

The Easiest—

Affordable High-quality Health Care for All Is the Easiest Problem to Fix in the United States

Not easy, just easier than any of the others—because we already spend enough
And also the most strategic problem because,
unless we fix health care, we won't be able to find the money to address the others

Alan Sager
Boston University School of Public Health
22 August 2026

U.S. health care is heavily addicted to more money each year to pay for business-as-usual.
When something can't continue, it stops.
Trump's 2025-2026 health spending cuts hurt many Americans.
They are the forerunners of a grave health care crisis.
In a few years—maybe 3 or 5 or 10—flows of added money will probably dry up.

Many patients will be unable to obtain needed care; many needed caregivers will go broke.
U.S. health care has no plan to cope with the crisis resulting from frozen revenue.

When U.S. health care falls into crisis, political pressure for reform will be irresistible.
But pressure for reform will be fruitless if we don't prepare now to act effectively.
“Never let a good crisis go to waste.”
Just as nations prepare for natural disasters, we must prepare to reform U.S. health care.

Because health care is so complicated, responses to crisis will fail
unless we prepare and test and coordinate a broad spectrum of reforms.
Reforms must seek ways to use today's vast—and already adequate—sums to fully protect and
serve all Americans and sustain all needed caregivers in the right places.

No rich democracy has ever covered all people solidly without containing cost—
or contained cost without covering all people solidly.
That will require blasting loose most of the clinical and administrative waste,
the high prices, and the theft that now snare up to 50 cents of each health dollar.
And turning that fat into clinical bone and muscle.
Only a crisis will permit and impel us to do this. Even then, it will be a tough, complicated job.

Reforming U.S. health care requires solidly covering all people, safely containing costs,
organizing and paying caregivers in trustworthy ways, ensuring solid primary care for each
American, sustaining the right hospitals and other caregivers where they are needed, and
addressing long-term care, mental health, pharma, and quality and appropriateness of care.

Our nation can win affordable and high-quality health care for all.
That will build confidence and liberate money to address harder problems our nation faces.

© 2026 Alan Sager
ISBN: 979-8-218-65989-9

Adhering to the principle of marginal cost pricing, there's no charge for this book.
Please feel free to share the book's URL, <https://www.healthreformprogram.info/>

I gratefully acknowledge inspiration, patience, and kindness over six decades from

Norman T. Joy
Alexander Swirsky
Stephen S. Cohen
Barney K. Schwalberg
Bernard J. Frieden
Jesselyn M. Brown

Thomas R. Willemain
Alan A. Altshuler
Robert Morris
James J. Callahan, Jr.
Sylvia Pendleton
Emily Friedman

Allan R. Meyers
Robert J. Master
Gail Douglas
Debbie Socolar
Norman A. Scotch
Robert F. Meenan

Thanks to Karen Antman, Don Giller, Josh Sager, Mitch Tyson, and Bob Zacher for comments, ideas, and challenges that greatly improved this book.

Thanks to Micah Hartman, at CMS's Office of the Actuary, for help in disentangling administrative cost data.



Josh Sager
3 May 1989 – 26 April 2025

This book is dedicated to the life and memory of our son, Josh, who died suddenly of heart failure and Ehlers-Danlos 1 week before his 36th birthday.

Josh was smart, honest, caring, insightful, compassionate, tough-minded, brave, and strong. He was dedicated to making the world kinder and safer.

This work is also dedicated to my wife, Sandy, to our son, Matt, and to the memory of Ruth and George, Ethel and Alfred, Rose and Herman, and Sylvia and Harry.

Contents

Contents	iii
Paradoxical but powerful	xi
Main points	xii
Overview	xiii
Words and acronyms	21
1. HOW THE U.S. WON HEALTH SECURITY FOR ALL– Error! Bookmark not defined.	
A NOTE FROM 2035	Error! Bookmark not defined.
A. You awaken in 2035	Error! Bookmark not defined.
1. And you are astonished	Error! Bookmark not defined.
2. The shape of reformed health care in 2035	Error! Bookmark not defined.
B. The nature and causes of the crisis outside health care..Error! Bookmark not defined.	
1. Threats to world peace persist	Error! Bookmark not defined.
2. Economic stresses grow: demands on the U.S. economy exceed its capacity Error!	Error! Bookmark not defined.
3. Social weaknesses and social splits	Error! Bookmark not defined.
4. Political incompetence and crisis	Error! Bookmark not defined.
C. Nature and causes of the crisis inside health care—delegitimization of more money	
for business-as-usual	Error! Bookmark not defined.
1. Amorphous worries	Error! Bookmark not defined.
2. A catalog of crises inside health care.....	Error! Bookmark not defined.
3. Cost crisis	Error! Bookmark not defined.
4. Access crises: Eroding coverage, suppression of care, and rising patient insecurity	
.....	Error! Bookmark not defined.
5. Caregiver crises	Error! Bookmark not defined.
D. Anticipating the health care crisis—and preparing to address it Error! Bookmark not	
defined.	
1. International, economic, social, and political background in 2025 - summary. Error!	
Bookmark not defined.	
2. Early steps—and missteps.....	Error! Bookmark not defined.
3. The crisis ignites	Error! Bookmark not defined.
4. The Red Team gets to work	Error! Bookmark not defined.
5. Overcoming opposition – real remedies that address causes of real problems. Error!	
Bookmark not defined.	
6. Relief, recovery, and reform	Error! Bookmark not defined.

2. NOT EASY—JUST EASIER THAN ANY OF THE OTHERS.....	Error! Bookmark not defined.
A. 1 – 2 – 6.....	Error! Bookmark not defined.
B. What is medical security?.....	Error! Bookmark not defined.
C. Addressing social determinants of life—what, why, when, and how?.....	Error! Bookmark not defined.
1. Why the growing interest in social determinants of life (SDLs).....	Error! Bookmark not defined.
2. Retail and wholesale SDL versions’ successes to-date and future prospects	Error! Bookmark not defined.
D. Assuring affordable medical security for all is the strategic intervention.....	Error! Bookmark not defined.
E. Triple aim or iron triangle?.....	Error! Bookmark not defined.
3. WHAT’S THE EVIDENCE THAT WE SPEND ENOUGH? UP TO ONE-HALF OF HEALTH SPENDING IS WASTED.....	Error! Bookmark not defined.
A. Changes over time.....	Error! Bookmark not defined.
B. Changes across nations, 1970 to 2020.....	Error! Bookmark not defined.
C. Waste.....	Error! Bookmark not defined.
Introduction – 2 views of waste – deep or shallow?	Error! Bookmark not defined.
Summary of different estimates and sources of waste.....	Error! Bookmark not defined.
1. Clinical waste—about \$1 trillion in 2024.....	Error! Bookmark not defined.
2. Administrative waste: Death by a thousand paper cuts – about \$750 billion in 2024	Error! Bookmark not defined.
3. High prices – some \$500 billion in waste in 2024	Error! Bookmark not defined.
4. Theft: U.S. health care has become the infirmary of kleptocracy – accounting for some \$250 billion in waste in 2024.....	Error! Bookmark not defined.
D. The 4 types of waste – Summary of causes and remedies	Error! Bookmark not defined.
4. MARKET FAILURE IS ONE SOURCE OF ANARCHY	Error! Bookmark not defined.
A. Promises of market competition—the opiate of the managers	Error! Bookmark not defined.
B. Sadly, health care thoroughly violates each of the market’s 7 requirements.....	Error! Bookmark not defined.
1. Many small buyers and sellers mean the market sets 1 price for each item	Error! Bookmark not defined.
2. No artificial (non-market) restrictions on supply, demand, or price	Error! Bookmark not defined.
3. Easy entry and exit.....	Error! Bookmark not defined.

4. Sovereign consumers have good information about price and quality	Error!
Bookmark not defined.	
5. Constant mistrust or suspicion	Error! Bookmark not defined.
6. Price tracks cost closely	Error! Bookmark not defined.
7. Sellers aim to maximize profit and profits reward efficiency and satisfaction of sovereign consumers' demands	Error! Bookmark not defined.
5. GOVERNMENT FAILURE IS THE OTHER SOURCE OF ANARCHY	Error!
Bookmark not defined.	
Introduction and overview: Governments fail to think and act strategically	Error!
Bookmark not defined.	
A. 10 examples of government failure	Error! Bookmark not defined.
1. Drugged, doped, and duped	Error! Bookmark not defined.
2. Pathetic primary care pat-a-cake policies	Error! Bookmark not defined.
3. Allowing insurance companies to hijack Medicare Advantage	Error! Bookmark not defined.
4. Relying on indiscriminate hospital closings purporting to save money	Error!
Bookmark not defined.	
5. Credulously and persistently believing that for-profit entities could rescue failing hospitals	Error! Bookmark not defined.
6. Triple botch: Weak cost controls, reliance on narrow networks, and the NSA	Error! Bookmark not defined.
7. Various regulatory failures	Error! Bookmark not defined.
8. States adopt putative caps on yearly health cost increases	Error! Bookmark not defined.
9. ACA mispricing, complexity, and bad behaviors	Error! Bookmark not defined.
10. Special financial patches	Error! Bookmark not defined.
B. Governments' five vital strategic health care jobs have been characterized by episodic dilettantism (ED)	Error! Bookmark not defined.
1. Shaping solid financial coverage that protects all citizens	Error! Bookmark not defined.
2. Containing spending on health care by capping available revenue	Error! Bookmark not defined.
3. Shaping the configuration of caregivers to support efficient delivery of needed care and to redeem the promise of financial coverage	Error! Bookmark not defined.
4. Promoting equitable delivery of effective and high-quality care	Error! Bookmark not defined.

