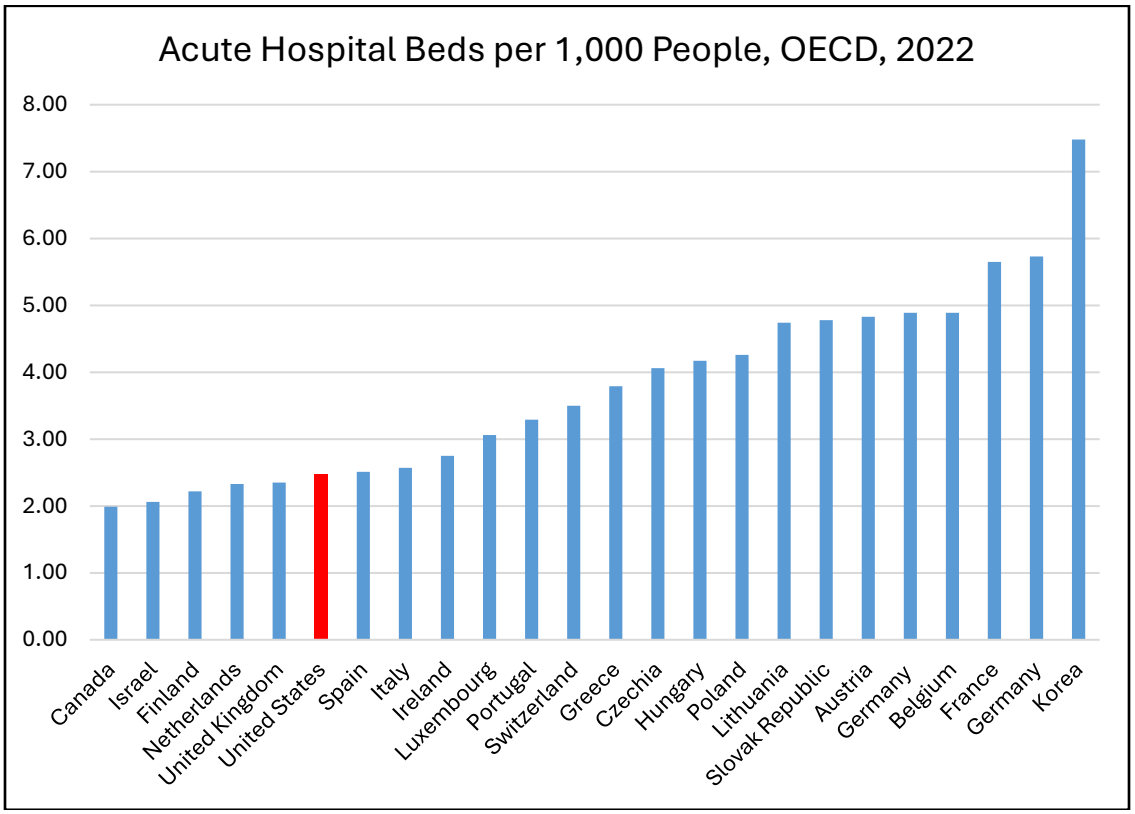
Insecurity was reinforced by rising hospital occupancy rates. In accord with one early-2025 projection, national yearly average occupancy rates were rising toward an expected 85 percent by 2032.[443] The main reasons were population aging combined with a drop in staffed beds.[444] This meant occupancy rates over 100 percent in winter months in many parts of the nation. A caution: hospitals have long reported "staffed beds" inconsistently and often inaccurately, as discussed in chapter 12.

Twenter reported on a 2024 study projecting a 9 percent rise in inpatient days, with numbers of high-acuity patient growing the fastest.[445]

This is one consequence of the 45 percent cut in U.S. acute hospital bed-to-population ratios from 4.4 per 1,000 people in the mid-1970s to 2.4 in 2018. Bed shortages began to be reported in parts of California, New England, New York, and elsewhere in the late-1990s and early-2000s.[446] [447] [448] [449] [450] Indeed, the U.S. cut patient-days per 1,000 people by almost 60 percent from 1980 to 2009 while inflation-adjusted hospital cost per person rose 109 percent.[451]

As discussed in chapter 3, the 2018 U.S. bed-to-population ratio was only three-fifths of the rich democracy average. Unsurprisingly, as indicated in Exhibit 1 – 13, the U.S. ranked near the bottom across rich democracies in acute hospital beds per 1,000 people in 2022. Clearly, higher bed-to-population ratios elsewhere are commensurate with affordable health care for all.

***Exhibit 1 – 13***




Note: U.K., France, and Germany are estimated.
Source: OECD, "Hospital Beds by Function," *OECD Data Explorer,* https://data-explorer.oecd.org/?tm=hospital%20beds&pg=0&snb=10, accessed 19 February 2025.
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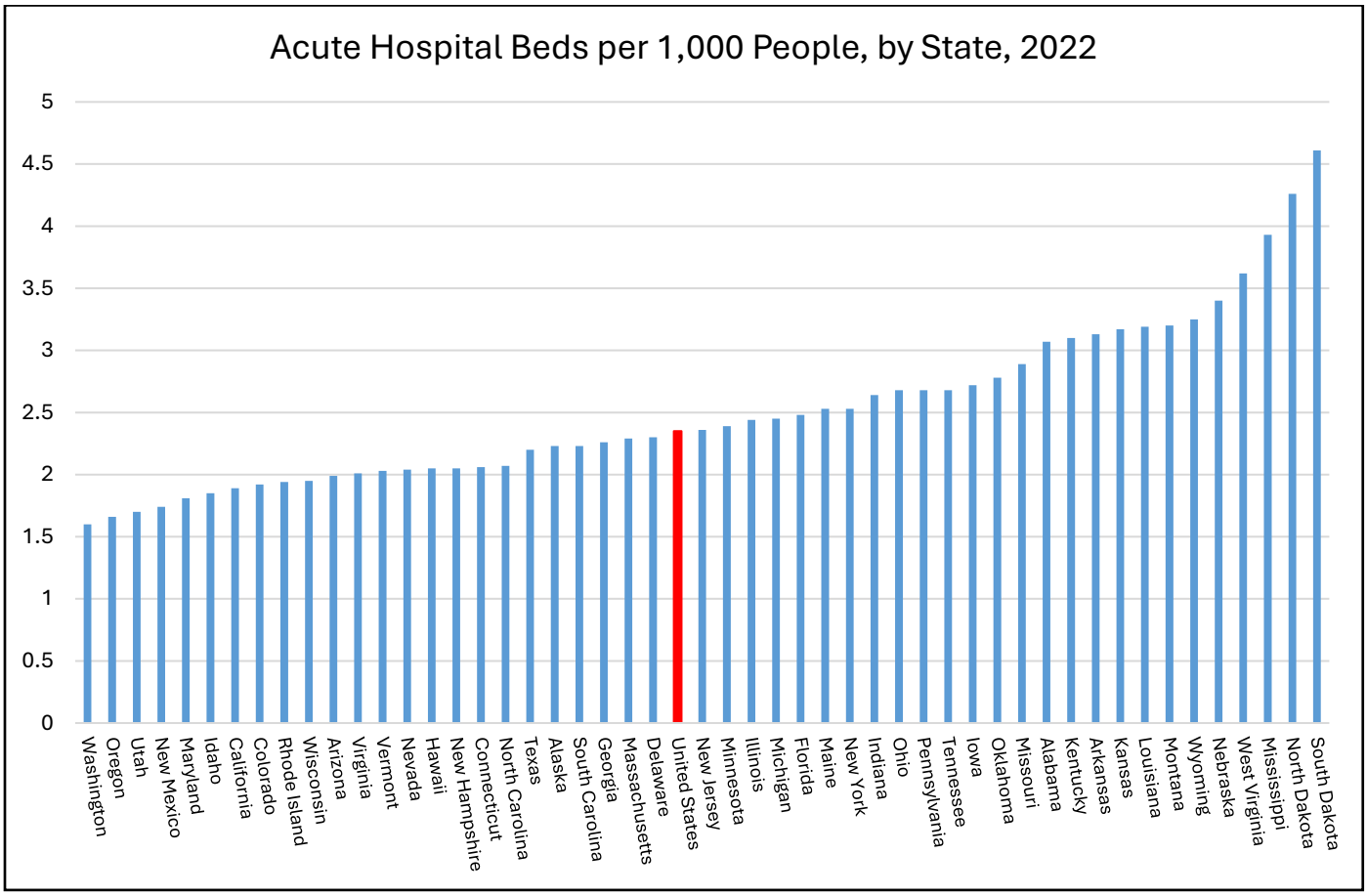
Indeed, the U.S. also ranked near the bottom across rich democracies in physician-to-population ratio. That translated into long waits to see a doctor. Physician shortages and growing difficulties in obtaining timely appointments, coupled with high costs of hospital care, shortages of available beds, and closings of hospitals—particularly in regions vulnerable to under-service—combined to magnify citizens' worries that needed care would not be available. Or that, if available, it would be more and more likely to be delivered in sub-optimal settings like the corridors of ERs or inpatient units.

As shown in Exhibit 1 - 14, many states had ratios substantially lower than the national average and were particularly vulnerable to saturation in the middle of weeks, particularly when seasonal rates of infectious disease were high. Especially if nurses to staff beds were in short supply.

A few prominent closings are now discussed briefly. They are taken up in more detail in chapter 12's analysis of hospital malconfiguration, its causes, and its remedies.

***Exhibit 1 – 14***




Source: "State Health Facts," Kaiser Family Foundation, using data from AHA Annual Survey of Hospitals, https://www.kff.org/other/state-indicator/beds-by-ownership.

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***Urban and rural hospital closings threaten access and frighten citizens, doctors, others—boosting support for reform***

Steady attrition of urban hospitals, decade after decade, undermined medical care in large expanses of many cities. Smaller and mid-size hospitals and those in Black or low-income neighborhoods have been much likelier to close. These are also discussed in chapter 12.

Hospital and ER care are available at only four locations in Detroit, a city of some 630,000 people in 143 square miles—and where snow isn't removed from side streets. Wide expanses of northern St. Louis, eastern Brooklyn/southern Queens, eastern Washington, D.C., southern San Antonio, and wide swathes of other cities have few or no hospitals and emergency rooms. Loss of hospitals in these areas under-cuts care by nearby physicians. Closing a hospital may trigger relocation or retirement by many of the doctors in private practice who admit patients to that hospital or rely on its services.

For-profit purchasers of failing hospitals usually promised to stabilize them, at least temporarily, but typically did not keep those promises. Many of these take-overs simply furthered financial shenanigans. Hospitals in Boston, Philadelphia, Providence, Waterbury, San Antonio, and other cities were undermined by complex patterns of sales, re-sales, and sell-offs and lease-backs of land and buildings involving Steward Health Care, Cerberus Capital, Prospect Medical Systems, and Medical Properties Trust. Alecto and MPT were involved in apparent plundering of hospitals in Los Angeles and Wheeling, West Virginia.[452] Prospect's unsavory behavior in suburban Philadelphia, San Antonio, New Jersey, Rhode Island, and Connecticut resulted in closed or destabilized hospitals and angry patients and politicians.[453] [454] [455] [456] Behind financial smokescreens, large sums have been grabbed by owners and lenders.[457] [458] [459] [460] These transactions all floated on revenue Americans generated in hopes of obtaining health care—revenue misappropriated for unintended purposes.

***Patients, taxpayers, employers, and workers were all harmed when health care was visibly exploited to grab money that citizens, employers, taxpayers, and patients thought they were paying to obtain medical services. Over time, for-profit caregiving was delegitimized—as were beliefs in both competitive free markets in health care and the functionality of financial incentives in health care.***

Early in 2024, two hospital crises afflicted eastern Massachusetts. State health officials asked hospitals to discharge patients as quickly as possible owing to "severe capacity challenges." [461] Major teaching hospitals' emergency rooms faced high numbers of visits. Many of these patients should have been admitted to inpatient beds. But very few beds were empty. Patients soon overflowed even hallways where patients sometimes wait for beds.

Mass General Hospital renewed its request to add 94 inpatient beds.[462] If the crisis were real, it was being used to support an appeal for increased bed capacity at one of the world's costliest hospitals, an addition that would boost hospital costs in the state. But the crisis might not have stemmed from a shortage of inpatient beds themselves—but rather from difficulty in discharging patients, owing in part to a shortage of nursing home beds or home health care capacity.

The second element of the perceived crisis was the looming financial meltdown of the 8 eastern Massachusetts hospitals operated by Steward.[463] State government found it hard to respond promptly to this threat to over 10 percent of the state's surviving hospitals. One reason was the state's consistent failure to monitor Steward and prevent it from selling its hospitals' buildings to MPT and expensively leasing them back. Or from diverting an excessive share of Steward's assets to the company's stockholders and executives. State government faced substantial legal and financial challenges in keeping the former Steward hospitals open. The state had, for decades, refused to enact either a solid hospital receivership statute or a solid source of emergency financing, such as hospital stabilization trust fund.

Successive governors and legislative leadership had been unwilling and unable to put their arms around hospital capacity, revenues, or costs. Consequently, state government did not know how many hospitals and ERs—with what capacity and in what locations—were needed to protect the health of the state's 7 million citizens. It did not know how much money needed hospitals required to efficiently deliver effective care.

After Steward was financially pillaged by insiders, it declared bankruptcy in 2024. That put its hospitals' fates in the hands of a bankruptcy judge in Texas. State government was forced to pay hundreds of millions in state subsidies to persuade non-profit hospitals to take over 6 of the 8 hospitals. This story is addressed in chapter 5.

Highly visible rural hospital closings—actual and threatened—in Mississippi, California's Central Valley, and elsewhere garnered substantial public attention. So did urban hospital closings in Atlanta, San Antonio, Cleveland, Brooklyn, and elsewhere. Concerns over both rural and urban closings were magnified by decades of steady attrition of hospitals disproportionately serving low-income and minority patients who were already vulnerable to deprivation of needed care.

As Medicare and other payers pursued "value-based" payments, growing numbers of large urban teaching hospitals worried they would be hurt financially. In past decades, these hospitals made money by winning high prices for high volumes of patients. Value-based payments might threaten those successes. Kocher and Wachter worried that "limited ability to redesign clinical workflows and inability to change their economic relationships with their own specialists and primary care providers" would keep these hospitals' costs high. They wrote that teaching hospitals would need to shift resources toward primary care and to devise ways to cut total costs of care.[464]

***Most major teaching hospitals found changes like these to be difficult and unattractive. Another choice was available. Instead of trimming their sails to the financial wind of value-based payments, major teaching hospitals could try to change that wind's direction. They could abandon hopes for more money via either business-as-usual or value-based care. Instead, they could press payers and politicians to craft cost controls, coverage mechanisms, and payment methods that promised them durable financial and clinical security.***

Reformers seeking to protect affordable access to needed care across broad regions should see at least one positive and at least one negative lesson in teaching hospitals' behavior. The positive lesson is in the multi-decade success of Johns Hopkins in helping to design and then navigate Maryland's all-payer prospective payment. Hopkins seems to have protected itself while supporting efforts to win financial security for other hospitals in the state.

A negative lesson is to note that politically influential major teaching hospitals have persuaded many Canadian provinces' ministries of health to protect those hospitals' budgets and to shift more care in their direction—even when this disadvantages lower-cost community hospitals in the same cities.[465] People with power or money are likely to be cared for at major teaching hospitals by medical school faculty. Governmental financial sympathy often followed.

**Rural closings**

In March of 2024, the sudden closing of two western Wisconsin hospitals operated by Hospital Sisters Health System, along with the scheduled closing of associated physician groups, disrupted care in Eau Claire, Chippewa Falls, and adjacent rural areas.[466]

A GAO summary showed that rural citizens are older and therefore suffered disproportionately from losses of their hospitals and doctors. Lack of evidence on need for rural hospitals and physicians, combined with weak political and financial commitment, impaired efforts to retain and rebuild rural care. The lifestyle choices of doctors completing residency programs rarely pushed them toward rural practices.[467]

It would be valuable to identify rural students who'd like to become doctors, pay for their medical education and residency, and then pay them to join a practice near where they grew up. They would enjoy support from family and friends, and also outdoors activities with which they grew up.

Rural hospitals can't survive without doctors to admit and care for patients. Rural doctors find it much easier to sustain their practices if a hospital is nearby. But few programs have addressed doctors' and hospitals' needs together.

Many rural hospitals could be forced to close in coming years. Projections from the Center for Health Care Quality and Payment Reform labelled 631 rural hospitals (20 percent) at immediate or high risk of closing.[468] Rural hospital survival was studied in valuable but episodic ways over many decades.[469] [470] [471] [472]

Drops in population in many rural counties, high rates of uninsurance and low rates of high-paying privately insured patients, loss of doctors to admit patients, and improved transportation all affected use and revenue of smaller rural hospitals. Patterns of rural hospital care and closings in the South imposed greater harms on Black citizens.[473] Closings and threatened closings in rural areas of the Midwest and Plains states mainly harmed White citizens.

A strong federal program to identify needed rural hospitals and assure them adequate financing would have been attractive to politicians in both parties. The Rural Hospital Emergency Program, which provided higher Medicare payments to rural hospitals that eliminated inpatient stays longer than 24 hours and thereby converted to freestanding emergency rooms, proved unappealing. By early 2024, only 14 hospitals had elected this option.[474] More needed to be done.

Unwilling to acquire evidence on which hospitals were needed or how much money they required, the federal government attempted to offer the cheapest possible acceptable political response. The federal government appeared indifferent to rural citizens' and caregivers' needs. Inadequate care resulted, followed by political anger. Most rural states voted Republican. ***Over time, the Republican party embraced support for rural health care reform for doctors, hospitals, long-term care, mental health, and other medical services.***

Well-publicized problems of rural hospitals in California and Mississippi exemplified both the sources of hospitals' difficulties and the low, slow, and mainly symbolic or cosmetic responses by state governments.

1. Madera Community Hospital. Madera County is in California's Central Valley, about 125 miles east of San Jose. It was three-fifths Hispanic in 2020.[475] The county's median household income of $66,700 in 2021 was 21 percent below the state's median. It was designated a rural medically underserved area.[476]

Covid crushed the hospital financially. In fiscal year 2022, the hospital suffered a negative total margin of 11.4 percent. Revenue was stable. The high deficit stemmed from an added cost of $10 million in contractual expenses for traveling nurses to replace ill, deceased, or retired RNs at triple the previous cost.[477]

In 2022, Fresno's St. Agnes Hospital and its owner, Trinity Health, offered to acquire and stabilize Madera.[478] [479] Trinity promised to invest $45 million to improve electronic health records at Madera and to finance the seismic retrofit required by state law.

California AG Bonta imposed six conditions on the sale. The sixth entailed providing emergency reproductive services, information about non-emergency reproductive care not provided, and information about alternative licensed caregivers.

Unsurprisingly, less than a week later, St. Agnes Hospital and Trinity Health withdrew their agreement to buy Madera Community Hospital. St. Agnes CEO Hollingsworth cited "'the complex circumstances and the additional conditions imposed by the AG.'" [480] [481] Republicans blamed the attorney-general for the hospital's closing in December of 2022.[482]

The nearest surviving acute general hospitals and emergency rooms for this county of 160,000 people were in Fresno, about 20 miles and 30 minutes away from Madera's population center.

Several factors impaired state ability or willingness to aid Madera or other hospitals. One is that California's Medi-Cal (Medicaid) program has long aimed to protect as many people as possible. For just as long, the state has paid low prices to hospitals and doctors in order to stretch finite dollars across more people.

A second is that the state would have to cut its budget to help address an expected $22 billion deficit for FY 2024.[483]

A third was that many hospitals in the state faced grave financial problems owing to combinations of Covid, low Medi-Cal payment rates, and state-mandated seismic retrofits. [484]

A fourth was that no party accepted accountability for inpatient, emergency, and ambulatory care for Madera County's 160,000 citizens.[485]

Late in July 2023, Adventist Health negotiated a preliminary agreement to re-open Madera Community Hospital.[486] That fell through in the face of high costs and inadequate financing.

It is much harder to re-open a hospital that has been closed for many months than to sustain an ongoing institution. Closing means that clinical and administrative staff were widely dispersed. One critic also pointed to quality problems at Madera that may have helped to destabilize the hospital.[487]

Subsequently, two small for-profit hospital groups were exploring ways to buy and re-open the bankrupt Madera.[488] Neither succeeded.

In December of 2023, the hospital's board chose to work with American Advanced Management to re-open and operate Madera, with an eye toward AAM's purchase of the hospital. A small for-profit operator, AAM was said to have stabilized two other California hospitals.[489] Some of AAM's activities have encountered legal difficulties. Nonetheless, in April 2024, Gov. Newsom approved a $57 million loan to AAM to help finance Madera's rebirth.[490] Not until mid-March 2025 did the hospital re-open.[491] Would it survive?

Madera's story testifies to the financial, clinical, and political complexity of stabilizing needed hospitals. And it underlines the absence of local, state, federal, or payer accountability for identifying and safeguarding needed institutions.

2. Rural hospitals in Mississippi. Five rural hospitals closed in Mississippi between 2005 and 2022.[492] In the fall of 2022, 220 rural hospitals nation-wide—10 percent of the national total—were said to be at immediate risk of closing. Of these, 24 were in Mississippi. These comprised one-third of the state's remaining rural hospitals. Immediate risk meant patient care revenues were not sufficient to cover cost of care before Covid hit, liabilities exceeded assets, or net assets could not cover even three years of operating losses.[493]

The state health officer testified at a November 2022 hearing that closings would harm access and outcomes. The state hospital association said that hospitals' costs had been rising faster than revenues and proposed boosting Medicaid payment rates. It did this after the Republican governor and legislature again refused to expand Medicaid eligibility under the ACA. The Democratic legislator who called the hearing said:

> What we need is somebody, somewhere in state government, who is charged with figuring what we want health care to look like now and five and 10 years down the road. Unless I'm terribly confused, there is nobody in your state government that has that charge.[494]

Hospitals in the Yazoo Delta were among the most vulnerable. The state health officer told the state board of health in October 2022 that at least six Delta hospitals' finances were very precarious.[495]

Although the state health officer advocated Medicaid expansion under the ACA, he did not expect that would happen soon or that it would do enough to relieve many citizens' poor health care or many caregivers' poor financial health.[496]

Early in January of 2023, the state medical association asserted that hospitals were failing because the state failed to expand Medicaid.[497]

At the same time, the medical association declared that "An overhaul of Mississippi's current system of health care is unmistakably essential." [498] [499]

The governor, who won re-election in 2023, opposed expansion. He warned that "'unless the Mississippi Legislature wants to invest and run hospitals in every community across Mississippi, it's a very slippery slope as to how big a check they want to write because keeping inefficient systems is not a good answer.'" [500] (It was not clear how the governor identified inefficiency.

He may well have been referring to money-losing hospitals, which might or might not be inefficient. He may have had in mind the state's relatively high bed-to-population ratio, as shown in Exhibit 1 – 14, though all 16 of the states with the highest ratios were heavily rural.) The house speaker also opposed Medicaid expansion. Interestingly, the lieutenant governor supported expansion.[501] [502]

In 2023, the legislature created a $100 million Hospital Sustainability Grant Program using American Rescue Plan Act money. One eligible hospital complained about high levels of paperwork and slow arrival of aid.[503] Possibly, Mississippi's program, like California's loan program, was intended to be symbolic, not effective.

Political, financial, and medical consequences followed. In mid-2023, the president of the hospital association renewed calls for Medicaid expansion.[504] An updated list of possible hospital closings showed two-thirds (or 49) of rural Mississippi hospitals operating at a loss.[505]

In March 2023, the Mississippi Hospital Association's political action committee donated $250,000 to the governor's newly-designated Democratic opponent. It had previously donated almost three-quarters of its money to Republicans—at a time when the American Hospital Association had been giving about 85 percent of its money to Democrats. Eight hospitals then withdrew from the state hospital association.

Despite high rates of hospital use, Mississippi's hospital cost per citizen in 2018 was fully one-sixth below the national average according to American Hospital Association data.[506] This suggests that Mississippi hospitals' financial problems stemmed from inadequate revenue, not excessive cost. But contradictory CMS data showed per capita hospital costs were only 2 percent below the national average in 2020.[507] The conflicting evidence points to the need for more accurate data on hospitals' revenues and costs.

Fully one-half of Mississippi hospitals' revenue in 2020 came from Medicare and Medicaid, well above the national share of 42 percent. Even so, private health insurance expenditures in 2020 were 6.0 percent of gross state product, over one-quarter above the national average of 4.7 percent of GNP. This means that private health insurance was a relatively heavy burden on employers and workers and the state's weak economy.

