5. GOVERNMENT FAILURE IS THE OTHER SOURCE OF ANARCHY

Introduction and overview: Governments fail to think and act strategically

Failure of market competition in health U.S. health care has meant high costs, very uneven access, malconfigured caregivers, and weak appropriateness and quality of care. The first main response to market failure has been private and government efforts to try to shoehorn health care realities to fit the requirements of competitive free markets. At best, those efforts have failed; at worst, they have exacerbated problems caused by market failure.

The second main response has been to try ameliorate those problems through various federal and state government actions. Most have been reactive, not strategic. Very few have adequately offset or clean up the harms caused by market failure. Exhibit 5 – 1 is a metaphor for governments' usual role in health care.

Exhibit 5 – 1

Government Is often Obliged to Clean up after Market Failure

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5. Government failure is the other source of anarchy

Most parties involved in health care see competitive free markets as primary and government action as secondary.

Unsurprisingly, then, most government efforts in health care are reactive.

Attempting to respond to abuses stemming from market failure fills the bandwidths of federal and state governments. And those bandwidths have been pre-emptively narrowed by politicians' trust in health care competition, by caregivers' and insurers' distaste for government action, and by weak political pressure on government to make strategic decisions in health care.

In light of primary care shortages, high drug prices, weak finances of many hospitals, and other problems, Rhode Island's attorney-general said "'We have come to the conclusion that the way we're doing health care isn't strategic—that that element of thinking doesn't exist in Rhode Island.'" [2171]

Governments could act effectively to protect access for all, contain cost, promote optimal caregiver configuration, and boost appropriateness and quality of care. In various ways—and to varying degrees of success, they do so in most other rich democracies. So why do they fail to act competently to improve U.S. health care?

When governments do attempt to be active and innovative, their efforts are typically hamstrung by lack of deep understanding of causes of U.S. health care problems and by weak knowledge of what's been tried and found to work in other rich democracies.

Attempted reforms are constrained by transient or weak political support and by the need to fit those reforms inside narrow gorges of opportunity, hemmed in by high rock cliffs of unchanged financial and care delivery arrangements. Few reforms even attempt to squeeze out any of the vast waste in U.S. health care and recycle it productively.

Most government actions—both reactive and active—merit the label of "policy by spasm." Reactions are usually quickly-designed responses to well-publicized abuses or harms stemming from market failures.

Active initiatives are usually small demonstration programs that are rarely financed adequately or run long enough to yield positive results or valuable experience. Most of the larger initiatives are driven more by ideology than evidence. Multiple scattershot variations on demonstration programs like ACOs and other value-based payment efforts make it hard to learn what actually works.

This chapter begins by describing 9 case examples of government failures. These are

- ✓ Failure to make meds affordable for all Americans
- ✓ Failure to take effective steps to ensure primary care for all
- ✓ Failing to anticipate that insurance companies would game and hijack Medicare Advantage, and refusal to claw back their undeserved revenue
- ✓ Relying on indiscriminate and dangerous hospital closings to save money
- ✓ Credulously and persistently believing that for-profit entities could rescue failing hospitals
- ✓ Allowing insurers to create narrow networks of doctors and hospitals—with promises they'll contain cost—and then responding ineffectively to the surprise bills that follow
- ✓ 9 states' adoption of putative caps on yearly health cost increases—a politically attractive policy that hasn't worked

- ✓ Mispricing of ACA insurance policies
- ✓ Offering special financial band-aids for caregivers or patients

The chapter's second section then sketches 5 sets of strategic decisions that governments need to make to craft a structure for health care to substitute for failed competitive free markets. These 5 are:

- ✓ Shaping solid financial coverage that protects all citizens
- ✓ Containing spending on health care by capping available revenue
- ✓ Shaping the configuration of caregivers to support efficient delivery of needed care and to redeem the promise of financial coverage
- ✓ Promoting equitable delivery of effective and high-quality medical care
- ✓ 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

Making these 5 big, strategic decisions well is essential to forestall demands that government make lots of small decisions. That would inevitably be done badly.

The chapter's third section analyzes the causes of governments' failure to-date to make sound strategic decisions. Some of the causes are broad and wide-ranging; they help explain failure to make many of the strategic decisions and their effects are felt throughout U.S. health care.

But other causes act narrowly by undermining competent public action to make one of the 5 strategic decisions. Specific causes will be discussed mainly in the individual chapters in the second part of this book. So, for example, causes of failures to assure financial coverage and access to care are taken up in chapter 7; causes of failures to contain cost are analyzed in chapter 8; and causes of failures to configure primary care or hospital capacity are explored in chapters 11 and 12.

The main clusters of broad and general causes are:

- ✓ Deference to market competition; this is pushed by
  - Doctors, hospitals, drug makers, and other caregivers that hope market rhetoric will help them to gain power over payers and higher revenues from them
  - Employers who believe that they and their insurance companies can contain health costs
  - Economists dominate health policy-making in Washington but their free market predilections preclude competent engagement with health care problems
  - (economitis)

- ✓ Wide and deep mistrust of governments; this is expressed through
  - Weak pressure on elected officials to take accountability for health care coverage, cost, caregiver configuration, or appropriateness/quality
  - Constitutional provisions of checks and balances designed to impede decisive and speedy legislative or executive action

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- Legal requirements to implement laws through detailed and often unenforceable regulatory micro-responses to politically-defined problems; often thousands of pages long, these frequently fail to satisfy judges (lawyeritis)

✓ Legislative and regulatory failures that further delegitimize government action—a repeating cycle of incompetence
- Weak pressure on governments to build capacity to diagnose health problems, learn their causes, understand possible remedies, and make effective decisions
- Role of economists and other advisors should be to provide technical input and evidence to elected officials, not substitute their own views about proper courses of action

✓ Failure to recognize the inter-dependence of coverage for all people, caregiver configuration, and cost control; this is explained by
- Accidents in the origins of U.S. health care
- Creating open-ended ways to pay caregivers
- Failing to pay for care in ways that obliged caregivers to consider value and cost, and to spend frugally
- Failing to cover all Americans well, opening the door to cost control via access suppression
- Preferring incremental patching that usually worsens problems
- Failing to build confidence that doctors and other caregivers can implement government's strategic decisions competently, efficiently, effectively, and honestly
- Fears that "if you break it, you own it"

✓ Distractions
- Supposing that fixing SDLs would obviate or substitute for fixing health care, thereby letting health care off the hook

The fourth and brief concluding section describes ways to enable and motivate governments to make good strategic decisions—and ways to implement these to cover all Americans financially, assuring that the right caregivers will be available to deliver actual health care to redeem the promise of financial coverage, contain cost, and improve appropriateness and quality of care.

A. 10 examples of government failure

The 10 are
✓ Failure to make meds affordable for all Americans
✓ Failure to take effective steps to ensure primary care for all
✓ Failing to anticipate that insurance companies would game and hijack Medicare Advantage, and refusal to claw back their undeserved revenue
✓ Relying on indiscriminate and dangerous hospital closings to save money
✓ Credulously and persistently believing that for-profit entities could rescue failing hospitals
✓ Allowing insurers to create narrow networks of doctors and hospitals—with promises they'll contain cost—and then responding ineffectively to the surprise bills that follow
✓ Regulatory skirmishing but spotty progress
✓ 9 states' adoption of putative caps on yearly health cost increases—a politically attractive policy that hasn't worked

- ✓ Mispricing of ACA insurance policies
- ✓ Offering special financial band-aids for caregivers or patients

1. Drugged, doped, and duped

As discussed in chapter 15, U.S. prescription drug spending quadrupled between 1994 and 2004. This led to pressure for federal action to make meds more affordable—particularly for patients on Medicare, who used lots of costly meds, on average.

Two main methods were available. One was to cut prices of meds. The other was to publicly subsidize purchase of high-priced drugs. (A third method is more complicated: It entails learning which meds are actually safe and effective, learning which patients actually benefit from which meds, and working with physicians to prescribe in line with these types of evidence.)

In France, the U.K., Germany, Canada, Australia, Norway, Israel, and other democracies, high drug spending has led to concerted national action to regulate or negotiate drug prices. It is widely appreciated elsewhere that the real value, even of safe and effective meds, is low if prices are so high that payers and patients can't afford them.

In the face of quadrupling U.S. drug spending, Congress faced pressure to act. But American politicians have been duped by drug companies' claims—and sometimes seduced by campaign contributions—to believe that only high prices and profits in the U.S. can finance worldwide research to develop breakthrough drugs. This is why Americans—4 percent of the world's people—give the world's drug makers about one-half of their world-wide revenue[2172] and an even greater share of their profits.

Congress steered wide of price regulation when it created Medicare Part D in the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA). This law passed by 1 vote in the House. It would not have passed if it regulated drug prices. (By contrast, Medicare sets prices it pays hospitals and doctors, and states set Medicaid prices for caregivers.)

Instead, the MMA subsidized individual purchase of prescription drug insurance through competing private plans. Deliberately fragmenting drug buyers allowed drug makers to continue to impose high prices.

Moreover, each Part D plan had its own premium, deductible, co-payment and co-insurance provisions, formulary, step therapy requirements, and network of participating pharmacies. This made it hard for Medicare patients to identify the plans that most affordably covered the meds they used. This was not accidental.

Confusion was intentionally designed in to the MMA. Without confusion, patients needing meds would be able to identify the Part D plan that covered their meds at the lowest premium plus OOP total cost.

Randomness is essential to allow insurers to set average premiums high enough to cover risks and garner profits. But meds are the single most predictable cost in health care. People who use lots of costly chronic-use meds in 2024 will tend to do the same in 2025. Predictability violates the randomness requirement of all insurance. When costs are predictable, people will

rationally sort themselves into the plans that give themselves the best deal—and insurers the lowest profits.

Confusion means that very few Americans enrolled in Medicare Part D drug plans are in the plan best suited to their needs.

To hold down the cost of federal subsidies, the MMA required heavy out-of-pocket payments by patients. Congress created a costly gap in coverage, misleadingly called a "donut hole." (Recall that donut holes are sweet and digestible.) The 2010 ACA included a provision to cover most drug costs in the former donut hole. But high drug OOPs persisted.

Congress therefore added a provision to the 2022 Inflation Reduction Act (IRA) to cap all Part D OOPs at $2,000 yearly starting in 2025. The cap would be adjusted for inflation subsequently. But capping OOPs meant that premiums would have to cover higher shares of drug costs. To forestall citizens' complaints about higher premiums, Congress voted to subsidize about one-sixth of the cost of premiums. But Trump in 2025 announced his intention to lower those subsidies, which will force Medicare patients to pay substantially higher premiums.[2173]

All this follows from the failure to act effectively to constrain drug makers' U.S. prices.

As also discussed in chapter 15, the 2022 did authorize Medicare to negotiate prices for 10 meds for 2026, adding 15 meds yearly. But the prices negotiated were almost three times higher than those actually prevailing, on average, in other rich democracies.

Continued failure isn't inevitable. The U.S. could choose to marshal its enormous buying power to get much lower prices for meds. And, as discussed in chapter 15, it could do so in ways that spurred innovative research. This means that Americans don't need to pay through the nose to get vital meds into our bodies.

Indeed, there's great reason for optimism about winning affordable meds for all Americans. It should be the easiest problem to fix inside U.S. health care. Why? Because most meds have high fixed costs of development, testing, and manufacturing the first pill. The incremental cost of producing the second pill is typically low. (By contrast, added surgeries, months of nursing home care, or weekly mental health visits have high incremental costs.)

Success would require accountability for setting yearly budgets for buying meds for Americans, negotiating or regulating prices, slashing OOP barriers to filling prescriptions written by doctors, and compiling evidence on which meds work for which patients.

It would also require accountability for identifying affordable and equitably shared payments for innovative meds that are actually safe, effective, and worth the money. This would entail learning savings won by some meds: A real drug to prevent Alzheimer's, for example, would slash nursing home and other LTC costs.

But continued failure is in the cards for a number of years—until a health crisis hits. Continued failure will feature politicians publicly sparring with PBMs, pressure to boost patient OOPs despite their discriminatory effects on people with lower incomes or higher need for meds, and drug makers' use of campaign contributions and fear to sustain high prices as long as possible.

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2. Pathetic primary care policies

Primary care means better care at lower cost. The shortage of primary caregiver in the U.S. does much to explain our high costs and weak and inequitable access to care. The U.S. suffers the third-lowest number of doctors per 1,000 people across the world's rich democracies. And a relatively low share of this small number of physicians work in primary care.

Hahn wrote that "Even dissemination of an overwhelming body of research highlighting the benefits of primary care in our health care system has been essentially ignored by our lawmakers for decades." [2174]

Even nominal exceptions to this observation strengthen its power.

No one is accountable for ***learning*** how many primary care doctors we require or ***acting*** effectively to train, pay, and retain them in primary care. Our nation has allowed politicians, payers, medical school deans, and others to substitute endless talk, hand-wringing, and symbolic efforts for effective action.

Even simple efforts to simply boost fees for doctors in short supply have been weak. They have been weak and indirect, means-oriented, not tightly tied to a specific goal of securing a given ratio of primary care physicians per 1,000 people.

Yu and colleagues mention, first, CMS's Primary Care Incentive Payment Program (PCIP). It boosted Medicare fees for evaluation and management visits by 10 percent between 2011 and 2015. But rises in primary care doctor supply or visits were nearly invisible. The rise in fees was too small. It applied only to Part B visits for patients in traditional Medicare. Many employed primary care doctors did not see increased incomes because the organization that employed them retained the extra payments. Also, the small extra payments lasted for too short a time to influence med students' residency choices.

The second is a 10 percent add-on for Part B visits to primary care doctors working in Health Professional Shortage Areas that has been in place for many decades. It has meant a tiny rise—perhaps 0.5 percent—in incomes. Unsurprisingly, the ratio of doctors per 1,000 residents of the HPSAs hasn't risen.[2175]

A third is building new medical schools and expanding existing ones—often with the promise of addressing primary care shortages. But results have rarely matched that promise. Growth in the number of osteopathic school grads has done somewhat more to boost primary care physician supply. But the share of all physicians—and of newly trained physicians—in primary care continues to fall.

Reasons are clear. Incomes are low. Prestige is low. Paperwork burdens are heavy. Patient panels are growing. Primary care physicians rarely admit patients to hospitals today and are increasingly segregated from other doctors.

Each of these is worth addressing. At heart, though, only 2 main methods could boost the supply of primary care doctors: compulsion and money. Compulsion means drafting doctors or

requiring them to spend a number of years in primary care before shifting to more lucrative procedure-performing specialties. Money means a serious boost in income.

Since the U.S. won't draft doctors in peacetime, money is the only remedy.

Unfortunately, no structure exists to explore, identify, or pay market-clearing incomes—that is, incomes needed to attract and sustain the right number of primary care doctors in the right places.

The financial calculation is simple. Suppose we chose to drop average primary care panel size to 1,000 patients. We'd need 340,000 PCs. Suppose we'd need to pay them an average of $400,000 yearly plus 30 percent for fringe benefits, making a total of $520,000 yearly. Total cost for PCs alone would be about $176 billion in 2025, or about 3.16 percent of national health expenditure this year of $5.6 trillion.

To this could be added cost of rent, medical assistants, liability insurance, medical records, and the like.

But from this could be subtracted the hours of unpaid, unsatisfying paperwork attending each patient's medical record and substantiating each bill. Since PCs see many patients daily, they must update many medical records, secure many prior authorizations, and complete many bills. As the old joke goes, the food's terrible but, at least, the portions are small.

But each American would have a primary care doctor who knew them, who could be reached easily by phone or e-mail, and who had time to offer first-contact care, to coordinate their care, to visit them in the hospital, and to check that meds were appropriately reconciled. Importantly, doctors would have time to investigate evidence supporting best practices in diagnosing and treating problems and coordinate patient care.