5. Creating trustworthy, transparent, simple, and durable structures for reconciling inevitable conflicts between providing care and containing spending—and between focusing on the floor or the ceiling	Error! Bookmark not defined.
C. Causes of weak government action.....	Error! Bookmark not defined.
1. Blind faith in markets.....	Error! Bookmark not defined.
2. Weak political pressure for competent government action in health care	Error! Bookmark not defined.
3. Low governmental competence	Error! Bookmark not defined.
4. A history of poor government choices in health care ..	Error! Bookmark not defined.
5. Accidents and distractions	Error! Bookmark not defined.
<i>Accidents</i>	Error! Bookmark not defined.
D. Remedies for weak government action	Error! Bookmark not defined.
6. WHAT NEEDS TO BE DONE? AND NOT DONE?	Error! Bookmark not defined.
A look back to recapitulate	Error! Bookmark not defined.
Up from anarchy	Error! Bookmark not defined.
<i>A look ahead</i>	Error! Bookmark not defined.
What should not be done—succumbing to the subtle and silent seductions	Error! Bookmark not defined.
7. ASSURING MEDICAL SECURITY AND HEALTH CARE FOR ALL	Error! Bookmark not defined.
Summary.....	Error! Bookmark not defined.
Why cover everyone?.....	Error! Bookmark not defined.
Insurance coverage without cost control leads inexorably to care suppression.....	Error! Bookmark not defined.
Why don't we cover everyone well?	Error! Bookmark not defined.
A. People lacking good coverage face barriers to equitable care	Error! Bookmark not defined.
1. Uninsured people	Error! Bookmark not defined.
2. Under-insured people	Error! Bookmark not defined.
3. Who gets what care?	Error! Bookmark not defined.
B. How and why do other rich democracies cover all people?	Error! Bookmark not defined.
1. Different paths to covering all people	Error! Bookmark not defined.
2. Conclusions.....	Error! Bookmark not defined.
C. Causes of failure to cover everyone and ensure access...	Error! Bookmark not defined.
1. 14 Causes.....	Error! Bookmark not defined.

2. Out-of-pocket payments and moral hazard	Error! Bookmark not defined.
3. Complex, confusing, and unfair financing.....	Error! Bookmark not defined.
4. Complex subsidies for different groups of Americans	Error! Bookmark not defined.
D. Paths to health care for all	Error! Bookmark not defined.
Overview of 6 considerations	Error! Bookmark not defined.
1. Incremental improvements in financial coverage and use of care ...	Error! Bookmark not defined.
2. Single payer and all-payer paths to covering everyone equally and well	Error! Bookmark not defined.
3. Health care for all - With eyes on controlling cost, paying caregivers, configuring them well, and boosting quality and appropriateness of care	Error! Bookmark not defined.
8. CONTAIN COST.....	Error! Bookmark not defined.
A. U.S. costs are high	Error! Bookmark not defined.
B. 4 types of waste and their causes.....	Error! Bookmark not defined.
1. Clinical waste.....	Error! Bookmark not defined.
2. Administrative waste	Error! Bookmark not defined.
3. High prices.....	Error! Bookmark not defined.
4. Theft	Error! Bookmark not defined.
C. Other causes of high costs	Error! Bookmark not defined.
1. Legacy of open-ended entitlements	Error! Bookmark not defined.
2. Legacy of CR, UCR, DRGs, and RBRVS	Error! Bookmark not defined.
3. What doesn't work: Unrequited faith in capitation and managed care, regulation, competition, financial incentives and penalties, formulaic payments, prevention/population health/SDLs, symbolic government restraints	Error! Bookmark not defined.
4. Wishful thinking during cost plateaus	Error! Bookmark not defined.
5. Benefits from past cost controls have been invisible, so apparent pain exceeds apparent gain.....	Error! Bookmark not defined.
6. Politically, advocates of cost control have been swamped by its opponents.....	Error! Bookmark not defined.
7 Politicians and employers need to be seen to be trying to contain cost, so they adopt methods that lack power and won't offend caregivers or patients	Error! Bookmark not defined.
8. It has usually been possible to rely on care suppressing to hold down cost increases	Error! Bookmark not defined.
9. Fragmented care delivery and payment impairs both health security and cost control	Error! Bookmark not defined.

D. Remedies for high costs	Error! Bookmark not defined.
1. Techniques used by other rich democracies	Error! Bookmark not defined.
2. Remedies for each of the four types of waste	Error! Bookmark not defined.
3. Gimmicks	Error! Bookmark not defined.
4. Thinking bigger—sometimes productively, sometimes not	Error! Bookmark not defined.
5. Incremental but consequential reforms	Error! Bookmark not defined.
6. Might generate political support for more powerful cost controls..	Error! Bookmark not defined.
7. Containing cost with eyes on universal coverage, methods of paying caregivers, caregiver configuration, and both boosting and making more equitable the quality and appropriateness of care	Error! Bookmark not defined.
9. PAYING CAREGIVERS IN WAYS COMMENSURATE WITH CARE FOR ALL AND COST CONTROL	Error! Bookmark not defined.
Main questions	Error! Bookmark not defined.
1. How much money is to be available to pay for care in each state? ..	Error! Bookmark not defined.
2. How to pay doctors?	Error! Bookmark not defined.
3. How to pay hospitals?	Error! Bookmark not defined.
4. How to transition to reformed payment methods?	Error! Bookmark not defined.
A. Problems	Error! Bookmark not defined.
1. Legacy of problems in paying caregivers	Error! Bookmark not defined.
2. Removing profit from caregiving	Error! Bookmark not defined.
3. Stripping away unfair or badly-targeted payments	Error! Bookmark not defined.
4. Reforms must reconcile capitation of people with payments to caregivers.....	Error! Bookmark not defined.
B. Causes	Error! Bookmark not defined.
C. Remedies	Error! Bookmark not defined.
1. Reconciling pooled revenues or capitation of populations with payments to hospitals and doctors	Error! Bookmark not defined.
2. Taking special note of special goals and financial needs	Error! Bookmark not defined.
3. Trust, but verify	Error! Bookmark not defined.
4. Paying hospitals.....	Error! Bookmark not defined.
5. Paying doctors	Error! Bookmark not defined.
10. ORGANIZATION AND DELIVERY OF CARE.....	Error! Bookmark not defined.
A. Introduction	Error! Bookmark not defined.

B. Ownership—buying out for-profit caregivers and insurers	Error! Bookmark not defined.
C. Governance and leadership reforms are essential to establishing trustworthy care without competitive free markets and with only strategic government action	Error! Bookmark not defined.
1. Governance.....	Error! Bookmark not defined.
2. Leadership	Error! Bookmark not defined.
D. Organizing care to enhance coordination and continuity for patients	Error! Bookmark not defined.
1. International differences	Error! Bookmark not defined.
2. U.S. evolution.....	Error! Bookmark not defined.
Causes of weak organization.....	Error! Bookmark not defined.
Remedies	Error! Bookmark not defined.
11. WHY IS PRIMARY CARE FOR ALL AMERICANS LIKE THE WEATHER? Error!	Error! Bookmark not defined.
A. Problems	Error! Bookmark not defined.
1. Too few primary care doctors.....	Error! Bookmark not defined.
2. Primary care is valuable.....	Error! Bookmark not defined.
B. Causes.....	Error! Bookmark not defined.
C. Remedies	Error! Bookmark not defined.
1. Remedies employed in other nations.....	Error! Bookmark not defined.
2. Traditional ineffective American remedies	Error! Bookmark not defined.
3. Modern ineffective remedies	Error! Bookmark not defined.
4. Promising remedies.....	Error! Bookmark not defined.
12. THE RIGHT HOSPITALS AND ERS IN THE RIGHT PLACES Error!	Error! Bookmark not defined.
A. Hospital configuration problems	Error! Bookmark not defined.
B. Urban hospital closings – policy context – causes – and effects ...	Error! Bookmark not defined.
C. Causes of configuration problems	Error! Bookmark not defined.
D. Possible remedies.....	Error! Bookmark not defined.
1. Dysfunctional remedies	Error! Bookmark not defined.
2. Realistic and functional remedies.....	Error! Bookmark not defined.
13. SAFE, DECENT, ADEQUATE, AND AFFORDABLE LTC	Error! Bookmark not defined.
A. Introduction.....	Error! Bookmark not defined.