Early in 2024, Chang and Miller reported that a number of southern legislative leaders decided to push their states to expand Medicaid under ACA provisions.[508]

In the spring of 2024, a bill to expand Medicaid, conditional on a work requirement, passed in both houses of the Mississippi legislature but died in conference committee.[509]

Six months later, Sommers and colleagues published a smart and trenchant analysis of the state's choices: do nothing and suffer poor health outcomes and hospital financial distress and closings; expand Medicaid with a work requirement; and expand Medicaid under ordinary ACA provisions. They noted the stark failure of Georgia's 2023 Medicaid expansion, which was contingent on requiring work: only 1 percent of those eligible enrolled and 92 percent of spending went to administering the program. Calling insistence on a work requirement "ideological", Sommers and colleagues asserted that ordinary expansion would benefit the state's economy, its hospitals, and its uninsured low-income citizens.[510]

Ten states' refusals to expand Medicaid constitute the most dramatically unreasonable, pernicious, and self-destructive behavior in U.S. health care today.

The breadth and duration of the persisting refusal remains hard to understand. So does the insistence on conditioning expansion on impractical, costly, and grossly inefficient work requirements.

To what degree did refusal to take Yankee dollars and expand Medicaid rest on enduring resentment toward Obama and the ACA itself, to racial politics, to a view that health insurance is a privilege to be earned and not a right—along with the belief that Medicaid is a welfare program, or to other factors?

Hospital closings undermined doctors who relied on those hospitals. Closings led some doctors to retire and others to relocate their practices. Rural doctors had long been in shorter supply than doctors elsewhere. And, by one forecast, rural physician availability nationally was expected to drop by 23 percent between 2017 and 2030.[511] Loss of doctors has long been a grave problem in the state with the greatest number of citizens per physician.[512] This is why, even though Mississippi's spending per citizen on doctors was only 74 percent of the national average in 2020,[513] the state's relatively few doctors garnered the highest average physician income in the U.S.[514] Astonishing. It is noteworthy that high incomes have not persuaded more doctors to stay in Mississippi or to relocate there.

Even worse, closings of many hospitals did little to improve the financial condition of surviving institutions that served displaced patients. Patients who secured substitute care brought their medical problems and their lack of insurance or low-paying Medicaid coverage with them.

Unsurprisingly, rural hospital closings result in increased travel time to the nearest surviving hospital.[515] Many of these survivors experienced medical and financial pressures when serving some of the patients displaced by closings.

Public dismay swelled when hospital closings in the Yazoo Delta and other lower-income areas were contrasted with the opening of a $30 million medical office building in Madison, Miss. in 2024.[516] Strikingly, Madison's median household income of $119,662 was fully 2.4 times the statewide median of $49,111.[517]

As rural hospitals closed, travel times to ERs rose. When patients displaced by a closing succeeded in obtaining substitute care, it was often at more expensive surviving hospitals. Higher costs at survivors might have stemmed from greater size and lower efficiency. Also, survivors might have gained greater leverage over private insurers, winning them higher prices. Access declined as cost of care and cost to patients and payers rose. Rural politicians—mainly Republicans—faced pressure to protect surviving rural hospitals.

When a Kansas rural hospital's emergency room closing was announced, Gov. Kelly, a Democrat, challenged legislative Republicans to expand Medicaid to help both patients and hospitals.[518] [519]

Even though only a few hospitals close in any area, in any decade, the cumulative effect of successive urban and rural hospital closings has been to denude large expanses of hospitals. It has also undermined practices of many doctors. Citizens of counties, small cities, or urban districts may be aggrieved.

But their worries were asynchronous. A hospital here one year, a hospital over there four years later. The gradual erosion made it hard to unify a political bloc to support hospital relief and reform. Politicians gave speeches. For years, nothing was done. But this changed after 2024. Mississippi saw a dramatic, visible, statewide loss of hospitals. Alabama, Georgia, South Carolina, and Texas suffered less acute but still visible erosion.

**Urban closings**

Urban hospital closings also gradually won greater attention and concern. One reason was the disproportionate closing of urban hospitals in Black neighborhoods (controlling for other powerful factors) decade after decade since the 1930s. The other has been the profound shift of patients from urban community hospitals serving mainly doctors in private practice to large medical school-affiliated teaching hospitals where physician care was dominated by faculty and residents. In 1950, 56 percent of acute hospital beds in 52 U.S. cities were in non-teaching community hospitals; that share fell to only 15 percent in 2020.[520] These changes harmed both access to care and cost of care.

Rising numbers of major teaching hospitals also faced financial crises; some are among the closings discussed briefly here and in more detail in chapter 12. Others face chronic financial distress and are at high risk of closing in the next decade.

Washington's D.C. General Hospital closed in 2001 at the behest of the city's mayor and the Congressionally-mandated Financial Control Board in the face of unanimous opposition from the city council. The only Level 1 trauma center in the city and one of two hospitals in the city's heavily-Black eastern half, DC General had long offered open-door service to uninsured patients who lacked alternative sources of care. It had relied on a substantial operating subsidy from city government.[521] The hospital's reputation had been clouded by a history of over-staffing. Its sprawling old buildings required replacement.

Instead, the mayor and health director sought to close the hospital, promising that money saved would buy health insurance for uninsured citizens and promote prevention, not treatment, by hiring primary care physicians and investing in social determinants of life.[522]

These promises were not kept post-closing. Instead, to protect access to emergency and inpatient care, the city was compelled to buy and run a substitute public hospital in the far southeast corner of the District, a hospital that had suffered grave financial and quality problems. Then, after years of fighting, two of the city's medical schools agreed to help staff a small but expensive new DC General. Built near the site of the former hospital, it opened in 2025. This amounted to costly change, but little progress.

St. Vincent Hospital in New York's Greenwich Village closed in 2010. It had been losing higher-paying privately-insured patients for a number of years. Its unusually kind open open-door care for AIDS patients in the early years of the epidemic won enduring gratitude from many citizens.

St. Vincent was financially and organizationally undermined by efforts to consolidate surviving Catholic hospitals in New York City. Those efforts saddled St. Vincent with debts that even a chapter 11 bankruptcy could not address. The hospital's financial problems grew during the 2008-2009 national financial crisis, a time when federal and state governments were unwilling or unable to help the hospital.

St. Vincent's closing meant that, after Hurricane Sandy hit in 2012, only one Manhattan hospital south of Central Park remained in operation. The storm shut four low-lying East River-adjacent hospitals and their ERs for many weeks.

Citing heavy losses, the parent corporation of that one continuously operating institution closed it early in 2025.[523] Advocates sought legal and regulatory tools to keep the hospital open.[524] Unsupported by city or state intervention, they failed.

Philadelphia's Hahnemann Hospital closed in mid-2019. A large hospital, it had been undermined financially by the Allegheny AHERF scandal [525] and then sold to a for-profit firm. The main teaching affiliate of a nearby medical school, a high share of its patients was covered by Medicaid and Medicare. Located near center city, Hahnemann's owner deemed it more valuable for the land it was built on than for continued operation as a money-losing major teaching hospital.

Loss of Hahnemann appears to have made Pennsylvania lawmakers more aware of dangers posed by for-profit ownership of hospitals.

A year later, during the early days of Covid, Steward Health Care extracted dozens of millions of dollars from the state by threatening to close its hospital in Easton.[526]

In 2023, Pennsylvania legislators sought to restrict closings by for-profit hospitals. That stemmed from closings of Springfield Hospital and Delaware County Memorial Hospital, owned by Prospect Medical Holdings,[527] and involved in a $1.6 billion sale-leaseback with Medical Properties Trust.[528] Then, early in 2025, with Prospect finally in bankruptcy and running out of cash, its receiver planned to close its two remaining Delaware County hospitals.[529] With 400 beds, those two hospitals admitted 25,000 patients yearly and served 75,000 ER patients. Initial efforts to move those two hospitals under a non-profit's umbrella failed owing to the high liabilities Prospect had stuck to the two; a second effort may succeed, at least for a time. Yet another for-profit threatened to close Scranton's Regional Hospital.[530] In Sharon, near Pittsburgh, a Steward- and MPT-owned hospital was bought out of bankruptcy by another small for-profit operator, Tenor Health Partners. Tenor declares its aim to "identify, own, manage, and turn around financially challenged hospitals." [531] Will that promise prove real or—like Steward's and Prospect's—feral?

These episodes of actual or threatened loss of hospitals owned by five different for-profit chains galvanized action by the Commonwealth's legislature and state governments elsewhere. Reforms included a receivership law that enabled a court-appointed receiver to write off wrongly acquired debt, a statute requiring the state to identify hospitals needed to protect the health of

the public, and a hospital stabilization trust fund—financed by small yearly assessments on hospitals themselves—to serve as a mutual aid insurer against loss of needed hospitals.

San Antonio's Texas Vista (formerly Southwest) Hospital was closed by Steward in the spring of 2023. It had been one of only two acute care hospitals in the southern, heavily Latino one-third of the city of 1.5 million people and 16 acute care hospitals. This resembles the unbalanced configuration of hospitals that had evolved in Washington, D.C.

Vista had been owned by successive for-profit companies; Steward bought it in 2017.[532]

The closing aroused public and political concerns, both national [533] and regional.[534] It came at a time of growing public scrutiny of Steward Health Care's finances, some of which involved sales and leasebacks of hospitals among Steward and Cerberus Capital and Medical Properties Trust.[535] [536] [537] [538] Another involved the purchase of a $40 million 190-foot luxury ship by Steward's president.[539]

Atlanta Medical Center, the second-largest hospital in Georgia by some measures, was closed by Wellstar, its non-profit owner, in November 2022. Wellstar insisted that it closed AMC because it had put $350 million into financing operating losses and some capital investments in the past six years, but had sustained a loss of over $100 million in the prior 12 months.

AMC's medical staff president said the closing would mean "'a public health emergency.'" The CEO of Grady Memorial, Atlanta's remaining open-door hospital, said the closing "'is incredibly tragic and disruptive to the patients.'" [540] AMC's medical staff, workforce and patients were reasonably demographically proportionate to the region's citizens.[541]

Less than two months after closing AMC, Wellstar announced it would partner with Augusta University Health "'to expand access to quality care for all Georgians.'"[542] But probably not those in Atlanta. Wellstar apparently did not fear losing money in Augusta.

Grady sought to care for patients displaced by AMC's closing. It received higher public subsidies, including $130 million in state aid, to help finance opening 200 more beds. Grady was said to be at capacity each day.[543]

Politically, individual hospital closings ceased to be flash-in-the-pan events. A one time, they had triggered a few news stories, speeches, posturing, and hand-wringing, but quickly faded from public view. Some experts applauded closings because they reduced inpatient bed capacity, which they imagined had engendered over-use and excess costs. Free market fans asserted that a closed hospital deserved to close because it could not garner enough revenue to cover its costs. Still, scrupulous free markets devotees noted that fewer competitors meant less competition and higher prices.

But AMC's closing in Atlanta, like successive closings in Pennsylvania, played out differently. Six months earlier, in May of 2022, Wellstar had closed another hospital, just south of Alanta. Politicians began to publicly question who should determine hospital survival and what would it take to assure continuity of hospital care where it was needed.

Georgia journalists shifted their focus from viewing hospitals like contestants in a multi-player game of Risk [544] [545] [546] and began considering effects of closings on patients and citizens and payers.[547] [548] Even seven months after the closing, a state senate committee hearing featured criticism of Wellstar's exit from Black areas of Atlanta and its $800-million investment in a majority-White county.[549]

Ten months after AMC's closing, a number of its former patients were still searching for substitute physicians. Travel times increased substantially.[550] This dislocation underlined two important issues. One was that patients—especially those with serious or numerous acute or chronic health problems—knit together fabrics of physician and hospital care. When these were torn by a closing, they took time to re-weave. And some holes in care were not filled. The second was that hospitals and doctors were not substitutes; rather they were symbiotic. Subtracting doctors could force a hospital to close. But closing a hospital usually precipitated relocation or retirement of many of its doctors.

At 13 percent, Georgia's uninsured population share was third-highest in the nation—behind only Texas and Oklahoma. In the face of rising payments to nurses and other workers, and higher costs of drugs and other elements of care—while revenues grew far slower—Grady's deficit soared. At the same time, more and more politician and voters—and hospitals—became aware that Georgia was forfeiting $3.5 billion each year by failing to expand Medicaid and thereby cover almost half its uninsured citizens.[551]

As Grady's costs continued to grow faster than its revenues, both Fulton and DeKalb counties and state government itself were squeezed financially. The 11 other Georgia counties using local property taxes to help finance hospital care felt increasingly squeezed.[552] Pressure to expand Medicaid continued to grow.

Other metro Atlanta hospitals sought a solution, lest they be faced with a rising overflow of patients from a fully occupied Grady. At the end of the summer of 2023, several hospitals in the region around Atlanta were deemed to be at "critical capacity," with shortages of inpatient beds resulting in patients backing up in ERs and hallways.[553]

Georgia hospitals that depended heavily on Medicaid remained vulnerable. Also, many employers came to resent the high prices imposed on employers by increasingly concentrated and powerful hospitals. Even in 2020, private health insurance costs per person in Georgia were 4 percent above the U.S. average. Because Georgia's economic product per person was only 91 percent of the U.S. average, private health insurance costs were one-seventh above the national average, as a share of the state's economy.[554] In 2020, only 36 percent of Georgia hospitals' revenue came from Medicare and Medicaid, well below the national share of 42 percent. Some employers began demanding a one-price regime for all payers, imitating the uniformity that an actual competitive market would achieve. This meant boosting Medicaid's prices and lowering those paid by employers and workers.

Primary care shortages—especially in predominantly lower-income or Black rural or urban areas—also attracted greater attention. In 2020, Georgia ranked 42nd-worst (highest) among the states in citizens per active patient care primary physician at 1,358 people per primary. This was 15 percent above the national average of 1,183 per primary.[555]

Elsewhere. Fully 90 percent of the hospitals in Detroit that were open in 1960 closed or merged into four surviving costly major teaching hospital sites in a 143-square-mile city.[556]

Chicago safety net hospitals have suffered chronic financial problems for decades. Efforts to stabilize them were weak.[557] [558] Covid markedly exacerbated staffing and financial problems.[559]

Hospital desertification advanced steadily in wide districts of Brooklyn, Philadelphia, Los Angeles, St. Louis, Washington, and other cities.

For example, MLK Community Hospital in Los Angeles County was resurrected through great dedication and effort on the site of the former King-Drew institution. But MLK was then financially besieged.[560] One reason was that three-quarters of its patients were covered by the low-paying state Medi-Cal (Medicaid) program.[561] Few alternative caregivers were available.[562]

Over time, the cumulative subtractions of hospitals and their doctors threatened ER, inpatient, and ambulatory care access for more and more patients. Nearby hospitals feared financial and patient care stresses when serving displaced patients. Local, state, and national politicians began to pay closer attention. Chapter 12 takes up hospital configuration in some detail.

**Care subtraction and financial plundering**

While access was compromised by hospital closings, financial pillaging and plundering multiplied in health care. Medicare Advantage plans harvested unwarranted high capitation revenue by making their enrollees look sicker by adding some diagnostic codes and gaming others. For-profit and non-profit caregivers boosted their revenue by upcoding patients and by providing clinically unnecessary services. Two emergency physicians' allegations of over-charging by HCA, if true, were very troubling.[563] And some large non-profit systems were accused of focusing on building pools of financial reserves to invest, or of milking money from hospitals in low-income areas to finance improvements in high-income areas.[564] [565] [566]

Subtraction of care was not unique to the United States. A number of community hospitals in Ontario, Quebec, Manitoba, and other Canadian provinces were threatened by efforts to consolidate more care in fewer and larger hospitals.[567] [568] [569] [570] Covid saw large numbers of closings of emergency and other services at Canadian hospitals owing mainly to staffing shortages.[571] These persisted through 2025.[572] Canadian health spending per person was only 49 percent of the U.S. level, down from 85 percent only a few decades earlier, so staffing and financial stringencies might not have been surprising.

But a mid-2023 summary of U.S. hospital departmental or service closings was surprising. Fully 45 hospitals were identified as closing maternity, psych, pediatrics, rehabilitation, burn, transplant, and other services.[573] An end-of-year compendium found 85 hospitals closing departments or ceasing to operate.[574]

**Hospitals' appeal for help.** Covid meant higher costs of care but lower revenues. Higher costs stemmed from the special ICU and other care needs of Covid patients, the burden of paying much higher incomes to large numbers of traveling nurses, protective equipment, and the like. Lower revenues stemmed particularly from the drop in profitable elective surgery

admissions. In 2023, as hospitals emerged from Covid's shadow, they sought various narrow or broad types of financial relief.

At the same time, press reports on bad behavior by wealthy non-profit hospitals besmirched those hospitals' reputations at the very time they—and other hospitals—sought more money. [575] [576] [577] One lengthy story highlighted profits won by some hospitals early in Covid but mentioned subsequent losses only in passing. [578]

In response to well-publicized hospital closings, California enacted a $150 million loan fund to tide over hospitals that could prove long-term viability. The loan program was derided as political sleight-of-hand, a distraction to disguise inaction, and devoid of practical value.[579]

California hospital leaders sought $1.5 billion in across-the-board revenue supplements for all hospitals from the state.[580] But this appeal was opposed as unfair and inefficient because it would provide extra money to hospitals that did not need it.[581] Seeking more money for all hospitals might unite hospitals but did not win much political support. Once again, lack of evidence on which hospitals were needed manifested the past lack of public accountability; it also enabled subsequent public irresponsibility. It precluded focusing finite state money on needed hospitals requiring higher revenue. The state had no capacity to differentiate.

Nationally, two different groups sought added money for hospitals that considered themselves at greater risk or to be more valuable than others.[582] America's Essential Hospitals, which lobbies for some 300 large urban hospitals, asked for $7 billion in designated federal money.[583] [584]

The American Hospital Association sought special designation of "metropolitan anchor hospitals" that served high shares of Medicaid, marginalized, or uninsured patients.[585] Possibly, the AHA aimed to build a foundation for seeking special financing for those hospitals.

These fragmented and competing appeals did not succeed. But—in concert with the increasingly visible hospital closings and service reductions—they served to remind state legislatures and Congress of the costs of continued inattention to hospital configuration.

Hospitals in Mississippi, Georgia, Alabama, Pennsylvania, California, and other states requested financial support from state governments. Little effective aid materialized.

Jackson Hospital and Clinic, a vital hospital in Montgomery, Alabama, was deeply in debt and had defaulted on $60 million in bonds in the fall of 2024. Facing closing, it appealed to both city and county to back an interim loan.[586] Both refused and the hospital filed for Chapter 11 bankruptcy protection in February 2025.[587] Local elected officials of both parties noted that the hospital served a wide area of the state and urged state support—beginning with Medicaid expansion under the ACA.

But while public officials' rhetoric was often expansive, public action was rare. Sausser wrote that rural health care had become "'trendy'" in the South but "Medicaid expansion has not." [588]

Major teaching hospitals were not immune to financial stress or disruption. Fass and Cavanaugh found that the finances of the 4 main academic medical centers in New York were stronger than other hospitals in the city but substantially weaker than their counterparts elsewhere in the nation.[589] In Boston, Mass General Brigham laid off 1,500 workers early in

2025.[590] Fitch Ratings lowered its outlook on the University of Pittsburgh Medical Center to negative after UPMC lost $400 million on operations in two years.[591]

Teaching hospital trustees and CEO, medical school deans, and physicians lobbied their powerful or influential patients to protect these institutions. The strength of that lobbying grew during the disruptive early months of Trump's return to the White House that saw gutting of federal agencies and threats to research financing.

### *b. Doctors' distress*

For decades before Covid, many doctors worried about being slashed between the scissor blades of constrained incomes and rising practice costs. Medicare, Medicaid, and private insurers all sought to slow rises in doctors' fees even as they imposed greater demands on doctors' time.

Payers demanded more data to substantiate bills for services given and to report quality measures. Payers forced doctors to work to obtain prior approval of care to be given, and more effort to appeal downcoding or outright denial of payment for care that had been given.

In hopes of containing rising health costs, payers sought to manage, regulate, incentivize, and penalize doctors. When these did not work, payers redoubled their efforts.[592] Doctors sought ways to insulate themselves from payers' pressures—and also ways to sustain incomes while abiding by (or gaming) growing numbers of rules.

No other nation has chosen to pay doctors in such demanding, complex, and corrosive ways. In ways that magnify mistrust between doctors and payers. In ways that waste so much time to accomplish so little of value. It is ironic that this scheme has the Newspeak title of "value-based payment."

Doctors were more likely to report symptoms of burnout than other working Americans.[593]

A number of doctors turned to politics to express their disaffection and anger. The AMA, which had long donated heavily to Republican politicians,[594] and which had fiercely opposed Truman's, Johnson's, and the Clintons' proposals for public insurance, Medicare, and universal coverage, came out in favor of Obama's ACA and fought Trump's efforts to repeal it.[595] Indeed, inside the AMA, opposition to single-payer financing was sustained by only a narrow margin.[596]

In 1990, three-fifths of doctors' political contributions to national political campaigns went to Republicans. By 2018, two-thirds went to Democrats. Declines in share of doctors in independent practices (businesses) were partly responsible. Doctors' shift paralleled a general and gradual re-orientation of more educated professionals toward Democrats.

U.S. payers long refused to adopt effective methods of containing total costs of health—employed in other rich democracies—or of paying doctors and other caregivers in ways commensurate with effective cost controls.

Or in ways that were, overall, reasonably financially neutral, trustworthy, and self-regulating.

Payers instead adopted indirect and manipulative methods of payment, including growing financial rules and incentives and penalties, in hopes of eliciting desired behaviors.

Doctors often resented the rules and incentives and penalties. Many tried to game them to boost revenue. Some did this to obtain higher incomes. Others sought only to offset payers' anticipated cuts, leaving doctors where they felt they deserved to be, financially.

In a health care world trumpeting markets, incentives, and greed—and one in which money was moved by increasingly complicated rules, some doctors felt liberated to pursue ever-higher incomes.

Payers and doctors became increasingly angry and suspicious toward one another. Payers' rules sought to hamstring doctors by challenging their clinical and financial independence. When doctors sought relief by selling their practices and becoming employees, they encountered new—and often greater—frustration, loss of control over both time and clinical decisions, pressure to boost billings, and alienation. Reports of doctor burn-out and early retirement became more frequent.

One doctor said:

> Nobody becomes a physician because they hope to feel like a cog in a factory. However, between meeting the demand of payers for referrals, denials of payment, and increased documentation requirements in order to assure proper reimbursement and risk adjustment, as well as an increasing number of production metrics, it can be difficult not to feel like a cog.[597]

Covid magnified these harms considerably. Doctors in primary care were probably particularly vulnerable to alienation, anger, depression, burnout, and moral injury.[598] [599] Since almost one-half of doctors are age 55 and above—including physicians in internal medicine, family practice, and pediatrics—[600] Covid may have led many who were able to retire to accelerate that decision.[601] A December 2023 survey by *Medscape* reported that two-fifths of doctors in their 50s planned to retire in their early-60s.[602]

Late in 2024, Horstman reported that one-half of primary care doctors reported burn-out, with one-third of these declaring their intentions to cease seeing patients within three years.[603]

Some younger doctors were also upset. Rosenbaum reported on a number of angry and alienated residents, many of whom resented those who urged them to view medicine as a calling. One thought that word "'is weaponized against trainees as a means of subjugation—a way to force them to accept poor working conditions.'" [604]

Growing shares of U.S. doctors abandoned private practice and instead worked for hospitals, large physician-owned groups, and even for-profit companies controlled by investors. This steady trend, combined with the growing financial incentives and regulatory constraints facing doctors, undermined physician autonomy and ignored the central importance of doctors in diagnosing and treating all of us well. And in assuring access to health care while containing its cost.