Securing enough doctors in currently under-served rural areas might require special bonus pay—or special recruitment of doctors who grew up in a certain rural area, who wanted to return to family and friends after (or during) residency, and who could enjoy a rural lifestyle.

Also, if these approaches worked, they would divert many of today's med and osteopathic grads into primary care. But that would cut the supply of grads for residency programs in oncology, cardiology, and surgery. So the number of new grads would need to be increased substantially.

Since it would take time to train many more PCs, one path forward would be to continue to rely ever more heavily on nurse practitioners to deliver primary care. A complementary path would be to allow NPs, as they gained experience and completed relevant coursework, to become licensed as primary care physicians.

Today, no one is accountable for doing any of these jobs. Indeed, the jobs don't really exist.

Why is that? Because markets fail and governments are not willing or able to step up.

That won't change as long as the nation remains uninterested in equitable and effective access to care, cost control, and boosting appropriateness and quality of care.

Come the crisis, pressure for change will follow. Will we be ready to ride that pressure in productive directions to win primary care for all?

3. Allowing insurance companies to hijack Medicare Advantage

Since the 1930s, some health care reformers have urged greater reliance on non-profit pre-paid group practices. With salaried physicians, capped budgets, and accountability for groups of people, they combined payment and care delivery responsibilities.[2176] [2177] Many believed that they would emphasize both prevention and early detection of illness, and that they would also save money.

The Medicare program proved costlier than its backers had supposed. Reformers responded by proposing that prepaid group practices and other health maintenance organizations be invited to enroll Medicare patients in hopes of containing costs and offering better integrated care.

Politicians and managed care advocates boosted Medicare Advantage plans that promised to cap previously open-ended financing and thereby cap spending. It was hoped that capping revenue would induce insurers running MA plans—and also hospitals and doctors—would rein in costly care of low value. McGuire and colleagues summarized the early steps toward MA.[2178]

Unfortunately, as noted in chapter 3, Medicare Advantage plans have for decades—persistently and increasingly—grabbed undeserved higher payments by making their members look like they should need more care than they actually do need or do obtain.[2179] [2180] [2181] [2182]

CMS modified its risk adjustment formula to try to make it more accurate, but over-payments to MA plans may have risen even higher owing to more successful gaming. Brown and colleagues found that MA over-pays for MA's healthier enrollees.[2183] Geruso and Layton found further evidence of up-coding.[2184]

Schulte and Hacker reported in 2022 that *Kaiser Health News* required three years of litigation to obtain summaries of 90 CMS audits of MA plans for 2011 through 2013. CMS had not yet sought to recoup extra payments identified in those audits, and had not even conducted any subsequent audits. They cite a former deputy director of the CMS Center for Program Integrity as saying "'I think CMS fell down on the job on this.'" [2185]

Abelson and Sanger-Katz reported that the Department of Justice considered MA fraud one of its top priorities but that CMS:

> has been less aggressive, even as the overpayments have been described in inspector general investigations, academic research, Government Accountability Office studies, MedPAC reports, and numerous news articles, over the course of four presidential administrations.[2186]

CMS has authority to cut payments to MA plans if they overbill but has never done so. Political popularity of higher MA benefits is one reason. A revolving door between regulators and insurers is another. Former CMS administrator Berwick said "'Even when they're playing the game legally, we are lining the pockets of very wealthy corporations that are not improving patient care.'" [2187] When the 2010 ACA sought to reduce over-payments somewhat, MA plans rallied their patient-members to lobby representatives and senators. The plans succeeded in neutralizing much of the attempted reduction.

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A July 2023 review of evidence by the Committee for a Responsible Federal Budget concluded that the added costs of MA could range between $810 billion and $1.6 trillion ove the next decade.[2188] The MA plans claim they are simply and legally compiling evidence on patients' medical diagnoses, information that is used to risk-adjust payments to MA plans. But when the risk-adjustments enable the MA plans to game payment formulas to harvest revenue that isn't used to cover higher actual costs of care for the identified diagnoses, the activity reeks of inappropriate payment.

Medicare's Prospective Payment Assessment Commission reported in 2024 that Medicare would pay MA plans $83 billion more than their cost in traditional Medicare. That's a 22 percent excess. And a rise of $8 billion, more than one-tenth, from the previous year.[2189]

A share of this excess is financed by higher Part B premiums paid by those who remain in traditional Medicare.[2190] That's an added layer of unfairness.

None of this should surprise us today. Study after study has found that MA does not save money. A quarter-century ago, the GAO found that MA boosted spending.[2191] The Medicare Modernization Act of 2003 responded by further hikes in payments to MA plans. Biles and colleagues reported that extra spending on MA had passed $11 billion in 2009.[2192] In 2011, McGuire and colleagues noted that the program had proven costlier than expected and called for federal action to pay MA plans in more careful ways. The HHS Office of Inspector General found in 2021 that MA plans improperly used chart reviews and health risk assessments to drive up their payments.[2193]

Manipulation of risk adjustment is not the only path to undeserved enrichment. The ACA created a quality bonus program (QBP) for MA plans. This adds payments to plans but never subtracts. In 2022, the additional payments summed to $10 billion. It is likely that Medicare got little or nothing of value for this money. A substantial majority of MA plans earn the bonuses. Skopec and Berenson conclude that two-thirds of the weighting of the bonus payments reward beneficiary satisfaction and program administration, not clinical quality.[2194]

Fully 85 percent of MA enrollees are in plans earning bonuses. Indeed, many MA plans apparently work harder to earn the stars (in Medicare's 5-star ratings of plans) than they do to improve patient care. It is remarkable that Congress has long allowed the MA bonus money to be earned and spent with so little regard for actual quality of care. And in ways that invite gaming, manipulation, or corruption.

For example, MA plans boost their star ratings by combining contracts. But this does nothing to improve patient health. A dramatic instance of this practice is Wellcare's 2016 purchase of Universal American. This "drastically improves the quality of Wellcare's Medicare Advantage plans, which ultimately means more money." Some 70 percent of Universal American's MA enrollees were in bonus-earning plans with 4 or 5 stars, while Wellcare had no such plans.[2195] Although under new management when it bought Universal American, Wellcare—as discussed elsewhere—had previously been noted for a long history of corruption that included denial of needed care, possible insider trading, and cheating investors.

Consequently, MedPAC's June 2020 report to Congress urged eliminating the QBP and replacing it with a two-sided budget-neutral program that would equalize financial penalties and financial rewards.[2196]

Despite some shake-ups in scoring, MA quality bonus payment will approach $12 billion in 2024.[2197]

Evidence is now clear that it's impossible to pay MA plans fairly—by giving them fixed sums of money in advance—without building an accurate, easy-to-administer, and difficult-to-manipulate method of adjusting for risk—for the likely average cost per patient of those enrolled in a particular MA plan.[2198]

Because no such risk-adjustment method is available, efforts to "pay for value," to incentivize caregivers to contain cost, boost quality, or to otherwise behave differently have not succeeded.

MA is a multi-decade federal failure. XX explanations are helpful.

First, among the first proponents of capitating Medicare patients were the early advocates of prepaid group practices. They'd hoped that a combination of primary care, prevention and early diagnosis, and merging a fixed budget with accountability for a group of people would result in careful spending by non-profit groups of salaried doctors.

Second, Ellwood mustered independent practice associations of doctors paid fee-for-services under the health maintenance organization tent. HMOs were to manage care. Over time, most were owned and operated for-profit. Because some early proponents retained affection for managed care, the new for-profit operators and the earlier reformers evolved toward continuing to support MA as a variety of value-based payment.

Third, successive clusters of congressional and DHHS leaders came to believe that competing MAs would save money and improve care—that they would be superior to traditional Medicare, with its old-fashioned pay-for-volume. The federal government chose to continue to believe that MA would lift the problem of soaring Medicare costs from their shoulders.

Fourth, as more and more Medicare patients were seduced to join MA plans—partly by benefits greater than available in traditional Medicare—political support for the program grew. It rose from 19 percent in 2007 to 54 percent early in 2025; CBO projects it will reach 64 percent by 2034.

Fifth, if Congress and the administration were to repudiate MA and try to dismantle it, they'd need to fight the insurance companies and patients who benefit from it. And they'd need to find an alternative. None appears to enjoy policy or political support today. Consequently, the federal government's most likely approach will be to work—or, at least, appear to work—to combat the worst MA aspects of extra payments. United Health's MA plan has been the main target in the first half of 2025.[2199] [2200] [2201]

4. Relying on indiscriminate and dangerous hospital closings that purport to save money

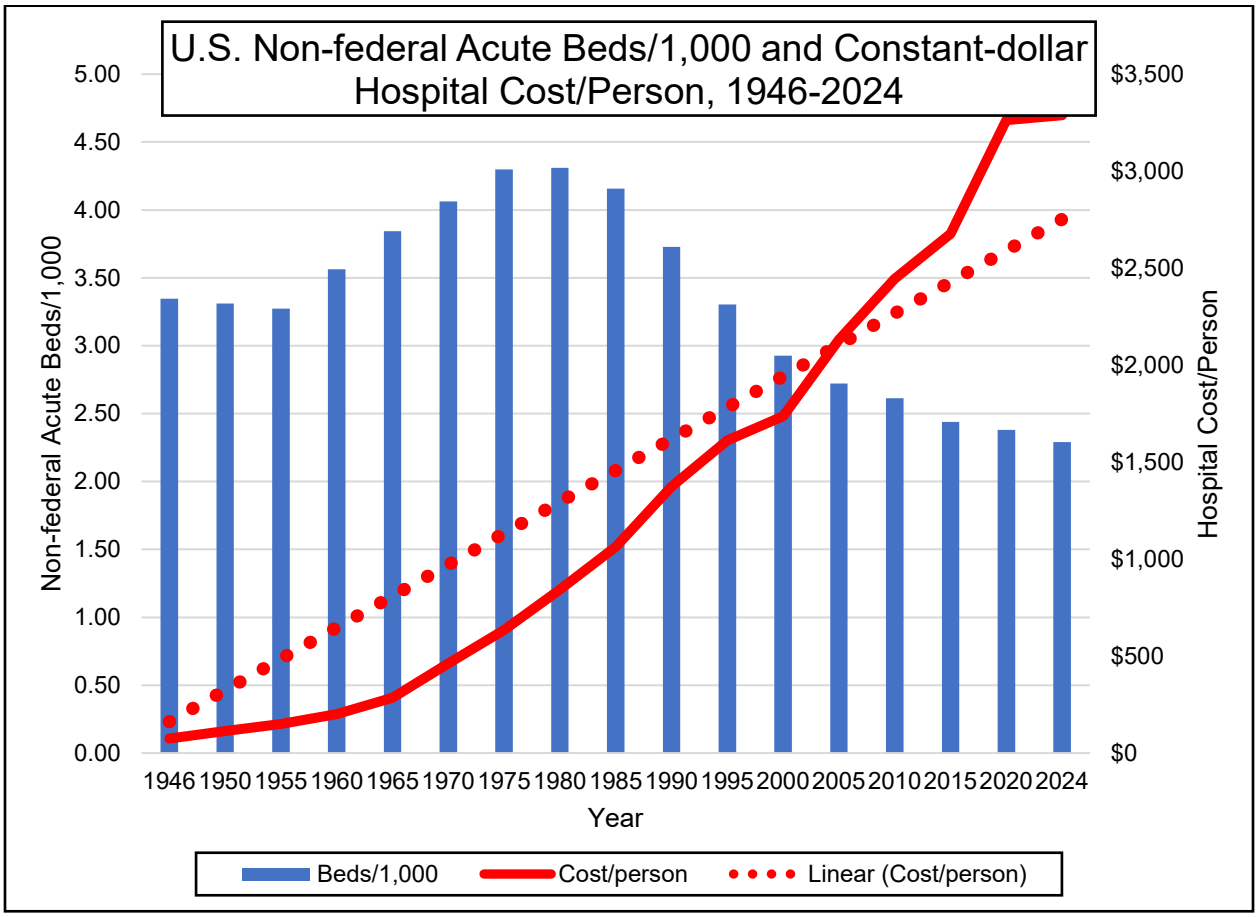
Instead of capping spending, federal and state efforts to contain costs focused tightly on cutting the supply of hospital care. Though the nature of the tie between costs and numbers of

hospitals and beds changed radically over time, the policy of closing hospitals persisted. This topic, summarized here, is discussed in detail in chapter 12.

The federal Hill-Burton statute was enacted a year after the end of the Second World War. It offered grants to cover one-third of the cost of building new hospitals in states with low bed/population ratios, and for improving, enlarging, or rehabbing existing hospitals. It aimed toward state-level targets of 4.5 acute care beds per 1,000 Americans and sought particularly to add beds in low-income Southern states. Those fearing a post-war economic slow-down owing to demobilization also intended the law in part as a pump-priming anti-recession public works program.

As shown in Exhibit 5 – 2, U.S. acute care hospital bed/population ratios indeed rose from 1946 until 1980. Hill-Burton helped to add beds, particularly in small cities of the South and West, until the mid-1970s, when it ceased to operate.

Exhibit 5 – 2



Source: Author's calculations from AHA *Guide Issue*s and *Hospital Statistics*, and from national health expenditure data from Office of the Actuary, DHHS. Constant dollars were calculated using the all-item CPI.

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In the 1970s, just as the U.S. was approaching target of 4.5 beds per 1,000 people established by the Hill-Burton law, expert and political views on hospital bed supply completely reversed direction. This happened for 5 main reasons.

First, the over-riding reason was the rise in cost of health care generally and hospital care specifically in the years after the passage of Medicare and Medicaid in 1965.

Second, was the growing worry about the soundness of the economy stemming from Viet-Nam era inflation and by the oil shocks of 1973 and 1979.

Third, some experts became concerned that adding beds would induce more use of hospital inpatient care, often unnecessarily. This worry, sometimes called "Roemer's Law," persisted even after hospital use fell.[2202] [2203] It helped to fuel or rationalize hospital closings for decades.

Fourth, hospital admissions, average length-of-stay, and occupancy rates began to fall, clearly overturning Roemer's Law. Acute hospital occupancy rates dropped from 78 percent in 1970 to 67 percent in 1990.[2204] This was owing about equally to reduced rates of discharges and reduced average length-of-stay. In the three decades from 1980 to 2009, the rate of hospital discharges from acute hospitals fell by one-third. So did average length-of-stay. Consequently, patient-days per 1,000 Americans fell by almost three-fifths.[2205] [2206]

These changes resulted from improved diagnostic technology like CTs and MRIs, improved surgical techniques like laparoscopic surgery, and improved anesthesia that permitted more same-day surgery. At the same time, financial incentives pushed HMOs and insurers to dodge paying for fixed costs of hospital care.

Fifth, growing interest in public health, prevention, and social determinants of life was associated with less interest in hospital care—or in paying for it.

Certificate of need laws, hospital rate setting, bed reductions, and health planning sought to slow health care cost increases. Rogatz and McClure were early proponents of closing entire hospitals as the best way to save money while removing notionally unneeded acute care beds.[2207] [2208] They hoped that closings would remove all costs of a hospital, both fixed and variable costs. McClure's recommendation proved durably influential.

Interestingly, McClure raised questions about this approach shortly after endorsing it. He was concerned that the hospitals most politically and financially vulnerable to closings were small and mid-size non-teaching hospitals—institutions whose cost of care was often lower.[2209] This after-thought was little-publicized and widely ignored in favor of McClure's initial report.