B. Problems.....	Error! Bookmark not defined.
1. Stresses on family.....	Error! Bookmark not defined.
C. Causes.....	Error! Bookmark not defined.
D. Possible remedies.....	Error! Bookmark not defined.
1. Reduce need for LTC.....	Error! Bookmark not defined.
2. Make more money available to pay for LTC	Error! Bookmark not defined.
3. Improve the quality of LTC	Error! Bookmark not defined.
4. Mobilizing and supporting families’ unpaid help	Error! Bookmark not defined.
14. MENTAL HEALTH – PARITY, NOT PARODY	Error! Bookmark not defined.
A. Problems	Error! Bookmark not defined.
1. Financing – low, and dropping	Error! Bookmark not defined.
2. Growing shortages in care capacity	Error! Bookmark not defined.
3. Quality, appropriateness, effectiveness, honesty, and compassion of care.....	Error! Bookmark not defined.
B. Causes	Error! Bookmark not defined.
C. Possible remedies.....	Error! Bookmark not defined.
15. GOOD AND AFFORDABLE MEDS FOR ALL—WITH STRONGER INCENTIVES TO INNOVATE	Error! Bookmark not defined.
A. Problem - Many patients don’t get the meds they need ..	Error! Bookmark not defined.
B. Causes – What are reasons many Americans don’t get needed meds?	Error! Bookmark not defined.
1. Failure to contain high prices and costs.....	Error! Bookmark not defined.
2. Failure to cover all people well	Error! Bookmark not defined.
3. Failure to address non-financial impediments to appropriate use of meds	Error! Bookmark not defined.
4. Medicare Part D – subsidizing drug makers’ high prices.....	Error! Bookmark not defined.
C. Remedies	Error! Bookmark not defined.
1. Gimmicks.....	Error! Bookmark not defined.
2. Regulate or negotiate drug prices.....	Error! Bookmark not defined.
2. Consolidate all payers and cap yearly drug spending ..	Error! Bookmark not defined.
3. Win safe, effective, and affordable meds for all—while more strongly rewarding innovation	Error! Bookmark not defined.
16. QUALITY AND APPROPRIATENESS	Error! Bookmark not defined.
A. What are the difference between micro and macro quality variations, and between quality and appropriateness of care?	Error! Bookmark not defined.

1. Micro and macro quality differences	Error! Bookmark not defined.
2. Quality versus appropriateness	Error! Bookmark not defined.
B. What causes each problem?	Error! Bookmark not defined.
1. Causes of micro differences in quality and appropriateness of care.....	Error! Bookmark not defined.
2. Causes of macro differences in quality and appropriateness of care.....	Error! Bookmark not defined.
C. Remedies	Error! Bookmark not defined.
17. GETTING REAL.....	Error! Bookmark not defined.
A. The story, recapitulated.....	Error! Bookmark not defined.
B. Other stories.....	Error! Bookmark not defined.
REFERENCES.....	Error! Bookmark not defined.

Paradoxical but powerful

Today, health reformers merely tinker because they consider serious change to be politically and financially impossible. But business-as-usual is unsustainable. A deep health care crisis is likely. That will mean an opportunity for real reform. We should prepare for that opportunity.

Cost must be contained to make coverage for all Americans affordable. But to contain cost without harming vulnerable people, we must cover everyone. No nation has ever covered everyone without containing cost—or contained cost without covering everyone. Today, small incremental reform looks like the only politically possible path. But access, cost, caregiver configuration, and quality are so interwoven that they need to be pursued in a coordinated way.

Social and behavioral forces influence our health more than does medical care. But spending lots more on social determinants of life will be impossible until health care costs are capped.

Besides, talk of spending more on social determinants of life won't cut health spending or improve coverage. It does let health care off the hook. Fixing health care can't be evaded.

We should prevent illness or injury whenever possible. But prevention inevitably fails. That's when medical care becomes valuable. But it also has a 100 percent failure rate.

So what do we hope to accomplish by spending almost one-fifth of the economy on health care? I suggest "medical security"—confidence that each of us will get effective, quick, competent, and kind care when ill or injured—without worry about the bill.

Health spending already suffices to finance medical security for all. But because ½ of the health dollar is wasted, many of us are insecure. Reform requires cutting waste, and that requires paying doctors, hospital, and other caregivers in financially neutral ways—to liberate them from worry about their own financial well-being. That strengthens their professionalism and altruism—so we can trust them to marshal our health dollars to do as much good as possible.

It is time to abandon the sterile debate between competitive free markets or detailed government regulation as remedies. No such markets do or can exist in health care. Market rhetoric is naïve, ideological or a calculated smokescreen for financial pillaging and plundering.

Governments must make big, vital decisions about full coverage, cost containment, caregiver configuration, and quality. They should not be asked to regulate details, a job they can't do well.

The care we get depends heavily on the caregivers we've got. Yet no one is yet remotely accountable for the configuration of caregivers—how many, what kinds, and in what locations—primary caregivers, hospitals and ERs, nurses, dentists, social workers, and all others. Good primary care is essential to protecting access and quality while containing cost.

Sadly, neither financially incentivizing (bribing) nor punishing caregivers can protect access, contain cost, or improve appropriateness or quality of care. Caregivers—and payers—can game incentives if they so choose. Incentives' main effect is to corrode doctors' professional ethics and hospitals' fiduciary duties. And citizens' trust in health care.

Doctors' decisions about how to diagnose and treat individual patients control spending of almost 90 percent of health care dollars. If doctors want to regain clinical independence and autonomy—liberation from prior authorization, claims denials, bosses' rules and productivity standards, and death by 1,000 paper cuts, they must embrace responsibility for spending finite—but vast—dollars carefully and in light of evidence about what care works.

Main points

1. Affordable medical security for all is the easiest problem to fix in the United States. Until we do fix it, we will be condemned as incompetent, cruel, lazy, and venal. When we do fix it, we will win a victory for competence and compassion, one that liberates hundreds of billions of dollars yearly. Victory will both inspire and enable us to tackle harder problems—like affordable housing, education and job training, national and neighborhood and personal security, safe energy, and the rest of the things you care about. Health care, itself, is strategic.
2. It's easiest, first, because we already spend enough. And, second, because ½ of health spending is wasted. Waste is why we fail to cover everyone, give much less care than the rich democracy average, at double the rich democracy cost per citizen, and die younger. It's easiest, third, because fixing it doesn't require comprehensive social/economic reform.
3. Anarchy plagues U.S. health care. It stems from failure of both a competitive free market and competent government regulation. Competition is the opiate of the managers—and of most health economists. Politicians have wasted time cleaning up the debris left by market failure. They should instead have been making the tough strategic decisions about covering all Americans, containing cost, and securing the right caregivers in the right places.
4. Our caregivers are financially addicted to higher doses of money each year. Payers flail to cut cost by suppressing access—by boosting out-of-pocket payments, denying care, incentives to under-serve, narrow networks, and administrative death by 1,000 paper cuts. Pressure to contain cost is weak partly because no one expects to benefit from it.
5. At some time—3, 5, or 10 years hence—added health care revenue will cease to flow.
6. This will happen at a time of crisis caused by some combination of recession; politically and economically incompetent responses to soaring federal interest payments; and defense spending demands to respond to Russia, China, Iran, or others.
7. People will disagree about the chance of a crisis but the harm would be enormous if one arose. Preparation now provides insurance that we'll be able to cope with crisis later. That entails developing plan to protect patients and caregivers—plans for squeezing out waste and using the savings to pay for care. Reform means putting our money in the hands of doctors and others under arrangements that allow us to trust them to care for all of us well and affordably.
8. Winning health security requires fixing health care. Social determinants powerfully affect health. Health care is so costly that finding the money and the political will to address social determinants won't be possible until we assure affordable health security for all Americans.
9. Fixing health care entails completely covering all people affordably, assuring needed caregivers adequate revenue to finance needed care, securing the right caregivers in the right places, and paying them in financially neutral ways—so we can trust them to marshal our inevitably finite resources to do as much clinical good as possible—as equitably as possible.
10. It takes a crisis to spur action but it takes time to craft effective, successful action. Health care is complicated and reform is even more so. Single payer or all-payer remedies are reform's start, not its end. Either can serve as the platform for deep reforms. All-payer coverage and cost control will do better at quickly squeezing out waste and at sustaining political support.