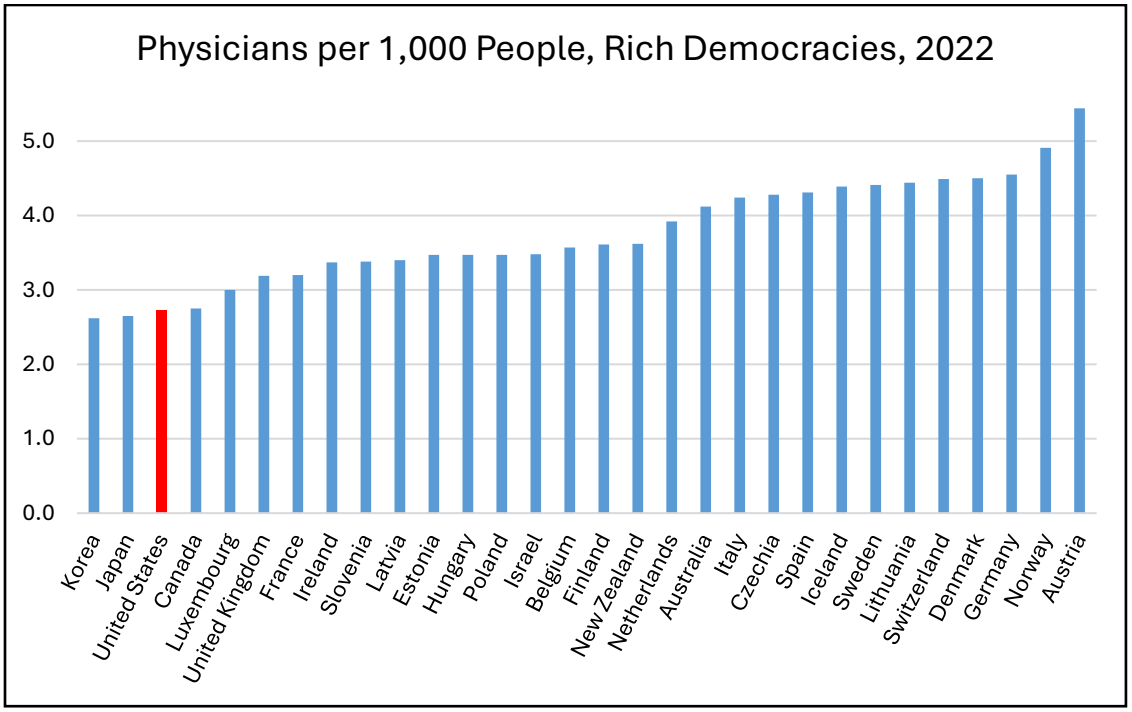
**The U.S. has fewer doctors and administrative burdens waste more of their time**

As shown in Exhibit 1 – 15, the U.S. was near the bottom in physicians per 1,000 people, across the world's rich democracies. But American doctors were probably highest in the share of their time diverted to administrative tasks.

A 2024 AMA survey of physicians reported high and rising rates of denial of authorization, delays in necessary care, patient abandonment of treatment, and serious harm to patients. Doctors also reported having to devote substantial time and cost to requesting prior authorization or appealing denials.[605]

These burdens particularly afflicted U.S. physicians in primary care. Administrative costs per patient do not vary very much, making them a fairly fixed add-on to the doctor's time per patient encounter. Primary care doctors saw many patients daily, and each visit required documentation for both billing and clinical records.

***Exhibit 1 – 15***




Source: OECD, *OECD Data Explorer,* Active Practicing Physicians, accessed 17 February 2025, https://data-explorer.oecd.org/vis?tm=physicians&pg=0&snb=15&vw=tb&df[ds]=dsDisseminateFinalDMZ&df[id]=DSD_HEALTH_EMP_REAC%40DF_PHYS&df[ag]=OECD.ELS.HD&df[vs]=1.0&dq=.....P.&pd=2015%2C&to[TIME_PERIOD]=false&ly[cl]=TIME_PERIOD&ly[rw]=REF_AREA%2CCOMBINED_UNIT_MEASURE.

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U.S. shortages of primary caregivers have long impaired patients' access to appropriate care and have increased costs.[606] Causes and possible remedies are discussed in chapter 11. Covid apparently disproportionately accelerated primary care physicians' retirement, making it

harder for patients to identify primaries accepting new patients. Instability of primary – patient relationships weakened trust between the two; it also magnified patients' insecurity.[607] [608]

The unavoidable consequences of fewer doctors and greater administrative burdens are a more frenetic professional work life, and less time to devote to patient care. And to self and family.

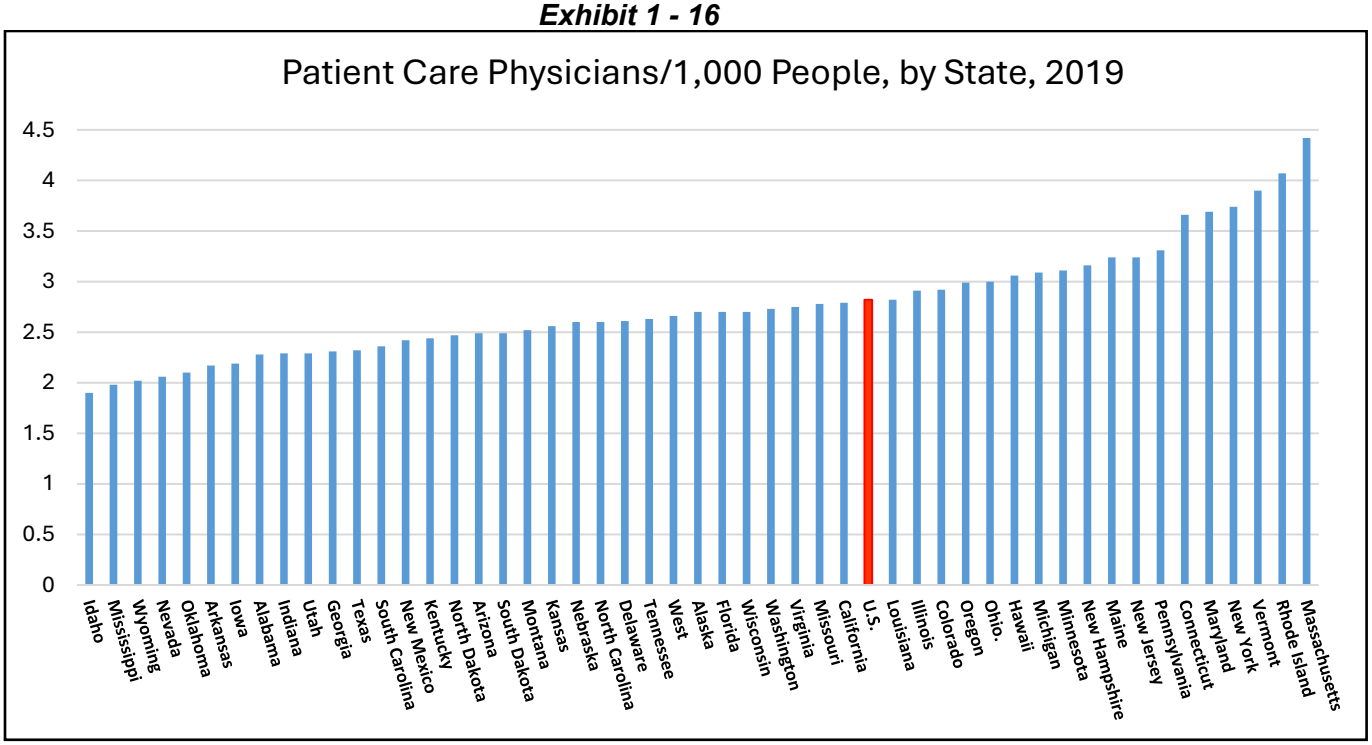
The rise of hospitalists and the disappearance of primary care doctors from hospitals has helped to integrate care during hospital stays. But it probably also undermined integration over time between primary and specialist physicians, and between outpatient and inpatient care. The emptying of hospitals' doctors' lounges and the greater use of EHRs reduced opportunity for face-to-face discussions between doctors. That meant fewer opportunities for confidence-building conversations and solid relationships.[609]

**Differences across the states**

The number of patient care physicians per 1,000 people in 2019 varied from 1.9 in Idaho and Mississippi to 4.4 in Massachusetts. See Exhibit 1 – 16. This means that patient access to physician care is particularly weak in many states.

The combination of low U.S. physician number per 1,000 people internationally, the high administrative burdens imposed on U.S. physicians, and the wide inter-state variation combined to impose substantial stresses on many doctors. Reformers had to face up to the challenge of adding doctors in under-resourced states and also in many regions within states with higher overall doctor-to-patient ratios.

***Exhibit 1 - 16***




Source: National Center for Health Statistics, *Health, United States,* https://www.cdc.gov/nchs/hus/topics/physicians.htm.

**Constrained income**

Many doctors had long supposed that private practice would allow them to bill payers what they wished or thought they deserved. But doctors' control over their fees and private practice itself have faced sustained challenges.

Many procedure-performing specialists found that Medicare's 1992 introduction of payment by fixed, regulated fees set by the resource-based relative value scale (RBRVS) reduced their fees and incomes.[610] Subsequent updates have been dominated by those very specialists,[611] helping to restore lost income and widening the income gap between doctors whose work was mainly cognitive (primary care, psychiatry, endocrinology, and rheumatology, for example) and doctors whose work mainly entailed performing procedures (surgeons and interventional cardiologists, for example.[612]

In 1997, Congress tried to cap the rise in total Medicare payments to doctors by imposing a Sustainable Growth Rate tied to GDP growth, but that proved politically unworkable. Effective for one year, its cuts in doctors' incomes infuriated many. It remained on the books until 2015 but was simply ignored until its abandonment in favor of conditioning fees on various quality measures—e-prescribing, use of EHRs, and incentives to hold down costs. That new arrangement was called MIPS, the Merit-based Incentive Payment System, implemented in 2019.[613]

And for 2023, Medicare cut doctors' fees by 4.5 percent,[614] followed 3.4 percent cut for 2024.[615] This came after a total rise of only 10 percent in base Medicare fees from 2001 through 2023.[616]

The AMA president asserted that doctors' real (inflation-adjusted, constant-dollar) fees from Medicare fell by 26 percent from 2001 to 2023.[617] [618]

Congress's tight controls on fee increases angered many doctors.

When a major payer like Medicare tried to limit doctors' incomes by cutting fees under the RBRVS formulas, it invited doctors to respond by working those payment formulas to restore or boost incomes. One method was to upcode patient care—to present information about the patient and the care the doctor provided that seem to put the care into a category that paid a higher fee.

Almost all state Medicaid programs paid doctors lower prices than did Medicare. They often imposed both delays in payment and extensive paperwork.[619] To the degree these realities deterred physicians from seeing patients covered by Medicaid, they suppressed access to care or forced Medicaid patients to see doctors in costlier settings like hospital clinics or ERs. Payers paid higher prices in those settings and continuity of care was often compromised.

When Medicare patients enrolled in private MA plans and when states farmed out their Medicaid programs to private contractors, both private entities had financial incentives to seek to squeeze payments to doctors.

Private insurers also squeezed doctors on price. They formed narrow networks of preferred providers who agreed to accept lower fees in hopes of winning higher volumes of patients—or

of sustaining current volumes. Doctors in solo practice or small groups had little power to bargain against insurance companies. They were paid lower fees.[620]

One doctor complained that Optum, part of United Health Group, "'denies and delays'" payments to doctors and then offered them heavily discounted payments in the notional form of loans that amounted to a 35 percent revenue haircut.[621] Caregivers also complained about what they regarded as insurance company collusion to set lower prices for out-of-network care.[622]

This was one reason for surprise bills: they manifested doctors' residual capacity to impose high charges on patients who wandered out of network or were otherwise unprotected by lower prices negotiated by insurers. Over time, more and more doctors saw that they couldn't win fights against payers and that selling their practices offered little in the way of durable financial relief but that it did impose greater private bureaucratic control. Those doctors therefore came to see greater value in politically negotiated fees for service, fees for time, capitation, salaries, and other methods of payment. Especially when these methods were accompanied by cuts in required paperwork.

**Added costs in money and time**

Doctors' costs rose for several reasons. The Medicare Economic Index, which measures dollar costs of doctors' practices, rose by about 47 percent from 2001 to 2023. Those costs included rent, utilities, office staff, malpractice insurance, and other dollar outlays. During these years, the base rate for doctors' Medicare fees rose by only 10 percent.[623] This may have induced many doctors to upcode their patients' illnesses or treatments or boost volumes of care.

Additionally, all payers have acted in ways that hiked doctors' costs by increasing time burdens. EHRs, prior approval, and appeals of denied claims were probably the three main generators of higher demands on doctors' time. Most of them also eroded doctors' autonomy.

Most payers demanded that doctors use EHRs to support billing, to document adherence to quality standards, and to help to pre-emptively build defenses against malpractice suits. Time devoted to nurturing the EHR is close to a fixed cost per patient encounter. So doctors in ambulatory practices, who treated more patients daily, were particularly burdened by these unpaid administrative obligations. This was a particular problem in primary care.

Doctors in primary care, cardiology, and orthopedics outpatient practices spent 2.6 hours weekly to report on a fraction of U.S. patients. In 2014, cost to the practices of reporting was $15.4 billion, or almost $20 billion in 2023 dollars. The average doctor's cost was about $40,000 in 2014, or some $52,000 in 2023 dollars.[624]

This effort was not productive. Bond and colleagues found that scores on Medicare's Merit-based Incentive Payment System (MIPS) for doctors were inconsistently associated with process and outcomes measures of quality. They concluded that "the MIPS program may be ineffective at measuring and incentivizing quality improvements among US physicians." [625]

Because efforts like MIPS consumed doctors' time and did little, at best, to help patients, they alienated and demoralized doctors. They accelerated burnout. DiGiorgio and colleagues therefore called for reforming quality measures to combat burnout.[626] There seemed no way to

accomplish this under the payment methods then prevailing. A different approach, therefore, would be to detach quality measures from payment.

The ACA required insurers to offer caregivers electronic payment options, but many insurers then imposed fees of up to 5 percent for doing so.[627] Even though CMS prohibited all but nominal fees. In the face of industry lobbying, CMS dropped its prohibition. Doctors (and hospitals) had good reason for resentment. Bipartisan legislation introduced late in 2023 would have banned such fees. Despite AMA and AHA support, that effort failed.[628]

As noted earlier, one study found that primary care doctors spent 52 percent of their work day nurturing the EHR.[629] As noted earlier, the time that EHRs demand of doctors are not inherent in the EHR software since keystrokes per progress note are much higher in the U.S. than in other nations using the same software.[630] Nor is FFS culpable, since it prevails elsewhere for doctors in ambulatory care.

Doctors, regardless of employment status, cited frequent and time-consuming insurer demands for prior authorization.[631] [632] [633]

Proposed federal regulations to modulate insurers' demands for prior authorization illustrated the difficulty of addressing doctors' complaints.[634] That proposal—once again—revealed the ***difficulty of relying on regulations to rectify or even modulate badly-designed and inherently untrustworthy methods of paying for health care in the U.S.***

Doctors—and patients—were harmed when insurers denied payment for needed care. High rates of ACA insurers' denials of payment for in-network care were discussed earlier. The problem was widespread and chronic. Gawande cited a billing expert who asserted that shifting from a money-losing physician practice to a profitable one depended on cutting insurers' denial rates from 30 to 15 percent.[635]

Mistrust between insurers and both doctors and hospitals was substantial. It seemed impossible to remedy. Payers and caregivers jockeyed over whether a patient was covered, what care was covered, how diagnosis and treatment should be coded, and the rate of payment. Caregivers controlled data relevant to coding a patient's diagnosis, need for treatment, and actual care given.

Insurers were financially motivated to seek reasons to deny claims, sometimes without appropriate professional—or even human—review.[636] Patients or doctors or hospitals were obliged to devote considerable time to fighting for payment. Apart from the ACA claims, little was known about denial rates, appeals, or their resolution.[637] Some patients and doctors resorted to shaming insurers on social media when prior authorization was denied.[638]

Another burden on doctors' time—and a growing source of doctor-patient friction—was the rise of high-deductible/high-out-of-pocket health insurance plans. These obliged doctors to try to extract a higher share of their revenue through numerous and often complicated small payments from patients.[639]

An added demand on time stemmed from different payers' very different administrative requirements and clinical rules. 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.[640]

Some physicians sought to harvest revenue opportunistically by devoting more time to profitable care and less to low-paying care. This sometimes entailed provided high-paying care even when it was not useful to patients and eschewed low-paying care even when it would have been useful.

Other doctors rendered high surprise bills to patients who intentionally sought care—or accidentally wandered—out of network. These generated added income but angered patients and politicians. State and federal legislation to combat surprise bills followed. And litigation over enforcing the federal No Surprises Act proved predictably prolonged and tedious.

Doctors tried to justify these decisions by asserting a right to charge what they wished, by declaring they needed to exploit gaps in the nets payers were throwing on doctors' incomes, or by claiming they were forced to fight payers' unfair financial fire with unfair counter-fire of their own.

Nonetheless, doctors' loss of control over their incomes, clinical decisions, and time—combined with inevitable anger and guilt over their own financial opportunism—inevitably proved morally corrosive.

This is not to write that the types of financial and clinical autonomy that doctors had long enjoyed were strongly positive. Berwick cogently described the first of three eras of medicine as one resting on a view—embraced and promoted by doctors [641]—of a noble, well-intentioned, trustworthy, and self-regulating medical profession.[642]

He asserted that this first era was discredited and overthrown by perceived high cost, waste, inconsistent diagnosis and treatment for patients with similar problems, inequality, and profiteering.

In Berwick's second era, mistrust of doctors gave rise to efforts that purported to promote accountability for cost and quality by monitoring doctors' actions, by incentivizing doctors to address cost and quality concerns, and by promoting competition in health care.

These changes markedly diminished doctors' financial and clinical autonomy but they did not make U.S. health care more effective, efficient, or equitable. Or affordable.

Added public regulation via RBRVS, MIPS, and SGR sought to restrict growth in doctors' incomes, shift money from doctors who performed procedures to those who did not, and reward doctors who embraced electronic prescribing and EHRs, and who adhered to some measures of quality of care. Nonetheless, the gaps between primary care and other cognitive doctors' incomes and those of procedure-performing specialists continued to grow.

These public regulations, their managed care and insurance company counterparts in private regulations, and doctors' own responses resembled continuous guerrilla warfare. Patients' care was easily caught in the cross-fire.

**Seeking shelter and security**

At the same time, doctors working solo or in small groups were obliged to take the prices offered by private insurance companies. In hopes of protecting their incomes, many doctors responded by merging their practices or by selling them to hospitals, insurance companies, or other corporations.[643] Vertical integration of hospitals and doctors—with hospitals buying doctor practices or developing close contractual relationships was not new. Touted by some as a way to save money through better coordination of care, vertical integration was typically viewed as financially and clinically desirable in most rich democracies. Baker and colleagues found it boosted prices and spending in the U.S.[644]

By 2022, 74 percent of U.S. physicians were employed. Of these, 26 percent were employed by hospitals, 27 percent by private companies (including insurance companies), and 46 percent by physician corporations.[645]

In an important paper, Zhe and colleagues identified reasons doctors sold practices, risks of abuse by corporate owners of doctors, and possible legal responses. But I think that those responses—while useful—were insufficient because they failed to address any of the underlying causes—any of the changes in health care—that pushed doctors to sell their practices or impelled hospitals or other entities to buy them.

Doctors worried that payers' financial incentives—coupled with purchase of their practices by hospitals, insurers, large doctor-owned corporations, or private equity—would corrupt doctors' clinical decisions. In June of 2023, the American College of Emergency Physicians approved a statement on the corporate practice of medicine. It asserted that only doctors should be responsible for diagnosing and treating patients, and that "any practice structure that threatens physicians' abilities to prioritize patient needs should be opposed." [646]

Some doctors sued their employers for violating state statutes barring corporate practice of medicine [647] or for promoting inappropriate care.[648]

But Zhe and others asserted that state laws prohibiting corporate practice of medicine constituted "a doctrine in name only". They believed that corporate ownership of doctors "is neither new nor inherently" a problem. But they noted that three-quarters of doctors were employed—something that "generated attention" by doctors, the public and "policymakers."[649]

They listed what they believed to be several advantages of corporate ownership—higher capital investment in doctors' practices, greater financial stability and efficiency, and "ability to scale up population health interventions." The meaning of the last is unclear.

"There is growing concern," they wrote, that owners "take control over clinical operations, management and staffing decisions, billing and coding practices, and negotiations with insurers—which may exert pressure on physicians to change care delivery." They cited evidence of increased prices stemming from leverage over pricing and "exploitation of payment loopholes," cuts in staffing, moral injury, and burnout.

This prompted Zhe and colleagues to examine states' corporate practice of medicine laws. Those range from no action to prohibition. But even strong laws, they perceived, had little or no effect owing to weak enforcement or clever corporate end-runs such as nominal doctor

ownership that masked actual corporate ownership and control via management service organizations or other maneuvers.

Zhe and colleagues offered three responses. States could strengthen their prohibitions against corporate practice by closing loopholes. They could also outlaw non-doctors' domination of—or even membership on—boards of professional corporations. And they could protect employed doctors by striking non-compete contractual provisions or gag clauses, and by safeguarding whistle-blowers' rights.

Large doctor groups were able to win higher payments for doctors' services from private insurance companies [650] but a substantial share of the added revenue remained in the hands of the practice owners. After becoming employees, when doctors' incomes were protected or rose, those doctors also faced greater managerial oversight and, sometimes, pressure to violate their professional judgments.

Owners sought to induce their newly-employed doctors to behave in more productive and more profitable ways. Warning hospitals against employing doctors, Goldsmith importantly wrote, "Physicians absolutely can be led, but only by people they trust and whose values they share." [651] [652]

Larger corporate entities continued to add doctors by buying formerly independent groups or the companies owning those groups.[653] [654] The share of anesthesia groups owned by either private equity or publicly traded corporations rose from 3.2 percent in 2008 to 18.8 percent in 2019. For emergency medicine groups, the share rose from 8.6 percent to 22.0 percent. In some states, the totals rose above 40 percent of practices.[655]

Many doctors seeking shelter by becoming employees discovered that their new homes collapsed. Some owners were not able to maintain promised payments to doctors. Envision, for example, had focused heavily on providing doctors to hospital ERs, but declared bankruptcy in 2023. The main reason seems to have been that some of the revenues it sought from sending surprise bills to out-of-network patients were curtailed by the No Surprises Act of 2020.[656] [657]

And the sudden closure of American Physician Partners in mid-2023 obliged 150 hospitals to quickly seek new sources of ER and other physicians.[658] APPs' doctors suffered varying degrees of instability. Many were not paid for months of work.[659] This corporate irresponsibility frightened doctors who suffered it—and colleagues to whom they related their experiences.

Goldsmith also noted regional variations in the shares of employed doctors.[660] Doctors varied across states in their primary care versus specialist shares, physicians per thousand citizens, and incomes. It is vital to keep these differences in mind. (Just as it is to differentiate among hospitals, as discussed earlier.) Failure to do so could lead to blind support for one-size-fits-all reforms that short-changed some doctors in some places or specialties while over-paying others.

When diagnosing or treating patients, most doctors preferred to rely on evidence about what's needed and what works. They therefore disliked financial pressures – even when they rewarded what's deemed clinically appropriate—and especially when they pushed giving unneeded care or refraining from giving needed care.

Financial incentives undermined professionalism. They corrupted. Especially when accompanied by greater demands on doctors' time—time devoted to obtaining prior approval from insurers, to providing data on quality measures, and to fighting denials of claims for payment.

Still, belief in the value and efficacy of incentives was powerful and widely diffused. Kindig wrote that "Population health improvement will not be achieved until appropriate financial incentives are designed for this outcome." [661] The federal government extensively embraced financial incentives in MIPS, MA plans, and Medicare accountable care organizations. These beliefs and embraces amounted to temporarily roping cement blocks to the ankles of health reform.

Some doctors suffered disruption in their practices, admitting privileges, and abilities to earn their incomes by caring for their patients. [662]

Some saw themselves as shock-absorbers, whose professionalism was exploited by increasingly brittle, stressed, and manipulative medical businesses.[663] [664]

And some saw direct harm to patients resulting from money- or rule-driven requirements for premature discharge from hospitals.[665]

Some doctors resented loss of income and independence and growing bureaucratization of their work.[666] Many reported burn-out, alienation, cuts in hours worked, and accelerated retirement. [667] [668]

All this is why some observers refer to reductions in doctors' financial and clinical and temporal autonomy as a "moral injury."

Several hospitals and doctor groups created small programs to address moral injury. Most aimed to ameliorate symptoms rather than address causes. But that was not surprising because they were located inside organizations that were, so far, uninterested in reforming larger elements of payment, administration, or anarchy.[669]

Growing shares of doctors saw that moral injuries could be cured only by thoroughly reforming how physicians were paid, organized, and oriented.