How to decide which hospitals to close? Some proponents of bed reductions initially employed planning to identify unneeded hospitals.[2210,2211,22122213,,2214,2215] But it generally proved more difficult to shut hospitals through careful and publicly accountable health planning than it had been to open or expand hospitals in accord with Hill-Burton plans.[2216,2217]

One reason was that some proposed closings, advocated by planners on grounds of cost or quality, appeared to disproportionately harm access to care for vulnerable urban [2218] or rural citizens.[2219] A second reason was that political power of large teaching hospitals might insulate them from planned efforts to close hospitals.[2220] A third was that that groups opposed to

closings sometimes organized effectively to influence public efforts to plan closings.[2221 ,2222, 2223,2224] (New York State has been a frequent exception; its Department of Health has been able to force closings of hospitals with major quality or physical plant problems.[2225])

Beginning in the late 1970s, most efforts[2226] to contain cost by reducing bed supply by closing entire hospitals turned away from governmental planning and toward squeezing hospitals financially.[2227] Facing a budget deficit, New York State cut Medicaid payment rates and substantial numbers of hospitals closed.

Some asserted that competition would close the right number of beds; that "the fittest survive, the weakest die"; and that "closed hospitals are those that were obsolete, unsafe, unneeded, underutilized, and/or below standard."[2228] Competition, then, would close unneeded or inefficient hospitals and survivors would be the right number and types of hospitals, in the right locations. In a state with both large budget deficits and large numbers of empty hospital beds, California opportunistically demanded that hospitals bid by price to obtain contracts to serve Medicaid patients.[2229,2230,2231,2232,2233,2234]

As discussed at some length in chapter 12, hospital closings have generally boosted cost while harming access to care. Effects on quality of care appear mixed.

One reason is that less costly hospitals were more likely to close. I've tracked some 1,200 hospitals in 52 U.S. cities from 1936 to 2020. In no decade was efficiency valuable in predicting survival.

Smaller and mid-size non-teaching hospitals were more likely to close, subtracting inpatient and emergency care from large swathes of many cities—and from rural areas. These losses made it harder for doctors in private practice to continue caregiving. Many retired or relocated after hospital closings. Loss of hospitals made it harder for affected regions to attract new physicians to replace those lost.

Hospitals in neighborhoods with high Black population shares were more likely to close decade after decade. Race was typically the second-most-powerful predictor of closings—after hospital bed size and teaching status (which were themselves closely correlated).

The belief that closing hospitals was A Good Idea that Would Save Money, combined with the belief that competition would close the right hospitals—the less efficient and less needed institutions—have helped to sustain this policy for some 5 decades.

These 2 beliefs helped state governments justify their refusals to identify hospitals needed to protect the health of citizens or act to assure that those hospitals were paid enough to finance efficient delivery of needed care.

State governments rarely responded to appeals for help when individual hospitals were threatened with closing, and when political pressure to save them temporarily crystallized. State hospital associations have rarely lobbied for state action to prop up needed hospitals.

Many federal payments to hospitals have failed to discriminate in favor of those needing higher revenue. At hospitals' behest, the section 340B drug program has been expanded to cover more and more institutions—with less and less regard to financial need for the subsidies. The program is badly targeted.

At the same time, Congress is considering ending its long-standing policy of paying 65 percent of bad debt for hospital care incurred by traditional Medicare patients for unpaid first-day deductibles for inpatient services and deductibles and co-insurance for outpatient services—as long as hospitals make reasonable efforts to collect what they're owed. The added federal payments amount to some $1.7 billion yearly. But Buxbaum and colleagues reported that smaller hospitals and those with lower margins would suffer greater harm.[2235]

5. Credulously and persistently believing that for-profit entities could rescue failing hospitals

Steward

Steward's bad behavior was sketched briefly in chapter 1. The analysis that follows focuses on Massachusetts state government's failure to act to identify and stabilize needed hospitals—and to rely instead on Steward's promises. Similar stories could be told about Prospect's pillaging of hospitals in Connecticut, Rhode Island, Pennsylvania, and other states. And about other for-profit chains' failures elsewhere.

In 2010, the Boston Archdiocese was beset by financial challenges. Donations were down and costs of obligations to compensate victims of clergy abuse were up. Education was seen by many as a greater concern than operating hospitals.

The archdiocese sought to sell its 6 Caritas Christi hospitals because most were losing money, because the hospital workers' pension fund was substantially under-financed, and because needed capital investments in buildings and equipment had been delayed.

Coakley, then Massachusetts attorney-general, permitted Cerberus Capital to buy the 6 hospitals from the archdiocese. The hospitals were renamed Steward Health Care. Cerberus retained the Caritas CEO to run them. Even though the hospitals relied heavily on lower-paying Medicare and Medicaid patients, the CEO promised to save them by boosting patient volume—and, therefore, revenue—by competing as low-cost alternatives to expensive teaching hospitals.

I asserted in 2010 that it would not be possible for Steward to make the profits demanded by private equity using ordinary methods of boosting volume and becoming more efficient.[2236]

Steward acquired a few more money-losing Massachusetts hospitals. Leveraging the newly-acquired Massachusetts hospitals, Steward subsequently bought hospitals in Texas, Florida, Arizona, Utah, Arkansas, Louisiana, Ohio, and Pennsylvania. It was hailed by some as the largest privately-owned hospital chain in the nation.

The attorney-general's office monitored some of Steward's activities for five years. State government did nothing when Steward betrayed its promise to operate one newly-bought hospital for ten years but instead closed it after 2 years. State government responded very weakly when Steward—in violation of state law—failed to submit detailed annual financial reports.

5. Government failure is the other source of anarchy

A more strategic failure was state government's indifference and inaction when Steward sold its Massachusetts hospitals' land and buildings to Medical Properties Trust. Between 2016 and 2018, MPT paid Steward $1.3 billion for the land and buildings owned by its 8 Massachusetts hospitals. Much of this money went to Cerberus. Steward leased back the land and buildings at rents that approached $400 million for 2020.

In 2020, in a complicated series of transactions, Steward came under ownership of its CEO and others. Cerberus departed, netting an added $335 million. Steward paid $111 million to its new owners.[2237] MPT sold one-half of its interest to Macquarrie, an Australian manager of pension funds for public employees.

In summary, Cerberus made money. Steward's CEO and fellow-executives made money. MPT and Macquarrie made investments that, in retrospect, seem reckless. The quality of care at Steward hospitals in Massachusetts has been questioned. The survival of many of these hospitals was uncertain for months.

In 2024, numerous press reports detailed mounting financial and clinical quality problems at Steward's Massachusetts hospitals. These were magnified by reports of Steward's closing of two hospitals in Texas, sale of five in Utah, and widespread failures to pay vendors. And by publicity about Steward's president's two yachts and two airplanes.

In May of 2024, Steward declared bankruptcy. It owed about $9 billion. Of this, $1 billion was owed to secured lenders who had received collateral, $7 billion was owed to MPT, and $1 billion was owed to various suppliers and contractors.[2238] Utah hospitals had been sold off. Two in Texas and one more in Massachusetts had been closed.

The bankruptcy filing put the fate of the surviving Massachusetts hospitals in the hands of its creditors and of a Texas federal judge who formerly worked as a lawyer for Steward. The hospitals' survival is consequential because Steward's Massachusetts hospitals held 7 percent of the state's staffed acute inpatient beds in 2022; they delivered almost one-tenth of all ER visits statewide.

But these statewide shares fail to reveal that Steward hospitals were major sources of emergency and inpatient care in substantial regions of the state—disproportionately in areas where citizens' incomes are below-average. A number of nearby hospitals, already crowded, would be inundated by patients displaced by closing of Steward facilities—or by bankruptcy-related disruptions of care at those facilities owing to loss of doctors and other clinicians, or by supply shortages.

A *Boston Globe* editorial optimistically asserted in early-May 2024 that, while Steward's bankruptcy "will disrupt Massachusetts health care…the state has tools to protect patients…."[2239]

That depends on what is meant by patient protection. The editorial credulously claimed that once patients enter individual Steward hospitals, the state's Department of Public Health has monitors who are supposed to "ensure they remain safe with adequate staffing and equipment." The state has also "activated a command center," and opened a web site and call center. (The web site provides only the most superficial and general information.)

The state's governor and attorney-general promised they would try to intervene in the bankruptcy proceedings. The AG said she'd petition the court to appoint an ombuds to advance

patients' interests in court. But these were flimsy face-saving gestures. The state could have—and did have—very little effective influence over bankruptcy proceedings.

When Steward declared bankruptcy, the state could do little more than send a lawyer to watch the bankruptcy judge referee claims of creditors against Steward. The remaining Steward hospitals were treated like chips in a poker game.

Unless state government became willing to put up cash.

The state's actions to protect individual patients who obtain care at Steward hospitals, while positive, were not enough to counter disinvestment, shortages of equipment and supplies, and departures of many workers. Perhaps more important, these were all retail steps that might help individual patients, not wholesale ones.

The state acted belatedly to identify which Steward hospitals—and which of their services—were essential to protect the health of the public. Or to intervene legally to wrest control of those hospitals from their owners and operators. Or assure that revenues at these hospitals were adequate to finance efficient delivery of needed care.

The governor was very clear about what she did not want. She did not want Steward to continue to operate in Massachusetts. And she did not want to expend state money to facilitate transitions to new owners/licensed operators, or to financially and clinically stabilize needed care. She was, unfortunately, less clear about what she did want, and about what she would do to accomplish that.

But—given the substantial rents owed MPT, the costs of needed investments in buildings and equipment, and the added costs of rebuilding professional clinical capacity and support services—it would be difficult to entice buyers without substantial rent write-downs and state subsidies. The became clear during the summer of 2024.

In mid-May 2024, Weisman and Bartlett reported a complaint by a member of the state's Public Health Council that "Nearby hospitals are finding that even as Steward's eight hospitals in the state remain open, certain lines of specialized care there are 'clearly declining'". And that "Some patients are being admitted, evaluated, and transferred out of Steward hospitals due to a lack of vital support services." But the state's public health commissioner "assured the council that state monitors are keeping watch on Steward hospitals' staffing, supplies, and patient care." [2240]

Instead of acting to shape events, the state's position was mainly passive. It appeared to be trying to stabilize patient volume, staffing, and revenue flow to Steward hospitals in hopes that new buyers/operators would acquire them. According to one report, state government discussed a state take-over of needed facilities by declaring a public health emergency. And it considered asking other multi-hospital corporations to run those Steward hospitals.[2241]

Choice of alternative operators was somewhat constrained by worries that enlarging existing hospital groups would—absent careful price regulation by the state—give those hospital groups even greater leverage to extract high prices from insurance companies. And also by fears that the costs of delivering care at the soon-to-be-former Steward hospitals would exceed available revenue. Those costs would include ordinary operating costs plus the costs of investing in recruiting professional and non-professional workers, rehabilitating and modernizing buildings, and buying equipment.

5. Government failure is the other source of anarchy

A common problem at Steward owned hospitals in various states was failure to undertake routine maintenance. One Florida hospital sold by Steward to Orlando Health had to be closed by its new owner owing to widespread mold, raw sewage leaks, and advanced deterioration.[2242]

It is no accident that the state was chronically ill-equipped to respond to Steward's financial and clinical exhaustion. Other demands on state resources are numerous. Health care is complicated. Many powerful hospitals, insurers, drug makers, and other groups oppose effective state action.

The exception has been the years of effective state government effort to expand insurance coverage. Its pioneering 2006 c. 58 statute became a model for the ACA 4 years later. This exception did not harm—and often helped—hospitals, insurers, drug makers, and others.

But state government has not been willing or able to take meaningful steps to contain health care costs, learn what care is needed in which places, or align the supply of care to meet those needs.

After buying Quincy Hospital and owning it for 2 years, and after promising to keep it open for at least a decade, Steward decided to close it. The state did nothing.

When Steward sold its Massachusetts hospitals' land and buildings to MPT in 2016-2018, the state did nothing. That year, Steward paid $790 in dividends to Cerberus Capital, which had financed the sale of the original 6 Caritas Christi hospitals to Steward in 2010—and to Steward insiders. A recent report by Steward's apparently reformed directors asserts that Steward was "likely financially insolvent" then.[2243]

When Steward failed to report corporation-level finances, as required by law, the state went to court but did not obtain the data it was owed. Some state officials blame Steward's failure to provide these data for the state's inability to intervene. But it is entirely unclear what the state would have done differently if it had gotten the data.

The former chair of the state's Health Policy Commission denied, in the words of a reporter, that the state was "asleep at the switch." Rather, "it was flying blind." The former chair said "'Once they left the state [by moving corporate headquarters to Dallas in 2018] and moved into this new world where they sold their hospitals to a real estate trust and then invested it back, and bought other hospitals all over the country, I can honestly say that we lost track of them." [2244]

Interestingly, the sale and lease-back took place during the 2 years before Steward moved its headquarters from Boston to Dallas.

While honesty is always refreshing, the underlying reality is that Massachusetts state government has for decades refused to acquire the knowledge, legal tools, or money to identify and stabilize needed but financially vulnerable hospitals. Indeed, the former Health Policy Commission chair had called only for "watchful waiting" when writing a task force report to the governor in 2002.[2245]

Continuing to decline any accountability, high officials blame Steward's past actions for problems besetting the chain's 8 Massachusetts hospitals still open early in 2024. This raises two troubling questions. First, why did the state stand by and tolerate the financial machinations, disinvestment by sale-leaseback of land and buildings, financial plundering of the

Steward hospitals, failure to obtain adequate supplies, and failure to maintain mechanical and structural systems? And second, why did the state remain so ill-equipped to anticipate problems, identify needed hospitals, and then act to conserve them?

In the end, state government arranged take-overs of 6 of the 8 Steward hospitals remaining open early in 2024. For a total payment of $343 million, the 6 were bought out of bankruptcy. Rhode Island Hospital bought St. Anne's and Morton hospitals. Boston Medical Center bought St. Elizabeth's and Good Samaritan hospitals. And Lawrence General bought hospitals in Methuen and Haverhill.

Steward hospitals required substantial financial infusions to restore them to good health. Only promises of state subsidies to the buyers made these sales possible. The cost to the state has been rumored by some to be in the high nine figures.[2246]

Two hospitals—Carney and Nashoba Valley—were closed. The state allowed this, claiming that no creditable bid was made for either hospital. But that probably reflected a state decision to force both to close. A creditable bid would certainly have been forthcoming if appropriate state financial backing had been offered. Such backing was essential to encouraging the take-overs of the other 6 former hospitals.

Nashoba's closing leaves a large gap in care northwest of Boston. Surviving hospitals and ERs are a half-hour away. Ambulance capacity is strained by long travel times. Some have asked whether the state failed to support a creditable bid for Nashoba because saving that hospital would have left the Carney, alone, to be closed.

The future of hospital inpatient care in Haverhill is also in doubt. Services are being closed. Loss of this hospital would mean that only 5 of Steward's 10 hospitals will, for now, survive.

It can be hoped that state government will perform better in the future. But there's little sign of that so far. The state's three main responses to Steward have been continued finger-pointing, promising protections against future private equity abuses in new legislation, and blaming imaginary market forces for the state's inability and unwillingness to protect 2 of the 8 Steward hospitals.[2247] That seems remarkably backward-looking—like the French Army's preparations to fight the last war.

State government may, someday, choose to plan actively to cope with the anarchy that results from profit-seeking in the absence of a functioning competitive free market. It may overcome its traditional failure to put its arms around health care and act strategically.

In the face of this publicity, the governor of Massachusetts was very clear about what she would not do. She wanted Steward to leave the state. She said no state money would relieve Steward's obligations. It was not at all clear what she would have state government do, affirmatively, to identify and safeguard Steward's hospitals and physician groups that were important to protect health security of the communities they served.

The governor is a very decent person and a very smart lawyer. Her paralysis was not personal or idiosyncratic.

Rather, it rested on at least three decades of state passivity. After briefly but not very competently copying Maryland's all-payer hospitals payment methods, and after participating

enthusiastically but ineffectively in federal health planning programs, Massachusetts lurched toward deregulation of health care. Weld, elected governor in 1990, pushed deregulation and reliance on market forces to contain costs. The Senate chair of the health care committee signaled his support for competition when he urged putting all the "scorpions" in a bottle and seeing which survived. He was referring to hospitals.