Overview

Health security's five elements are full financial coverage for all people, cost control, the right caregivers in the right places, equitable delivery of appropriate and high-quality care, and solid grounds for trusting caregivers to serve all of us as well as possible.

U.S. health care is the most costly, unequal, and ineffective of all the world's rich democracies.

Winning health security requires reforming health care and cutting waste. No rich democracy has covered all people without containing cost—or contained cost without covering everyone.

Winning health security requires addressing a number of elements inside health care in a coordinated way. These include financially covering all people, containing costs, reforming methods of paying doctors and hospitals that puts dollars in the hands of caregivers who are willing and able to spend them to do as much clinical good as possible, configuring caregiving to match patients' needs, and leveling up the appropriateness and quality of care.

Prevention is valuable in itself but is no substitute for reforming health care. Prevention has a 100 percent failure rate. Medical care is actually useful when we are inevitably ill or injured.

Addressing social determinants of life (SDLs) like housing, nutrition, education and job training, the environment, community and personal security, and personal behaviors would improve health and all other aspects of life.

But that would not cut health costs. Besides, big money to finance investments in SDLs is lacking. One reason is that rising health care costs sponge up rising shares of GDP.

Strategic health care reforms cut waste to finance health security for all, protect needed caregivers, and liberate dollars to address other domestic and international demands.

U.S. health care's sustainability has long been plagued by rising costs, growing administrative and clinical waste, and inattention to primary care, needed hospital services, long-term care, and mental health. Powerful groups of doctors, hospitals, other caregivers, insurance companies, and investors have fought for ever more money to finance business-as-usual.

All have resisted reform despite growing suppression of needed care, rising administrative waste and mistrust and theft, soaring costs, and provision of much care of marginal clinical value. These are all manifestations of growing anarchy in U.S. health care.

The nation's current prosperity is fragile, bought in part by high federal deficits that are unprecedented in good economic times. Trump's 2025 health care cuts are dangerous to patients and caregivers. They are forerunners of the grave crisis ahead—the storm clouds that presage the hurricane.

Those in Washington who seek to shrink deficits and to find money to address other pressing domestic and international challenges will push Congress to freeze spending on Medicare, Medicaid, and ACA subsidies. The freeze will frighten caregivers, employers, state and local governments, and citizen-patients. All will come to agree that there's no alternative to squeezing out wasted health care spending and using it to finance both health security for all

people and financial stabilization of all needed caregivers. By 2035, putting health care on a sound foundation will remind Americans we can be both competent and compassionate, building confidence in tackling the harder jobs before us.

Part I – Chapters 1-5

Chapter 1, purportedly written in 2035, describes why and how the U.S. chose to cover all people, cap spending and costs, and paid caregivers in ways commensurate with affordable care for all. Deciding to plan in detail to respond to a financing crisis proved essential. That planning effort swept aside years of ineffective proposals for incremental reforms, proposals whose designers had been constricted by their perception of what was politically feasible.

Crises in the larger economy, polity, and society—combined with crises inside health care itself badly disrupted U.S. health care. These crises made business-as-usual in U.S. health care clinically and financially unsustainable.

It was recognized that failure to prepare for health care's meltdown would be a tragedy. First, because of the harm to humans' health and security. Second, because of the disruption and bankruptcy of many needed caregivers. And third, because both harms were seen to be preventable.

It finally became clear that the \$6 trillion in U.S. health care spending in 2026—6 times defense spending—sufficed to pay for the care that works for all the people who need it. It became clear that one-half of that money was wasted on ineffective or low-value care, administrative folly stemming from mistrust and complexity, high prices, and outright theft.

Only a crisis could generate the political and financial power to blast loose most of the wasted money. And failure to prepare would let the crisis go to waste. A Red Team was formed to develop and coordinate three levels of responses to health care's meltdown--relief, recovery, and reform.

The Red Team's planning work was viewed as buying low-cost insurance against that risk that a crisis would arise but find us unprepared. It's hard to think clearly in the middle of an earthquake or hurricane.

Until the crisis hit, reformers who sought more accessible, affordable, equitable, and appropriate U.S. health care were forced to work around the edges. They tried, variously, to address the shortage of primary caregivers, high medical debt, high-priced drugs, failures of mental health parity, and unavailable and unaffordable long-term care. They tried to rein in costs by "bending the cost curve."

Those reformers proved remarkably ineffective. Mostly not their fault. Power and money were arrayed against them. But partly their fault. Embracing improved insurance coverage and subsidies, financed by higher spending on health care—while suppressing use of that coverage through high out-of-pocket payments, prior authorization, and narrow networks—meant failure to build political capital to cover all Americans. Embracing modest and badly designed cost controls like "value-based payments" to caregivers failed to slow cost increases. Those controls were stripped of effective political support because no one visibly benefited from them. Improved coverage—like hearing aids for elders or dental care for people of working age—were never linked to the success of cost controls.

For decades, most health care policy research and reform proposals had come to radically predictable conclusions. No one was surprised by the findings of a health research study. Or by a reform that actually worked and could be scaled up.

Crisis was predicted to open the political and financial and professional windows to real reform. Think March 1933.

But opportunity could not be enough. It would be essential to prepare to seize it—as Roosevelt mainly was not—which is why unemployment remained high until 1940.

Preparation entailed developing detailed, credible, and tested plans to address the myriad and interlocking problems and harms a health care meltdown would entail. U.S. health care is too complicated to talk about “Medicare for All.” And reforming health care coverage, revenue-raising, caregiver-paying, caregiver configuration, and actual organization and delivery of care amidst crisis was doubly complicated. Particularly because the reforms had to be financed by squeezing out clinical and administrative waste, high prices, and theft.

U.S. health care suffered a century of clinical and financial anarchy. That resulted from two things. One was absence of a functioning competitive free market (none of a market’s 7 requirements are or can be satisfied in health care). And the other was absence of competent, strategic, coordinated, and sustained government action. Reforming health care during crisis required acknowledging and overcoming these two sources of anarchy. Competition can have at most a minor and symbolic role in health care. Strategic government action would be essential.

The Red Team was charged with planning and testing ways to financially cover all Americans well, to redeem their plastic insurance cards by assuring that competent and nearby caregivers are available and willing to serve them, and to liberate and motivate and oblige caregivers to spend our vast but inevitably finite dollars as carefully as possible.

Returning to 2025, **chapter 2** offers evidence and argument that affordable and high-quality medical security for all is the easiest problem to fix. Improving prevention and public health and addressing social determinants of life complement—but do not substitute for—medical care. Prevention has a failure rate of exactly 100 percent. And it does not cut health care spending.

As discussed in chapters 5, 7, 8, 9, 11, and 12, indirect attacks on the problems of cost, access, caregiver configuration, and quality rarely succeeded. Often, they were not intended to succeed—but rather to posture to placate aggrieved, noisy, but politically weak people.

Finding hundreds of billions of dollars to finance wholesale action on social determinants is a fantasy—for now. Worse, that fantasy lets health care itself off the hook. It reduces pressure to fix health care. Fixing health care will liberate vast sums to address social determinants.

Chapter 3 offers complementary evidence that we spend enough on health care. It asserts that clinical waste, administrative waste, excess prices, and theft consume up to one-half of U.S. health spending.

Honest errors, greed, political barriers, and technical difficulties explain some of the persistence of waste. But most waste survives because it is deeply and intimately integrated with how our

nation raises money to pay for health care, how we strive but fail to contain cost, how we cover people, how we pay caregivers, and how we organize and deliver health care.

Waste is often the hardest cost to cut. Three examples: Conducting prior authorization is expensive. PA infuriates caregivers and delays needed care but eliminating it is imagined to boost costs. If hospitals and doctors ceased to give useless or low-value or unwanted care, their own financial problems would grow. PBMs are increasingly judged to be either financially corrupt or untrustworthy. They are almost invisible outside the U.S. But extruding them from the nation's health care seems politically, organizationally, and clinically impossible.

Most waste survives owing to the anarchy that pervades U.S. health care—anarchy resulting from the comprehensive failures of competitive free markets and competent government action.

Crisis might provide strong political pressure and will to act to squeeze out waste. But because U.S. health care is so complicated, reforms must be even more complicated. They have to start by deeply understanding where we are, and set clear objectives.

Even if a crisis generated pressure for deep and broad reform, it would still be necessary to design, test, and prepare to implement those reforms. These jobs have not yet even begun.

Reform requires coordinating five things: protecting all people financially, containing cost, paying caregivers in trustworthy and financially neutral ways that are commensurate with coverage and cost control, better configuring doctors, hospitals, and other caregivers in proportion to citizens' need for health care; and raising health care's floor—the levels of appropriateness and quality below which we let no one fall.