In the wake of Covid, resident physicians have voted to unionize in numbers larger than seen in recent years.[670] [671] [672] Previously concentrated in urban public hospitals, unions have spread to non-profit teaching hospitals like Mass General – Brigham, Stanford, University of Southern California, Montefiore, and University of Vermont. In some cities, unionization was spurred by substantial increases in residents' housing costs while incomes have stagnated.[673] Doctors at Salem Hospital, part of Mass General – Brigham, unionized.[674] Primary care doctors and also hospitalists at Allina in Minnesota and Wisconsin have also voted to unionize.[675] [676] So have anesthesiologists affiliated with Cedars-Sinai in L.A.[677] Some believe that loss of autonomy accelerates physician unionization.[678]

Data on the number of doctors in unions are probably incomplete. The AMA estimated that perhaps 17,000 belonged to unions in 1998, rising to 47,000 in 2014 and to 68,000 in 2019.[679]

Still, unionization rates for other doctors remain low.[680] Many employed doctors—some three-quarters of U.S. physicians—are unwilling or unable to unionize even though many declare frustrations with the conditions under which they work.[681] [682]

Covid elevated the already-high level of personal, professional, and financial stress felt by many doctors.[683] Death, illness, and disability afflicted many doctors and other caregivers. Rates of burnout and early retirement rose.

Sites where doctors practiced also suffered. Community health centers, important sources of primary care for lower-income patients, were battered both clinically and financially by Covid's demands and stresses.[684]

A private physician group serving 70,000 patients in eastern Massachusetts abruptly declared bankruptcy with no warning to patients and with no continuity plan.[685] Disruption of physician care further subtracted needed services from a region already battered by the loss of two hospitals, one to flood and the other to fire.

Rhode Island's Anchor medical group announced its closing early in 2025, leaving 25,000 primary care patients unmoored and facing great difficulty finding new primary caregivers. The practice asserted that low payment rates impaired its ability to recruit doctors to replace those retiring. Rhode Island was considered to be short about 300 primary care doctors.[686]

Many doctors and their practices became increasingly fragile, both professionally and financially. Fragility angered most doctors. Many were willing to embrace reforms that liberated and empowered them to do as much clinical good as possible for their patients. As long as they felt they were paid adequately and fairly. Especially if frustrating and time-wasting burdens were lifted from their shoulders.

### *c. Drug delegitimization*

Prescription drugs should be the easiest health care sector in which to win affordable equity. That's because the incremental cost of making more meds is very low. The first pill's cost of discovery, testing, and manufacturing is very high. The second pill is cheap to make. This is particularly true for small-molecule meds made chemically. Large-molecule drugs made biologically are costlier, but their costs are falling.

This should make it possible to make effective and safe meds available to all who need them without boosting spending on drugs. The current drug regime makes this impossible. Consequently, for example, Congress's Medicare Part D coverage was much costlier than it needed to be.[687] [688]

U.S. prescription drug prices and spending per citizen had long been the highest in the world. Public and private efforts did little to make meds more affordable. Drug makers were more effective in protecting their prices and profits than payers were in protecting the patients, taxpayers, and employers whose spending generated those profits.

Drug makers bought competitors or innovators to build pricing power and sustain revenue growth.[689] Drug makers worked patent laws to extend their monopolies via evergreening.[690] For decades, AbbVie and a related company exploited gaps in patent law to extend their monopoly over a valuable arthritis drug, Humera. One report asserted that this run of legal and financial exploitation was about to end as biosimilars would begin to be sold.[691] But, in another view, PBMs disdained these lower-price biosimilars because the PBMs made more money by channeling patients to Humera.[692]

Drug makers 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 dodged taxes by claiming that all their income 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 the 2017 tax cut law made this possible.[693] While different in legal form, this crudely parallels the practice of tunneling nursing home profits, discussed shortly.

Failed private efforts to make meds more affordable included touting pharmacy benefits managers (PBMs), greater use of generics, step therapies, and excluding drugs from formularies. Part D plans tightened their restrictions on drugs they'd pay for in the decade after 2011.[694]

Drug makers priced many new meds—including a number of cancer and Alzheimer's and hemophilia drugs—at very high levels [695] [696] [697]—often far out of proportion to their added clinical value. Proponents of new Alzheimer's drugs sought prematurely to boost their use by patients even though their efficacy was unproven.[698]

But the greatest financial threat to payers—and to patients—came from those new meds that were effective, safe, potentially valuable to large numbers of patients, and required regular use for a long time. Proposals that Medicare cover new classes of diabetes drugs to help obese or overweight patients lose weight were a powerful example of this threat. Their prices were so high and their potential use so wide that their cost to Medicare could have doubled Part D spending.[699] Drug makers lobbied for Medicare coverage [700] and investors were "salivating".[701] Employers were generally unwilling to include them under their health insurance plans.[702]

Even long-established products, like epinephrine auto-injectors, continued to see remarkable price rises.[703]

**Weak negotiations and growing outrage over price differentials**

The Inflation Reduction Act (IRA) of 2022 finally authorized Medicare to begin negotiating prices of a few (10) medications starting in 2023, with lower prices to take effect in 2026.[704] Part D spending on the first 10 drugs chosen for negotiation was $46 billion in 2022, almost one-fifth of the Part D total. [705] Early experience with Colorado's Prescription Drug Affordability Board suggested steps to take and others to avoid.[706]

One tool manufacturers used to offset effects of negotiations was to set higher-than-planned initial prices for new drugs and raise prices faster-than-planned on existing drugs.[707] Drug makers had nearly doubled their prices on 25 top-selling drugs paid for by Medicare Part D plans.[708] This analysis excluded the 10 meds selected for first-year negotiation.

Another tactic was to challenge the new law in court.[709] [710] Merck sued on grounds that federal regulation of prices paid by Medicare would be a taking of property without just compensation under the Fifth Amendment. The U.S. Chamber of Commerce sued on grounds of due process, complaining that Medicare's negotiations with drug makers didn't face review in court.[711]

Hopkins reported on effects of Medicare's negotiations with drug makers.[712] In the end, Medicare's first year of price negotiations saved much less than many hoped or expected. Discounts from drug makers' fantasy prices looked large, but cuts from actual prices previously paid were much smaller.

As shown in Exhibit 1 – 17, Medicare succeeded in negotiating drug makers down from their list prices for the first group of 10 drugs chosen for negotiation, but those had never been the prices actually paid.

Much more revealing was the wide gap between Medicare's negotiated prices and the mean of the prices prevailing for the same individual drugs in 11 other rich democracies.

Medicare's negotiated prices were about two and three-quarters greater than those actually in place in the 11 other nations.

***Exhibit 1 – 17***

***Medicare's Negotiated Prices for 10 Drugs versus Actual Prices in 11 Nations***

| Drug | List prices | Medicare's negotiated prices | 11-nation actual mean | Medicare % of 11-nation mean |
|---|---|---|---|---|
| | | | | |
| Equilis | $594 | $249 | $76 | 328% |
| Enbrel | $7,402 | $2,335 | $734 | 318% |
| Entresto | $688 | $314 | $139 | 226% |
| Farxiga | $582 | $182 | $54 | 337% |
| Flasp | $134 | $134 | $50 | 268% |
| Imbruvica | $16,391 | $10,619 | $5,670 | 187% |
| Januvia | $573 | $117 | $39 | 300% |
| Jardiance | $611 | $204 | $52 | 392% |
| Stelara | $12,748 | $4,490 | $2,882 | 156% |
| Xarelto | $542 | $206 | $82 | 251% |
| | | | | |
| Median | $603 | $228 | $79 | 284% |
| Geometric mean | $1,251 | $503 | $189 | 267% |
| Mean | $4,027 | $1,885 | $978 | 276% |

Sources: Medicare's list prices were included in Jared S. Hopkins, "Medicare Negotiated Lower Prices for These 10 Drugs," *Wall Street Journal,* 15 August 2024, https://www.wsj.com/health/pharma/medicare-prescription-drugs-lower-prices-e8eceeb7.

Medicare's negotiated prices and prices prevailing in 11 other rich democracies are from Delaney Tevis, Matthew McGough, Juliette Cubanski, and Cynthia Cox, "How Medicare Negotiated Drug Prices Compare to other Countries," Peterson-KFF Health System Tracker, 19 December 2024, https://www.kff.org/health-costs/issue-brief/how-medicare-negotiated-drug-prices-compare-to-other-countries/.
- - -

Even though the negotiations' results were on the pathetic side, few were aware that such high prices persisted. Because public opinion had strongly backed negotiating drug prices and because few were aware its meager results,[713] Republican opposition to negotiations discredited both the party and competitive market views on health care.[714]

At the same time, the limited success of the negotiations undermined the Democrats' position of taking only weak action. Medicare would pay less exorbitant prices than it had previously done, but not enough to offset the effects of very-high-priced and frequently prescribed new meds for diabetes, obesity, and other problems. The IRA's cap of $2,000 per person per year on Medicare Part D OOPs, together with persistently high prices, meant rising Part D premiums for patients and rising subsidies from Congress.

Seeking to rebut drug makers' constant cry that lower prices harmed innovation, some analysts asserted that the IRA—along with the Advanced Research Projects Agency and the National Biotechnology and Biomanufacturing Initiative—would actually reward and support clinically valuable new meds.[715]

During his first term, Trump viewed high U.S. drug prices as subsidies to other rich nations. He called for prices of Medicare Part B drugs—mainly cancer and other drugs infused in hospitals or doctors' offices—to be set in some proportion to prices paid in other nations. This went nowhere but Trump renewed and greatly broadened his attempt to seek price parity during his second term.

He roused public attention and outrage to the unjustifiably high gap between U.S. and other rich nations' prices.[716] This primed the nation for a successful push for international drug price parity after the crisis hit. See chapter 15.

Some experts proposed ways Medicare might tie prices to meds' clinical value, making for higher prices for better meds. This seemed reasonable on the surface, especially when clinical value was clear. The Institute for Clinical and Economic Research (ICER) urged this approach.[717] It offered a way to curb high prices for meds that offered little clinical benefit. But value long proved hard to judge. It was even subject to manipulation. ICER's approach appeared to leave room for political influence of drug makers to be considered in price-setting.

When value was actually gauged accurately, it meant high prices for patients, high spending for payers, and profits for manufacturers of effective and safe meds that help lots of people. Those high prices caused either higher insurance premiums, higher taxes, or higher patient out-of-pocket payments.

Unwilling or unable to act effectively to rein in drug prices, payers sought to restrict use of meds. This paralleled the decades of failed focus on volume of hospital admissions or doctor visits

embodied in the "value-based payment" crusade. Joyce and colleagues found that private Medicare Part D plans heavily boosted their regulatory constraints on prescribing expensive meds, especially brand-name drugs. Prior authorization, step therapy, and exclusions from formularies became more common between 2011 and 2020. Some 32 percent of compounds were restricted in 2011. That share rose to some 45 percent in 2020.[718] Restrictions on prescribing angered doctors and patients. Lower prices would liberate doctors to more easily prescribe more valuable drugs.

The Inflation Reduction Act boosted Medicare Part D drug plans' share of the costs for patients who use expensive meds. Anderson and Anderson warned that this could lead some plans to cease operations while other plans might try to defend themselves financially by further impairing patient access to costly meds by instituting harsher step therapy or formulary restrictions. Patients might decide to switch Part D plans, which could also lead to switches in the pharmacies they use. These changes could disrupt continuity of care.[719]

This points to the fear, voiced by many before the Medicare Modernization Act added Medicare Part D in 2003, that costs of meds were so predictable that separate, stand-alone drug plans could not feasibly be offered through traditional insurance owing to risk of underwriting death spirals.

It also points to the risk that well-intentioned reforms can have unforeseen and undesirable consequences as payers and caregivers respond to changed financing or care delivery arrangements. The Red Team, discussed later in this chapter, had to bear this in mind constantly.

**Something different**

It was silly to pay high prices for safe and effective meds even when they were actually superior to options. High prices and high OOPs deterred many patients from filling prescriptions. And they invited private employers, their PBMs, and Medicare Part D plans to restrict use.

An attractive alternative was to establish low prices for good meds—for new drugs that are effective, safe, and used by large numbers of people. Low prices made them attractive to doctors, patients, and payers. Companies that innovated to develop such meds could be rewarded with large dollar prizes in place of high retail prices. Prizes would incentivize development of meds the nation—and patients—need and can afford.[720]

Patients or their insurers would pay prices for new meds equal to marginal (incremental) cost of manufacturing plus small fees for distribution and dispensing. Fixed costs of research, of clinical trials, and of learning how to manufacture the first pill—plus substantial profits—would be covered from an innovation prize fund. Size of prizes would reflect anticipated clinical benefits. In this way, incentives to innovate would remain strong but patients would pay low prices for good meds. The cost of innovation would be kept out of the price of the pill.

An important advantage is that the innovation budget to pay prizes would be financed by all rich nations hoping to offer good new meds to their citizens. The U.S. would cease to subsidize the starving Swiss.

Low prices would also preclude counterfeiting or stealing drugs, particularly those donated to impoverished nations.

But drug makers fought the proposal to pay prizes. It was alien to their business model. They labeled it a financial threat. It rested on two foundations that were not yet established: an adequate innovation budget for meds and also on trust between drug makers and those who'd allocate any such budget.

That approach made all effective meds affordable, incentivized and rewarded breakthrough research, not investments in low-risk copy-cat drugs, and also simplified administration. PBMs vanished.

The promise of affordable meds plus innovation helped power reform efforts during the 2028-2029 crisis.

**PBM dysfunction**

Pharmacy benefits managers began operating in the 1960s, soon after insurance companies began offering prescription drug coverage. Initially, that coverage took the form of an indemnity benefit. Patients paid for meds at the pharmacy and submitted claims for partial insurance reimbursement. Typically, at first, policies called for regular—often quarterly—deductibles and 20-25 percent co-insurance.

In the 1970s, growing numbers of HMOs began to offer drug coverage with no deductibles and only nominal co-payments, obviating reimbursement claims. These were popular provisions and private insurance companies were forced to adopt them. Employers and insurers feared that use of meds would rise because this method lowered financial barriers to filling prescriptions.

Seeking to contain costs, they turned to PBMs. At this time, data processing became established in pharmacies, permitting them to check patients' eligibility, covered meds, and required OOPs with insurers or PBMs.

PBMs embraced this job. Employers and private insurers carved out drug coverage and PBMs administered it. One drug maker, Merck, bought the Medco PBM. Federal regulators forced divestment. Instead, PBMs merged. In 2023, three PBMs—ExpressScripts, CVS's Caremark, and UnitedHealthcare's Optum—manage meds for almost 90 percent of the 270 million people with prescription drug coverage via PBMs.[721] [722]

PBMs have been sued by unions and others representing covered patients for failure to discharge their fiduciary duty to advance their clients' interests. They have been accused of accepting payments from drug makers—sometimes nominally to provide data on use of meds or doctors' prescribing patterns—in exchange for promoting higher-priced meds. [723] [724] [725] [726] [727] [728] [729]

Federal Trade Commission studies have pointed to PBMs' bad behaviors. One was to raise the cost of drugs to Americans. A second was to squeeze independent pharmacies.[730] A third was to charge some $7.3 billion above estimated acquisition cost for specialty generic drugs

between 2017 and 2022. Almost all this money was for drugs to treat cancers, multiple sclerosis, and transplants.[731]

PBMs can be seen as a species of parasites, bleeding money from U.S. health care but failing to ensure affordable patient access to needed meds. Even many drug makers despise them, sometimes appearing to regard their behavior as extortionate. They waste money. They suppress access to care.

PBMs are widely disliked by many American patients because they are often seen as barriers to obtaining and affording needed meds. So what good are they? In the absence of concentrated payer pressure to win lower prices, PBMs are seen by payers as essential to containing spending on meds—precisely by imposing OOPs and by making it hard for patients to use costly meds. They also act as political lightning rods, drawing public anger away from insurers. They are one way to "outsource the no."

***Anger toward PBMs' increasingly visible bad acts fueled patients', voters', and employers' support for reforming health care.***

The alternative was to win lower prices and to assure financing of innovation, as just discussed. Drug makers fought that alternative because they lacked confidence that U.S. drug spending would remain high enough to float their profits. Until the political and financial crises arising in 2028-2029 convinced drug makers that they had no choice but to accede to reform.

Outside the U.S., PBMs were nearly useless—and very rarely used—because governments or payers elsewhere negotiated or set drug prices. Canada was an exception because Canadian Medicare covered meds badly, allowing PBMs to assume a role there.

**Rising OOPs**

Higher OOPs deterred adherence to prescribed drugs for diabetes or heart failure, meds that need to be taken for long times.[732] Essien and colleagues went out on a limb and concluded that "Improving adherence to guideline-based therapies may require interventions that reduce out-of-pocket prescription costs."

In 2021, roughly one person in seven with income below 200 percent of the federal poverty level reported saving money by not taking a prescribed medication. One-fifth of people with disabilities and over one-fifth of uninsured people said they did the same.[733]

The 2022 IRA did cap annual Medicare Part D out-of-pocket costs at $2,000 yearly, starting in 2025. This was a substantial drop, one that helped many who had been heavily burdened. But it obliged a rise in patients' Medicare Part D premiums, federal subsidies, or both. After 2025, the OOP cap was indexed to a measure of inflation.

Americans lacking Medicare Part D protection had much less protection against OOP drug costs. Private insurance through the job increasingly included separate OOPs for meds, along with a separate annual OOP maximum for meds. This meant that patients suffering costly acute or chronic illnesses faced much higher total actual OOP burdens than they might have expected.

Moreover, many new meds had high prices and very high OOPs.[734]

Ordinary Americans widely viewed drug OOPs as the most hated manifestation of high U.S. health care costs and of needed but unaffordable care.[735]

Early in the 2028-2029 crisis, that anger—coupled with the promise of winning affordable meds and sustained innovation—helped undermine the legitimacy of business-as-usual in pharma specifically and U.S. health care generally.

**Shortages**

A U.S. Senate staff report found an active shortage of 295 meds in the U.S. at the end of 2022.[736]

IQVIA tracked and analyzed the drug industry. It reported that one-quarter of drugs in short supply at the end of 2023 had suffered this problem for more than five years.[737]

In the spring of 2023, almost all of the 27 large cancer centers in the U.S. reported shortages of widely used chemotherapy meds.[738] Shortages were expected to persist for many months and to oblige doctors to allocate the meds to patients most likely to benefit.[739] For two very widely-used cancer drugs, grave shortages stemmed in part from quality control problems at two factories in India producing about one-half of the U.S. supply.[740] Other causes included the apparent unprofitability of making many vital generic drugs, the failure to examine or mitigate causes of that unprofitability, and absence of either timely notification or an adequate reserve supply.[741] No U.S. payer or combination of payers was accountable for paying prices high enough to elicit sufficient manufacturing.

This was a great source of worry for cancer patients, their families, and their doctors.

And also a growing source of frustration for already-busy pharmacists in drug stores. They were forced to devote time to track down a pharmacy that has a supply of a prescribed med, or work with the doctor and insurance company to find a substitute med that's on formulary.

Only about 15 percent of active pharmaceutical ingredients used in generic drugs in the U.S. were manufactured domestically.[742] Some drug shortages resulted from quality problems in offshore manufacturing of both meds and their ingredients.[743] The FDA, which was supposed to regularly inspect all plants supplying meds for Americans, was at best inconsistently effective in protecting drug safety.

Many essential products were also in short supply. These included surgical mesh, tourniquet cuffs, and contrast media for CT scans.[744] When a tornado damaged a Pfizer plant in North Carolina, production of one-quarter of the company's sterile injectable supply for U.S. hospitals was disrupted.[745]

Compounding pharmacies, which manufactured meds without FDA approval, expanded to address some shortages.[746]

More broadly, high prices, high OOPs, low added value of many new meds, debates over whether a number of new meds should even be approved, and supply shortages all worked to

magnify insecurity. Frustration with high prices grew when they were repeatedly and publicly contrasted with low incremental costs of manufacturing.

***Patients' growing frustration and anger over shortages, high OOPs, very high prices for many new meds, low incremental costs of manufacturing most meds, administrative burdens like step therapies and formularies helped to fuel demands for health care reform.***

**Retail frustrations**

Waiting times to pick up prescriptions at retail pharmacies lengthened in some places. Post-Covid, some drug stores lacked sufficient pharmacists and clerks to dispense the volume of meds prescribed. Demands on retail pharmacists' time grew. These included developing work-arounds to cope with drug shortages, addressing insurance-related complications that arose when a doctor prescribed a med not on the patient's formulary, explaining unexpectedly high co-pays and co-insurance to patients with coverage, and counseling patients forced to pay high co-insurance prices owing to the design of their insurance—or their lack of it.

Demands on retail pharmacists' time were matched by shortages of pharmacists available and willing to work retail at the salaries offered by the large chains that increasingly dominated retail drug sales. Those demands were modulated, in part, by the drift toward dispensing 90-day supplies of chronic-use meds, and by the inroads of mail-order pharmacies.

Some patients who arrived at pharmacies to pick up prescriptions faced frustrations owing to waiting times, non-availability of a prescribed med, learning that a prescribed med was off formulary, or high OOPs. Some patients, stressed or worried by illness, expressed anger at pharmacists, adding to the latter's unhappiness.

It is difficult to develop objective measures of the changes in the number of retail prescriptions dispensed per retail pharmacist over time. One reason is the growing number of 90-day prescriptions dispensed for chronic use meds. Also, in 2016, the method of counting numbers of prescriptions was changed from the previously-used number actually dispensed to numbers of 30-day-equivalent prescriptions. Accordingly, the number of retail prescriptions rose from 4.4 billion in 2015 to 5.8 billion in 2016. Additionally, drug stores were adding pharma techs who could prepare prescriptions. Pharmacists had to sign them out, though. Finally, many drug stores took on the job of administering vaccines, adding to burdens on pharmacists and others.

Blank and Schreiber wrote two reports in 2022 describing growing stresses facing a number of pharmacists. These included longer hours, more intense demands on their time, faster-paced work, anxiety, and difficulty finding time for breaks, lunch, or personal needs while on the job.[747] [748]

To the degree that these difficulties were real and growing, they raised doubts about the sustainability of chain drug stores' business plans. In 2025, Walgreens sold itself to a private equity company through a leveraged buy-out. One reason seems to have been its failure to ally itself with partners big enough to grab high prices from PBMs; another was its unprofitable investments in primary care or urgent care.[749]

More generally, patients' often-frustrating interactions with pharmacies strengthened Americans' irritation and anger toward business-as-usual in U.S. health care.

### *d. Long-term care and mental health*

Covid magnified decades-old problems facing long-term care and mental health care coverage, access, financing, capacity, and care delivery.

Both LTC and mental health care have been inherently difficult to finance and deliver. Each faced high incremental cost per hour of help to people in need. This was owing to the obligation to pay more caregivers to help more patients. This contrasted powerfully with the low incremental costs of making higher volumes of meds once the first pill was found to be safe and effective.

Decades of debate about reforms to improve access, affordability, and quality of LTC and mental health care yielded some small and scattered improvements. But much more needed to be done. Problems grew faster than remedies.

#### Long-term care

The State of Washington created its own mandatory long-term care insurance program. California, Minnesota, and other states considered acting.[750]

These efforts were not commensurate with the accelerating rise in disability associated with rising numbers of older people—especially very old people.[751]

Effects of aging were sometimes magnified by earlier (younger) onset of illnesses and chronic conditions.[752] When that happened, need for both LTC and primary care (especially from geriatricians) increased substantially. This view was contrary to the "compression of morbidity" perspective advanced by some gerontologists.[753] It was frustrating that fully 44 percent of geriatric medicine residency slots went unfilled in 2024.[754] This was similar to rates in previous years.

Even before Covid struck, many long-term care services suffered from shortages of workers. Low pay, often associated with low Medicaid payments, was one reason.[755] [756] Problems of shortages of nursing home care, its quality, its staffing and management, and its financing were magnified by Covid.

Exhibit 1 – 18 shows changes between 2015 and 2024 in numbers of nursing homes and residents, staffing, and residents as a percentage of the over-65 population. The number of nursing homes fell by 5 percent and the number of residents by 10 percent. Hours of care per patient-day from RNs, LPNs, and aides fell by 8 percent. One crude measure of reliance on nursing homes—residents expressed as a percentage of Americans over age 65—fell by 40 percent. Residents expressed as a percent of Americans over age 85 fell by over one-quarter.