State government refused to forge any of the tools required to identify and protect needed hospitals. It has simply refused—for over a decade—to analyze the types and volumes of needed hospital services at various locations even though a 2012 state law required it to do so.[2248]

It has refused to adopt a solid hospital receivership statute, one paralleling its excellent nursing home receivership statute. The latter allows the state to petition a state court to intervene to appoint a receiver to an endangered nursing home. The receiver may petition the court to set aside debt obligations acquired improperly.

And it has refused to establish an Essential Hospitals Stabilization Fund, financed by tiny assessments on hospitals themselves, to accumulate money to protect and reform needed hospitals that get into financial trouble.

Massachusetts state possesses very limited capacity to understand health care, to protect access to care, to configure caregivers in proportion to need, to contain cost, or to protect appropriateness and quality of care. How to explain this—in the state that has been first in formally insuring a very high share of its people, and that has been first also in health care costs per person (both before and after improving insurance coverage?

One reason is ideology—the convenient preference for market remedies that relieve state government of the need to think, act, or make choices.

A second reason is lack of knowledge and understanding. Disengagement from the core realities of health care—adequate numbers of primary care doctors or mental health caregivers, decent quality of nursing home care, ER and hospital inpatient capacity, affordability of health care, the dangers of care suppression via under-insurance—have left successive governors and legislators at foundering in a sea of dollars and talk.

A third reason is weak political pressure for smarter and stronger state action. Reformers may focus excessively on formulaic policies like Medicare for all or a public option; they may not connect closely enough with day-to-day problems of unaffordable care or primary care shortages. Weak support for better state action is coupled with political opposition to it from hospitals, private insurance companies, and other groups.

Risks of crowding in ERs and acute inpatient hospital wards is likely to frighten others.

Highly visible state dithering on the sidelines of a bankruptcy proceedings, while crooked debtors and deluded creditors play poker, using Massachusetts hospitals and doctors as chips, will astonish many.

And the prospect of spending $600 to $700 million in state money to conserve and rebuild care at hospitals willfully cannibalized and run down by Steward will infuriate many more.

Is this a "pretty good" outcome? [2249]

5. Government failure is the other source of anarchy

The state appears to have artificially minimized its costs of salvaging hospitals from Steward's depredations. Bills keep rolling in. Late in July of 2025, state government agreed to pay $66 million to buy St. Elizabeth's Hospital from Apollo Capital, which had acquired it from MPT.[2250] This was almost 15 times the state's initial offer.

State government is likely to bury some of costs of reviving the 6 remaining Steward hospitals in extra Medicaid and other payments shared with the federal government or private insurers.

Re-creating a free-standing ER near the former Nashoba Hospital will not be cheap.

Moreover, when hospitals close or face crises, physicians who use the hospital may accelerate their plans to retire or may relocate their practices. Patients' care can be disrupted for short or long times. Displaced patients may be forced to seek care from physicians who admit to more costly surviving hospitals.

Massachusetts has certainly not been alone in suffering harm from Steward and in failing to protect its citizens and hospitals. Texas, Utah, Florida, and other states have also suffered and failed.
Federal action has been mainly symbolic. In March of 2024, in the face of corporate health care mergers, leveraged buy-outs, and sales/lease-back arrangements that raise prices and profits but that had identifiably harmed quality of care, Biden ordered FTC and DOJ anti-trust regulators and DHHS to investigate "private-equity profiteering" in health care.[2251] It is hard to imagine this is anything more than political posturing. Or that it will have any meaningful or durable effects on policy, finance, costs, access, or quality of health care.

Reeling from the Steward crisis, and perhaps embarrassed by its own weak and tardy responses, Massachusetts passed legislation early in 2025 that it claims would to more tightly track and regulate private equity ownership and milking of acute care hospitals.[2252] Unfortunately, the law split enforcement and other responsibilities among the state's Health Policy Commission, Department of Public Health, Center for Health Information and Analysis, and attorney-general's office.

Massachusetts thereby joined Indiana, Minnesota, New Mexico, Oregon, and California in legislating purported responses to bad behavior by private equity-controlled companies.

Surprisingly, Pennsylvania still had not done so by mid-2025 despite repeated legislative efforts stemming from Steward's attempt to hold one hospital's survival hostage to state payment increases during Covid, and—more consequentially—from Prospect's financially ruinous milking and subsequent closing of its hospitals in Delaware County.

With Prospect having declared bankruptcy, its 3 hospitals in Connecticut appear to be suffering ongoing deterioration. After Yale-New Haven withdrew its offer to buy the 3, no purchaser seems available to pay prices the chain demands for them.

Its 2 Rhode Island hospitals are also deteriorating and the only interested non-profit buyer has not run hospitals previously and, unsurprisingly, is finding it hard to sell bonds to finance its purchase of the 2. As discussed in chapter 4, Brown University Health had worked to block an earlier sale of the 2 hospitals to Mass General – Brigham, and the state's attorney-general had,

on anti-trust grounds, blocked a subsequent proposed acquisition by Brown University Health itself.

The August 2025 closing of Weiss Memorial Hospital, an important caregiver on Chicago's North Side, manifests another failure of private equity to stabilize and rebuild formerly non-profit hospitals.[2253] The Private Equity Stakeholder Project had reported in 2023 on the machinations of Pipeline Health in acting to de-stabilize needed Chicago-area hospitals.[2254]

Kannan and Song reported that after a second private equity owner bought a hospital from a first private equity owner—as happened to Weiss Memorial—operating margins fell by over 8 percentage points.[2255]

The legislation enacted by Massachusetts, Indiana, and the other 4 states purport to respond, belatedly, to private equity depredations. All are narrow in their exclusive attention to private equity. All ignore the general threat to health care stemming from profit-seeking in the absence of a competitive free market.

All these efforts stem from wishful thinking. Owners of public or non-profit hospitals that run into financial trouble and face threats of closure may wish to believe promises made by for-profit companies that offer to buy and restore them. But the new owners typically have actual agendas that differ greatly from their promises and from the hopes of the original owners and their communities.

State governments' underlying failure is refusal to identify hospitals (and ERs and maternity and psych and other services) needed both to directly protect the health of the public, and indirectly to serve as a foundation for the work of needed physicians.
Their related and perhaps least-forgivable failure is that they have been gulled or seduced into crediting the promises of for-profit purchasers of financially stressed public or non-profit hospitals. Or, even worse, that they have cynically pretended to believe those promises—because they enable state governments to pretend they do not have to act.

This cynical symphony has 4 movements.

- ✓ First, a distressed but needed hospital, its workers, patients using the hospital's services, and some politicians clamor for state intervention.
- ✓ Second, the for-profit is allowed to buy the hospital, promising to address clinical and financial problems through targeted investments and better management. State government is delighted because it is now off the hook, both financially and politically.
- ✓ Third, the for-profit avoids investing new money in the hospital, sells off all assets it can, sometimes demands state subsidy to sustain operations (taking the hospital hostage), and then declares bankruptcy. The hospital closes.
- ✓ Fourth, state government, crying crocodile tears, declares that the closing proves that the hospital wasn't really needed because the closing is a legitimate judgment of an imaginary competitive free market—one that, sadly, even the financial and managerial prowess of the for-profit owners could not reverse. Some states contritely pass weak and narrow laws that, they declare, would prevent a repetition of the recent depredations. Greedy and creative for-profits, fast on their legal and financial feet, will find ways to skirt the new regulatory apparatus.

5. Government failure is the other source of anarchy

6. Triple botch: Weak cost controls, reliance on narrow networks, and the NSA

Across the world's rich democracies, U.S. is radically atypical in several important ways. One of the most salient is the failure of our payers to cap or substantially constrain yearly care spending. A second is allowing and even encouraging payers to form narrow networks of doctors and hospitals in hopes of containing prices and use rates for health care. A third is responding to the resulting pressure to protect patients from out-of-network bills through state and federal law.

High U.S. health costs were documented in chapters 2 and 3. Evidence that up to one-half of our health spending is wasted was presented in chapter 3. And chapter 8 will discuss in depth the nature of the cost problem, its causes, and its remedies.

Starting in the 1950s, failure to contain cost by simple methods that are clinically, financially, and politically sound spurred reliance on managed care. Large Kaiser plans featured capped revenue through capitation for defined groups of patients plus prepaid group practices with salaried doctors. A variant was the capitated independent practice association, with its looser confederation of or physicians paid fee-for-service subject to financial constraints. Both paid exclusively for in-network doctors and hospitals, except in emergencies. Worried about rising spending, Medicaid and then Medicare began tinkering with capitating patients to managed care organizations. Today, three-quarters of Medicaid patients are covered through managed care arrangements, and one-half of Medicare patients are enrolled in Medicare Advantage plans.

Backlash against exclusive networks led many HMOs and insurers to offer preferred provider networks. Care from preferred doctors and hospitals carried lower deductibles, co-pays, co-insurance, and yearly OOP maximum payments. Out-of-network care was generally much less well-covered.

Insurance companies formed narrow networks of doctors and hospitals to try to extract lower prices per episode of care in exchange for greater volumes of patients. As mentioned in chapter 1, some ACA plans established very narrow networks that included only about one-tenth of doctors and hospitals in a given region. These plans' premiums were only about 6 percent below average.

Patients often incurred high out-of-pocket costs for care they thought was well-insured. Some patients fell into obscure coverage gaps. Others were penalized by insurers' clerical errors, some accidental and others systemic. Other patients unknowingly obtained care from out-of-network caregivers; inaccurate or out-of-date directories of in-network caregivers were often responsible. Some networks had such low capacity that timely appointments could not be scheduled with in-network doctors. Others required patients to travel considerable distances to in-network caregivers.

Narrow networks chronically impair access and impose higher OOPs on people with lower incomes and weaker capacity to navigate the complicated world of U.S. health care. But acute outbreaks of dramatically high and unfair surprise bills captured public and political attention. Attention was magnified when the Kaiser Family Foundation's *KKF News* launched its crowdsourced Bill of the Month series in November 2018.

After years of frightening press reports of patients put under financial siege by doctors' and hospitals' surprise bills, after over 30 states legislated various responses, and after years of

deliberations, Congress enacted the No Surprises Act in 2020 and Trump signed it a month before leaving office.

It is noteworthy that surprise bills have not been presented to Americans covered by Medicare or Medicaid—just as they don't exist at all in other rich democracies. They are an American illness, one stemming from incomplete private insurance coverage, failure to regulate prices charged private insurers, and also private insurers' paucity of tools to hold down their medical spending. Had private insurers not formed narrow networks, patients could not stray outside them, exposing themselves to surprises.

Surprise bills afflicted privately insured patients who obtained care from out-of-network doctors or hospitals. Main reasons for straying out-of-network were medical emergencies, lack of knowledge of which caregivers were in-network, and inability to prevent an out-of-network assisting surgeon or anesthesiologist from appearing and billing unexpectedly.

The NSA protected privately-insured patients financially. It capped patients' OOPs for emergency out-of-network care, for out-of-network physicians at in-network hospitals, air ambulances, and certain other services at the levels they would pay for in-network care.

But the NSA was insufficiently precise regarding insurance company rates of payment to out-of-network doctors or hospitals. At the behest of some caregivers, ***Congress refused to simply establish fee schedules***—such as Medicare's or the median of in-network rates—plus some percentage boost. Instead, it created a complicated process for arbitrating payment rates.

The NSA defined a "qualifying payment amount" (QPA) for arbitrators to consider as one factor influencing their decision regarding the insurer's payment to an out-of-network caregiver for services covered by the NSA. The QPA is:

> the median of contracted rates recognized by the plan for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the same geographic region in which the item or service under dispute was furnished, adjusted for inflation.[2256]

The Biden administration's first regulations for arbitrators were overthrown by a federal district court in Texas in February of 2022.[2257] A second set of regulations—considerably more modest[2258] and less prescriptive—was overthrown a year later by the same judge.[2259] In August of 2024, a 5th Circuit federal appeals bench affirmed the 2023 decision.

The judges ruled that the federal regulators had gone beyond the discretion afforded them by the NSA specifically. The general breadth of such discretion had also been narrowed by the Supreme Court's *Loper Bright* decision earlier in 2024. .

The Texas Medical Association's victories in court have prevented federal regulators from requiring arbitrators to begin by considering the QPA as the foundation for its decisions, from requiring that arbitrators ignore evidence that is not credible, and that arbitrators explain their reasoning when departing from the QPA.[2260]

By 2024, it had become clear that caregivers who demand arbitration have won very substantial financial payoffs. By the last quarter of 2023, the annualized rate of new filings for arbitration had risen rapidly to 1.2 million cases.[2261] According to Hoadley and colleagues, only 4 groups

filed 70 percent of 2023 cases. All groups were private equity-financed. And about one-half of cases were filed in Texas, Florida, Tennessee, and Georgia.

Caregivers won increasing shares of cases over time, rising steadily from 72 percent to 85 percent from the first to fourth quarter of 2023.

Even more consequentially, when caregivers won, arbitrators chose to award them payments that averaged about 3.2 to 3.5 times the median QPA, Hoadley and colleagues reported.

Why does that matter? Because these high payments will entice other caregivers serving many out-of-network patients to develop their own capacity to file for arbitration. Caregivers serving fewer such patients will rely on commercial firms to prepare and file, in exchange for a share in the winnings.

As appeals grow, insurance companies' financial liabilities for out-of-network care will rise substantially.

And those costs can be expected to rise considerably in the years ahead because fewer doctors and hospitals will continue to accede to insurers' demands for lower payments in exchange for membership in a narrow or preferred network. Since patients will pay the same OOPs for out-of-network care covered by the NSA, more and more doctors and hospitals will find it financially desirable to remain out-of-network.

This means that the effectiveness of narrow networks in containing U.S. health care spending—never very substantial—will decline over time. The short list of tools available to employers and their health insurance companies to hold down spending will shorten further. Reliance on boosting OOPs will grow. And that will annoy more workers more visibly and more powerfully than current reliance on narrow networks.

In these ways, the NSA's typically weak, complicated, and politically compromised legislative language has become a bonanza for lawyers and consultants—multiplying administrative waste—while boosting spending substantially.

The NSA thus signals a triumph of more money for business-as-usual in U.S. health care. It was crafted as a political response to the frightening human problem of surprise bills. Indeed, it caps patients' OOP financial obligations at in-network rates. This addressed ordinary Americans' worry that they'd be plagued by some types of surprise bills.

But the NSA appeases private equity-backed doctor groups by shifting costs to private insurers and the businesses that pay them. Therefore, the NSA has served as a platform for higher payments to those caregivers who fight for them. It rewards aggressive efforts to water down and muddy the original NSA statute, tenacious litigation, and persistent regulatory appeals. It boosts payments to caregivers and also administrative waste.

And it encourages doctors and hospitals to appeal arbitration awards that paid them less than they could expect by fighting. Over time, arbitrators can be expected to learn to dodge fights by hiking their initial awards.

What would simple and effective federal legislation to address surprise bills look like? It would probably need to repudiate narrow networks themselves. As long as narrow networks exist, the caregivers who remain outside them will make the political and legal case that they are entitled

to higher payments than those inside the narrow networks. After all, the narrow networks were created to extract lower prices, and the caregivers inside them have accepted those lower prices.

Once this principle is acknowledged, size and methods of payments to doctors and hospitals can be discussed and negotiated. Just as happens in nations with real health care.

As Rodwin and I wrote about the NSA in October 2022:

> The law amputated the most politically and visibly gangrenous consequences of unregulated private insurance in the United States in ways that enable business-as-usual in private health insurance to persist, subject to unnecessarily complex arbitration rules that magnify administrative waste.[2262]

For decades, most government regulatory responses in health care have entailed addressing some of anarchy's symptoms, very rarely any of its causes. The results seldom surprise those who expect government to fail. This is a fool's game.

Worse, many government actions, already complicated in themselves, engender further unexpected new problems and complications that, themselves, cry for remedies.