Chapter 4 argues that financial and clinical anarchy beset U.S. health care owing to failures of competitive free markets and of competent government action. None of the 7 requirements for such markets are met in health care—or can be. So efforts designed to shoehorn health realities to fit free market theories—like boosting out-of-pocket payments, posting information about various prices, or anti-trust litigation—have not worked and can't be expected to work. Advocating markets has the effect of justifying financial incentives, greed, and profits—not one of which is legitimate or functional in health care.

Chapter 5 describes how market failures evoke regulatory responses. It explains why these are rarely competent or effective. U.S. governments generally ignore making the big, strategic health care decisions well—decisions about coverage, cost control, caregiver payments, and configuration, or quality of care. Failure to make the big decisions well, combined with the many abuses that stem from dysfunctional markets, obliges government to try to craft complicated—and generally unworkable and unenforceable regulations. Public regulatory activity in health care mostly amounts to a game of whac-a-mole that the moles and their lawyers regularly win—and that undermines confidence in public action.

The alternatives to failed markets and failed regulatory micromanagement are a) to ask government to make a modest number of big decisions well and b) to find ways to put money in the hands of altruistic doctors, hospitals, and other important caregivers under conditions that allow us to trust them to spend it as effectively, efficiently, and equitably as possible.

This alternative is not naive. It is honorable and ethical—but it is also pragmatic and affordable. Both competitive free markets and detailed government regulatory micro-management have

*failed in health care. "When you have eliminated the impossible, whatever remains, however improbable, must be the truth."*¹

Transition – **Chapter 6** sums up the difficulties plaguing U.S. health care and pivots toward eight specific areas for reform. Together, the eight areas entail coverage for all people, caps on spending and costs of care, paying trustworthy caregivers in trustworthy ways, securing the right numbers and types of caregivers in the right places, streamlining organization and delivery of care, and improving appropriateness and quality. It summarizes what needs to be done and also what needs to cease.

Crafting tools to monitor implementation of the complementary reforms will be challenging. Which measures of progress are important, easy to obtain and gauge accurately, and hard to manipulate to enrich special interests or weaponize arguments against reform?

Part II – Chapters 7-10

Each chapter in this section describes an important problem, analyzes its causes, identifies possible remedies, and suggests which remedies are more likely to work, to be acceptable politically and popularly, and to mesh well with remedies to other problems.

Chapter 7 examines coverage for all Americans. Solid financial coverage is part of the foundation for health security. Cost control is essential to winning financial coverage. Paying caregivers sensibly, reorganizing care delivery, adequate primary care, and well-configured hospitals are also essential to health security.

This chapter identifies cost, political, and other barriers to assuring financial coverage for all Americans' health care costs. It points to the growing reliance on care suppression to save money and catalogs the methods of care suppression. It assesses the range of policies to overcome those barriers. It explains why solid coverage for all people is essential to controlling costs for all of us. And why cost control is essential to finding the money to cover all of us.

Key reform elements include cutting out-of-pocket burdens substantially, shifting all payers steadily toward paying the same prices for the same care, primary caregivers for all Americans, ending narrow networks of caregivers, and effective cost controls that obviate reliance on care suppression in hopes of saving money.

Either single payer or all-payer financing could serve as a solid platform for those reforms. Single payer would replace private insurance premiums and out-of-pocket payments with tax dollars. It would slash administrative waste. Unfortunately, single payer would require a very large tax increase—perhaps \$2.1 trillion per year—to replace private premiums and OOPs. Pushing that increase through would take time; that would delay reforms that squeeze out waste and recycle it. Politically, even though single payer would save money, those who'd pay higher and highly visible taxes would be angry. Those who'd benefit would be vaguely and transiently grateful. The asymmetry of pain and gain is powerful.

All-payer would channel private insurance, Medicare, Medicaid, and other organized sources of revenue into one reservoir. On the surface, the existing programs would persist, but they are their money—and their covered benefits—would gradually be blended.

Single payer can seem simpler and more attractive but all-payer reform might work better in practice. One reason is that single payer advocates would be forced to invest considerable energy, time, and political capital to pass legislation to replace some \$2.1 trillion in private insurance premiums and out-of-pocket (OOP) payments. This would have to be done before most work to reform organization and delivery of care or improve caregiver configuration could begin. A second is that all-payer reforms could probably respond quicker to the crisis in coverage and caregiver survival by carving out substantial wasted spending and using it to offer emergency coverage and revenue relief. A third is that all-payer reforms would, on the surface, offer greater continuity of coverage, which might reassure Americans during a period of crisis.

Chapter 8 discusses cost control. It analyzes reasons for decades of failure to contain cost and suggests practical steps forward. One cause was weak motivation to contain cost because no one stood to gain much and many stood to lose. Because the push to cover all people was weak, so was the push to contain cost to make coverage for all people affordable. Another cause was that great waste and high cost were deeply embedding in health care. Effective cost control becomes possible after realizing that it is essential to cope with the freeze in federal health dollars, that covering everyone was essential to containing cost, and that attacking waste could liberate very large sums to protect access and sustain needed caregivers.

Chapter 9 examines the mechanics and politics of paying doctors, hospitals, and other caregivers in ways that are compatible with medical security for all, cost control, reconfiguring caregivers, and more appropriate and higher-quality care. If payers make \$XXX available to care for a defined group of people, how does that translate into fair and acceptable payment for individual doctors, hospitals, nursing homes, dentists, and others? Since neither competitive free markets nor competent government regulation of details can function effectively in health care, self-regulation by caregivers is the only remaining option. Caregivers must be paid in ways that make them financially neutral in their clinical decisions, and that liberate them to carefully marshal huge but finite dollars to do as much good as clinically possible.

Chapter 10 takes up ways to organize and deliver care more effectively, efficiently, and equitably. Since for-profit caregiving can't be legitimate—because no competitive free market is present, since non-profits have often themselves been untrustworthy, and since no method of organizing and delivering care regulates itself—the motivation and competence of institutional trustees and CEOs are vital to shaping accessible, affordable, equitable, and effective care. How to get the right people?

How can coverage, caregiver configuration, and appropriate, high-quality care for all fit together? How can doctors, nurses, other clinicians, hospitals, nursing homes, home health care, mental health, and other components be woven together to drive health security for all people? Malconfigurations of care are, for many Americans, one of the most concrete and visible manifestations of health care anarchy. Reconfiguring care is one of the most powerful ways to demonstrate to Americans that reform is working for them.

Part 3 – chapters 11-15

These chapters examine the 5 most challenging and important aspects of health care itself: primary care, acute hospital configuration, long-term care, mental health, and pharma.

Chapter 11 focuses on primary care. Primary care is essential in itself. And it is vital to assuring access, containing cost, and winning appropriate health care for all. It has elicited many words but virtually no effective action—so far. Without primary care, patients often fail to use care well. Patients who lack a solid relation with a trusted primary care doctor are more likely to delay care-seeking. The short—and worsening—supply of primary care doctors is owing to low incomes, heavy paperwork burdens, and lack of time to build trusting relations with patients—or assure coordination and continuity of comprehensive care. Shortage of primary care means fragmented care and higher cost. Health care increasingly resembles a solar system—minus a sun to hold the planets in their orbits.

Why is that? Partly because no entity, public or private, has any accountability for identifying how many primary caregivers America needs, or for paying enough of them well enough to enter and remain in primary care. Free tuition, loan forgiveness, and similar paltry policies have failed.

What changes are needed? How to win political support for financing those reforms? Boosting primary care doctors' incomes to \$400,000 yearly plus 30 percent for fringe benefits would be a good start. So would cutting panel size to about 1,000 patients. This would cost a total of about \$175 billion yearly, or about 3 percent of health spending. Cutting pointless paperwork would be a useful complement.

Good primary care is essential to ensuring access to care, high-quality and appropriate care, and health care cost control. Persisting inertia on training and paying for primary care will paralyze reform. Because it takes so long to train doctors, continued delays in training and paying many more primary caregivers will impede reforms in access, quality, and cost. This means that primary care reform is the critical path forward. Because it will take the longest time to address, it must command large and prompt investments as soon as possible.

Chapter 12 examines the configuration of hospital care, how it can be improved—and financed. Rural hospital closings are one manifestation of anarchy in hospital configuration. Another is the high rate of closings of urban hospitals, especially mid-size non-teaching hospitals, and especially in Black neighborhoods. When hospitals close, doctors who'd relied on them often choose to retire or relocate their practices.

Hospital care has become increasingly expensive and concentrated in fewer, larger institutions.

Only one state even has a list of the hospitals and ERs needed to protect the people's health. It is the only state with the legal obligation—and analytic skills—to pay each needed hospital enough money to finance efficient delivery of needed care.

Chapter 13 sketches the deepening problems in long-term care. Causes include the high cost of LTC, which stems from the need for many hours of help daily for weeks, months, or years. It examines the aims of LTC. What do disabled people want? And how can LTC help advance safe, comfortable, and dignified care that accords with those preferences? It suggests a few practical ways to bridge the widening gap between growing need and constrained resources.