All this meant less care for fewer people. Some of the drop may have reflected some higher-income and less disabled elders' choice of assisted living over nursing homes. Some may have

manifested high death rates of nursing home residents during Covid.[757] (By one estimate, one-fifth of the 634,000 Americans dying from Covid nationally before mid-August 2021 were nursing home residents.[758] That would be about 133,000 nursing home residents. Death rates were 23 times higher nationally for nursing home residents than for Americans over age 65 residing elsewhere.) And some of the drop may, simply, have resulted from cuts in the number of beds nursing homes were able to staff.

***Exhibit 1 – 18***

***Changes in Nursing Homes, Residents, Staffing, and Share of Over-65 Americans, 2015-2024 (red = drop)***

| | 2015 | 2024 | % change |
|---|---|---|---|
| Nursing homes | 15,648 | 14,827 | 5.25% |
| Residents | 1,367,548 | 1,226,089 | 10.34% |
| | | | |
| RN/LPN/aide hours/resident/day | 4.13 | 3.80 | 7.99% |
| | | | |
| Americans>65 | 45,994,000 | 68,564,000 | 49.07% |
| Americans>85 | 5,575,000 | 6,860,000 | 23.05% |
| | | | |
| Resident % of people >65 | 2.97% | 1.79% | 39.86% |
| Resident % of people >85 | 24.53% | 17.87% | 27.14% |

Sources: Priya Chidambaram and Alice Burns, "A Look at Nursing Facility Characteristics between 2015 and 2024," Kaiser Family Foundation, 6 December 2024, https://www.kff.org/medicaid/issue-brief/a-look-at-nursing-facility-characteristics/.
U.S. Census Bureau, population estimates by age, 2015, 2022, and 2025.

Nursing homes' rising reliance on staffing agencies for direct care workers added to homes' financial stresses. Bowblis and others found that in 2018, 23 percent of nursing homes used workers from staffing agencies; those workers were about 3 percent of staff. Comparable numbers for 2022 were almost one-half of nursing homes and 11 percent of staff. Those agency workers cost nursing homes 50 to 67 percent more than non-agency workers.[759] The direct care workers included RNs, LPNs, and nurses' aides.

This increased reliance reflected nursing homes' inability or unwillingness to pay all workers enough money to secure needed numbers of direct caregivers. Higher cost of agency-supplied workers magnified nursing homes' financial travails.

Gandhi and Olenski questioned the depth of nursing homes' financial difficulty. They estimated that the 2019 profits reported by nursing homes may have been only 37 percent of their actual level.[760] The rest of the profits were found to be buried by paying inflated prices when conducting business transactions with related parties—parties controlled by or associated with the owners of the nursing homes themselves.

Nursing home closings magnified disruption of residents' lives at an already chaotic time. Shortages of nursing home beds forced some to seek shelter at facilities far from their families.[761]

Hundreds of D.C. residents had to relocate to Maryland nursing home beds because open beds were so hard to find in the District.[762] In December of 2023, the unexpected closing of St. Louis's largest nursing home left 170 residents scrambling for places to live.[763] Unsurprisingly, that was a low-quality facility that had been awarded only one star by CMS and had been fined repeatedly for poor care. Early in March 2024, a Pittsburgh-area nursing home closed suddenly. Residents had to be relocated quickly. Some families briefly lost contact with residents. Though a headline blamed the closing on a "staffing shortage", that had been caused by many instances of delayed or non-payment of workers.[764] So the underlying problem was inadequate revenue, excessive costs, or bad management.

Some of the cuts in nursing home use reflected higher-income elders' preference for assisted living and other sites of care. But for most Americans, financing for home and community services was not remotely adequate to substitute for the cuts in nursing home use. Nursing home closings, difficulties in finding substitute care for displaced residents, and the rising numbers of hospital patients awaiting nursing home care testified to long-term care shortages.

Transfer trauma. Unexpected nursing home closings were disasters for many long-stay residents. The nursing home was their home. Their relationships with other residents and with staff were important. Closings sundered relationships, displaced residents spatially, and magnified existing insecurities associated with declining functioning and increasing dependence on others.

Relocations owing to unplanned closings caused death rates to spike. Paulin called this "transfer trauma." [765] She described one case study of a Virginia nursing home closed by Ballard. Ten of 20 long-stay patients died within nine months of the closing. This was not an isolated problem: Paulin identified bad behavior elsewhere.

Unexpected nursing home closings disrupted lives and they killed residents. Yet few state governments acted to identify vulnerable homes, take steps to prevent closings, or even monitor resident relocation. Or to accept any accountability for preventing or modulating harm from closings.

One reason was state governments' general unwillingness to put their arms around any aspect of caregiver configuration. A second may have been a belief that it would be dangerous to learn more about which nursing homes were needed, and about how much revenue they might legitimately need to remain open and delivery care of acceptable quality. That knowledge might have built pressure on states to increase the daily rates at which their Medicaid programs paid nursing homes.

One problem magnified others. Shortages of staffed nursing home beds forced acute hospital patients who were ready for discharge to remain in hospital beds. That forced patients awaiting beds to back up in ER hallways. Crowded hospitals petitioned states for permission to build more beds. While states were sometimes reluctant to agree—because the crowded hospitals are very often the costliest—they typically acceded to the hospitals' demands.[766] Shortages of nursing home beds may have been an even bigger problem in rural areas than in urban or suburban ones.[767]

The American Hospital Association asserted that average length of stay in acute care hospitals for patients to be discharged to post-acute caregivers rose by almost one-quarter between 2019

and 2022. Increases in numbers of patients waiting to be discharged to nursing homes, home health care, or inpatient psychiatric care were all substantial.[768]

From early 2022 through early 2023, about 1,000 Massachusetts acute hospital patients per day could not be discharged because no nursing home bed was available. They amounted to about one-seventh of average daily hospital census.[769] The main reason was the decline in nursing home capacity. The number of residents of Massachusetts nursing homes fell by 23 percent from 2010 to 2023—from 43,000 to 33,000. From 2011 to 2022, though, the state's old age dependence ratio rose from 21.6 percent to 28.7 percent. (That ratio is the over-65 population divided by the population aged 16 to 64.) [770]

Some believed that nursing home closings, bed shortages, and staffing shortages would continue to disrupt hospital attempts to discharge patients and might put more pressure on under-staffed and under-paid home health care workers.[771] Moreover, while Medicaid financing of nursing home care was inadequate, support for home health was even worse.

A core challenge was that Medicaid financed a high share of LTC. In most states, Medicaid paid the lowest prices for each type of health care. This was much more consequential for LTC than for hospital or doctor care or for meds. Those other sectors had many more privately insured and Medicare patients than they had Medicaid patients. Medicaid set prices for almost 7 in 10 Massachusetts nursing home residents in 2017, only slightly above the national average.[772] Higher-priced Medicare and privately paid residents were too few to make up for relatively low Medicaid prices. This problem went beyond nursing homes; it pervaded LTC.

This is why the proposed 2025 federal Medicaid cuts are likely to further undermine the safety, adequacy, and decency of long-term care.[773] [774]

Assisted living facilities, like nursing homes, faced shortages of staff—both skilled and unskilled—needed to address needs of increasingly disabled, medically unstable, and older residents.[775] [776]

Even before Covid, nursing home staffing levels were declining.[777] During Covid, nursing homes lost a high percentage of their caregivers to death, illness, retirement, or alternative employment. Between February of 2020 and February of 2022, nursing home employment fell from 1,589,800 to 1,340,500, a drop of 15.1 percent. Nursing homes were expected to be years behind hospitals and other caregivers in restoring employment to pre-Covid levels.[778] [779] In June of 2023, SNF employment remained 12 percent below that of February 2020.[780]

Proposals to address nursing home closings and bed shortages, inadequate staffing, and quality problems included higher Medicaid payment rates, state take-over of nursing homes,[781] and also a national long-term care insurance benefit.[782] At heart, it was essential to address low pay and difficult working conditions.[783] But very little was done about either problem.

It is frightening to note that a February 2024 study from the DHHS Inspector General's office [784] described what one report called nursing home "staffing shortages and employee burnout still at crisis levels and many facilities struggling to stay afloat."[785]

Medicare's hospice program had long been criticized for hospice agencies' caregivers' high costs and, often, failure to deliver services they were legally and ethically obliged to provide.[786] [787] [788] [789] Some three-quarters of hospices were run for-profit. The repeated failure of many

such hospices to deliver decent care, and their theft of substantial sums—combined with the failure of the privatized Medicare Advantage program to save money—made it troubling to witness a CMS proposal to test private insurance companies' capacity to cut the hospice program's cost.[790]

Many workers, managers, and owners care deliver valuable long-term care to dependent Americans with kindness, skill, and professionalism. But other vulnerable people in need are not helped, are exploited financially, or are neglected or abused daily. Weak financing and attention to long-term care may not happen until acute care's house is put in order. Recognizing this probability helped impel health care reform.

**Mental health and substance abuse**

Awareness of mental health services' scarcity and inequitable financing grew slowly for decades and then rapidly during the Covid years.

During the 19th and early 20th centuries, high rates of urbanization, industrialization, international and internal migration, and various infectious or chronic illnesses left many Americans isolated, impoverished, and unable to care for themselves. States built large numbers of mental hospitals to house many of these citizens. By 1950, the number of mental hospital beds equaled the number of acute medical beds.

Under-financed during the Depression and stripped of workers during World War II, decency of care at many state mental hospitals—perhaps most—grew so inadequate and often criminally abusive that they became a well-publicized national scandal.[791] Reports by Ward.[792] Maisel,[793] Deutsch,[794] Gorman,[795] and others were remarkably influential.

Nationally, over 95 percent of inpatient mental hospital beds were closed between 1950 and 2020. Long-term inpatient care for mental health problems ceased to be available. Three forces were at work.

First, in the 1960s and 1970s, a large share of older state mental hospital residents was simply transinstitutionalized to newly-built nursing homes where federal Medicaid dollars paid one-half to three-quarters of the cost. In time, most of the state governments that set payment rates for nursing homes proved unwilling to pay prices high enough to finance safe, adequate, and dignified institutional care.

Second, the deep cuts in mental hospital beds were partly owing to hopes that medications would control symptoms of many severe mental illnesses. Unfortunately, many people with mental health problems were unable or unwilling to regularly take meds that could stabilize their functioning.

The third force cutting use of mental hospitals was improved legal right to care in the least restrictive environment. Sadly, the rhetorical power of this ethically and legally sound change did not translate into adequate provision of non-institutional care.

Outpatient community mental health centers and other sources of non-hospital support and care were radically under-financed.[796] For some Americans with mental illnesses, meds and outpatient supports made real differences. They supported safe, independent, and liberated

life. For others, more troubled, jails, streets, and homeless shelters were not adequate alternatives to the former institutions. It's possible to make a terrible problem worse. Those who incautiously say "anything must be better than this" can fail to act effectively to ensure improvement.

All this may amount to an instance of moving the problem—from the state mental hospitals, discredited as unacceptable sites of care—to other places where no one could be held accountable for absent or failed care.

It may have proved easier to relocate cognitively impaired Americans from large institutions, sometimes called schools for people with mental retardation, into independent living or supportive housing in group homes.[797]

Even acute short-term hospital mental health treatment became increasingly unavailable or deficient in quality. The shortage of beds in psychiatric hospitals worsened during Covid.

**Parody, not parity**. Despite legislative, regulatory, and legal action to advance mental health parity, mental health coverage, payment rates, and caregiver availability were, in practice, generally well below those for somatic health. For example, Volk and colleagues, writing about "ensuring access to behavioral health providers", described standards "that address" access to mental health services under ACA plans. These pertained to numbers of mental health caregivers in network, travel times to appointments, and the like. But they adduced no evidence that these stronger requirements resulted in adequate capacity—or that improved access to care resulted.[798]

Blanchflower and Bryson reported that rates and severity of mental health problems like anxiety, worry, and depression worsened badly during 2020. These problems subsided during the two following years. Covid vaccination was likely to result in improved mental health.[799]

Panchal and other asserted that "Concerns about mental health and substance use remain elevated three years" after Covid arrived, "with 90% of U.S. adults believing the U.S. is facing a mental health crisis…." [800] Covid meant higher rates of anxiety, depression, drug overdoses, deaths from alcohol, and suicides.

Covid meant higher need for mental health care. It highlighted and magnified existing shortfalls and maldistributions in money to pay caregivers and in caregiver availability. In response, some payers have covered virtual meetings with mental health professionals—telehealth.

But unmet need swamped financing improvements and flexibility in care delivery.

### SDLs, long-term care, and mental health

Chapter 2 will assert that financially protecting all Americans against health care costs, containing those costs, and boosting appropriateness and quality of care rest on reforms inside health care itself. Because that is where the money lives--$5.3 trillion in 2025—and where up to one-half of today's spending is wasted. As discussed in chapters 5, 7, 8, 9, 11, and 12, proposals for indirect efforts to reform health care have very rarely succeeded. Often, they were

not intended to succeed—but rather to posture to placate people who are legitimately aggrieved, noisy, but politically weak people.

More equitable and more adequate financing of SDLs would be good if we knew which were strategic or how to spend more money on them effectively. But broad and costly proposals for wholesale efforts to address housing, education and job training, personal and neighborhood security and criminal justice reform, and other social determinants of life and well-being can't secure remotely adequate financing until health care costs are contained. Still, because SDLs are so important, we should continue to press the experts in each sector to learn more about which are strategic and how to pursue them effectively.

Those proposals are already, in one important respect, more reasonable than the many politically attractive but failed or inadequate policies pursued to fix health care problems themselves.

Those policies include rebuilding primary care by forgiving med school debt, insuring more people but suppressing access to care, cutting hospital costs by closing the less expensive hospitals and allowing survivors to merge and raise their prices, pushing generics to slow growth in pharma costs, "value-based payments" and "accountable care organizations" that substitute rhetoric for real reforms, laws that demand mental health parity without adequate financing, and—generally—relying on imaginary competitive market forces or ineffective public regulation to fix any health care problems.

If we keep pursuing policies that don't work, we undermine our confidence in our capacity to fix health care.

Some put SDLs first because they think SDLs are more valuable than medical care. Others imagine that addressing SDLs will cut health care costs. Both arguments reduce pressure to fix health care. That enables business-as-usual to continue, letting health care off the hook. And thereby undermining hopes of finding serious money to take on the SDLs.

That said, LTC and mental health are two aspects of health care that are the most heavily integrated with social determinants of life. LTC is mostly about help from other people—mainly unpaid help from family members. Good LTC requires good housing, food, physical security, and other elements of ordinary living.

Similarly, good mental health rests heavily on social and economic factors like loving kindness of family and friends, work and adequate income and economic security, housing and food, personal safety and security, and relationships with loved ones and friends.

### *e. Patient, caregiver, and payer insecurity, anger, and fears over health care's anarchy and unaccountability*

Some Americans had higher incomes and greater medical security. Others were on the edge, both financially and clinically.

When many Americans needed health care, they faced financial and clinical insecurity. High rates of disenrollments from Medicaid for administrative reasons—not for real loss of eligibility—were discussed at length earlier in this chapter. Fears about Medicaid cuts grew after the second Trump inauguration.

Failure to extend the expanded ACA subsidy premiums enacted in 2021 forced many millions to drop or downgrade their ACA insurance.

Some patients worried about finding new primary care physicians when their own doctor retired or when their insurer switched them to a new narrow network. They worried about loss of hospital ER and maternity services—and of entire bankrupted hospitals.

Fears of loss of caregivers were compounded by often-unaffordable premiums and OOPs, and by administrative barriers to care like prior approval delays and retroactive denials.

Hospitals worried whether payments would be adequate to cover rising costs of nurses, other workers, meds, or supplies. Although patients continued to be legally entitled to open-ended services, capitated HMOs, MA plans, ACOs, Medicaid managed care, and PBMs all were financially incentivized to save money. So they worked to hold down payments to hospitals and other caregivers. That restricted both prices paid per unit of care and also volumes of services.

Patients and doctors worried about the corrosive effects of financial incentives to give less care, even as public and private payers continued to tout accountable care organizations and pay-for-value. Putative reformers marketed those changes aggressively—even in the face of growing evidence that they did not work.

***Fortunately, the ACOs and value-based payments had the potential to be useful in one important way—if they pressed or motivated caregivers to learn to spend money more carefully. Once caregivers became financially neutral fiduciaries and professionals, they would be liberated (and obliged) to use the same skills to identify and deliver the care that works for the people who need it, and to prioritize high-value/low-cost care. All while living with inevitably finite dollars. And without being bribed.***

Doctors worried about threats to their incomes and professional autonomy. They faced burnout from the Covid years. Some responded by selling their practices to hospitals, large physician groups, insurers, or private equity in hopes of boosting or stabilizing their incomes. But they often lost autonomy and suffered constraints on their clinical judgments after selling. If they didn't sell, they faced higher exposure to insurers' squeezed fees, prior authorization requirements, down-coding, and claims denials.

Many nurses and other clinicians in hospitals experienced burnout, short-staffing, never-ending paperwork, and pay that did not keep up with inflation.

Disagreement about causes of burnout—and its remedies—was considerable. As often happened, the government response was to prepare a plan,[801] one whose diagnosis, prescribed remedies, and financing were little more than words.

Nursing homes remained short-staffed and lacked enough beds to accept patients ready for discharge from hospitals. Quality problems persisted at many nursing homes.

Public payers worried about finding the tax revenue needed to pay caregivers adequately. And to afford high-priced new meds.

Employers worried that their insurance companies and PBMs simply lacked effective and acceptable tools to contain cost and protect quality. The prices commercial insurers paid to hospitals were found to be double those paid by Medicare Advantage plans run by the same insurers.[802]

In the post-Covid years, employers worried even more that slow increases in public payment would push caregivers with leverage to seek substantially higher prices from insurance companies—thereby boosting employers' own premiums costs. They saw that hospital and doctor consolidations gave caregivers more leverage over private insurance companies and the employers who financed insurance premiums. Employers gradually abandoned reliance on their insurance companies and benefits managers. They leaned toward coordinated public-private all-payer financing.

Friction among doctors, hospitals, public and private payers, drug makers, and patients/citizens/workers continued to grow.

In parallel, the failures of free market competition and of traditional government regulation in health care became increasingly visible and frightening.

In 2028-2029, the crises outside health care—international, economic, social, and political—combined with the systematic delegitimization of business-as-usual inside health care—led Congress to freeze federal spending on Medicare, Medicaid, and ACA subsidies. The access, cost, and caregiver crises inside health care helped guide Congress, state legislatures, employers, doctors, hospitals, other caregivers, and citizens and patients toward addressing these crises in serious and coordinated ways.

They succeeded.

But preparation proved essential.

## D. Anticipating the health care crisis—and preparing to address it

In Kubrick's movie *2001*, alien intervention sparked earthlings' tool-using.[803] But aliens played no known role in U.S. health care reform.

Nor did simple enactment of single payer health care, however desirable that might have been. Too many people saw single payer as a top-down imposition—a good idea, with many valuable aspects, but one that seemed to threaten too many interests and too much rapid disruption—such as a doubling of the personal income tax and an elimination of private insurance coverage and payments by employers.

Nor did gradual improvement from within tip the scales toward reform, as Berwick and colleagues had hoped.[804] (As a motive for change, pursuit of something better good is, unfortunately, much less powerful than escape from something terrible.)

Still, Berwick and colleagues offered four valuable ideas for reformers: 1) the U.S. spends more than enough to cover everyone, and better health care can liberate dollars for other valuable purposes; 2) the necessity of respecting local social and medical cultures; 3) "improvements in care will require trust from the public," and clinicians will be much more influential than payers or politicians in winning that trust; and, similarly, 4) "public and professional confidence is key".

### 1. International, economic, social, and political background in 2025 - summary

Rising threats to world peace from Russia, China, North Korea, and Iran led the federal government to substantially boost defense spending on both hardware and salaries.

The nation faced economic challenges. In 2023, surprising many, the U.S. economy weathered inflation and threats of recession post-Covid. But persisting high federal deficits—never before seen in periods of full employment—portended trouble. The nation was floating, both economically and politically, on a stormy ocean of debt.

Demands on the economy outstripped its capacity. Lowering high housing costs required building much more housing—which had to be coordinated with improved highway and public transportation. That housing, along with building out energy generation and distribution, better education and job training, infrastructure, and other sectors called for higher public and private spending. But little of the needed money materialized.

Instead, continued high federal deficits—exacerbated by tax cuts and higher interest payments on the national debt—led many in Congress to work narrow the yearly gap between revenue and spending. Tax increases were politically unpopular. But efforts to cut non-defense discretionary spending achieved little because it was such a small share of federal spending. Also, cuts in some federal discretionary programs early in Trump's second term failed to visibly slow rises in the national debt—but they did further inflame relations between red and blue

politicians and their voters. Some Republicans' eyes turned toward cutting Social Security, Medicare, and Medicaid entitlements.

A core political choice emerged: At a time of growing international and economic threats, would problems inside health care work to further destabilize the American economy, society, and politics? Would they exacerbate anger between the right and the left? Or could the U.S. successfully address health care costs, access, quality, and caregiver configuration in ways that actually saved money—liberating resources to address the tougher problems that continued to afflict the nation?

Widespread fears that more money would not continue to flow to sustain business-as-usual in U.S. health care merged with growing hopes that cutting health care waste would save lives, money, and caregivers. That union of fear and hope led many doctors and hospitals and other caregivers, public and private payers, voters, and politicians to support careful, coordinated, and rapid reforms in health care coverage, cost control, caregiver payments and configuration, and quality of care.

## 2. Early steps—and missteps

### 2024 elections and their aftermath

Trump persuaded Congress to extend and even deepen his 2017 tax cuts. These were financed in part by Medicaid cuts. The pace of nursing home and hospital closings accelerated. Expiration of enhanced ACA subsidies cost a dozen million Americans their health insurance coverage.

Defense spending rose. Military conflicts in Europe and Asia disrupted oil supplies and international trade. Inflation rose. Tariffs pushed inflation up to 8 percent yearly. The Fed raised interest rates to try to temper inflation. But that caused federal interest payments on the national debt to double to $2 trillion yearly. The economy slumped into recession. Unemployment spiked above 8 percent. The federal deficit soared. Political, social, and economic rancor grew.

The Democrats re-took control of the House in 2026 but Republicans, with few competitive Senate seats to defend, retained a narrow Senate majority.

Unexpectedly, the severity of the crises diminished the credibility of the hyper-partisan political outrages and grievances voiced by the far right and far left. Pragmatic remedies to attack problems gained credibility. They were studied seriously by a high-level bi-partisan Congressional commission.