Years ago, I knew a small child who suffered a medium-size cut on his ankle on a hike early in the summer. A few plastic bandages later, the cut seemed to heal, but the skin around the cut became inflamed. Ointment, gauze pads, and adhesive tape followed. The skin redness and swelling reached the hip before someone figured out that the child was allergic to the tape used to secure the bandages.

In summary, please consider this sequence for surprise bills.—

1. U.S. payers fail to unite to contain cost and cover all people.
2. Employers, insurers, and free market economists opt for higher out-of-pocket payments to cut volumes of care used by sick or injured people.
3. Insurers build narrow networks of doctors and hospitals, hoping to win lower prices from those caregivers in exchange for promised higher volumes of patients.
4. This makes it much easier for patients to wander out of network, especially in emergencies.
5. And it entices a few financially predatory caregivers to stay out of network but ambush patients who need care urgently.
6. Also, directories of in-network caregivers are often inaccurate.
7. It's no surprise that surprise bills ensue. Often in five figures; sometimes more. They are surprises because they afflict people who thought they had decent insurance.
8. State governments feel the first pressure to respond and dozens try to protect their citizens.
9. But state laws can't protect over one-half of privately insured patients—those whose employers "self-insure" for health care costs. This means the employer, not an insurance companies legally bears the financial risk.
10. Since only federal action can regulate these surprise bills for patients covered by self-insuring employers, Congress faces pressure to act.
11. Congress enacts a No Surprises Act and then-Pres. Trump signs it in December of 2020. It declares that emergency and certain other care must be covered as if it were in-network, with no more than the customary out-of-pocket burdens on patients.

12. In the face of strong pressure from doctor and hospital groups, Congress did not provide for regulated total fees for the emergency and other services covered by the law. Instead, it invites insurer and caregiver to negotiate prices or accept binding arbitration.[2263]
13. Six different groups of hospitals, doctors, and air ambulance companies affected by the NSA's protections sued to block various aspects of the law.[2264] [2265]
14. Caregivers complain that insurers conspire to depress prices for out-of-network care generally, and in ways relevant to dispute resolution under the NSA.[2266] [2267]
15. The number of surprise bills requiring independent dispute resolution exceeds expectations.[2268]
16. Arbitration proves surprisingly costly, some $5 billion over three years or about $1.7 billion yearly.[2269] That would be enough to pay some 3,200 FTE primary care physicians $400,000 yearly plus 30 percent fringe benefits. At current average primary care panel size of some 2,000 patients, that number of doctors could care for about 6.5 million Americans.
17. At the same time, doctors complain that insurers are refusing to pay them even after disputes are resolved.[2270]
18. A federal judge finds that CMS's policy of bundling appeals and its high charge for appealing require closer looks. CMS temporarily suspends dispute resolutions.[2271]

Failure to contain costs sensibly engenders narrow networks. They cause surprise bills. Demands for public action lead to passage of the NSA of 2020. But doctors and hospitals fight for higher prices through arbitration. Unenforceable but annoying regulations delegitimize government action.

7. Various regulatory failures

Regulating nursing home capacity to respond to emergencies

Federal efforts to oblige hospitals, nursing homes, and other institutions to plan to respond to emergencies were energized by well-publicized caregiver failures during Hurricane Andrew in South Florida[2272] and Hurricane Katrina in Louisiana.[2273] Development of regulations began in 2007 but draft regulations were only released for public comment in 2013. They did not become effective until November of 2017.[2274]

A large share of regulators' attention was focused on nursing homes. These institutions rely heavily on Medicaid- and Medicare financed patients. Nursing homes have low (and declining) shares of private patients who can be charged unregulated prices. Medicaid prices in many states have probably been inadequate to finance safe, adequate, and dignified care for increasingly disabled residents.

Problems of nursing home quality have been frequently reported in the press. Detailed and lengthy state and federal regulatory responses have been almost as common.[2275] Some prolonged nursing home – regulator fights have been generalized [2276] while others have concerned specific proposed regulations for provision of back-up generators and frequency of testing them.[2277] Nursing homes plead lack of revenue to implement regulations and regulators demand compliance. Finger-pointing is common but progress toward improved nursing home safety is spotty at best.

Gaming payment regulations

Much larger examples concern methods of paying hospitals and doctors. These are taken up elsewhere. U.S. payment methods—particularly those used by Medicare and Medicaid—are characterized by poorly validated formulas that rest on weak research, leavened by occasional political interventions—such as the one that pays a large western Massachusetts hospital as if it were located across the border in central Connecticut. Methods and adequacy of payments to hospitals and doctors are not calibrated to secure the right or volumes of care in the right places. That is, they are not driven by outcomes. Rather, they are set by abstract formulas—one borrowed (to pay hospitals) and one specifically engineered (to pay doctors). Each method yields up both malconfigured care and constant political, regulatory, and legislative fighting.

Free preventive services

A third example is the 2010 Affordable Care Act's requirement that insurers cover preventive services, typically at no charge to the patient. Prioritizing preventive services follows from a belief these are more valuable than curative care. As discussed in chapter 2, though, Cohen and colleagues analyzed cost-effectiveness ratios for 279 preventive and 1,221 curative interventions. The two sets of ratios were distributed very similarly, suggesting that preventive and curative interventions have been equally cost-effective.[2278] It might make more sense to make all primary care visits free to the patient. Or all care—as argued in chapter 7.

The decision to draw a boundary around preventive care has resulted in much financial and legal skirmishing. If care crosses the border from screening to treatment, it ceases to be free to the patient and can result in substantial bills.[2279] It can be difficult to demarcate the boundaries between prevention and cure. The colonoscopy is free to the patient but removal of a polyp discovered during the colonoscopy is not. Further, confusion about how to code and pay for various services that lie near the border between prevention and treatment means frequent skirmishing over bills and unexpected financial troubles for patients.

Mello and O'Connell described "wielding heretofore sleepy doctrines of administrative and constitutional law to undercut health initiatives." The *Braidwood* decision from a federal judge in Texas held that the U.S. Preventive Services Task Force members lacked constitutional authority to define which services were to be covered at no charge to the patient. And that mandating coverage of pre-exposure prophylactic meds for HIV violated religious rights.[2280]

Religious or moral or political issues will arise in many coverage decisions. But these factors have been elevated by the ACA's dec

Shachar and Kaplan reported that the Fifth Circuit Court of Appeals' decision on Braidwood opens the door to further litigation, continuing the clouding of coverage of preventive services.[2281]

Separately, Hoagland and colleagues found that patient demographics affected denial of coverage for preventive services.[2282]

Minimum care shares (medical loss ratios)

A final example is the establishment of minimum care shares or medical loss ratios. The ACA requires insurers to expend at least 85 percent of premium income on actual health care for groups larger than 100 workers. No more than 15 percent could go to marketing, advertising, administration, and profit.

This seems clear. But, in practice, insurers quibble about whether efforts that purport to improve quality or appropriateness of care would qualify as spending toward the 85 percent care share requirement. If so, there would be more room for profit in the remaining 15 percent.

In response, regulators could write increasingly detailed rules to survey and demarcate this boundary. But fights will persist.

Until insurers can be trusted to behave well. And—because of comprehensive market failure in health care—a necessary condition for trust will be that all insurers are non-profit. What will be insurers' role after health care is reformed? Their roles will not include deciding which services should be covered, for which patients, how and how well caregivers are paid, or how to contain cost.

In a multiple-payer or all-payer arrangement, having multiple insurers would allow small measures of citizen choice of carrier. But insurers would function as conduits from ultimate payers (citizens, taxpayers, workers, and employers) to caregivers. Minimizing the leakage from those pipes will mean less administrative waste and more money to finance health security for all Americans.

8. States adopt putative caps on yearly health cost increases

In 2012, Massachusetts became the first state to establish a yearly target growth in health care spending.[2283] A new Health Policy Commission was to set yearly targets for what was defined as "Total Health Care Expenditures." These were Medicare, Medicaid, private health insurance, and similar spending that could be tracked from year-to-year reasonable accurately and easily. The state's calculations indicate that the money tracked was about two-thirds of the comparable federal estimate of health spending in Massachusetts.[2284]

(The same law established a state Health Planning Council, which was obligated to inventory all the nature and location of caregivers, make recommendations for the appropriate supply and distribution of needed caregivers, and propose plans for obtaining needed caregivers in the right places. Tellingly, this section of the law was never implemented.)

By mid-2025, some 8 states had followed Massachusetts in enacting laws that set thresholds for state-wide increases in health care costs.

Unfortunately, no evidence has been adduced that these targets have actually slowed health care cost increases. One proponent, Koller, wrote:[2285]

> Since their inception in Massachusetts, state-level spending growth targets have received much attention and support from policy experts for their conceptual logic. "How can you lose weight without a scale?" is how one person put it. A combination of public and private funding has supported both state-level work and standards

> setting and learning across states. As the programs mature, the "theory of change"—that goals and sold public evidence on systemic cost drivers will create the grounds for policy action eventually leading to measurable improvements—is proving out, even if that action is slow in the face of predictable industry resistance.
>
> At first glance, however, these aspirational targets seem to have had little impact: In the most mature program, Massachusetts, year-over-year health care cost growth has exceeded the state target four of the past five years. Health spending in the states that have followed Massachusetts' example have also generally surpassed the targets—with the exception of the year with pandemic-suppressed use.

Actually, it is easy to lose weight without a scale: consume fewer calories and burn more of them. The results that matter will be visible.

A useful rule for state and federal health legislation is that the bill that can pass won't work and the bill that could work won't pass.

State legislatures, feeling pressure to do somethings about health care cost increases, have passed laws setting spending growth targets. Although the benchmarks have been described as a "shared goal" that is rhetorical, not real. The Massachusetts effort has been praised,[2286] but it does not seem to have been effective. This has proven to be only a feel-good performative strategy, not one with practical effect. It is a substitute for effective action.

As discussed in chapter 8, the main way to actually contain spending is to cap it in advance and then work with caregivers and others to make the cap work. Unfortunately, spending growth targets do not cap spending in advance. In Massachusetts, state law created a regulatory mechanism to try to identify spending in excess of targets. Massachusetts has 11 years of data on actual spending versus the thresholds. By 2023, actual spending was $4.2 billion (5.7 percent) above that year's threshold.[2287]

The accuracy of this figure rests, in part, on the validity of the adjustments for health status/severity of illness, a component of the measurement of yearly Total Health Care Expenditures (THCE) in the state.[2288]

The state established another regulatory mechanism to try to attribute excesses to individual caregivers, and then seek to recoup or offset high spending. But it is not easy to make these attributions accurately and fairly, controlling for changes in volumes of different types of care, severity of illness, and prices paid. The state's Center for Health Information and Analysis identifies hospitals and other health care entities "'whose increase in health status adjusted medical expense is considered excessive and who threaten the ability of the state to meet the health care cost benchmark". It refers them to the Health Policy Commission.[2289]

Despite substantial over-spending, only one hospital system has been implicated as accountable. CHIA identified the Mass General – Brigham (MGB) system as a source of spending in excess of the state's threshold and referred its finding to the HPC. The HPC concluded that MGB had spent $293 million above the benchmark on privately insured patients from 2014 through 2019.[2290]

In January 2022, the HPC voted to require MGB to submit a performance improvement plan (PIP). MGB initially promised to save $104 million; the HPC rejected this. The HPC then approved MGB's 18-month amended PIP in September of 2022, one promising to save$177

million over 18 months. The rate of savings would be about $120 million for one full year. The plan was implemented from October 2022 until March of 2024. In December of 2024, the HPC concluded that MGB had saved the promised sum.

I'm sure the HPC is sincere in that conclusion, one supported by a substantial final report on the PIP. But the example of MA plans to wrongly boost their revenue by manipulating underlying data on patient needs is troubling. I'm concerned that caregivers or insurers that are motivated to manipulate complex payment methods to earn and keep more money—sometimes for noble reasons and sometimes for other reasons—can usually succeed.

Let's suppose, though, that implementing the PIP meant that MGB did forego some revenue. It is remarkable that regulators took so long to document MGB's unwarranted revenue and obtain some repayment. A decade passed from the time the extra money began to be garnered by MGB until the PIP was completed.

For context, MGB's HFY 2024 revenue from patient care and premiums, combined, was some $15.6 billion. So the $120 million in reduced income that year was about 0.8 percent of patient care and premium income. The $120 million was 0.6 percent of the system's $19.4 billion in net assets (accumulated wealth).[2291]

What else could have been done?

First, the initial merger that created MGB should never have been approved. It was tainted by untrue or unsupported assertions by the hospitals that the merger would save money and boost quality, and by lazy and unquestioning acceptance of those assertions by state officials and regulators.

It is noteworthy that MGB's excessive revenues were won mainly by obtaining higher prices from private insurers. And that the savings required by the PIP were won mainly by cutting those prices somewhat. It has long been clear that MGB has been able to extract extraordinarily high prices from private insurers. Ability to do so was one of the main reasons for the original 1994 merger between the Massachusetts General and Brigham & Women's hospitals. One or the other of these 2 institutions had long been a must-have hospital—one that each insurer must have in its network. Merged, the 2 no longer needed to compete by price for contracts with private insurance companies.

Testifying to the power, influence, and prestige of the 2 hospitals' leaders, trustees, and allies, the original merger proceeded without even a public hearing.

Second, de-merging the 2 would be one way to lower prices they are able to charge private insurers. It is remarkable that advocates of competition have not urged such a de-merger. Efforts in recent years to integrate the 2 flagship hospitals may have been aimed more to make de-merger more difficult, and less to win efficiencies or quality improvements, as MGB leaders have claimed.

Third, as discussed in chapters 8 and 9, setting a budget for each hospital before the fact would be more efficient, clean, and quick than an after-the-fact effort to try to recoup money exceeding the state's threshold.

Proponents of the policy of state action to cap yearly cost increases have been wildly optimistic. They have over-sold this mechanism, this gadget.

The caps are substitutes for effective action. Caps have not been effective in saving money because they do not enjoy wide political support for either on their goal of containing health spending or their method of doing so.

Further, from a mechanical regulatory standpoint, it is very hard to attribute over-spending to individual hospitals, physician groups, or insurers. This makes the MGB PIP something very different from a success that will discourage other hospitals from over-spending. The time and administrative cost required to extract a small pay-back from one highly visible over-spender must leave other caregivers fairly comfortable that they will not be disturbed.

9. ACA mispricing, complexity, and bad behaviors

The Affordable Care Act boosted insurance coverage in three main ways. It mandated that children to age 26 be covered on parents' private health insurance. It expanded Medicaid to all people with incomes up to 138 percent of the federal poverty level (FPL). This eliminated the former type of coverage, which had been restricted to only 4 specific types of people—families with dependent children, elders, disabled people, and blind people—at highly variable incomes set by states. And it subsidized private health insurance purchase by people with income between 1 and 4 times the FPL through federal- or state-operated marketplace plans.

The last method has proven unnecessarily complicated and also unexpectedly costly to patients. Obama and Congress putatively aimed to induce competition across insurers and to allow patients lots of choice of subsidized insurance plans. The ACA therefore offered 4 levels of plans—bronze, silver, gold, and platinum—with actuarial values of 60 to 90 percent of health care costs. (The actuarial value is the average share of costs paid by insurance, with the rest paid OOP.)

This complicated design, coupled with weak federal and state enforcement of statute and regulations, gave insurers lots of leeway to abuse the program to make money.

Dorn and Jost explained that one-half of Americans whose premiums were subsidized by the ACA were in bronze and silver plans with very high deductibles. They claimed that insurance companies under-priced silver plans because they were highly profitable—even after Trump ended special federal payments to finance cost-sharing reductions for low-income silver plan enrollees.

Low-income patients have been acutely sensitive to premium differentials and appear to have been less likely to consider high OOPs associated with low premiums when choosing an ACA plan. But the high OOPs end up deterring low-income enrollees from using much health care—which helps make those silver plans so profitable to the companies.