Chapter 14 seeks feasible ways to improve mental health care delivery and financing.

Chapter 15 asserts that winning affordable meds for all Americans is the easiest problem to fix inside the easiest problem of health care itself. How can we attain the two good things we need?—strong incentives to innovate coupled with low prices for meds that actually are safe

and effective. A first key step will be to integrate FDA decisions about safety and efficacy of new meds with decisions to pay for those meds using a portion of a yearly meds budget. A second will be to share costs of research fairly with other rich nations. A third will be to reward meaningful pharmaceutical innovation very generously while keeping the costs of the first pill out of the price of subsequent pills.

Part 4 – chapters 16 and 17

Chapter 16 examines sources of low and unequal quality in health care and identifies reforms that shift attention and resources to raising the floor—the worst care we allow many people to suffer—while giving somewhat less attention to the ceiling—the best care available to only a minority of people. It focuses on the strong tendency to deliver lower-quality care to the very citizens who are most vulnerable. And it also addresses the causes of more random problems of inappropriate or low-quality care. This overcomes the dominant view of quality today: “The ceiling is appealing, so ignore the floor.”

And **chapter 17** brings together the book’s main assessments, evidence, and recommendations. It then describes the main alternatives to careful and comprehensive reform, and discusses the dangers they would pose to Americans and America.

This book makes no claim to working outside the box. U.S. health care today is box-less.

The anarchy that pervades U.S. health care has steadily washed away all traces of a coherent, affordable, equitable, respectable, and accountable box. The job that faces Americans is not to think outside the box—but rather to find ways to construct a solid, functional, and durable box.

And to tell the story of how it could be built. Financially, politically, medically.

Too many of us struggle to make incremental improvements against great odds. Improvements that are, it seems, vulnerable to easy reversal when political winds shift. That’s because most past reforms rest on shallow foundations, vulnerable to flooding and rot. They were not crafted to be durably affordable, widely embraced politically, or acceptable to enough patients or caregivers or payers or voters.

With \$6 trillion spent on U.S. health care in 2026—and with up to half of it wasted—crafting durably affordable, equitable, and effective health care should be the easiest problem to solve in our nation. It is the only one on which we already spend enough money.

A crisis in health care financing, stemming from an event like a freeze in federal health dollars—will require deep and coordinated reform.

Since it’s hard to design and sew parachutes for passengers whose plane’s motor has just stopped, we should begin now to prepare. We should plan for relief, recovery, and reform.

Words and acronyms

Words

The words “consumer” and “provider” are often used in health care. That is a mistake.

Why? Because they are mechanical and not very human. And because they falsely suggest that a functioning competitive free market exists in health care—one where equally informed and powerful buyers and sellers seek the best deal for themselves.

Vaughan of Delaware’s Bayhealth wrote that some:

physicians find [provider] a very negative and derogatory term to address them. It is felt to have come from insurance companies and others who are trying to make medicine transactional, as opposed to a relationship between patients and physicians.ⁱⁱ

Krugman asked:

How did it become normal ... to refer to medical patients as “consumers”? The relationship between patient and doctor used to be considered something special, almost sacred. Now politicians and supposed reformers talk about the act of receiving care as if it were no different from a commercial transaction, like buying a car—and their only complaint is that it isn’t commercial enough.”ⁱⁱⁱ

Dinerstein wrote that:

calling the patient “consumer”. . . reduces physicians to knowledgeable salespeople, thoughtfully helping you select the proper diagnosis and treatment. More importantly, being a consumer creates an unrecognized responsibility, to have enough knowledge to clearly articulate their problems and needs. This is a difficult task for physicians with years of dedicated training; it is an impossible burden for a patient, especially when fear or anxiety accompany their concerns.

Being a patient is the ability to trust that your vulnerability will be acknowledged and respected. Being a physician is to recognize you are being entrusted with need, not desire, and to act as a servant to those needs.^{iv}

Since both “consumer” and “provider” suggest a functioning free market, it is ironic that they entered health care talk from two federal laws to finance health planning. Building on the War on Poverty’s themes of citizen participation and of maximum feasible participation of the poor in programs affecting them, the federal health planning laws of 1966 and 1974-5 demanded majorities of “consumers” on their governing boards.^{v vi} Consumers were those who did not give health care. Similarly, Medicare labeled as “providers” those caregivers eligible to be paid by the program.^{vii}

These two words should and will be avoided whenever possible. Instead, words like “patient,” “person,” “human,” or “citizen” will be used in place of “consumer.” Each is intended in its most universal sense, not in a narrow or legal sense.

Similarly, the word “caregiver” will be used in place of “provider.” The word “caregiver” is sometimes used to refer to unpaid family, friends, and neighbors who support elders, disabled Americans, or children. In this book, those kind helpers will be called “family, friends, and neighbors.”

Still, as Fein reminds us, the Newspeak was not adopted randomly:

[P]hysician-administrators speak the language that they speak because they reflect the world in which they live and the system in which they function. If society wants them to use different words, it must create conditions that encourage them to do so. This means replacing existing payment systems and funding patterns....^{viii}

In a policy paper from the American College of Physicians, Sulmasy and Carney consider use of “provider” to be a symptom of compromised ethics and weakened professionalism.^{ix} Generally, the word “caregiver” will be used in place of “provider.” Caregivers include professionals like doctors, nurses, dentists and also organizations like hospitals, ambulatory surgery centers, nursing homes, and hospices.

The words “market competition” make it hard to understand health care problems, their causes, or effective remedies. (Similarly, it is not helpful to talk about the “players” in the “health care.”)

One director of a large health policy agency used the word “market” 52 times in a 45-minute talk in January of 2023. He said things like “the market rewards X” or “punishes Y.” Life would be happier—and health care would be much more affordable and simple—if we could count on the lure of profit to spur cost-cutting innovations, overthrow health care monopolies, slash prices, and excise clinical and administrative waste. But we can’t—for the many reasons catalogued in chapter 4. So we should avoid worshipping—or even invoking—an imaginary golden calf.

Vladeck and Rice wrote that market thinking is ideological. They meant that word both in its current use as the opposite of pragmatic, and in its earlier use to describe “a system of thought or beliefs that served the interests of a particular group or class by concealing underlying power relationships.”^x

Acronyms

Health care has far too many. And they breed rapidly. New ones are manufactured by would-be reformers much faster than old ones become extinct. Some once-good acronyms have been expropriated: HSA refers today to Health Savings Accounts, no longer to regional planning bodies called Health Systems Agencies.

Fewer acronyms would signal better, simpler, cheaper, and more trustworthy health care. It is not comforting that the French make even more profligate use of acronyms.^{xi} This book will try to use the 150 or so acronyms that follow as seldom as possible.—

ACA	Affordable Care Act of 2010 (Obamacare) - Medicaid expansions, subsidized individual insurance, children <26 covered under parents’ private insurance
ACO	Accountable care organization
ADI	Area Deprivation Index – a measure of social predictors of higher health costs – a factor in calculating HEBA, the Health Equity Benchmark Adjustment

Overview

AHIP	America's Health Insurance Plans – lobbying arm of insurance companies
REACH	A type of ACO – Realizing Equity, Access, and Community Health
AHA	American Hospital Association
AHEAD	States Advancing All-payer Health Equity Approaches and Development – 2023 federal demonstration program to propagate Maryland-style all-payer and fixed budget methods of paying hospitals
AHRQ	Agency for Health Care Research and Quality (formerly NCHSR)
AI	Affordable idealism or assured integrity or accountable institutions—not artificial intelligence
ALF	Assisted living facilities – supportive housing for disabled elders who do not want or need nursing home care; usually financed privately (since Medicaid rarely pays for ALF care) so are affordable only for more affluent people
AMA	American Medical Association
AMC	Academic medical center
APC	Medicare's ambulatory payment classification – similar to inpatient DRGs, but for outpatient care at hospitals
BC	Blue Cross - original private (non-profit) hospital insurance, started by regional or state hospital associations in the 1930s
BS	Blue Shield - original doctor insurance, started by state medical societies in 1930s, usually merged with state or regional BC plans now
CAH	Critical access hospital - one of some 1,300 fairly isolated rural hospitals that are cost-reimbursed by Medicare, not paid by DRGs
CBO	Congressional Budget Office
CHIP	Children's Health Insurance Program – federally-financed and state-run program created in 1997 to cover children in families whose incomes are too high to qualify for Medicaid
CHNA	Community health needs assessment—the ACA obliged hospitals to conduct these every three years
CNA	Certified nursing assistant – they provide most care in nursing homes
CMI	Case mix index is average case weight of Medicare DRGs, a measure of both severity of illness and expected cost of care
CMMI	Center for Medicare and Medicaid Innovation
CMS	Center for Medicare and Medicaid Services (named HCFA until 2001)
COPA	Certificate of Public Advantage – states can award these to trump anti-trust laws and allow a monopoly-creating merger when believed to be desirable
CPI	Consumer price index – a measure of inflation – its medical component is almost meaningless since it measures charges, which are rarely paid – PPI is much better
CPR	Customary, prevailing, and reasonable fees paid doctors - Medicare's name for UCR (usual, customary, and reasonable) - used before 1992 switch to RBRVS
CPT	Current procedural terminology - prepared by AMA - classifications of physicians' services - usually for billing; sometimes to compare quality
CQI	Continuous quality improvement (also called TQM, total quality management) – seeks to improve systems of care, not blame individuals
CR	Cost-reimbursement - Blue Cross plans' main original method of paying hospitals, also adopted by Medicare from 1966 to 1983
CY	Calendar year
DHHS	U.S. Department of Health and Human Services