Demands to reform health care became politically pressing. Newly-coalesced public and private advocates sought health care cost control combined with health care for all and financial stability for needed caregivers. They and their allies worked to publicize their view that U.S. health care had become inequitable, ineffective, inefficient—and financially unsustainable. They worked to build an echo chamber to magnify their argument—one paralleling, in method, the echo chamber allegedly built to boost support for Obama's Iran nuclear program.[805] [806]

***It became increasingly obvious that—***

***Growth in revenue for health care would soon be insufficient to finance business-as-usual. (This was sometimes likened to a failure of an airplane to stay above stall speed, leading the plane to plummet earthward. And it was also likened to an electric brownout or rolling blackout, when electricity generated isn't sufficient to satisfy demand.)***

***Current cost control methods did not contain cost or cut waste. But they did boost the numbers of uninsured and under-insured Americans, which suppressed access for many people and impaired health security for even more people.***

***None of the 7 requirements for competitive free markets were satisfied—or could be satisfied—in health care. Competition could not contain cost, protect access, or give us the caregivers we need, where we need them.***

***At the same time, federal and state governments had failed in making the strategic decisions that governments alone could make well: Which caregivers were needed in which locations? How to contain total spending on health care? How to assure medical security for all? Failure to make these big decisions left government regulators with the job of trying to clean up the abuses and debris left by failed market competition. Public regulatory and other tools were not adequate to protect either patient care or many of our needed caregivers.***

***Financially protecting all Americans would be unaffordable without cost control. And costs could not safely be controlled (without heavy harm to vulnerable citizens) until all Americans were financially protected.***

***Containing costs while protecting access to care—and the caregivers who made that access real—required recycling health care fat.***

***Politicians, employers and workers, ordinary citizens needing care, and caregivers themselves were ready for change. Adding money for business-as-usual ceased to be the lowest common political denominator. The defenders of health care fat were routed.***

***In these ways, U.S. remedies for health care costs followed many of the paths taken decades earlier by other rich democracies to reform spending, coverage, and caregiver payment.***

***Spending money more carefully required engaging doctors, hospitals, and other caregivers. Doctors' patient-by-patient decisions about how to diagnose and treat individual patients spent almost 90 percent of the health care dollar.***

***Our money, in this sense, has always been in doctors' hands. Unfortunately, though, doctors (and other caregivers) came to give excessive and increasingly detailed attention to their own revenues.***

***That shifted their focus from doing as much good as possible for patients with the huge—but inevitably finite—dollars available.***

***Cost control failures led to imposition of layers of unproductive public and private financial and regulatory micromanagement of doctors' clinical decisions.***

***The only way to liberate doctors from that intrusive micromanagement was to pay them generously but in financially neutral and trustworthy ways.***

***Doing so enabled us to enlist doctors in the hard job of serving as fiduciaries—who are accountable for marshaling the vast but finite health dollars to do as much clinical good as possible.***

***Health care's share of the economy surged during the stagflation of 2025-2028. The economy floated on very large federal deficits—which are financially and politically unsustainable.***

***Health care financing had floated on those same deficits.***

***Thorough health care reform had to address financial coverage for all Americans, effective and trustworthy cost containment, caregiver payment methods, caregiver configuration, and quality and appropriateness of care itself.***

***Reform therefore required coordination of a number of moving parts, each with its own complexities, political challenges, and resistance.***

***Unless the parts were at reasonably well coordinated, it would have been impossible to fix any of them safely and durably. Why is that?***

***First, because covering everyone affordably requires cost control but cost control that's medically and politically safe requires covering everyone.***

***Second, because controlling cost requires squeezing out waste.***

***Third, because squeezing out waste relies on paying caregivers in financially neutral ways. That's essential to cutting all the administrative waste that stems from today's mistrust between payers and caregivers. And it's equally essential to liberate doctors to squeeze out clinical waste and use the savings to deliver and pay for needed care for all of us.***

***Fourth, because balanced and well-configured caregivers are essential to redeeming promised financial coverage by delivering actual medical services.***

***Fifth, because quality of care is very uneven today—and that will be a persisting challenge to equity if it is not addressed. Better evidence on appropriateness of care will be essential to chopping clinical waste.***

***The stakes were high for health care. And just as high for the nation. Only by fixing health care would it be possible to find the money to finance re-industrialization, affordable housing and transportation, good education and job preparation, safe streets and homes, adequate defense, and promoting strong family and social life.***

***Cleaning up our strategic health care act would win a victory for competence and compassion. And we would find—in that victory—the inspiration, encouragement, and dollars needed to roll on to successive victories over the dangers and difficulties that plagued the nation.***

**Opting for reform**

In 2029, given a choice among higher taxes and spending, cuts in access to health care, and increased borrowing, Congress compromised on none of the above. Reform was the only alternative. Congress spotted the fork in the health care road and took it.[807]

At the time, few thought this was inevitable.

Just as in Churchill's Britain in the spring of 1940,[808] a dangerous option had to be rejected.

That option—simply coping with less revenue by cutting care—was considered but then decisively vetoed. Because that would have damaged access in ethically and medically and politically unacceptable ways. Because uninsured and under-insured people would have suffered disproportionately from worsening care suppression. Because it was a recipe for fear, anger, disruption of caregiving, caregiver bankruptcies, and harsh rationing. Because fights between payers and caregivers had become more frequent and ferocious. And because it had proven for years to be a feeble cost control tool because it perpetuated vast waste inside health care.

So wiser heads in federal and state governments, business, medicine, hospital care, and other sectors saw the need to compromise to close the widening gap between revenue and costs. Public and private payers, caregivers, and advocates of health equity helped to craft essential reforms or acceded to those crafted by others. Most agreed on reasonable and comprehensive reforms, just in time.

Few predicted this a decade previously. Vladeck had pointed to the historic mistrust of government in the U.S. and the constitutional provisions that worked against concerted government action. He described three types of substantial political change in the U.S. One was the realigning elections like those of 1928-1932 and 1980-1994. A second was consequences of war, such as the ways in which the Second World War resulted in expansions of private and then public health insurance. A third was social change like the evolution of public attitudes toward smoking.[809]

It appeared that all three types of change helped to shape U.S. health care reform.

## 3. The crisis ignites

***After the 2026 mid-term elections, the combination of rising federal deficits, higher interest rates to finance new federal debt and re-finance rolled-over old debt, rising unemployment and inflation, powerful pushes to boost defense spending, unabated***

***increases in health care spending, rising levels of uninsurance and under-insurance, growing awareness of waste in health care, appreciation that cutting waste was impossible without changes in how caregivers were paid, and recognition of the link between high health costs and unequal health care access together spurred politicians to think harder about health care spending, costs, coverage, and actual access to care.***

***In February of 2029, the newly-elected 121st Congress voted by wide margins to cap federal Medicare and Medicaid and ACA subsidy dollars going forward at the levels of 2028, unadjusted for inflation. President XXXX signed the new cap immediately.***

***Congress continued to debate related legislation to sustain other revenue flows to health care, to fully insure all people, and to identify and sustain needed caregivers.***

***Private employers—and state and local governments (employing 20 million workers)—had reason to fear that the federal cap would induce doctors, hospitals, and other caregivers to seek even higher prices from private insurers, boosting private and public employers' premiums.[810] [811] With average premiums for family coverage already above $30,000 yearly, most employers knew that, during tough economic times, they could not absorb the financial shock of still higher premiums to offset the cap on federal dollars. Panicking, employers decided that engaging seriously with reform discussions was the best way forward.***

***Many doctors, hospitals, and other caregivers were frightened by public and private payers' efforts to restrict payments for health care. And by continued increases in caregivers' own costs. More and more caregivers joined the reform discussions.***

***Fortunately, between 2025 and 2028, small teams of U.S. experts in health policy, finance, coverage, politics, management, and actual health care delivery had anticipated the chance of a federal funds freeze and destabilization of health care. They had begun designing and testing ways to protect Americans and our caregivers from the effects of the cap on federal health dollars.***

***During these years, the widely-recognized severity of the crises inside and outside health care diminished the credibility of the hyper-partisan political outrages and grievances voiced by the far right and far left. Pragmatic remedies—many developed by those teams of experts—gained credibility. They were studied seriously by a high-level bi-partisan Congressional commission in 2027-2028.***

***The commission's members increasingly leaned toard using the power and opportunity of the crises to leverage broad health care reforms.***

***They had to prepare. They knew that the opportunity to reform health care might come suddenly, just as quickly as the Kaiser's armies collapsed in the fall of 1918—or as the second Russian empire collapsed in 1989-1990. So the commission's members and the small teams had to work with both caregivers and payers to find ways to conserve what was sound and to devise substitutes for what was essential but had fallen apart.***

Congress's February 2029 vote to freeze federal health dollars at 2028 levels shocked caregivers, patients, state governments, and private employers. But it did not surprise them.

They had watched for many years the growing international, economic and financial, social, and political challenges facing the nation. They had witnessed the access, cost, caregiver, and other crises deepening inside health care. And the many erratic, badly thought-out, and reckless federal actions of 2025-2026. Along with the delegitimization of decades of traditional free market thinking and reactive government regulatory action in health care. Combined with the increasingly-well-publicized evidence that up to one-half of health care spending was wasted.

Caregivers desperately sought stability.

Patients under treatment demanded continuity of care, and patients with new illnesses and injury were anxious to obtain needed care.

Public and private payers all sought to slow increases in their own spending.

But these payers noted well that traditional cost controls like higher OOPs, higher employee premiums, and narrower caregiver networks relied on suppressing use of care. These were all dangerous to uninsured, under-insured, and lower-income Americans. All such cost controls would magnify social and political tensions. And they did nothing to squeeze out and recycle clinical or administrative waste.

Many payers and patients—and caregivers—worried that slowing cost increases would be politically impossible without guaranteeing that patients' needs would be met. And that doctors, hospitals, and other caregivers would be paid enough to give needed care.

The employers who financed private health insurance also sought to protect themselves—though in different ways. Employers feared federal cuts would push hospitals and doctors and drug makers to seek higher prices from insurance companies. Insurers would then raise employers' premiums. Employers sought to block or pre-empt any such hikes.

State governments were concerned that the remaining 75 million Medicaid patients—almost one-fourth of the nation's people—would suffer even greater financial barriers to gaining good medical care. Medicaid payment rates had long been the lowest of the major payers. The federal freeze on Medicaid spending would push those rates down substantially because the recession made it hard for states to afford to increase their own payments for Medicaid. The recession also made many more people eligible for Medicaid.

**Elements of reform**

Increasingly afraid of the unfolding financial and clinical crises afflicting caregivers and patients, and of the ominously reduced flow of added money for business-as-usual, the caregiver and patient advocacy groups sought to craft cost controls that protected them both.

This was daunting but they succeeded. The cost crisis was resolved in ways that improved access to care, buttressed needed caregivers, and designed ways to pay caregivers that were commensurate with both access to care and cost control.

The reforms had 10 core elements. Many of these were codified in federal legislation that followed the freeze in federal health care dollars.

First, yearly caps on health spending for the nation. (After considerable debate, wealthy individuals were not prohibited from spending their own money as they wished.)

Second, pooling of all public and private streams of revenue in one reservoir. A new federal law required that employers sustain annual insurance payments per employee in 2028 nominal dollars (not adjusted for inflation). This made it unnecessary to raise federal taxes to replace private insurance premiums. That money joined federal Medicare and Medicaid dollars (and the states' own 2028 nominal dollar Medicaid payments) in the pooled revenue reservoir.

Third, backing each American's insurance card with money from the reservoir. That meant paying caregivers with the money in the reservoir. This money was divided into pools to cover care for residents of the 50 states. States needed to build their capacity to competently, efficiently, and equitably spend the money under their control. Some low-population states joined with one or more nearby states to jointly manage their money.

Fourth, full coverage for all Americans with only nominal OOPs. The alternative, conditioning OOPs on income, was rejected as impossible to administer competently and inexpensively.

Fifth, identification and stabilization of all needed caregivers—primary care and specialist physicians, acute care hospitals, ambulatory services, long-term care, mental health, and others. Adding caregivers in short supply—particularly in primary care and in mental health, and particularly in states or regions with low supply.

Sixth, paying physicians by simple methods of fee-for-service, salary, and capitation. Paying hospitals and other organizations by yearly fixed budgets. And working with drug makers to generously reward safe/effective new meds while lowering prices of old meds to rich-democracy averages.

Seventh, crafting financially neutral methods of paying physicians, hospitals, and other caregivers, and ending financial incentives and penalties. Relying on honor, professionalism, altruism, trust, and fiduciary duty to lead caregivers to spend finite dollars as carefully as possible.

Eighth, simpler and more trustworthy payment methods liberated hundreds of billions of dollars yearly formerly wasted on administration and bill-paying. Financially neutral payment methods liberated doctors to weed out ineffective, wasted, and low-value care, making it possible to serve all Americans effectively, efficiently, and equitably.

Ninth, although the reform elements—channeling revenues into one national reservoir, replacing financial incentives with financial neutrality, covering all people, and protecting all needed caregivers—initially looked counter-intuitive, especially to Republicans anxious to shrink the federal government, they soon came to be widely recognized as the only path toward containing health care costs, covering everyone, securing the right caregivers where they are needed, and boosting quality.

Tenth, the few, big, and strategic health care decisions concerned cost/spending caps, covering all people solidly, identifying and stabilizing needed caregivers, paying caregivers in trustworthy

ways. When federal and state governments made these decisions well, doctors and other caregivers were liberated to make the billions of small decisions about how to diagnose and treat 340 million Americans yearly. With the huge sums already available in 2028: some $6 trillion in health spending, or about $17,000 per American.

## 4. The Red Team gets to work


The Red Team was formed in 2025 to plan comprehensive responses—in the public interest—to access, revenue, cost, waste, quality, and caregiver crises manifested and magnified by the anticipated freeze in federal dollars to pay for U.S. health care. Or by similar discontinuities.

It was financed by a series of foundation grants averaging $2.5 million yearly—about equal to $45 per $1,000,000 spent on health care yearly.

It sought ways to convert crises into opportunities.

The Red Team's originators certainly did not suppose that crises were inevitable. But if crises had even a 5 percent chance of occurring, preparation was warranted. Passengers on cruise ships must participate in lifeboat drills even though the risk of using them is very far below 5 percent. The same applies to wearing seatbelts when driving or flying.

Anticipation and preparation are vital. That's why gas companies have installed seismic or excess flow valves that turn off the gas automatically when they detect broken gas mains. Gas from broken pipes fed fires that did more damage to San Francisco in 1906 than did the earthquake itself. It is hard to prepare protocols to prevent fires by manually shutting the valves in gas pipes under a city if you wait until the earthquake hits.

Similarly, most electric companies have protocols for shutting down power when horrible windstorms hit. Apparently, the Los Angeles Department of Water and Power failed to develop such a plan; this may have caused some of the devastating fires that swept the area in January of 2025.[812]

The Red Team was created to foresee grave crises and develop effective responses. The alternative would be to try to fix health care while it was falling apart—something like repairing an airplane in mid-air.

This meant that the members of the Red Team did not need to debate whether grave crises in health care would occur. Their job was to develop plans to respond to various emergencies.

Importantly, the Red Team could not rely on the federal government's typical crisis response—spending more money—since lack of money was predicted to spark the crises.

The Red Team's work was guided by 9 principles and insights.

**First**, although crisis might permit and motivate large-scale reforms, worries would be wide and deep. Unsympathetic or anxious or opportunistic critics or reforms would be quick to mobilize and loudly castigate perceived failures, shortcomings, or even delays.

**Second**, the Red Team therefore had to identify early valuable victories it could be confident of winning. These would build political capital.

**Third**, undertaking large, complex changes at a fraught time demanded careful analysis, considerable skill, mobilization and cooperation of key participants, smart public relations, co-optation or pacification of malcontents, patience, reassurance, and experience.

**Fourth**, frustrations in designing and implementing reform in Vermont—where politicians, caregivers, and voters were largely sympathetic—point to the need to craft carefully and test robustly.[813]

**Fifth**, the Vermont experience also highlights the importance of deciding which reforms would be mandated and which might be optional.

**Sixth**, all reform requires testing and complicated reforms with many moving parts require more extensive testing. Tests in small states would identify problems and allow reformers to gain experience. But tests must be big and long enough to accurately measure what works and what does not. Complete tests would include as many important reforms as possible. The Red Team therefore developed a minimum list of those elements.

**Seventh**, the Red Team expected that, by 2028, most caregivers, citizen-patients, citizen-voters, payers, and politicians would come to share three important insights. The first was that containing cost was politically, ethically, and humanly impossible unless accompanied by strong access guarantees to protect vulnerable patients' access. The second was that effective cost controls required restricting revenue flowing to caregivers. But the third was that restricting revenue would harm caregivers financially and damage patients medically—unless waste could be cut in ways that liberated dollars already spent on health care and put those dollars in caregivers' hands, thereby restoring a reasonable balance between caregivers' revenues and costs—and also boosting real spending on needed health care for all.

But how to accomplish that? What would it take to slash wasted spending, capture the savings, and make them available to affordably finance needed health care for all Americans? How would access to care for all Americans and financial stability for all needed caregivers be protected and enhanced?

How could these complex and interdependent tasks be performed during a crisis? Relief, recovery, and reform are often thought of as sequential jobs, but they may actually need to be inter-mingled. For example, how to find the money to relieve financially beleaguered caregivers or patients unable to afford care without quickly launching reforms to squeeze out clinical and administrative waste, theft, and high prices?

**Eighth**, each of the 13 Red Team groups sought to identify the most powerful resources and supporters pertaining to its activities. And the most dangerous health delivery, financial, or political threats to its success.

**Ninth**, although no crisis big enough to spur enactment of solid reform was expected before 2029, any such prediction is risky. Witness the unanticipated economic, political, and international turmoil arising during the first months of 2025.

In 2025, the Red Team therefore prepared a set of emergency responses that could be enacted, financed, and implemented on short notice. It was updated semi-annually in light of ongoing Red Team analyses.

## *Health security for all—and its 5 requirements*

The Red Team defined the goal of health care as health security for each American—confidence that each of us will receive effective, competent, quick, and kind care without worrying about the bill. It identified five requirements for health security.

The first was full financial coverage of all services for all people for all needed and effective care. This meant ceasing suppression of access. No more than nominal out-of-pocket (OOP) payments. No medical debt. No narrow networks of caregivers to block access. No bureaucratic impediments like prior authorization or retroactive denials of payment. No provision of high-cost/low-value care before better and more affordable care is provided.

The second was well-configured caregivers, available and willing to redeem the promise of full financial coverage. This meant retaining or obtaining the right numbers and types of caregivers located in the right places. These included primary care for all, adequate and accessible hospitals with ER, inpatient, specialist physician, and other services, adequate long-term care and behavioral health, and affordable meds.

The third was to contain costs in ways that were humanly acceptable to patients, caregivers, and payers—in ways that promoted health security. This began by paying caregivers in financially neutral ways, free of incentives or penalties, that allowed the nation to trust those caregivers to deliver as much needed care as was clinically and financially feasible.

Clinical productivity was sustained by a combination of good management; high morale; inculcation of altruistic, professional, and fiduciary outlooks for caregivers; and liberation from hostile bureaucratic oversight by insurers.

Health care became self-regulating. Doctors knew that the budgets available for hospital, pharmaceutical, long-term, and other care for their patients were finite and needed to be spent wisely, prudently.

The fourth was to address the very uneven access to care, technical quality, and appropriateness and adequacy of care in different places in the U.S.

But, fifth, where to find the money to expand financial coverage and address caregiver shortages and malconfigurations, and uneven quality? Responding to the crisis sparked by the freeze in federal financing required squeezing out the huge sums that were already included in health care spending but that were actually wasted. That entailed protecting caregivers from bankruptcy and patients from worry or panic that needed care would be denied. It also required

arranging soft landings and re-employment for the millions of clerks and others who would be displaced by administrative simplification.

The five clusters of required reforms were not easily coordinated. Some were sequential; others needed to be performed simultaneously. Some could be done quickly but others would take years. Numerous complications could easily arise. As many as possible needed to be anticipated and planned for.

One predictable requirement was to quickly begin the jobs that took the most time.

A second was to quickly win valuable and visible successes, while avoiding discrediting failures.

A third was to craft reforms that addressed problems—and causes of problems—as directly as possible. For example, if we want more primary care doctors—and can't draft them, we must pay them more money. And if we want equitable access to care, all payers must pay the same price for the same services, and OOPs must be minimized. If want to contain cost, we must cap dollars available to be spent. If we want to contain cost and boost access, we must cut waste.

## *Organizing to meet the crisis*

The Red Team's first months began by specifying the main measurable aims for access, caregiver configuration, cost control, quality, and recycling previously wasted money.

They continued by sketching the methods of quickly making progress toward attaining those aims. How could money and care be shifted to phase in the improvements in access and the re-configuration of caregivers required to redeem that access—all while avoiding bankruptcy of needed caregivers? How could waste be squeezed to generate the working capital required to finance and lubricate individual reforms?

And how to remain aware of the risk that well-intentioned reforms can have unforeseen and undesirable consequences as payers and caregivers respond to changed financing or care delivery arrangements? The Red Team had to hold this risk in mind constantly.

The Red Team established 14 working groups. The groups' tasks, budgets, and personnel varied considerably. Exhibit 1 -19 summarizes the main tasks of each group and the other salient groups with which each mainly coordinated.

***Exhibit 1 -19***

***Main Multi-year Tasks of the 14 Red Team Groups***

| | **Main tasks** | **Coordinate with** |
|---|---|---|
| A | Sustain flow of $s to state revenue reservoirs—prevent revenue leakage, dissipation—consider governance options for the reservoirs—how to allocate the money quickly, effectively, and fairly?<br>Easier to sustain visible public dollars; harder with private insurance money; hardest with OOP dollars—so need substitute for OOP<br>Squeeze out waste, capture, recycle | B C D F G |

| | | |
|---|---|---|
| B | Reassure patients that care will be sustained during the crisis<br>Finance sustained access and financial coverage, broaden them, cut OOPs and debt, and win early and visible access improvements<br>Identify ways to cut waste quickly and use it to sustain and broaden access<br>Build political capital by winning early successes | A E F H I |
| C | Assess current caregiver configuration<br>Identify needs for care and gaps between needs and current supplies<br>Devise ways to fill gaps, and win early and visible progress<br>Build state or multi-state capacity to take on these and other strategic jobs | B D F H |
| D | Reassure caregivers that they will be paid throughout the crisis<br>Devise better ways to pay caregivers—that liberate them to cut clinical waste by marshaling dollars to do as much clinical good as possible, to build payers' trust in caregivers and caregivers' own clinical and financial accountability—and thereby to cut administrative waste; capture/recycle both types of waste<br>Identify ways to cut waste quickly and use it to sustain and promote needed care | A C E F I |
| E | Promote professional and altruistic outlook for physicians and fiduciary outlook for hospitals and other institutions<br>Institute strong auditing provisions to spot theft and criminal penalties to deter it | B C D G |
| F | Rapidly build primary care capacity<br>Immediately, train NPs and PAs<br>For long haul, boost primary care doctors' incomes substantially, increase medical/osteopathic school capacity | B C D |
| G | How to reform overall organization and delivery of care?<br>How to finance buy-out of equity in for-profit caregivers?<br>Arranging job training and other soft landings for displaced clerks, others | B C D E F |
| H | Identify sites/caregivers of low access, quality, and appropriateness of care<br>Specify ways to remedy them, gauge cost of reforms, and develop plans and implement those remedies | B C D E F |
| I | Identify different attitudes toward relief, recovery, and reform<br>Anticipate and respond to concerns raised by caregivers, patients, investors, politicians, and others<br>Consider a range of approaches—from one national plan to high levels of state (or multi-state) options—perhaps relying on 3-4 federal templates | B C D E F |
| J | Plan for improved access to care badly covered today—LTC, mental health | B C F |
| K | Plan for improved access to affordable prescription drugs | B F |
| L | Integration group – do the pieces fit?— identify conflicting policies and gaps<br>Do revenues cover costs?<br>Are relief, recovery, and reform moving forward successfully, winning greater support, or are key pieces not working? Do any of the latter threaten to discredit the entire enterprise?<br>Test elements of the plan quickly to learn what works and what does not<br>Consider federal versus state responsibilities for strategic decisions<br>Collect essential data and develop procedures for setting standards | All |
| M | Politics group – identify reform's political supporters and organize them<br>Identify opponents and seek ways to enlist them or counter their worries so they become neutral<br>Identify reform elements that generate great support or opposition | All |
| N | Emergency group – prepare reform responses to threats that arise at any time—well before the anticipated 2028 arrival of the crises inside and outside health care | All |

**Group A** addressed ways to sustain the streams of dollars as they were gradually channeled into single national or state revenue reservoirs, to squeeze out waste and capture the dollars saved, and to make the savings available for recycling. Some recycling is easy. If nurses and doctors could be enabled by simpler payment methods and malpractice reform to devote less time to defensive care and defensive documentation, much money would be saved. A greater share of each doctor's and each nurse's time could be devoted to caring for more patients more carefully. It designed and developed legislation and robust enforcement mechanisms to avoid financial leakage, identify any leaks, and plug them.