Dorn and Jost further asserted that insurers illegally set premiums to reflect risk. They contrast this with the experience in Texas and New Mexico, where state law requires ACA insurers to 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.[2292]

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 complexity of setting health insurance premiums. And in part from insurance companies' willingness and ability to game—and even violate—federal law to make money for themselves.

In 2024, Biden proposed a set of rules for ACA insurance market reforms and consumer assistance. The rule addresses seven persisting problems in ACA-subsidized private insurance plans—failure to standardize plans to permit easy comparisons, persistence of misleading names of plans, adequacy of doctor and hospital networks, standards for appointment wait times, inclusion of essential caregivers, standards for patient navigators, and reforms to curb bad behavior by brokers.[2293]

Broker malfeasance has been a chronic problem in ACA plans and also in MA. Biden's 2024 ceilings on fees for MA brokers were largely nullified by a Texas federal judge.[2294]

The lesson here is establishing complicated arrangements that purport to make for greater choice end up as complicated opportunities for exploitation by badly-motivated Americans. It is easy to make clean, clear responses to the problem of plans bribing brokers or of brokers extorting fees from plans. One response is to standardize one plan that covers care that works for people who need it. The second response is to ban for-profit health insurance companies on the ground that no competitive free market legitimates profit-making.

Instead, we see bad, complicated programs engendering opportunities for corruption, which prompts regulation, which is enmeshed in the courts for years. Governments set themselves up for exhausting dissipation of purpose and energy, and for public perception of incompetence.

Biden's set of 7 rules in 2024 would have been only after-the-fact efforts to curtail bad practices that the ACA's design itself invited. The ACA did not need to rely on 4 levels of plans and multiple competing plans at each level. It did not need to permit insurers to rely on narrow networks of caregivers. It did not need to be so complex as to require navigators to choose among plans. And it certainly did not need to rely on brokers to help Americans choose or enroll in plans. The strategic failures in plan design invited endless regulatory whac-a-mole.

10. Special financial patches

Some government actions are not regulatory. A number of programs offer special supports for patients or caregivers.

Section 340B

One example is the section 340B program. This was discussed briefly in chapter 3 under the heading of waste. Created by the Veterans Health Care Act of 1992, the 340B drug program traded expanded Medicaid eligibility for drug makers that discounted their prices to certain designated "safety net" caregivers.[2295] Those caregivers are then allowed to charge payers the prices they wish. The 2010 ACA considerably expanded eligibility. Over one-half of the nation's hospitals are now eligible. And it accounts for roughly 1 percent of U.S. health care spending.

Expanded eligibility increased the 340B program's political support. The program's main supporters have been the hospitals, health centers, and other caregivers that have garnered added revenue by re-selling at high prices the meds that drug makers are compelled to sell them at low prices. Extra help to caregivers deemed worthy comes not from public dollars but from squeezing drug makers. There's ample reason to squeeze drug makers. But, while 340B has been politically expedient, it has not done enough for Americans who can't afford their meds.

Section 340B was justified by some as a way to put money into the hands of caregivers believed to be needy, so they could devote that money to make meds more affordable to lower-income patients. This was intended as a partial substitute for the nation's political inability to constrain drug makers' prices to make meds affordable for all Americans.

The ACA's expanded eligibility has meant drug makers lose more profit, boosting their opposition to 340B.

Knox and colleagues compiled a scoping review in 2023. They cautiously concluded that "The 340B program has benefited hospitals, clinics, pharmacies, and patients, but its expansion has led to calls for reform." [2296] Levengood and colleagues published a second scoping review in the following year. They concluded that non-profit disproportionate-share hospitals were exploiting the program to boost their margins.[2297]

Reformers have criticized the program for its inefficiency and poor targeting, and for its failure to sufficiently help low-income patients. Some of these caregivers badly need the added money (and much more). But others do not. This makes the program highly ill-targeted and inefficient.

DiGiorgio and Winegarden criticize 340B on 4 grounds: That it gives discounts to caregivers not patients; that it shifts money from drug makers and payers to large hospital conglomerates; that hospitals are not obliged to report how they spend the surpluses they garner by selling the drugs at higher prices; and that the program does not requires caregivers to devote those surpluses to help financially needy patients.[2298]

One of the main responses to these problems has been to demand "transparency." One proposed federal law, which has not passed and seems unlikely to move forward, would have required 340B caregivers to include in their yearly Medicare Cost Reports their net revenue from the program and how it is spent.[2299] Since caregivers' revenues are fungible, it is risibly absurd to demand that caregivers report a connection between certain dollars garnered and how they are spent. That's an invitation to bureaucratic creativity. The reality is that a vague general subsidy to some hospitals and other caregivers will be spent well by some and badly by others.

This regulatory response testifies to good intentions that 340B should actually help people most in need, to a belief that "transparency" is a useful tool, and to the political reality that neither of these are effective in actually reforming the program.

An inefficient program badly crafted for its political expediency can't be improved by more transparent public reporting.

Drug maker have seized on the program's weak targeting of patients in need as reason or pretext for cutting its cost to themselves. J&J has tried to force hospitals to pay full price for drugs and later request rebates to lower net prices paid.[2300]

The American Hospital Association responded that J&J's action was an "'an example of big drug companies taking unilateral action to advantage themselves at the expense of hospitals that care for America's most vulnerable patients.'" The Health Resources and Services Administration (HRSA), which administers 340B, said that J&J's proposal violated the 340B statute. J&J then sued HRSA; it was joined by Lilly. Lilly claimed that the proposed rebate method would improve "'transparency, efficiency, and program integrity.'" [2301]

Mascata and Laws are among the reformers and patient advocates who have aligned themselves with the drug makers' position that 340B help patients, not "Covered Entities," the caregivers eligible for 340B discounts.[2302] They focus on transparency, so it is not clear how a re-focus on patients would be crafted.

The first problem with 340B is that it was designed to channel money to certain caregivers without a prior determination of which caregivers are needed in what locations, without an estimate of how much money they require to efficiently deliver needed care—especially to vulnerable patients, and without reason for expecting the added money to be spent to help its intended low-income beneficiaries. The second problem with 340B is that it doesn't directly tackle the problem of high U.S. drug prices. Instead, it requires drug makers to forgo a tiny share of their unwarranted U.S. profits to help out a wide swathe of hospitals and other caregivers—some of which need added revenue and others of which don't.

The program is also complicated and administratively wasteful. Most work-arounds are. Nikpay and Halvorson have described 340B's increasing administrative complexity and associated mistrust perceived by the federal government, the eligible caregivers, and drug makers. Seven special administrative functions are managing "drug discount cards, enrollment, auditing, revenue capture, referral management, inventory management, and 340B ESP assistance." [2303] (ESP in this instance might stand for "easy and secure platform" but this is not certain.) Drug makers established ESP in hopes of avoiding what they regard as paying unfair double discounts on meds (federal 340B discounts and either state Medicaid discounts or private insurers' PBM-negotiated discounts). Some institutions benefiting from 340B discounts regard ESP as an attempt by some drug makers to shrink their revenue loss by ceasing to extend some discounts they are legally or contractually obliged to offer.

The 340B program's substantial financial benefits to eligible caregivers mean considerable legislative, regulatory, and judicial squabbling about the boundaries defining eligibility. A number of large medical centers sued HRSA in 2023 to block new rules delaying coverage of offsite outpatient facilities.[2304] Proposed federal legislation would make rural emergency hospitals eligible for 340B benefits.[2305] Drug makers have pushed legislation to markedly shrink the number of eligible hospitals.[2306]

The 340B program exemplifies governmental adoption of politically feasible policies and its failure to make competent strategic decisions. The law that could pass—340B—traded drug makers' expanded Medicaid access for discounts to certain Covered Entities. This deal cost the federal government no money. The ACA's expansion of the number of Covered Entities substantially increased drug makers' revenue losses. At the same time, it separated financial benefits to Covered Entities, which could garner surpluses by reselling discounted meds at higher prices. Over time, the program appeared to help the Covered Entities more than it helped low-income patients or those needing high-priced meds. But this has been hard to determine. Increased regulatory and political energy has been devoted to debating the shape of 340B. The jobs of protecting vulnerable people, learning how much money various caregivers require, or actually providing them with adequate revenue have been generally ignored.

HPSA designation and associated primary care financing

A second example of weak public action is federal designation of health professional shortage areas and efforts to support primary care in those areas. Most are rural; some are urban. Designation rests on low ratios of doctors or dentists to residents.

A cluster of special federal programs aiming to boost primary care in HPSAs has arisen in recent decades. The National Health Service Corps provides help with repaying debts if they agree to work in HPSAs for at least 2 years. It also has a scholarship program for those who commit to practicing in HPSAs for a time. Another program helps medical and dental students if they commit to working in HPSAs for at least 3 years. Medicare adds a 10 percent bonus payment to eligible doctors serving its patients in HPSAs. Additionally, foreign medical graduates find it easier to obtain visas if they practice in HPSAs. A Teaching Health Center graduate medical education program subsidizes training physician residents. Several states offer special loan repayment support for doctors working in HPSAs.

Together, these scattershot programs are helpful. But they are radically inadequate.

Markowski and colleagues found that, since 1965, a county's designation is not statistically associated with either lower death rates or higher doctor density. Spending is about $1 billion yearly.[2307] Possibly, financing has not been adequate to build durably higher doctor/citizen ratios in HPSAs. Or hospital, rural health center, and other institutional support for retaining doctors has been too week. Or both.

Designating HPSAs would have been a more constructive step if it had been tied to a commitment to specific objectives, to effective programs, to adequate primary care financing in HPSAs, to financing adequate institutional support, and to a national policy on primary care. Instead, HPSAs and their associated cluster of small programs have functioned as a substitute for solid action, not a means toward it.

First, a commitment to specific objectives would have set a floor under rural primary care supply—so many primary care physicians, nurse practitioners, and physician assistants per thousand citizens. Given the nature of rural practice, training in family medicine that combines pediatrics, adult medicine, obstetrics, and basic surgery would be essential.

Second, programs commensurate with reaching those objectives would be created. These might include recruiting local residents who've proven academically proficient for college and medical school, and financing their tuition—if they commit to returning to the areas where they were raised. This approach would have much higher retention rates than parachuting urban-oriented physicians for temporary service in rural areas. People raised in a given rural region would have family and friends in the area. They would be likely to enjoy rural lifestyles. They would be socially integrated.

Third, financially, it would be important to assure sufficient incomes to attract and retain needed doctors, NPs, PAs, and RNs in rural areas. While no free market functions anywhere in health care, there remains a "market-clearing price" for all workers. Since our nation is not willing to draft doctors, we must pay enough money to attract and retain the doctors we need where we need them.

Fourth, institutionally, 4 essential supports for rural primary care practices must be built. One is creation of on-site or nearby primary care teams, so no single doctor would be on call for 168 hours weekly. A second is adequate support at primary care sites to stabilize patients who require stabilization before they can be moved. A third is strong specialist back-up via telemedicine. A fourth is speedy transportation to secondary or tertiary hospitals when needed.

Fifth, a special policy for primary care in HPSAs may seem appealing, but primary care and physician configuration generally should be matters of national policy. Otherwise, more primary care in HPSAs will mean less primary care elsewhere in the nation. Setting boundaries between HPSAs and the rest of the nation makes arbitrary 0/1 distinctions in what is inevitably a continuum.

Creating arbitrary boundaries

Unlike most rich democracies, U.S. health care categorizes humans, types of medical services, and caregivers. Perhaps the most consequential categorization affecting humans is that patients with insurance are covered by programs that pay very different prices. This very rare in other rich democracies.

The ACA's distinction between no-OOP preventive services and curative services, while well-intentioned, is probably not sensible medically or financially. Chapter 4 argued that OOPs are foolish ways to make patients operated as free-market-theoretical-consumers. And chapters 7 and 8 will argue that OOPs are deeply unfair and ineffective ways to improve appropriateness of care or contain its cost.

The legal, administrative, and political difficulties in defining and enforcing the border between preventive and curative services was discussed earlier in this section.

U.S. hospitals are categorized in various ways. Medicare for decades made generous bonus payments to teaching hospitals, ostensibly to cover overhead costs associated with training residents.

Medicare and Medicaid make extra payments to "disproportionate share hospitals," those serving higher shares of Medicaid and uninsured patients. States allocate Medicaid disproportionate share money, and often fail to match extra dollars to hospitals facing extra financial needs.

Medicare pays smaller rural hospitals in isolated areas their actual costs of care (cost reimbursement), not revenue set by Medicare's prospective payment formula.

The 2025 federal budget resolution appropriated special financial support for rural hospitals. These institutions were thought to face greater distress from the resolution's own Medicaid cuts. But the procedures for distributing the special dollars are unclear at best. Available money will be only about 37 percent of what is needed to replace dollars subtracted by the resolution.[2308] And, as always, federal and state governments will be flying blind—entirely lacking assessments of which hospitals are needed, with which service and volume capacities, or the sums they require to finance efficient delivery of needed care.

The various uncoordinated federal financial bandages respond to pressures from various hospitals and the politicians associated with them. But they are no substitute for fair payments to all needed hospitals. That would require learning what hospitals are needed and how much money they require to efficiently deliver needed care. Outside the state of Maryland, interest in learning either of those two things has long been very low.

Government is called upon to make these detailed regulatory or programmatic responses because it establishes or allows arrangements that are not self-regulating, that are not trustworthy—and that engender the very problems that government regulatory responses purport to combat. Governments are often asked to clean up the consequences of market failure. Examples include efforts to compel ACA plans to adhere to community rating, to push Medicare and Medicaid plans to include adequate numbers of doctors and hospitals in their narrow networks, to combat skimming and diagnosis harvesting by MA plans, to combat theft in many sectors, and to develop regulations to cope with insurers' and brokers' expensive or illegal practices that have arisen in response to the ACA's extraordinarily complex design.

Why are most government actions in health care strategic failures or time-wasting and ineffective regulatory responses?

The 10 government actions just described offer some insights into reasons most government actions in U.S. health care fail. Strategic failures often result from design flaws. Those, in turn, stem from factors like weak political support for effective action, weak understanding of the extent of market failure, weak knowledge of public actions that have worked in other rich democracies, or of the necessity for governments to act competently in health care.

In sum, federal and state governments have not developed solid institutional capacity to understand the nature of health care problems, diagnose their causes, identify possible remedies, and implement them effectively.

Amateur hour. A dramatic example of incapacity is revealed by the Department of Health and Human Services' August 2025 announcement that it will create a special committee of experts to provide ideas to reform Medicare, Medicaid, ACA-subsidized insurance, and CHIP. [2309]

The Department's press release highlights a desire for input on:[2310]

- Actionable policy initiatives to promote chronic disease prevention and management;
- Opportunities for a regulatory framework of accountability for safety and outcomes that reduce unnecessary red tape and allow providers to focus on improving patient health;
- Levers to advance a real-time data system, enabling a new standard of excellence in care, rapid claims processing, rapid quality measurement, and rewards;
- Structural opportunities to improve quality for the most vulnerable in the Medicaid program; and
- Sustainability of the Medicare Advantage program, identifying opportunities to modernize risk adjustment and quality measures to assess and improve health outcomes.

The problems identified are all of small or medium size. All stem from various underlying weaknesses in U.S. health care. The Department's desire to seek outside input from volunteer outsiders manifests the lack of internal capacity to understand health problems or address them. This amounts to a confession of inadequacy.

5. Government failure is the other source of anarchy

Many regulatory failures result from the mismatch between tools available to government regulators and the fractured and dispersed problems they are asked to address. Others result from the legal and political and financial friction they encounter in using those tools,

Successive failures undermine both politicians' and regulators' morale. Both become adverse to dealing with health care. So, when political pressure for action builds—to address human suffering, gross over-spending, or terrible theft—politicians and regulators go through the motions. But their hearts and minds are rarely engaged. Cynicism abounds.