DOH	Drivers of health – a CMS approach to SDOH or SDLs that considers solely food, housing, transportation, utility bills, and personal security
DRG	Diagnosis-related group, one of 740 or so categories of discharges from hospitals that are Medicare's units of payment for inpatient care using Medicare's IPPS
DSH	Disproportionate share hospital - recipients of special, extra Medicare and Medicaid payments for serving higher shares of Medicaid, Medicare, and uninsured patients
DSO	Dental service organization – groups of dentists, often investor-backed or – controlled, that negotiate with dental insurance companies
DT	Diagnosis and Treatment – systemic evidence-based analysis of problems, their causes, and remedies that actually address causes
ED	Emergency department – fancy name for emergency room
EHI	Employer-sponsored health insurance – also EPI or ESI
EHR	Electronic health record—intended to include broader information than EMR
EMR	Electronic medical record
EMTALA	1986 Emergency Medical Treatment and Active Labor Act - requires hospitals with ER to treat and stabilize emergency patients - can still send bill
ER	Emergency room
ERISA	Employee Income Retirement Security Act of 1974 - 1 provision prohibited states from regulating health insurance plans in which the employer (not the insurance company) bore risk
EPI	Employer-provided insurance—also ESI or EHI
ESI	Employer-sponsored insurance = EPI or EHI
FAT	Proposed Food Assistance Tax on spending on meals away from home in excess of \$15 per person; revenue used to expand SNAP
FFS	Fee-for-service method of paying doctors, dentists, or other clinicians – actual fees can be set by lots of different methods
FFT	Fee-for-time – simpler method of paying doctors, especially primary care physicians (or primaries) – by hours worked
FFY	Federal fiscal year – starts 1 October – FFY 2025 contains 1 January 2025
FMAP	Federal matching assistance percentage - share of a state's Medicaid costs paid by federal government—higher for low-income states and during economic crises
FPL	Federal poverty level – set at \$30,000 for a family of 4 in 2024 – but the typical rich democracy sets its poverty level higher, at one-half median income ^{xii} – that one-half would be about \$49,250 in the U.S. in 2023, ^{xiii} or about 60 percent above “FPL”
FSA	Flexible savings account – a rigid way to set aside earned income to pay OOPs with pre-tax dollars – offers much greater benefits to those in high federal tax brackets
FTC	Federal Trade Commission - one of the two main federal anti-trust organizations
FTE	Full-time equivalent (workers) - Usually, all full-time workers + one-half of part-timers = FTEs
FYE	Fiscal year ending (on a certain day, such as 30 September for federal fiscal years)
GAO	Government Accountability Office - Congress's investigative arm –called the General Accounting Office until 2004
GBR	Global budget revenue – Maryland's name for hospitals' fixed yearly budgets—also called hard static budgets
GIM	General internal medicine
GME	Graduate medical education – usually, of doctors
GDP	Gross domestic product, value of all goods and services in a nation
GSP	Gross state product – state equivalent of GDP

Overview

HCA	Health care accountability – state that is opposite of anarchy – relevant parties are clinically or financially accountable
HCA	Hospital Corporation of America – the first and largest for-profit hospital chain
HCC	Hierarchical condition categories – used to risk-adjust capitation payments to Medicare Advantage plans – recognized as wide open to corrupt generation of massive undeserved revenues by making patients seem costlier than they really are
HCFA	Health Care Financing Administration (renamed CMS in 2001 = federal Medicare + Medicaid agency)
HCFA	Health Care for All = name for Massachusetts and national reform groups; earlier, used by Herb Dennenberg, late Pennsylvania insurance commissioner ^{xiv}
HDHP	High-destructible health plan – which people must choose if they wish to contribute money to an HSA (health savings account)
HEBA	Health Equity Benchmark Adjustment (when capitating REACH ACOs serving people whose care is predictably more costly for either medical or social reasons)
HHS	U.S. Department of Health and Human Services (also DHHS)
HMO	Health maintenance organization, responsible for serving finite population with fixed dollars – one type is PGP (pre-paid group practice with salaried docs – Kaiser is prominent example); other type is IPA (independent practice or professional association with FFS-paid docs)
HPSA	Health professionals shortage area (federal standard is <1 PC per 3,500 people)
HRRP	Medicare's Hospital Readmissions Reduction Program
HRSA	U.S. Health Resources and Services Administration – part of DHHS
HRSN	Health-related social needs = social determinants of health = social determinants of life
HSA	Health systems agency - federally-financed regional health planning agencies of 1970s
HSA	Health savings account - place to invest before-tax \$s - which could be used to pay OOPs, coupled with high-OOP high-destructible health plan – particularly benefits higher-income Americans
HSCRC	Health Services Cost Review Commission – Maryland hospital payment regulatory authority, learning on the job since 1971
HTA	Health technology assessment
HUD	U.S. Department of Housing and Urban Development
ICD	International classification of diseases, published by WHO
IHS	Indian Health Service –federal agency to provide health services to first Americans – quality problems arise – owing partly to under-financing, caregiver shortages
IPA	Independent practice (or professional) association - FFS-type HMO with independent doctors paid FFS and static budget
IPPS	Medicare's prospective payment system for hospital inpatient care – payment by DRGs
IRA	Inflation Reduction Act of 2022 – empowered Medicare to negotiate prices of 10 meds in first year, and more subsequently; boosted federal subsidies for insurance purchase through ACA marketplace plans, thereby lowering families' premiums
IRMAA	Medicare Part B and D Income Related Monthly Adjustment Amount – can be viewed either as a take-back of federal subsidies to Part B and D premiums for higher-income recipients, or as a steep tax on higher-income recipients
LIS	Federal Low-income supplement to help citizens afford Medicare Part D drug plan premiums

Overview

LTC	Long-term care - needed for months or years, not short-term rehab or recuperation
MA	Medicare Advantage - capitated part of Medicare featuring competing managed care plans – designed to save money but failed to do so owing to insurer gaming of capitation payments by making enrollees look sicker than they actually are
MACPAC	Medicaid and CHIP Payment Access Commission – advises Congress on Medicaid and CHIP access, payment rates, and methods of payment
MAT	Medically assisted treatment (for substance abuse)
MACRA	Medicare Access and CHIP Reauthorization Act of 2015 – codified notional incentive payments to doctors – refer to MIPS
MCO	Managed care organization – umbrella term for HMOs, PPOs, ACOs, and other O-methods of capitating payments to care for groups of people
MedPAC	Medicare Payment Advisory Commission – independent group advising Congress on Medicare payment rates and methods
MEI	Medicare economic index – aims to track changes in physicians’ cost of practice
MIPS	Merit-based Incentive Payment System - Medicare pays doctors more money if they use EHR, adhere to quality measures, and contain cost – imagined to mean “pay for value”
MLR	Medical loss ratio – insurance business term for percentage of insurance premiums going to pay for actual health care; also called “care share;” the ACA set a minimum care share of 85% of premiums for groups of more than 100 employees
MPFS	Medicare physician fee schedule (using RBRVS – resource-based relative value scale)
MPT	Medical Properties Trust
MSSP	Medicare shared savings program (using ACOs)
NCHSR	National Center for Health Services Research – Congress cut funding cut and almost eliminated it after its analyses angered small group of doctors (see also OTA) – now reconstituted as AHRQ
NHE	National health expenditures – all money spent on U.S. health care yearly, some \$4.7 trillion in 2023
NHS	U.K.’s National Health Service
NP	Nurse practitioner
NSA	No Surprises Act of 2020 – made progress addressing surprise bills
OACT	Office of the Actuary of CMS – which measures federal and state health care cost
OASI	Old Age and Survivors Insurance – Social Security
OASDI	Old Age, Survivors, and Disability Insurance – Disability was added in 1972
OECD	Organization for Economic Cooperation and Development – the club of (mainly) rich democracies (38 in 2023)
OIG	Office of Inspector General - investigates fraud, other bad behavior; each federal department has one
OON	Out-of-network = care obtained outside a network established by an insurance company’s PPO (preferred provider organization) or other narrow network
OOP	Out-of-pocket payments = deductible, co-insurance, or co-payment, up to yearly OOP maximum
OTA	Congressional Office of Technology Assessment – defunded and closed owing to pressure from a small group of doctors who felt financially threatened by its analyses
P4P	Pay for performance—ostensibly different from paying by the unit of care
P4V	Pay for value (not volume) – used interchangeably with P4P