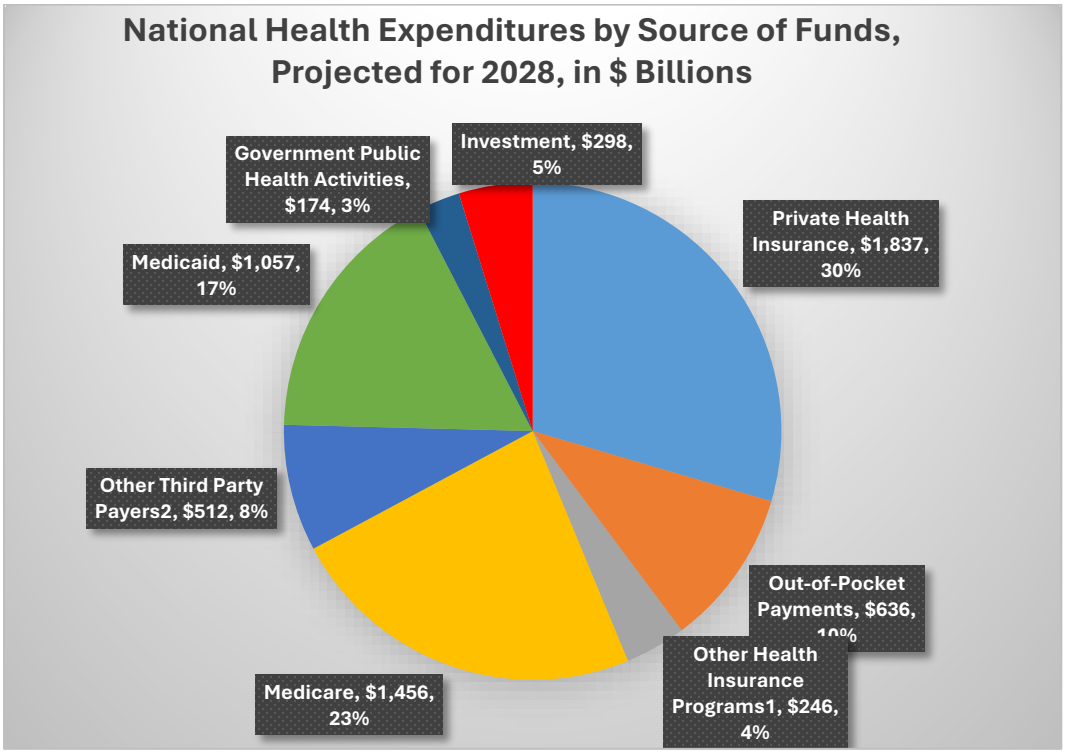
Responding to the health care crisis entailed relief, reform, and recovery. In past economic crises—like the Depression of the 1930s—these generally proceeded sequentially. Sadly, the financial collapse of 2007-2009 saw only relief and recovery but no real reform.

But in the health care crisis, the money to finance relief—under a freeze in federal health spending—would have to be freed up through reform. So the three steps would be intermingled in time, not sequential. This complicated progress but its linkages helped to impel reforms that might otherwise have lacked sufficient political support.

The Red Team sought to assure immediate relief for caregivers at risk of bankruptcy and for patients at risk of losing coverage or care. Would enough money be available to both relieve caregivers from threats of bankruptcy and also protect and expand coverage?

To do both, sustaining different streams of revenue would require very different approaches. Exhibit 1 – 20 displays projected 2028 revenue by source. Also, waste-cutting efforts would need to be initiated promptly.

***Exhibit 1 – 20***



Source: Office of the Actuary, CMS, Projected Health Care Spending, Table 3, updated September 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected.
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Medicare, Medicaid, and ACA subsidy financing, while frozen in 2028 dollars, remained enormous and secure. Congress gradually channeled each state's spending under the three programs to states' own pooled reservoirs. The same was done for two of the other main health insurance programs: Children's Health Insurance Program and Department of Defense health programs. The third, Veterans Administration programs, warranted careful consideration. Action on it was deferred.

Three other revenue streams might be vulnerable to leakage. Each threat warranted prevention or counter-action.

First, a recession in 2028 could impede somewhat the flow of private health insurance dollars predicted to finance fully 30 percent of total spending. Some employers could try to boost out-of-pocket payments or employee share of premiums, which might result in reduced use of care, coverage, and flows of dollars to caregivers. Congress might legislatively impose maintenance-of-effort and claw-back requirements on private employers and also on state and local governments. Employers could pay premiums to their insurers, but those companies would immediately pass the money along to the all-payer reservoir. Insurers would cease paying caregivers.

But preventing leakage of these payments would require thought. Private and public employers and workers would be relieved that their premium contributions would be frozen in 2028 dollars, but some employers might try to dodge that maintenance-of-effort requirement. For example, some might try declaring bankruptcy and then reincorporating. Group A was charged with designing robust, simple, and legal methods to prevent leakage.

Second, out-of-pocket payments, equal to about 10 percent of spending, were much higher in some sectors—dental care, long-term care and mental health, and prescription drugs. Retaining these OOPs as a condition of receiving care would be inequitable. But it would be hard to quickly replace much of the anticipated $636 billion in OOP revenue for health care.

If so, incremental cuts in OOPs would be necessary. Prescription drugs would be a good place to start. Nationally negotiating drug prices with manufacturers—or regulating them—would allow speedy and substantial reductions in OOPs for meds.

Third, other health insurance programs were predicted to finance almost one-quarter of a trillion dollars of health care in 2028. These include worksite health care, other private or charitable revenues—including hospitals' revenues from interest and dividends and capital gains, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, various other state and local programs, and school health.

It might be logistically and difficult to sustain revenue flows from some of these programs and to channel them into the single reservoir. Also, the special-purpose SAMSHA, IHS, and MCH money might well be allowed to continue to flow to traditional recipients. The future of hospitals'

substantial non-operating revenue—interest, dividends, and capital gains—would probably depend on treatment of the hospitals' own endowments that generate these returns.

For a number of years, Americans retained their separate plastic Medicare, Medicaid, Blue Cross, and other insurance cards but those cards gradually came to have equal value. Over 5 years, all payers shifted to paying the same prices for the same care. OOPs were rolled back substantially and also made uniform across payers. Benefits were standardized.

In a few years, public and private revenues were pooled in one reservoir. That money was devolved to states, regions, and individual caregivers.

**Group B** addressed ways to protect and pay for continued coverage, steadily broaden it, and cut out-of-pocket payments and medical debt. It sought to reassure patients that access would be sustained and expanded for all Americans.

Group B's early work included refining estimates of the costs of the main efforts to expand financial access to care and the timing and sources of revenue to pay for those expansions. The main expansions were covering currently uninsured Americans, lowering OOPs markedly, establishing single prices for all payers for each type of care, and eliminating narrow networks of caregivers, prior authorization by payers, and retroactive denials of payment by payers. Costs would vary with timing of implementation.

Group B considered options for scheduling the various expansions. It considered their benefits to Americans and costs and availability of revenue.

No matter its eventual benefits, transition from anarchy to durably affordable health care for all was expected to be fraught with worrying challenges.

These changes required crafting methods of paying doctors and hospitals in ways commensurate with slowing cost increases and assuring health care for all Americans—while satisfying doctors' and hospitals' reasonable revenue requirements.

They also required substantial boosts in the number of primary care physicians and nurse practitioners. And stabilizing the finances of all needed hospitals and other essential caregivers.

These coordinated reforms allowed doctors to reassure their patients that access to health care would be strengthened even as total health care spending was capped.

Pooling revenue did not mean a big government take-over of health care. Rather, it was the means to put money in the hands of doctors and hospitals by methods that cut waste, that encouraged and obliged caregivers to marshal the vast available revenues to better serve patients, and that also made it possible to slash OOPs and other financial barriers to care. These steps addressed what Altman called many American voters' two health care concerns—worries about unaffordable care plus mistrust of "big government liberalism."[814]

One way to make doctors happy about the responses to crisis would be by eliminating the suits for malpractice. The requirement to prove a tort in court meant that few victims of bad or ineffective care were financially compensated and that few of the small minority of abusive, chemically or cognitively impaired, or incompetent doctors were identified, re-educated, or

extruded from the profession. Costly defensive medicine did result. Ending suits for malpractice required drafting and legislating alternative mechanisms for compensating victims of bad or unsuccessful care and for addressing dangerous doctors.

The other way to make doctors happy was to cut their paperwork. Since mistrust is the mother of most paperwork, cutting administrative waste required paying doctors in financially trustworthy and simple ways. While also asking them to take accountability for spending the rest of the health care dollar effectively, prudently, and equitably. Doctors' decisions about how to diagnose and treat us effectively control almost 90 percent of spending on health care for individuals. Doctors keep about 10 percent of that 90, making the 10 percent strategic.

During the early months and years of relief, recovery, and reform, reassurance from accountable and trusted caregivers would be essential to reassure the public and to rebuild U.S. health care.

U.S. doctors encountered almost 4 million patients on an average day. If most physicians explained to their patients that they, as doctors, supported reform, patients would be patient and give reform a chance. If not, not. Group I therefore planned ways to build physician support.

To succeed, that effort would have to differ greatly from the incoherent, unprepared, contentious, ill-equipped, and often unscientific responses to Covid in the U.S. Those responses undermined public confidence in public health and government generally.

It would be valuable to build political capital though early successes in boosting access to care. Failures would dissipate that capital and discredit reform.

Red Team members noted the importance of early successes in winning public and caregiver confidence, and in snowballing political capital to help power subsequent reforms. They therefore identified visible and fairly quickly- and easily-won objectives to pursue initially.

From the start, the Red Team identified opportunities for implementing distinct, individual, but foundational reforms—actions that did not require careful coordination.

Three reforms saved money and captured some of the savings. The first was federal legislation establishing a standard penalty of one year in jail, prorated, per $100,000 in health care theft from or by a caregiver or payer. The False Claims Act was amended to provide for one-third of recovered stolen funds to be deposited in a new national Health Care Reform Trust. Some $15-20 billion yearly was added to the Reform Trust.

The second was legislation to cap prices of 25 high-volume/high-price prescription drugs at the average set in a dozen OECD nations. One-half of the money saved was retained by public and private payers, and one half was rebated to the Reform Trust. Yearly rebates were $25-30 billion.

Since many people who can't afford dental care want it badly,[815] $5 billion yearly was used to finance training of dental therapists, newly licensed in all states, and to integrate their practices with dentists. Working with dentists, the dental therapists would identify, excavate, and fill cavities at affordable prices. Dentists would continue to deliver the more complicated care.

A second was immediate coverage of hearing and vision care under Medicare at a cost of $25 billion yearly.[816]

The third immediate saving was won by ending the Medicare Advantage program and devoting its extra payments—estimated by MedPAC at between $84 and $99 billion in 2025 alone [817]—to financing added benefits for all Medicare enrollees. And in 2025, Trump decided to boost MA payments by an added 5 percent or $25 billion yearly.[818] Those benefits included full dental coverage under Medicare Part B. Gangopadhyaya and colleagues estimated that cost at $60 billion for 2023.[819]

Group B worked to identify other specific, concrete, and visible improvements that could be quickly implemented, along with sources of revenue to finance them.

**Group C** addressed current caregiver supply, needed configurations, and methods and costs of sustaining and improving configuration. It also considered ways to boost state governments' willingness and capacity to perform these jobs—and also jobs addressed by groups B, D, H, and others.

It is not simple to learn which hospitals are needed and how much money they require to efficiently deliver needed types and volumes of care. But decades of experience from Maryland's Health Services Cost Review Commission helped other state governments do this job.

The same would be true of deciding and negotiating how much to pay various salaried physicians practicing in different hospitals in various locations. Lessons from Kaiser plans that own their hospitals and from the VA might guide payment levels. Similar work would be required to set up ways to pay physicians in ambulatory practices.

Primary care demands special attention. Even though a competitive free market is absent in health care, the notion of a market-clearing price remains important. This simply means, how much must be paid to get enough primary caregivers in the right places? A direct approach would be to cease monkeying around with failed, weak, and indirect methods like tuition debt relief and simply to ask what salary would a primary care doctor require to work in various locations.

**Group D** developed, tested, and advised on methods of paying caregivers that allowed deep cuts in administrative waste while liberating doctors to maximize value and efficacy of diagnosis and treatment. It convened advisory groups of caregivers, patients, and legacy payers.

Cutting clinical and administrative waste would allow caregivers to sustain needed patient care and avoid bankruptcy. How to cut both types of waste? The most useful remedy is also the most complex. It would entail ceasing to pay hospitals for each admission or ER or outpatient procedure or visit. And ceasing to pay doctors' individual fees for each service provided in hospitals.

These changes would entail putting each needed hospital on a budget and paying each doctor who works in a hospital by salary.

Group D compiled and disseminated procedures for calculating hospitals' yearly budgets—revenues required to finance efficient delivery of needed care.

It relied heavily on techniques developed in Maryland over the past 50 years. Experts from the Maryland Health Services Cost Review Commission, building on 50 years of incremental experience, volunteered to help draft model state legislation.

Doctors took accountability for allocating those budgets carefully—to weed out futile or very low-value and high-cost care, and to make sure the budgets last for the entire year. Hospitals are able to offset reduced revenue by slashing their billing and collections staffs. They are actually able to hire more nurses and other caregivers.

Hospitals were made financially neutral. They must expend their entire operating budgets each year. But they can't over-spend. Unable to gain a surplus or suffer a deficit, they are not at risk financially. They and their doctors therefore must act as fiduciaries. No one makes money by giving excessive care or by withholding needed effective care. Federal grants cover capital costs. Hospital budgets include the money needed to pay doctors who admit and care for patients at the hospital.

More populous states would develop their own capacity to set hospital budgets. Less populous states might join together or with nearby states.

Budgets would oblige hospitals and doctors to devote available money and clinical time to doing as much good as possible for patients in need. They would weed out unnecessary or low-value/high-cost care. If they embraced professionalism, altruism, and fiduciary duty, and if they were paid in financially neutral budgets and salaries, they could be trusted to marshal the huge sums that would still be available in 2028 and subsequently.

Group D deemed it essential for state governments to build their capacity to understand health care and make strategic decisions to improve it affordably. Congress calls on governors of each state to report each year to their legislature on the state of the state's health care. The reports are supposed to begin with an assessment of the adequacy of primary care, the numerical shortage of FTE primaries, and a practical plan to steadily remedy that shortage within a decade. The reports are also meant to identify the adequacy and financing of acute hospital care, long-term care, mental health, and other important types of care.

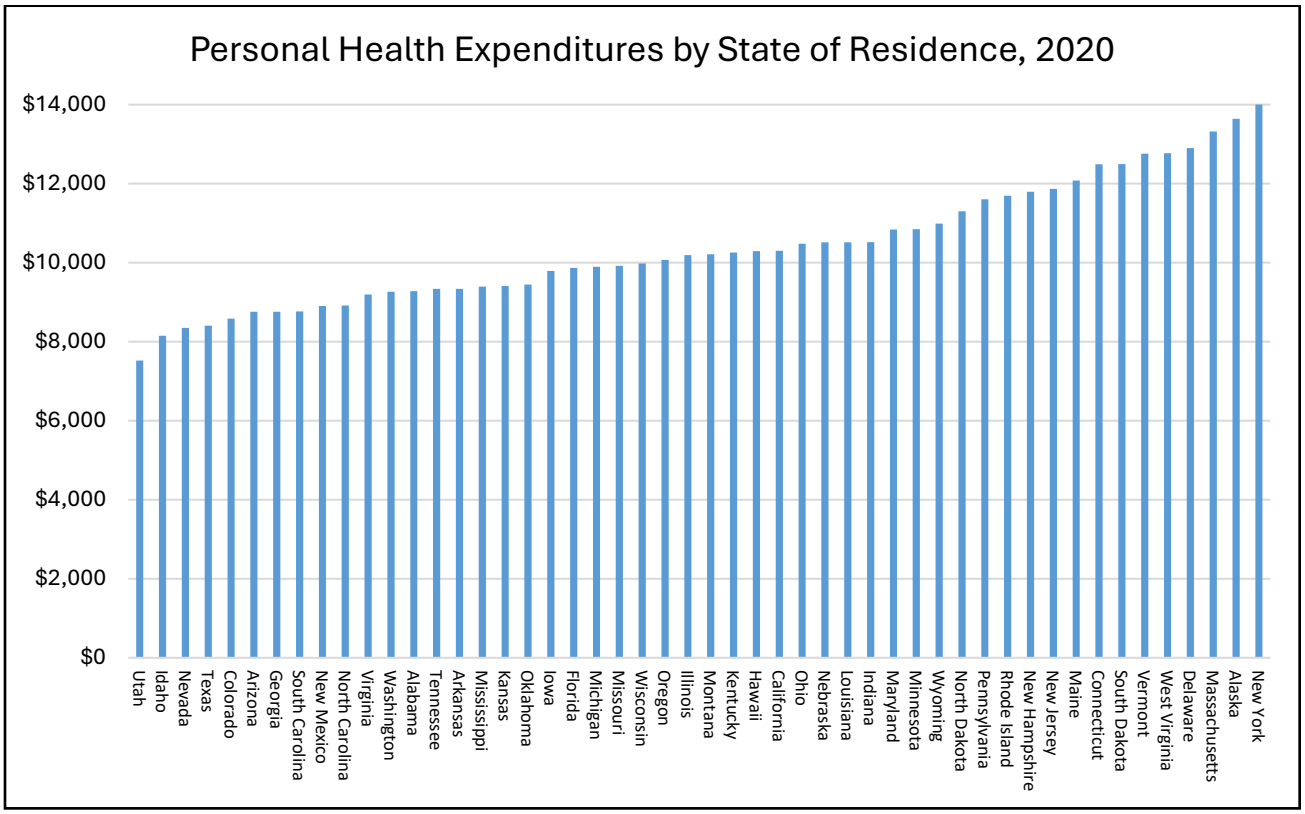
Payment to sites like ambulatory surgical centers merit special attention. In Pennsylvania, ASCs were 10 times as profitable as hospitals, statewide, in 2023. A combination of payer mix—more privately insured patients and fewer Medicare and, especially, Medicaid patients was one factor. Another may have been efforts by doctors with ownership shares in ASCs to steer patients with more profitable procedure codes to their ASCs. A third may have been ASCs' greater efficiency. Group G would consider the phase-out of for-profit caregiving but that would be a multi-year process, so payments to ASCs still warrant attention.

One challenge was to provide fair amounts of money to each state—money to use to finance hospitals' budgets, physician salaries, prescription drugs, and other types of care.

In 2020, personal health care expenditures per capita by state of residence—dollars devoted to caring for individuals—varied widely across the states. (Please refer to Exhibit 1 – 21.)

In 2020, per capita spending in New York was 1.86 times that in Utah. To what degree did this reflect variations in need for care, in professional standards regarding types of care appropriate to diagnose and treat various patients, in adequacy of insurance coverage, in adequacy of caregiver supply, in costs of living (input costs), in efficiency of care, or in other factors?

***Exhibit 1 - 21***




Source: Office of the Actuary, CMS, State Health Expenditures by State of Residence, 2020, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence.

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These factors were at play in many—probably most—states. In that case, which of these factors should influence adjustments across the states in allocations from the national reservoir?

And when should adjustments be made? It might be well to begin with the levels of spending prevailing in 2028. And then boosting health care budgets faster in states where spending had historically been least adequate. This would reduce somewhat the number of elements that would have to change in the early years of reform.

Alternatively, should each state create, fill, and manage its own reservoir, supplemented by different levels of aid from Washington? Much redistribution in money to pay for health care took place in 2025: Medicare and Medicaid raised a great deal more money in states with higher per capita incomes. Medicare was mildly redistibutionary across the states and Medicaid was very redistributionary.

A further consideration is border-crossing. Some states' caregivers serve substantial shares of patients from adjacent states. Also, major referral sites like Mayo and Cleveland clinics attract patients from many states.

**Group E** sought to promote altruism in professionals and fiduciary outlooks in non-profit hospitals and other organizations. It coordinated with Group D on payment reform efforts because simple and trustworthy payment methods, combined with altruistic and fiduciary outlooks, are vital to cutting administrative waste and also clinical waste.

Seeking to reinforce professionalism, federal and state legislation recognizes that malpractice laws do little to protect or compensate injured patients or to weed out or re-educate dangerous doctors. And that defensive medicine is costly. So states enact no-fault legislation to pay added medical costs and replace lost earnings of those harmed by medical care. This helps cut defensive but unnecessary medical care. A separate process is established to identify and then either re-educate, modulate privileges, or de-license dangerous doctors.

Changes in hospital and doctor payment and malpractice aim to make health care more self-regulating, relying increasingly on professionalism, honor, and fiduciary duty to do as much good as possible with the huge but inevitably finite budgeted money.

Separate state and federal legislation defines medical fraud and theft, setting minimum penalties of 1 year in jail for each $100,000 stolen, plus restitution of stolen money. The law is vigorously enforced by skilled prosecutors, some of whom had formerly represented plaintiffs or defendants in medical malpractice cases. Criminal prosecutions replace no-contest pleas.

Happily, the early shifts toward budgets for hospitals and assured incomes for doctors mean simplified payments and fewer opportunities for theft—along with weaker motives for stealing. Finite budgets make it clear that theft kills—that money stolen can't be used to pay for needed medical care. This stiffens the spines of prosecutors, judges, and juries.

**Group F** aimed to rapidly boost primary care capacity.

Decades of mouthing empty words about the importance of primary care simply cease. They are replaced by 5 meaningful actions. First, full-time primary care doctors' incomes are boosted immediately by $50,000 yearly. This is done through combinations of FFS, capitation, salary, and fee-for-time. Incomes will rise to $400,000 in a few years. The aim is to expand the number of primary physicians plus nurse practitioners to reduce panel size to 1,000 patients by 2034.

Primary care and other doctors serving ambulatory patients could be paid by combinations or blends of payments by salary, capitation, fee-for-service, and fee-for-time are all tried. Gradually at first, and then at accelerating speeds, doctors in ambulatory practices recognize that simpler and more trustworthy arrangements mean much lower administrative costs. Primary care and other doctors in ambulatory practice downsize their administrative staffs.

Third, high schools in rural areas are asked to identify students who do well in science, are personable, enjoy rural activities like hunting/fishing/hiking/skiing/snowmobiling, and have deep

local family ties. Their college and med school tuitions are fully paid on condition they return and work in family practice.

Fourth, primary care residencies are established in each primary care group of three or more physicians. After one post-medical school rotating internship/PGY 1 in a teaching hospital, the new PC residents begin seeing patients in the PC group. Diagnosis and treatment decisions for each of their patients are reviewed at the end of each day. Timely hallway consultations with supervising docs support those decisions.

Fifth, Congress calls on governors of each state to report each year to their legislature on the state of the state's health care. The reports are supposed to begin with an assessment of the adequacy of primary care, the numerical shortage of FTE primaries, and a practical plan to steadily remedy that shortage within a decade. The reports are also meant to identify the adequacy and financing of acute hospital care, long-term care, mental health, and other important types of care.

Speedy growth required greater reliance on NPs and PAs—particularly for care of established patients with well-diagnosed or chronic conditions. Integrating NPs and PAs with primary care doctors improved continuity, comprehensiveness, coordination, and quality of care. Training of NPs and PAs was financed in part by state and local governments expecting to obtain added NPs and PAs, and in part with money from the Health Care Reform Trust.

Medium-term primary care growth required more primary care physicians. As discussed in chapter 11, this required paying primary care doctors substantially higher incomes.

But, recognizing the overall national shortage of physicians, training more doctors in total was also essential. Otherwise, diverting doctors in short supply to primary care would create or worsen shortages in some specialties. Federal and state dollars helped subsidize growth in seats in medical and osteopathic schools by 1,000 per class, yearly. That meant training 1,000 more students in the first year, 2,000 in the second year, and so on. Ambulatory sites to train primary care residents (after their first post-graduate year of rotating internships in hospitals) were identified and expanded.

Parallel actions were planned for dentistry, much of which entails primary care for teeth.

**Group G** addressed reforms in the overall organization and delivery of care. It developed a schedule for buying out the equity in for-profit caregivers and insurers, and identified ways of building accountable and trustworthy governance in all non-profit and publicly-owned caregivers.

This means the gradual end of for-profit caregiving—by hospitals, ambulatory surgical centers, nursing homes, home health agencies and hospices, and the rest. State and federal governments float bonds to compensate owners for their equity in for-profits. Ending for-profit caregiving would arouse considerable opposition but this would be mitigated somewhat by compensating owners for lost equity.

Great cuts in administrative waste mean cuts in health insurance company employment of about 95 percent. Group G prepared ways to re-train and otherwise develop soft landings for clerks, programmers, and others displaced by slashing administrative waste. For about 3 years,

retraining and temporary unemployment insurance would be financed by a small share of reduced waste.

Workers liberated from unproductive administrative jobs in hospitals, doctors' offices, and insurance companies fill shortages in construction (particularly in housing), manufacturing, direct care in nursing homes and home health, child care, public education, and other sectors.

**Group H** identified challenges to equity of access, quality, and appropriateness of care and sought ways to address them. Some of its efforts were systematic but others identified and responded to individual hot spots of dangerous care. Each informed the other about problems and remedies. Group H sought first to bring all care up to an acceptable floor, below which no patient's care should be allowed to fall. Second, it sought ways to raise that floor steadily.

States and hospitals cooperate in developing standards for efficiency, appropriateness, quality, and equity of care. Revenue does not depend on these. But under-performing hospitals are, instead, put in receivership under new state laws. New trustees and administrators are appointed. Their duty is to work with physicians to identify causes of problems and develop and implement plans to address them.

Each state identifies regions—rural counties and urban neighborhoods or zip codes—where health and health care are at dangerous levels owing either to high rates of illness and disability or to shortages of physician, hospital, and other caregiving capacity, numbers, or quality of care. State plans identify causes of danger, design remedies and finance ways to address them.