We can briefly consider reasons for the failure of public action in some of the 10 areas just examined.

Politically, governments in the U.S. have not faced effective political pressure to make meds affordable for all Americans through basic price controls or negotiations. Drug makers threaten, in effect, that we will all die if the U.S. restricts their prices—because life-saving research will be the first investment drug makers will cut.

Powerful forces have blocked federal actions—have undermined political support—to win primary care for all, to identify all needed hospitals, stabilize each financially, and—therefore—to obviate reliance on false for-profit saviors. The barriers include deep faith in market competition, historic mistrust of government, and decades of failure to build capacity in government to even pose the 5 key questions discussed in the next section. Nothing—and no one—is accountable for acting in any of these 5 areas.

Unwillingness and inability to safely constrain cost increases led to incompetent public action and opened the door to incompetent private action. Accidental or intentional misdiagnosis of causes of high Medicare costs led the federal government to craft and expand a remedy like Medicare Advantage. A blind belief in competition, privatization, and managed care led Congress to ignore the gross financial abuses of MA plans. The plans' ability to mobilize many of their members to support continued subsidies helped to paralyze Congressional action to rein in MA.

Similarly, absence of effective cost controls invited private insurers to create narrow networks of doctors and hospitals—with promises they'd contain cost. When this created the problem of surprise bills, government responses remained excessively complicated and will prove increasingly ineffective.

In the same vein, states have adopted putative caps on yearly health cost increases—a politically attractive policy that hasn't worked.

Owing to these failures, the cost controls that harm access to care have been widely tolerated, encouraged, and even applauded in the U.S.. Failed public and private cost controls have allowed growing reliance on OOPs, caregiver shortages, and private regulatory barriers like prior authorization and retroactive denial of payment. As discussed in chapters 4 and 7, these work to suppress access, particularly to low-income Americans and also people who need lots of medical care to diagnose and treat their illnesses and injuries.

Failure to cover all people well led to crafting the ACA to rely in complicated ways on competing private insurance plans, mispricing of ACA policies, confusing patient choices, and exploitation of both patients and federal taxpayers by insurers and brokers.

5. Government failure is the other source of anarchy

The same failure led to adoption of complicated and badly-targeted financial band-aids to help selected groups of hospitals. Or to promise to help certain patients.

Government regulatory responses typically fail. Worse, it is usually impossible for them to succeed. One reason is that governmental failure to make smart strategic choices leads to visible abuses that prompt calls for compensatory government action. But when the abuses are widespread and when they proliferate in the moist, dark conditions created by bad strategic choices, regulators can't act effectively.

Fly swatters are functional responses only when very few flies are present. Curran has asserted cogently that public regulations in health care work only when they embody widely-agreed good practices and enjoy overwhelming support.[2311] But regulatory and other government responses will be ineffective when many or most MA plans financially abuse the formula used to risk-adjust monthly capitation payments, when for-profit hospital chains are systematically untrustworthy, when insurance companies all hope that narrow doctor and hospital networks will help them hold down premiums, and when neither doctors nor med schools nor teaching hospitals nor payers nor patients lobby effectively for more primary care.

Government actions are sometimes, simply, uninformed or rest on misdiagnoses of causes of a problem or are spurred by wishful thinking. Consider the proposal to adapt value-based payment to enhance equity of health care.[2312] At best, evidence that value-based care saves money is very weak. Its reliance on financial incentives to change caregiver behavior is highly speculative.

Mann and colleagues have identified proposed federal regulations, issued in April 2023, that "could bolster" access for Medicaid and CHIP patients.[2313] They repeated the same assertion a year later.[2314] One new rule requires states to report both their own state-regulated Medicaid payment rates and those of their managed care plans. A second sets federal standards for measuring access, including maximum wait times for mental health, primary care, obstetric, and similar appointments. A third requires monitoring of actual access to care, including secret shopper attempts to secure services through Medicaid managed care plans. (This is especially important in Medicaid because the Supreme Court has held that neither patients nor caregivers can challenge adequacy of states' payment rates, leaving Medicaid patients vulnerable to under-service.[2315]) A fourth sets federal standards for access to home and community-based services.

It is hard to imagine how any of these regulations would be enforced effectively—to meaningfully "bolster access" in the face of Medicaid's low rates of payment in most states, many caregivers' reluctance to serve Medicaid patients, and states' own varying motivations to protect Medicaid patients' rights to care.

In the same vein, federal and state governments have been unable and unwilling to regulate the adequacy of caregiver networks of MA plans, Medicaid managed care plans, or ACA marketplace plans. The same governments have been unable and unwilling to investigate and regulate plans' high rates of denial of coverage or of prior authorization for care. Or the plans' high rates of refusal to pay claims for care given. Chapter 1 described many states' administrative expulsion of eligible people from Medicaid in 2023-2024 on flimsy technical grounds, and the federal government's refusal to act effectively to protect those people.

5. Government failure is the other source of anarchy

When markets fail and when governments fail to make strategic decisions well, public regulators face incessant demands to address the resulting widespread abuses. They are rarely able to do so competently or simply.

One reason is that caregivers, payers, or other parties exert political pressure to craft statutes that are very hard to implement sensibly and efficiently. This makes the jobs of regulators very difficult. The key condition for effective regulation described by Curran—rare need to enforce regulations because they embody widely shared views of what is right—is nearly always lacking in health policy.

A second reason is the same interested parties may work to undermine strong or clear regulation.

A third is that, over time, the proliferation of statute, regulation, and court decisions creates a maze that is difficult for humans to navigate. Witness the incredible complexity of navigating the rules for Medicaid eligibility during the program's first 5 decades—until the ACA's Medicaid expansion offered great initial clarity.[2316]

A fourth is that some recent court decisions manifest legal and political theories that Congress cannot or should not be allowed to delegate its authority to regulators. This view reflects overall mistrust of government. Its result will be to hamstring effective governmental action in many arenas. As discussed earlier, the end of Chevron deference to administrative agencies' expertise could further handicap already-slow traditional regulation. It could even impede enforcement of laws prohibiting kickbacks and other illegal behavior.[2317]

A fifth is the rule-making process itself. Federal agencies must first file a notice of proposed rule-making that invites public comments. Only after considering those comments can a final regulation be issued. A difficulty that usually arises here is that organized interests have much greater resources to read and prepare detailed comments on proposed regulations. And they often have financial motivations to do so.

One recent example concerns public comments on Medicare national coverage determinations (NCDs) for medical devices. Of 444 doctors or groups of doctors commenting, three-quarters had received general or research-related payments from manufacturers who might be affected by the NCDs. Only one acknowledged a conflict of interest. Four-fifths of commenting hospitals had received general payments, but none acknowledged a conflict of interest.[2318]

Patients or family members submitted 52 of 681 comments. Fully 99 percent of comments supported expanding Medicare's coverage.

And a sixth is that regulation is usually not an effective tool to respond to market failure. Cooper and colleagues concede this in their discussion of hospital acquisition of doctors' practices. They write that those purchases pose "new challenges for antitrust regulators who don't have the resources to block the thousands of deals that are occurring annually." [2319] Almost all mergers were below the federal government's threshold for reporting. Cooper and colleagues urge Medicare should pay the same price for physicians' services, regardless of the site of care or ownership of the practice. They also urge the FTC and other regulators, along with state governments, to focus on the more consequential practice acquisitions. Neither public sector response—in payment or in regulation—seems unlikely today.

5. Government failure is the other source of anarchy

Market failure in health care is matched by governmental failure. Governments' actions in U.S. health care are characterized by episodic dilettantism. As a result, 5 important and strategic jobs are badly performed.

B. Governments' five vital strategic health care jobs have been characterized by episodic dilettantism (ED)

Governments need to make 5 strategic decisions to craft a structure for health care that substitutes for failed competitive free markets:

1. Shaping solid financial coverage that protects all citizens
2. Containing spending on health care by capping available revenue
3. Shaping the configuration of caregivers to support efficient delivery of needed care and to redeem the promise of financial coverage
4. Promoting equitable delivery of effective and high-quality medical care
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

Making these 5 big, strategic decisions well is one of the two keys to ending the decades of demands that governments respond to market failure with policy posturing and regulatory reactions. The latter oblige governments to make lots of small decisions. They inevitably do so badly.

The second key is crafting trustworthy arrangements, implemented by trustworthy doctors and other caregivers, to sensibly spend our vast but finite dollars effectively and equitably. This entails making not 5 strategic decisions for the nation, but rather thousands of decisions every hour to diagnose and treat Americans who need medical care.

Neither federal nor state governments are doing the 5 strategic jobs seriously, systematically, or competently. Instead, governments suffer from ED—episodic dilettantism. They engage in policy by spasm. They are not consistently engaged in identifying health care problems, analyzing their causes, formulating possible remedies, negotiating politically and financially feasible paths to implement those remedies, and coordinating coverage, care, and cost considerations.

Anarchy and unaccountability result when competitive free markets are absent and when government fails to develop substitutes. The first is inevitable; the second is unacceptable.

But while the second is unacceptable, it is still understandable. Americans are not, today, willing to trust our health care—and nearly one-fifth of the economy to governments.

Partly by accident and partly by intent, U.S. governments have not been obliged to cover all people affordably, so they have not felt effective pressure to contain cost, configure caregivers, or assure equitable high-quality care.

The 5 essential strategic government jobs are now described. Section C, which follows, analyzes the causes of governments' failures to make the big strategic decisions in health care. And the chapter's final Section D discusses possible remedies.

The review of the 5 jobs that now follows sketches ways in which U.S. governments have failed to do each, and the specific causes of each of the 5 failures. It then describes strategies adopted by governments—sometimes in concert with payers, caregivers, and others—in the world's other rich democracies and reasons for adopting them. No nation's health care is close to perfect, but governments elsewhere have done well enough at substituting for market failure that they outperform the U.S. in containing cost, covering all people, delivering more care, and enjoying superior health outcomes.

1. Shaping solid financial coverage that protects all citizens

This is not a job that even the most perfectly competitive free market can undertake. Markets ratify the current distribution of purchasing power; they allow people to spend money they have to buy what they wish. Purchasing power manifests a combination of income—yearly earned plus unearned income—and accumulated wealth. Both are highly unequally distributed in the U.S. Making health care affordable for all therefore requires substantial redistributions of purchasing power—from rich to poor and from healthy to ill, injured, or disabled. This would be true even if a competitive free market were imagined to exist in health care.

Assuring equitable financial coverage by redistributing purchasing power is, happily, a job that governments are very competent to undertake. Sadly, though, it is a job at which U.S. governments have done badly.

Private health insurance in the U.S. has survived because it has worked well enough and long enough and for enough people. Government's tax-financed health insurance for older and disabled Americans through Medicare, and for lower-income Americans through Medicaid have been enacted to cover people whose medical costs were too high for any private premiums to cover, or who are too poor to afford any substantial premiums. Absent political pressure to cover all people, substantial gaps persist. The ACA sought to fill some of those gaps by subsidizing purchase of private insurance for many. The American Rescue Plan Act of 2021 and the Inflation Reduction Act of 2022 substantially boosted federal subsidies for purchase of ACA plans through the end of 2025.

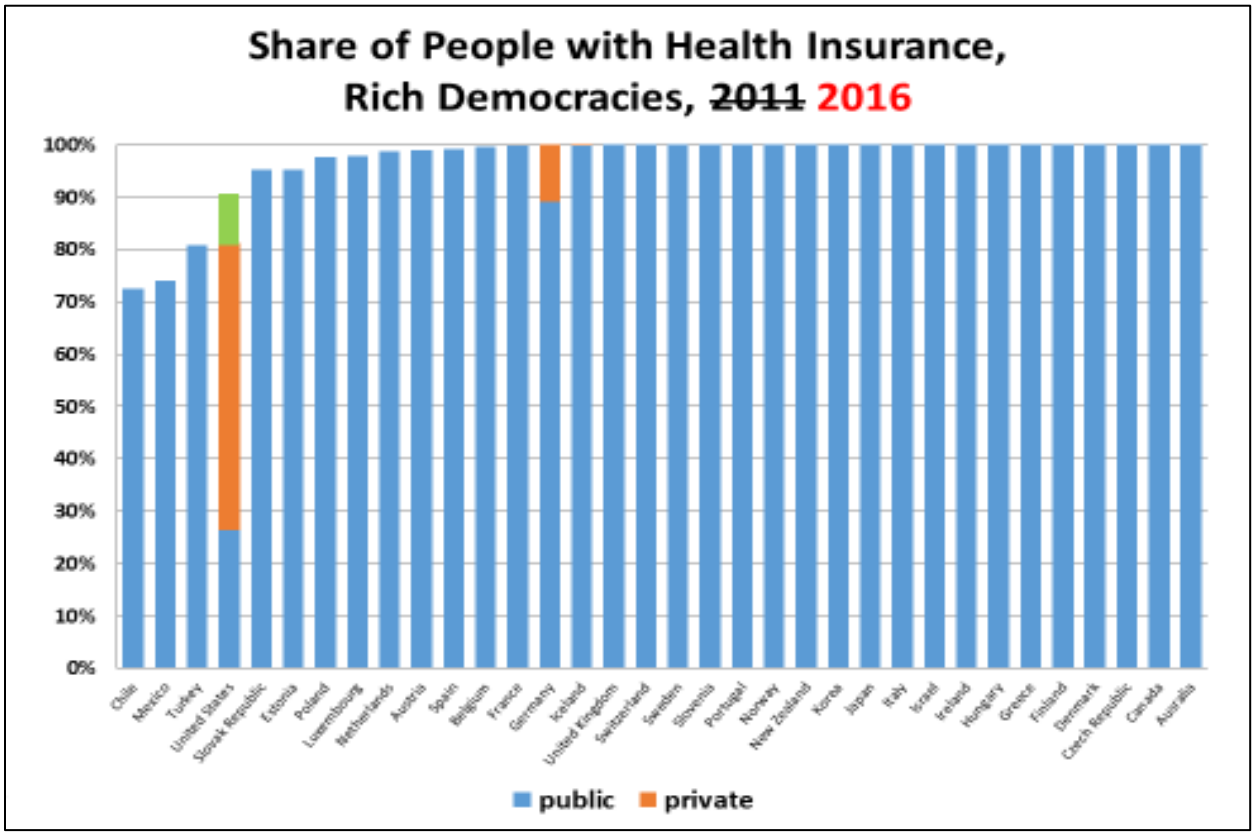
The U.S. is the only rich democracy member of the Organization for Economic Cooperation and Development (OECD) that does not protect all—or essentially all—of its citizens against costs of health care. This is shown in Exhibit 5 - 3, which also indicates, in green, the coverage added in the U.S. by the Affordable Care Act of 2010.

Lack of financial protection against health care costs in the U.S. takes four main forms. All are complicated.

First, some people are entirely uninsured. About 30 million Americans—some 9 percent of us—lacked any health insurance in mid-2022. Their numbers rose after millions were extruded from Medicaid after the Covid emergency led to temporary suspension of regular recertification of

eligibility. Further rises will result from Medicaid work requirements enacted in 2025. Ending enhanced ACA subsidies at the end of 2025 could push 5 to 10 million more people out of coverage.[2320] A recession resulting from tariffs or other economic factors would also be harmful.

Exhibit 5 – 3



Second, many other Americans are dangerously under-insured: that means they would be unable to afford needed medical care or would choose not to obtain it owing to inability to pay. Lower-income people are more likely to be under-insured.[2321] Lack of money to pay rising deductibles, co-insurance, or yearly out-of-pocket maximum payments is the single biggest source of under-insurance. The estimated share of under-insured people with private health insurance below age 65 rose from 12.4 percent in 1977 to 18.5 percent in 1994.[2322] The ACA might have cut this number, particularly for patients newly covered by Medicaid, which typically has very low out-of-pocket burdens. (Unfortunately, the ACA's sponsors accepted high OOPs for the law's subsidized individual mandates to buy insurance.) Possibly, 10 or 20 percent of Americans—about 33 or 66 million people—are under-insured today. That share may well be greater.