PA	Physician assistant
PAAM	Profit, administration, advertising, and marketing
Part A	Medicare social insurance for inpatient hospital care and a little SNF (skilled nursing facility) care, financed by 2.9 percent payroll tax on all earned income
Part B	Medicare insurance for doctor care, hospital outpatient care, and certain drugs, one-quarter financed by premiums and three-quarters by federal general revenues
Part C	Medicare Advantage plans = private, capitated plans that enrolled one-half of Medicare patients by the fall of 2023
Part D	Medicare's main prescription drug benefit, financed one-quarter by premiums and three-quarters by federal general revenues; delivered through private insurers
PBM	Pharmacy benefits manager – hoped by some to squeeze drug makers to obtain lower prices for employers, workers – not found in other nations – have sometimes betrayed fiduciary duty to clients
PBP	Population-based payment (such as capitation)
PBS	Policy by spasm – whimsical adoption of policies—often absent evidence that they work—that don't address causes of problems—often in reaction to failed policies
PC	Primary caregiver (pediatrician, family practitioner, general internal medicine internist, sometimes OB or NP or PA)
P-D	Patient-days (average daily census * number of days in year or other period)
PGY	Post-graduate year(s) after medical school (PGY1 = former rotating internship)
PHCE	Personal health care expenditures, the 85% of NHE that pays for care for individuals; it includes <i>caregivers'</i> administrative costs (PHCE excludes the 15 percent of NHE going to research, <i>payers'</i> administrative costs, construction, equipment, and insurance company profits)
PHI	Private health insurance – an umbrella term for employer-sponsored insurance, individually-bought private insurance, and sometimes the ACA's subsidized individual insurance bought via ACA marketplaces
MM	Member-months – a handy denominator that combines full- and part-year member of a managed care or other organization – distinct from M&Ms
PMPM	Per member per month – often used to denote monthly capitation rates that a payer gives to a managed care operation, which is then responsible for delivering needed care to those members; could also refer to rates of use of x type of care PMPM
PMPU	Per member per utilizer – rates of use of y type of care by those who actually use it during a certain period
PPGP	Pre-paid group practice - Kaiser-type capitated HMO responsible for total static budget, with salaries for doctors and budgets for hospitals owned by the PPGP
PPI	Producer price index - hospital and doctor indices used to calculate inflation-adjusted constant dollars; the PPI measures prices actually paid, unlike the medical care component of the consumer price index (CPI), which measures charges and is meaningless because hardly anyone pays caregivers' charges
PPO	Preferred provider organization - with lower OOPs if patient uses preferred doctors/hospitals – these narrow networks do little to contain cost but can impair access to care
PPS	Medicare's prospective payment system (also called IPPS for inpatient hospital care) adopted in 1983
RBRVS	258 Resource-based relative value scale - how Medicare pays doctors' fees - adopted in 1992 – intended partly to narrow gap between incomes of doctors who think and those who perform procedures - imagined by its developers to measure actual cost

Overview

	of care and price that would be paid in a competitive free market – it's another formula-based payment
RCM	Revenue cycle management - extracting payments from patients or from third party payers
REACH	Realizing Equity, Access, and Community Health – an ACO option starting in 2023
RU	Revenue per unit of care (actual sum paid for care)
RUC	AMA's relative value update committee, dominated by specialists, that recommends price adjustments – those are subject to RBRVS's zero-sum requirement
RVU	Relative value unit = a measure of time, skill, and effort required to deliver a particular professional treatment (usually by a physician)
SAMHSA	Substance Abuse and Mental Health Services Administration, part of U.S. DHHS
SDL	Social determinants of life
SDOH	Social drivers (or determinants) of health
SGR	Medicare's sustainable growth rate, a method formerly employed to limit rise in total Medicare payments to doctors in proportion to economic growth
SNAP	Federal Supplemental Nutrition Assistance Program, formerly called "food stamps"
SNF	Skilled nursing facilities - nursing homes that Medicare and Medicaid will pay for
SNP	Special needs plan in Medicare Advantage, mainly for dual eligibles (D-SNP)
SSDI	Social Security Disability Income – recipients become eligible for Medicare after 2 years
SSI	Supplementary Security Income
SUD	Substance use disorder – abuse of or addiction to alcohol, nicotine, or other chemicals
USC	Usual source of (primary) care – an individual caregiver or an organization
TM	Traditional Medicare – not Medicare Advantage
USC	Usual source of (primary) care
VHA	Veterans' Health Administration - delivers acute, ambulatory, mental health, and LTC to U.S. veterans
WHO	World Health Organization

MACPAC has an extensive list of acronyms here, <https://www.macpac.gov/reference-materials/reference-guide-to-federal-medicare-statute-and-regulations/macpac-acronyms-list/>.

References

-
- ⁱ Arthur Conan Doyle, *The Sign of the Four*, Racine, Wisconsin: Whitman, 1922, https://www.google.com/books/edition/The_Sign_of_the_Four/peM_AQAAMAAJ.
- ⁱⁱ Cited in Andis Robeznieks, “This Health System Says Calling Physicians ‘Providers’ Is Not OK,” *AMA Practice Management*, 22 August 2023, <https://www.ama-assn.org/practice-management/physician-health/health-system-says-calling-physicians-providers-not-ok>.
- ⁱⁱⁱ Paul Krugman, “Patients Are Not Consumers,” *New York Times*, 21 April 2011, <https://www.nytimes.com/2011/04/22/opinion/22krugman.html>.
- ^{iv} Chuck Dinerstein, “All I Want for Christmas Is to Be a Physician, Not a Provider,” *American Council on Science and Health*, 18 December 2017, <https://www.acsh.org/news/2017/12/18/all-i-want-christmas-be-physician-not-provider-12299>.
- ^v “Comprehensive Health Planning and Public Health Services Amendments of 1966,” P.L. 89-749, Section 314(a)(2)(B), 58 Stat. 693, 42 U.S.C. 246, 3 Nov. 1966.
- ^{vi} “National Health Planning and Resources Development Act of 1974, P.L. 93-641, Section 1512(b)(3)(C)(i), 88 Stat. 2234, 42 U.S.C. 300k, 4 January 1975.
- ^{vii} Andis Robeznieks, “This Health System Says Calling Physicians ‘Providers’ Is Not OK,” *AMA Practice Management*, 22 August 2023, <https://www.ama-assn.org/practice-management/physician-health/health-system-says-calling-physicians-providers-not-ok>.
- ^{viii} Rashi Fein, “What Is Wrong with the Language of Medicine?” *New England Journal of Medicine*, Vol. 306, No. 14 (8 April 1982), pp. 863-864, <https://www.nejm.org/doi/full/10.1056/NEJM198204083061409>.
- ^{ix} Lois Snyder Sulmasy and Jan K. Carney, “Physicians Are Not Providers: The Ethical Significance of Names in Health Care: A Policy Paper from the American College of Physicians,” *Annals of Internal Medicine*, published online 10 February 2026, <https://www.acpjournals.org/doi/10.7326/ANNALS-25-03852>.
- ^x Bruce C. Vladeck and Thomas Rice, “Market Failure and the Failure of Discourse: Facing up to the Power of Sellers,” *Health Affairs*, Vol. 28, No. 5 (September/October 2009), pp. 1305-1315, <https://www.healthaffairs.org/doi/10.1377/hlthaff.28.5.1305>.
- ^{xi} Matthew Dalton, “France Has Met the Enemy and They Are ACRONYMS,” *Wall Street Journal*, 24 October 2024, <https://www.wsj.com/lifestyle/france-acronyms-french-language-bureaucracy-d906d40f>.
- ^{xii} OECD Data, “Poverty Rate,” 2023, <https://data.oecd.org/inequality/poverty-rate.htm>, accessed 14 December 2023.
- ^{xiii} Administration for Families and Children, Department of Health and Human Services, “State Median Income by Household Size for FY2023,” for Low Income Energy Assistance Program (LIHEAP), https://www.acf.hhs.gov/sites/default/files/documents/ocs/COMM_LIHEAP_Att1SMITable_FY2023.pdf, accessed 14 December 2023.
- ^{xiv} Herbert S. Denenberg, “Health Care for All,” *The Progressive*, 10 July 2007, <https://progressive.org/magazine/health-care/>.