**Group I** sought to anticipate and respond to frustrations and challenges to relief, recovery, and reform from caregivers, patients, and politicians.

It began by acknowledging the very different views held by various caregivers, patients, and politicians toward relief, recovery, and reform. Group I tried to identify which aspects of the crisis response required consistence and rigidity in order to make them functional, and which could safely allow variation.

Some resistance to reform is inevitable. Free market enthusiasts will reject coordinated strategic public action on cost, coverage, or caregiver configuration. Insurance companies and hospital CEOs will fear the pain they'll suffer while undergoing detox from competition, the opiate of the managers in health care.

Advocates of traditional and modest government action will prefer to rely on traditional regulation and litigation to temper the worst evils and abuses inside U.S. health care. They forget that winners legislate and losers litigate. And also that these traditional methods have largely failed for decades to protect access or quality, contain cost, or better configure caregivers.

Some reformers continue to embrace silly ideas like "pay for value" and "accountable care. They choose to ignore realities like the Congressional Budget Office's report on a decade of failure of the Center for Medicare and Medicaid Innovation to save money.[820] [821] Some try to finesse the failure of the silly ideas. They choose, instead, to believe that health costs are under control because, they imagine, these ideas have persuaded doctors to serve patients more

carefully, frugally, and effectively.[822] But we've heard this song before.[823] [824] As shown in chapter 8, health costs never climb steadily as a share of the U.S. economy. They remain a flat share for years and then jump upward.

Some doctors fear restrictions on their revenues, added bureaucracy, and compromised clinical freedom owing to capped revenue and obligations to spend finite health dollars carefully. They worry that these burdens will be even greater than the intrusive and incomprehensible mass of public and private regulatory interference in the practice of medicine under which they suffer today. Perhaps they fear that it will be too challenging to take clinical and financial accountability to spend health care dollars more flexibly, effectively, and equitably. Not an easy job.

It will help win doctors over if reform means eliminating suits for malpractice and offering more equitable and effective remedies for harm to patients and for physician errors.

Dramatic cuts in doctors' paperwork burdens will help win them over.

Like some doctors, some non-profit hospital trustees and executives fear loss of financial independence and are reluctant to accept fiduciary responsibility to spend finite dollars carefully. Some executives anticipate losing the chance to improve margins by boosting revenue by hiking volumes of care or gaming payment mechanisms. All worry about the need to learn new skills to attain new objectives, and about the loss of now-obsolete skills like marketing for more money and shmoozing with insurance executives. If hospital administration becomes simpler, CEOs will preside over smaller empires. And they'll be paid less money to do less complicated jobs.

For-profit stockholders and managers at hospitals and nursing home chains fear loss of income and power.

Insurance company executives fear loss of their incomes, prestige, functions. Stockholders fear loss of streams of dividends and capital gains income from for-profit hospitals, insurance companies, nursing home chains, and the like.

Drug makers fear diminished profitability and restrictions on their freedom to game patents and FDA approvals to milk undeserved revenues.

Some lawyers fear loss of income when patients lose ability to sue for malpractice.

Some citizens/patients worry that reforms may cut the types and amounts of care they get. Some will be frightened by anti-reform ads that announce inevitable rationing, time-consuming bureaucratic barriers, and loss of needed caregivers.

Early testing of reforms in a few small states would help ease these fears. One state might agree to cover all people, cap spending, and liberate doctors to marshal finite dollars. Some hospital-doctor systems or HMOs will embrace the same policies. Some of these efforts will succeed. Their proponents will proselytize.

**Group J** sought to protect and improve long-term care and mental health services. It recognized these were the two areas where winning affordable and equitable care was most

difficult. That's because many people needed help for extended times, because the incremental cost of added hours of help was high, because need for care was often hard to determine, and because outcomes were hard to measure—or, even, to specify. At least, few established politically powerful stakeholders opposed reform. The group inventoried past efforts that were effective in ameliorating shortages of care. It sought innovative ways to boost adequacy of care. The group's work respected LTC's and mental health services' wide and deep interactions with the various social determinants of life.

**Group K** aimed to win effective and affordable meds for all. It recognized from the outset that the low incremental cost of making more meds offered a real opportunity to do better. But it also recognized the great financial and political power of drug makers.

Group K's plans focused, first, on established a cap on money to spend on drugs yearly.

One option was to channel all money to pay for meds into a single national pool. The pool's managers would negotiate prices with drug makers. Another option was to allow individual states or clusters of states to create multi-payer pools for buying prescription drugs for patients. But here, the pools would unite and form a common front to negotiate nation-wide prices with manufacturers. The individual pools would then pay for meds for the people they covered.

Patients paid only nominal co-pays for meds.

Drug makers then saw the value of negotiating a peace treaty with the pooled payers, one that would pay substantial prizes for high-value new meds while keeping the prices of those meds to patients very low. Other rich democracies join the U.S. pool to share in using (and paying prizes for) good new meds. To complement the prizes in spurring innovation, federal dollars subsidize fixed costs of laboratories aiming to develop new meds.

The capped dollars were used to pay first for high-value/low-cost drugs. Low-value/high-cost drugs would not be covered—unless drug makers agreed to slash their prices.

Second, plans then moved to creating mechanisms to establish prices (with drug makers) that were in line with those prevailing in other rich democracies.

The third element of the plan was to create a trust fund to pay prizes for effective new meds. The trust fund would then own the patents for which it awarded prizes. It would license manufacture and sale of meds at cost of manufacturing, distribution, and dispensing. This would reward innovation but keep the fixed cost of finding, testing, and making the first pill out of the price charged for meds.

Group K drafted federal legislation outlawing pharmacy benefits managers, creating a structure for setting all prices for all new prescription drugs under patent, and requiring both identification of drugs suffering shortages and preparation of practical plans to address those shortages.

It planned a substantial pilot program to win markedly lower nation-wide prices for 25 recently-patented high-priced safe and effective meds. An organized pool of public and private payers persuaded several drug makers to sell their patent rights in those meds for negotiated sums, called prizes. (These could also be viewed as anticipatory pre-factoring of pre-receivables—paying drug makers for meds they'd not yet sold.) The payers then made the meds available to

their patients at prices adequate to cover incremental manufacturing, distributing, and dispensing costs. The payers recouped some of the cost of paying prizes by welling licensing rights to other U.S. payers and foreign nations. That revenue was used to pay prizes to buy added patents, continuing the cycle.

**Group L** identified methods and measures for monitoring the clinical, managerial, political, and financial progress of relief, recovery, and reform. It sought to identify markers for progress, success, and outright failure.

It searched for policies and programs that might fail, why that might happen, corrective steps, and even substitute approaches. It identified essential reform elements. It sought substitutes for each—approaches that could be implemented quickly in event of failure of essential elements.

It also thought through sequencing of related activities, such that progress in one area would not be impeded delays in a related area—delays that might stem from inadequate financing, failure to foresee practical difficulties, or resistance from caregivers or other stakeholders.

Group L also looked for quick successes—easy victories—that could be one throughout relief, recovery, and reform. Those successes would maintain political support and other momentum for continued progress.

In its first year, Group L identified data essential to crafting future reforms and began collecting them. These included careful national estimates of patient care physicians and dentists. What were the actual numbers of patient care FTE physicians? It designed a parallel detailed census of hospital, nursing home, ambulatory surgery centers, and other organized caregivers. It sought to learn care capacity in various services, actual volumes of care, revenues, and costs.

Working with groups C, D, F, and G, Group L began setting national minimum standards for ratios of various caregivers to population. Maximum standards would also be considered.

In the second year of its work, the Red Team convened committees of stakeholders with multiple viewpoints and skills to help to advance its efforts. It sought a wide breadth of ideas by recruiting groups of caregivers and of payers. The caregivers were organized into separate committees of doctors, nurses, social workers, dentists, hospital trustees, hospital and nursing home managers, and other important caregivers. The payer's committee included Medicare, its financial intermediaries, state Medicaid programs, insurance companies, employer groups, HMOs, ACOs, and other managed care organizations.

Group L supported tests of key elements in several states, red and blue. Successes won converts nationally. Pre-successes (failures) of elements of the plan guided partial or complete re-working.

Experimentation was essential. Just as the 1942 North Africa landings and 1943 Sicily landings helped build competence needed for Normandy to succeed, so reformers had opportunities to implement coordinated and comprehensive reforms at sub-state and state levels just as the 2028 financial crisis galvanized national action.

In the second year of its work, 2027, the Red Team practiced implementation of the key access, caregiver, cost, and waste-reduction elements of its crisis plan in several rural counties in two states, counties that had suffered both hospital closings and loss of needed physicians.

The surviving hospital in each county received a simple budget for the fiscal year. It included money to pay salaries to all physicians caring for patients at the hospital. Primary care doctors and dentists could elect salary, capitation, fee-for-service, fee-for-time, or a combination of methods. All were designed to attain a target income for a hard-working and productive caregiver. Budgets for meds, long-term care, and behavioral health were established.

The implementation period was preceded by a year of planning, design, and recruitment of clinicians previously in short supply. Clinical funds included dollars saved by cutting administrative costs by three-quarters. Payments for meds, devices, equipment, and other purchased items were at shadow prices equal to the lowest prices prevailing in eight rich democracies.

In the third year of its work, 2030, the Red Team won permission to implement its reforms across two low-population states, one in the rural west and the other in the east.

**Group M** sought ways to magnify political support for reform and address concerns of opponents.

"Will you be next?" In mid-2025, a number of reformers from several states came together to build a campaign to mobilize and unite American citizens' generally unformed and amorphous worries about health care into a more cohesive force for specific and concrete but strategic reforms.

Recognizing that, sadly, fear is stronger than hope, the campaign's initial theme was "Will you be next?" The power of this question was driven home by dozens of public protests and parallel social media mobilizations against specific health care horrors, injustices, and threats to medical security. Some of these afflicted individual patients dramatically; others harmed substantial groups.

These reminded observers of the way in insurance company premium increases in California of up to 39 percent, in combination with insurance company rescission of coverage for care already approved and given, helped to revive Obama's 2010 push to improve coverage when it seemed to be about to die.[825] [826] [827] [828]

Each drive identified victims of harm, ways in which their suffering could have been prevented, causes of the harm, those who benefited from the practices resulting in the harm, and the ideas, actions, failures to act, and laws—and their sponsors—that permitted or protected the harms or their perpetrators.

Poignant examples of unnecessary harm from denial of care capture the public's attention. Keller has written compellingly of the ways in which medical error, lack of accountability, and weak primary care combined to kill her uncle—and how none of the caregivers involved took their mistakes to heart or sought to learn from them.[829] The tragic death of Libby Zion at a New York hospital had powerfully galvanized the campaign to cap hours of work for residents.[830]

In these ways, organizers sought to connect the specifics to the general in ways that strengthened citizens' understanding of what things were wrong with U.S. health care and how they might be addressed.

This campaign steered clear of abstract and sweeping proposals like single payer or Medicare for all. It sought to win victories that built political capital, bestowed concrete benefits while minimizing costs, paid balanced and coordinated attention to access and cost and caregiver configuration and quality, made sense to most citizens, and educated Americans about the nature of health care problems, their causes, and their remedies.

**Group N** was formed to prepare emergency responses to individual or partial crises that arose before the expected date of 2028. It therefore prepared a list of things that could go wrong and steps to set them aright.

This was valuable in itself. Also, it helped the other groups sharpen their thinking about what might happen and what might be done about it. For them, it identified discrete actions that could be valuable in themselves, some of which could also be taken as part of a comprehensive crisis response. Those might be candidates for early implementation to build credibility and confidence in the Red Team's work.

The interaction of very-short-term and medium-term analysis and planning benefited both groups.

## 5. Overcoming opposition – real remedies that address causes of real problems

The path to designing, enacting, and implementing reform was neither straight nor narrow. Rather, many outside pressures and internal conflicts and frustrations accumulated gradually—partly by accident and partly by intention—to wash away much that did not work in U.S. health care. If reform is sometimes a mighty flood, it is still fed by accumulations of drops of rain and flakes of snow, much as the Mississippi enters the Gulf of Mexico after gathering waters from 32 states.[831]

Unlike the Mississippi, reform flowed both from the top, down and from the bottom, up. Reformers sketched changes in methods of raising money, paying caregivers, reconfiguring their numbers and types and locations, containing costs and cutting waste, covering all people, and leveling quality upward. They learned to dream realistically—to make fewer speeches and more concrete plans.

At the same time, many individual Americans became frustrated and angry by inability to obtain needed care, by high premiums and out-of-pocket costs, by incomprehensible public and private regulations, and by lack of trusting relations with primary caregivers.

Many doctors fretted over their own paperwork, loss of independence, control by forces they neither understood nor liked, alienating financial incentives that rewarded bad behavior, and

threats to their income. Many clinicians emerged from the Covid crisis burned out, frustrated, and alienated. They found it hard to regain their footing. Hospitals worried about revenues growing too slowly to keep up with inflating costs, and about difficulty finding enough of the right workers.

**Problems**

American health care has long been plagued by weak, insecure, and uneven access. By high costs. By shortages of needed caregivers in some places. By very mixed appropriateness and quality of care.

These problems worsened during decades of accidents and bad decisions.

As a result, medical care—which should have been a source of security in the face of illness and accident—increasingly was a source of medical—and financial—insecurity.

Remarkably, the world's other rich democracies cover all people, give more care while spending much less, and live longer. And they do so in very different ways. None are perfect. But they are better than ours.

This makes it even more remarkable that the U.S. has failed to adopt any of the different ways to arrange health care that work well in other nations.

Prevention has a 100 percent failure rate. Illness and disability inevitably follow.

But denial of needed care to some and provision of excessive and wasteful care to others are not inevitable. Medical debt is not inevitable. Long travel times and waits for appointments are not inevitable. Fragmented and uncoordinated care is not inevitable. Medical insecurity is not inevitable.

And health care does not need to persist as The Sponge, absorbing an added quarter-trillion dollars yearly—money that could be better spent on job training, building housing and transportation to lower costs of living, infrastructure, environment, criminal justice and policing, and rebuilding our capacity to protect ourselves and nations that share our values.

***Persisting market failure and government incompetence in health care are not things we need to live with and die from.***

***Health care for all—medical security for all—rests on financial access, cost control, and the right caregivers in the right places—paid by methods that advance equitable care while containing cost.***

***Fine care for everyone is possible without denying needed care to anyone.***

***Lack of accountability for giving needed medical care is not inevitable. Nor is lack of accountability for carefully spending huge but finite health care dollars.***

***Patients who get care, citizens and employers who pay for care, and the doctors, hospitals and others who give care all suffer in various ways from current arrangements.***

***Building alliances among patients, caregivers, and payers will magnify pressure to address the needs of each of the three.***

Our nation's health care coverage, caregiver, cost, and quality problems have causes and remedies.

**Causes**

U.S. health care's problems had real causes. It helps to revive an old saying, "If you see a turtle on top of a post, you know someone put it there."

**Exhibit 1 – 22**
**A Turtle on a Post (Problems Have Causes)**

A **first** important cause was failure to articulate what we want from our health care. I think the aim is medical security for all Americans. That has three elements: a plastic card promising financial protection, doctors and dentists and hospitals and other caregivers to redeem the card's promise, and competent and financially neutral caregivers to ensure we get the right care and that the huge but finite health care dollars are spent as well as possible.

A **second** cause was widespread reliance on a competitive free market to address many health care problems. Since health care does not and cannot come close to satisfying any of the 7 requirements of a competitive free market, relying on one is very close to worshipping the golden calf.

Owing to the failure to contain health costs by methods that actually have worked in other rich democracies, U.S. payers—both public and private—have financially incentivized doctors and hospitals and insurers and MA plans and others to cut costs.

But, absent competitive free markets in health care, financial incentives distort and even corrupt clinical judgments about diagnosing and treating individual patients and spending decisions by hospital. Incentives induce caregivers to think about money selfishly, in ways that undermine quality of care and equitable access to care, and in ways that boost costs.

And these incentives give rise to the regulatory micromanagement practiced by public and private payers. These, in turn, magnify administrative waste, anger, and frustration with exploding health care bureaucracies.

A **third** cause was over-reliance on government regulations to restrain or remedy or try to clean up harm from the many abuses thrown up by failed markets. Those regulations are usually ignored, evaded, litigated, or gamed by their targets.

Governments can't win at their customary game of regulatory whack-a-mole. It is a distraction. It is a fool's game.

Governments do have a vital job. It is to make competent strategic decisions that can shape health care for the better. Governments can cap spending and therefore cost, financially cover all of us well, configure caregivers to match need, and raise the floor under quality and appropriateness of care.

A **fourth** cause was inability to recognize that failed market forces and failed government actions mean that U.S. health care is characterized by anarchy. Anarchy means lack of clinical or financial accountability. Anarchy allows one-half of today's U.S. health spending to go to waste.

A **fifth** cause was that many in health care are doing well financially—albeit undeservedly. They are afraid that reform would harm them. Some buy, cannibalize, and close financially distressed hospitals. Others plague health care with empires of billing clerks, claims deniers, prior authorization deniers, and other armies of unproductive private bureaucrats. Still others steal health care dollars. Anarchy allows all these forms of pillaging and plundering to flourish.

A **sixth** cause was the widespread belief that U.S. health care is the best in the world, and that changing it will harm us. A prime worry, voiced repeatedly, is that reform would cause U.S. health care to suffer the U.K.'s national health service's well-publicized under-financing; long delays for ambulance arrival, appointments with specialists, and non-emergency surgery; and angry doctors, nurses, and other caregivers.[832] [833] [834] The main response to this concern is that real U.S. health spending per person, adjusted for purchasing power, is about 2.3 times that of the U.K.[835]

Instead, it is useful to recognize that the world's other rich democracies cover all people, cost about one-half as much per person as U.S. care, provide more doctor visits and hospital admissions—and that their citizens live longer than ours. And that they raise money and pay caregivers and organize care in very different ways.

But their ways work and ours do not.

A **seventh** cause was that reformers waste time pursuing distractions. For example, confronting and working to fix problems of health care access, cost, caregiver configuration, and quality means abandoning the pretense that costs of illness can be cut by preventive medical care or by boosting spending on social determinants of life. Both of those are good because they relieve human suffering. But neither effort could cut health care costs. Besides, more money to pay for wholesale remedies for SDL problems simply isn't available. Yet.

The main effect of focusing on SDLs was to let health care off the hook by diverting pressure for real reform. Without fixing health care itself, the money to address SDLs seriously will never materialize. The Big Sponge needs to be squeezed.

A similar distraction was working to shift supposedly costly non-emergency care out of the emergency room by boosting ER co-pays. This does not work because it doesn't address the powerful forces propelling patients to use the ER—lack of insurance, lack of a primary caregiver, or inability to reach a primary caregiver. This also ignores the high fixed costs of the ER. Were ER visits cut in half, fixed cost per visit would double.

Another distraction was pushing feeble reforms. Subsidizing medical school tuition for primary care doctors or writing off some of their debt does little to boost primary care. Relying on more competing generics to bring down drug prices is just plain dumb because 85 percent of drug spending is on brand name drugs under patent. Closing hospitals doesn't save money when the less costly hospitals close; that pushes patients into costlier surviving hospitals—which often merge to boost their prices even higher. Raising patient OOP cost deters use across-the-board; it doesn't induce sick people to shop by price and quality. That's a joke—played mostly on the people who find it harder to afford the OOPs. Pursuing policies that have been proven not to work makes Americans feel futile and incompetent.

**Remedies**

Governments needed to make a few key strategic decisions. Making them well allows governments to focus on monitoring and auditing—to safeguard health care from waste and theft, and to ensure equity.

The first key decision was to cover all Americans equally. The second is to contain cost by capping spending. Each of these is essential to accomplishing the other. The third is to pay doctors and hospitals by methods commensurate with coverage for all and cost control.

Ineluctably, at heart, this meant putting the money in the hands of doctors—or under their control—in ways that allow all of us to trust them to spend it carefully. That, in turn, means finite budgets for hospitals and financially neutral methods of paying doctors—such that doctors' incomes don't depend on their decisions about how many to serve or whom to serve, or by what methods.

And that required having the right numbers and types of doctors and hospitals in the right places. Configuration is key. Some of its essentials are rebuilding primary care throughout the nation, ensuring that the right hospitals are financed adequately to deliver the right care in the right places, training and retaining enough nurses, training enough dentists and dental therapists to serve all Americans, and shaping and financing adequate, safe, and decent long-term care and mental health care.

Some of these things could be done quickly. Others take more time. Fortunately, we have enough money—if we choose to spend it better. Do we have enough time? We won't know unless we prepare to act when the opportunity arises. Or when crises compel.

**Political support**

A number of large accidents and mostly well-intentioned but unpredictably unfortunate choices had combined to shape U.S. health care in 2025. That care was widely believed to be ineffective, unaffordable, unsustainable, and unequal.[836] It was anarchic, unaccountable to anyone for anything, and prone to gross inefficiency and substantial theft.

But it was also well-entrenched and very hard to change. It had support from many of those patients able to afford and obtain good care, from many doctors and other caregivers, from insurance companies, and from those suspicious of reforms who could not see a path forward to anything better.

Its critics were mainly those who could not afford care or sought reform in coverage, cost, caregiver availability, and equity that other rich democracies had achieved in recent decades.

In 2025, roads to health care reform seemed blocked. Political progress was difficult. Congress was not willing to vote for changes that lacked strong backing. No useful reforms had that strong backing. Few state governments were competent to put their arms around health care problems or devise and implement remedies. The very notion of relying on politics to substitute for markets to fix health care was rejected by many Americans and their representatives. Support for covering all people, removing financial barriers to care, and containing health care costs was broad but generally shallow and disorganized.

How, then, did Americans choose to reform health care financing and delivery so thoroughly and, apparently, so successfully—at least, so far?

The military, political, and economic cataclysm of World War I swept away czars, kaisers, and sultans. It challenged established ways of thinking, acting, working, and governing.

No such single change evoked the U.S. health care reforms of the past decade.

Rather, the accumulating external and internal threats were responsible.

Cracks in the foundations, a leaking roof, broken windows, widely-disseminated lead paint, termite infestations, and a failed heating plant forced a choice between demolition/replacement of the health care edifice and its thorough rehabilitation.

Some internal threats included the human and financial dislocations that began during the Covid years from 2020 through 2023 but persisted subsequently.[837] These included burnout of many professional caregivers; resignations and retirements; staffing shortages; and revenue growth that was often insufficient to cover growth in expenses.[838]

Other internal threats included suppression of access in hopes of containing cost, the steady melt-down of primary care, the closing of needed rural and urban hospitals, the crisis of unaffordable meds, and the rapidly growing need for long-term care as the U.S. population over age 65 exceeded 20 percent by 2030.

This book posits that reform also stemmed from a series of threats from outside health care—

threats from other nations, economic challenges, social problems, and the collision between rising health care costs and an unsustainable federal deficit.

The crisis leading to reform was sparked by the political fights over the size of the federal deficit, the quarter-trillion-dollar yearly rise in health care spending that crowded out other valuable things, and Congress's decision to freeze spending on Medicare, Medicaid, and ACA subsidies.

The dried brush and logs that caught fire were inside health care itself. Hospitals, doctors, nursing homes, and other caregivers were frightened. So were their workers. Employers paying health care for one-half of Americans feared that hospitals and doctors would try to offset the federal freeze by raising prices paid by insurance companies acting for those employers. Patients were afraid they'd be blocked from obtaining needed care by higher OOPs or premiums, by loss of primary caregivers, by hospital bankruptcies and closings, and by shortages of nursing home beds.

All parties were furious about the wasted health spending that impoverished health care amidst financial plenty.

Payers, caregivers, and patients saw opportunities to do much better by squeezing out fat from existing spending and recycling it as clinical bone and muscle.

But doing that required action to cover all people solidly, contain cost by capping spending, paying caregivers in ways that oblige them—and allow us to trust them—to spend money carefully.

All this obliged abandoning reliance on competitive free markets or traditional government action, mostly reaction—both of which failed health care for decades.

It's not easy, even with hindsight, to chart the precise path taken to reform health care.

But it's certain that U.S. health care was spiraling downward both financially and clinically. Our people long deserved medical security. Our nation couldn't afford to permit health care to continue to act as The Sponge, absorbing money that is badly spent inside health care and is desperately needed for more important purposes outside health care.

And that made it essential to get ready. Ready to act to fix health care when it became politically and financially impossible to continue to paper over health care's problems.

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