Even many privately-insured Americans who thought they were well-covered have discovered otherwise when they received high surprise bills. These usually resulted from obtaining services from caregivers outside their insurer's network of covered or preferred caregivers. Those caregivers have long been able to charge whatever prices they wish. After years of well-publicized bills for five and six figures, over 30 states and then Congress enacted limits on surprise bills. Trump signed the No Surprises Act (NSA) in December of 2020. It capped

patients' responsibility to pay for out-of-network care at the OOPs their insurer required for in-network care. But the NSA did not establish a fee schedule for insurers' shares of bills for out-of-network care but instead established a complex dispute resolution process. Adjudicators were obliged to consider a number of factors.[2323] Some doctors and hospitals have argued successfully in court that this process was tilted to benefit insurers. Consequently, CMS was twice obliged to suspend dispute resolutions during 2023.[2324]

This illustrates the complexity of finding straightforward remedies for a number of seemingly discrete individual problems in U.S. health care. The difficulty here arises from surprise bills' multiple roots. Those roots include lack of standard rules governing which patients are covered for which services when given by which caregivers, lack of standard prices for individual medical services, lack of coherent controls on spending, and permitting private insurance companies to try to contain their own spending by inviting some caregivers to join narrow networks if they offer lower prices. These are all symptoms of a long-standing unwillingness to negotiate a peace treaty for U.S. health care, one with simple provisions for coverage, cost control, and caregiver payments. Absent such a treaty, removing surprise bills from the jaws of American medical care has resembled attempts by an unskilled dentist with trembling hands using slippery tools to extract an infected molar with five long roots from the mouth of an angry person.

Third, many people are effectively uninsured for dental care, hearing aids, eye care, mental health care, or long-term care. Only about one-half of adults covered by private health insurance had any dental coverage.[2325] Plans often cover only a small share of dentists' bills, obliging patients to pay lots of money OOP. The same is true for those MA beneficiaries with dental coverage.[2326] Medicaid plans must cover children's teeth but adult dental coverage subject to individual state politics and budget crises.[2327] In many states, Medicaid fees for dental care are so low that patients find it hard to locate a nearby skilled dentist who accepts their coverage. And despite enactment of federal and state laws demanding mental health parity, many ostensibly insured people suffer long wait times for an appointment or outright inability to find a mental health caregiver who accepts their insurance.[2328]

Fourth, some 66 million Americans rely exclusively on Medicaid for coverage. Because Medicaid pays much lower prices than other major third parties, Medicaid patients sometimes face financial barriers to obtaining needed care; these are sometimes magnified by Medicaid managed care plans that face financial incentives to withhold services.

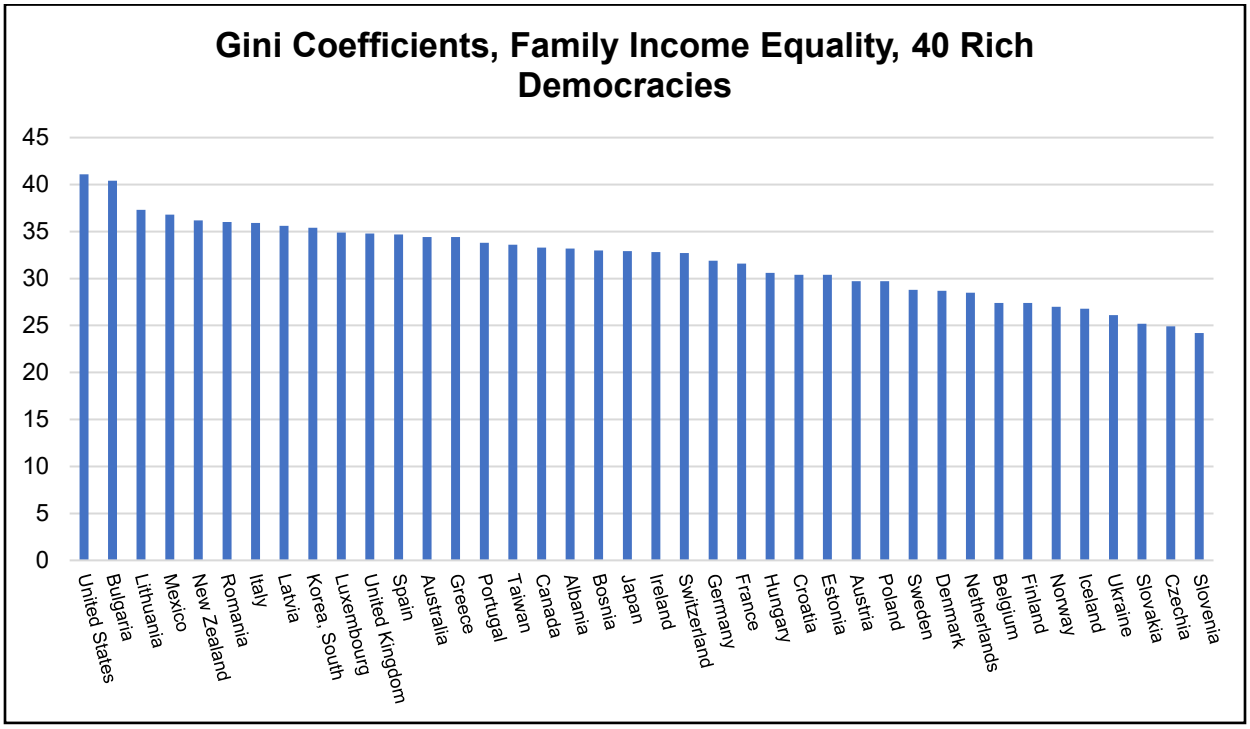
There are probably 7 main causes of the failure to financially protect all Americans against health care costs.

First, the distribution of incomes is less equal in the U.S. than in other rich democracies. Exhibit 5 - 4 displays the Gini coefficients for 40 rich democracies. A higher coefficient means a less equal income distribution. (A coefficient of 1.0 would mean that one family had all of the nation's income. A coefficient of 0.0 would mean that all families had equal incomes.) The U.S. has the least equal income distribution of the 40 rich democracies included. Our income inequality has been rising since the 1980s.

Second, U.S. health care costs per person are much higher than in any other rich democracy. The reasons for high costs—and for failures to contain them—are discussed briefly shortly and then in much more detail in chapter 8. Indeed, it is noteworthy that the U.S. has often sought to control cost by methods—such as higher out-of-pocket payments—that actually undermine or weaken financial protections for the very people whose access to health care is more

precarious. By contrast, payers' cost controls in other rich democracies are often designed to keep equitable access affordable for all citizens.

Exhibit 5 – 4



Third, politically, the political path to improved coverage for Americans is typically paved with new health care dollars, not with sums squeezed out of current health care spending that is wasted or marginally valuable. Expanded coverage is sometimes touted as a way to cut health costs via prevention, but that is mainly a political argument, not one resting on much evidence.

Fourth, the combination of high health costs and unequal incomes with spending new dollars makes it much more politically difficult to buy tickets of admission to medical care for all citizens. That's because this combination means that substantial sums of money must be trucked from people who have it to people who do not—if the latter are to be able to afford needed medical care. It is both expensive financially and difficult politically to shift so much money. U.S. expansions in numbers of people with nominal insurance cards is often accompanied by higher OOPs, managed care, and narrow caregiver networks that have the effect of suppressing access.

Fifth, political resistance to governmental redistribution of purchasing power is magnified by perceptions of governmental incompetence, mistrust of government, and a preference for relying on market action. Many of the citizens or businesses that would pay higher taxes or premiums to finance improved coverage might be particular opponents of government action. As well, doctors, hospitals, drug makers, and other caregivers might fear government efforts to improve coverage—even though that would mean more paying customers, other things equal—if they suspect governments might try to impose lower prices or lower total revenues to make

the improved coverage more affordable. Please recall, in this connection, the AMA's fierce opposition to the passage of Medicare.[2329]

Sixth, effective support for political action to improve coverage is weak because those who'd benefit are often unorganized as voters and also unable to offer substantial campaign contributions. As will be discussed in chapter 7, people who are uninsured or under-insured today are disproportionately poor, Black, or Latine. Racialized politics—which persist in large parts of the South—have impeded coverage expansions. Ten states have still not (in August of 2025) expanded Medicaid coverage as allowed under the Affordable Care Act of 2010. Of these, 7 are among the 11 states that seceded from the Union in 1860-1865.

Seventh, just as cost controls make it easier to cover all people, so does covering all people make it easier to control cost. If everyone is must be covered, cost increases must be affordable—and they must be effective without relying on access suppression. Since the U.S. commits to neither, the pressure to do either is far weaker than in other rich democracies.

2. Containing spending on health care by capping available revenue

This is a job for which governments and other payers are accountable in all rich democracies outside the U.S. But here, it is no one's job—certainly not the job of federal of state governments. Why are we so dramatically different?

Since other rich democracies pay high shares of the cost of health care with public money or semi-public money, they typically cap spending on health care because politicians try to avoid raising taxes. (The reasons they rely more heavily on public money are discussed elsewhere in this chapter.) These nations therefore craft methods of paying doctors, hospitals, drug makers, and other caregivers in ways that are commensurate with the national or all-payer yearly total spending.

Cost control in U.S. health care is an ever-receding pot of gold at the end of the rainbow. Most people think it's a good idea in the abstract, but political support is jokingly low.

Witness the applause for Massachusetts in pioneering a yearly target on growth in health spending. That this ineffective policy should garner praise and imitation testifies to its merely symbolic value. It does not work,[2330] and that may be the reason it is being copied. It also attracts attention from policy analysts, some of whom address questions like whether the growth target should be adjusted for higher-than-expected general inflation.[2331]

Why is political support for effective action so weak? Because caregivers prefer more money for business-as-usual over less, because few people trust government to do anything well, and because cost control promises no visible and immediate benefits to anyone.

And because the practical political commitment to health care for all remains low.

Cost control failures are self-reinforcing. As health care spending has grown, so have the budgets of caregivers, the number of their employees, and their political power. Non-profits demand higher revenues; for-profits seek higher returns on investment; and workers seek

higher pay. All can be expected to oppose cost controls unless they have reason to believe they will be better off by embracing them. This reinforces chapter 1's view that it will take a crisis for the U.S. to get serious about containing health care costs safely—by blasting loose waste and recycling it.

Until then, it is likely that politically-motivated demands that sick people—the weakest party, with the least information—will continue to be spurred by higher OOPs to contain health care costs by cutting their own use of care.

Government actions to contain cost that rely on promoting competition are ineffective because free markets competition in health care is itself unattainable—for reasons analyzed in chapter 4. As discussed in chapter 12, hospitals have sought to consolidate in part to boost their prices, and regulatory action to prevent hospital mergers have rarely been successful.

As just mentioned, Cooper and colleagues concede that government regulation to block hospital acquisition of doctors' practices has failed. Regulators "don't have the resources to block the thousands of deals that are occurring annually." [2332] Instead, they urge reliance on a combination of payment reform that might make the acquisitions less profitable to hospitals and less appealing to doctors.

Similarly, the Federal Trade Commission and the Department of Justice have done little to promote price competition by drug makers. Daval and colleagues found that the FTC initiated an average of only 1 enforcement action and 3 merger actions against drug makers yearly between 2000 and 2022. They concluded that the FTC pursued "only a small fraction of the estimated misconduct and consolidation in the pharmaceutical marketplace." [2333] While acknowledging "legal and practical limitations," Daval and colleagues still suppose that the FTC could develop tools to effectively promote competition. This may be a triumph of hope over experience. Even worse, even if FTC efforts succeeded, they might well amount to a misallocation of energy. As discussed in chapter 15, only about 10 percent of drug spending goes to generics, the sector where price competition is probably most feasible.

In the years since the Second World War, governments of the world's other rich democracies pledged to cover all people. That is possible only when costs are contained. And pressure to contain cost stems from the necessity of paying for everyone's care—combined with the substantially higher share of health care costs borne publicly elsewhere.

This means that governments elsewhere must respect the competitive free market's absence in health care—and substitute for it—by undertaking competent strategic public action. This entails crafting methods of raising money, deciding what care is covered, paying doctors and hospitals and other caregivers, and shaping the supply of caregivers with eyes toward what care works and is affordable.

Politicians who hope to be re-elected try to avoid either tax increases or reductions in health care access. To keep themselves in office, they seek ways to hold down costs to keep everyone insured. They must also keep doctors, hospitals, and other caregivers reasonably happy. This is a challenge everywhere. Governments elsewhere are constantly alert and organized to do so.

To protect access to care, payers elsewhere must avoid steps that constrict volumes of care. They avoid incentivizing lower volumes through magical thinking like "pay for value." That's

because they can't afford to bet their political farms on wishful thinking and unproven theories about cost control methods. They are generally reluctant to tolerate for-profit care. They hold down administrative waste because it means either higher cost or lower access.

In the U.S., refusal and inability to cap spending oblige cost controllers to choose between constricting prices and constricting volumes of care. The U.S. has opted for higher service prices and caregiver incomes but lower volumes and access to care. The evidence on rates of doctor visits and hospital admissions compared with real spending per person in the U.S. versus other rich democracies, reported in Exhibit 3-2, made this clear.

Why has this happened? One reason is that private and public health insurance in the U.S. has been just that—insurance, which entails paying legitimate individual claims. This means that health care financing has been open-ended, so spending has rarely been explicitly budgeted or capped. A second reason is that doctors, hospitals, drug makers, and others have been able to lobby powerfully in against restrictions on their prices, on their incomes, or on total health care spending. A third is that, absent comprehensive spending caps, public and private payers still worry about rising spending but, lacking effective tools, they resort to a succession of appealing but ineffective gimmicks that make health care more complex and annoying but do little to contain cost. Attempts to spur competition, capitation, and financing gimmicks are prominent in these failed efforts.

No gimmick is more durably appealing—or eternally less effective—than Medicare Advantage. Touted as a competitive managed care alternative, it has for decades cost more than traditional Medicare. By one recent estimate, Medicare over-paid MA plans by 20 percent ($75 billion in 2023).[2334] MA was sold as a way to constrain spending on Medicare patients but has failed to do so.

What MA does is to constrain patients. Seduced by added benefits financed by extra federal subsidies, younger and healthier Medicare patients enroll in MA. Plans' constraints—narrow caregiver networks and prior authorization are initially less consequential.

But, as patients age and suffer more serious health problems, as they face denial of approval for some care, and as they seek to be treated by out-of-network caregivers, they often find it hard to return to traditional Medicare owing to medical underwriting of Medi-gap coverage for patients who return to traditional Medicare in almost all states. That is, insurance companies may choose not to offer Medi-gap plans to patients whose expected costs are judged to be too high—or charge much higher premiums.[2335]

Nonetheless, some advocates of greater competition in health care urge continued tinkering with MA in hopes it will work fairly and efficiently to contain cost.[2336]

For example, in December 2023, the Biden Administration announced new efforts to boost "transparency" of MA plans—in hopes of "increasing transparency" in the MA market.[2337] It purported to do so by requesting information "from the public on how best to enhance MA data capabilities…." Apparently offered as a substitute for effective action, it rests on some reformers' hope that better information and more informed consumers will somehow generate pressure for MA plans to act with greater efficiency, effectiveness, or decency.

This vacuous activity may have been sparked by an April 2023 Kaiser Family Foundation report complaining that Medicare beneficiaries and policy makers lacked adequate data on plan performance.[2338]

5. Government failure is the other source of anarchy

A second reason is that supporters of cost control are weak and merely mildly motivated. The persistent disconnect between containing costs and doing specific good things—of containing cost in order to pay for good things—makes most cost control proposals merely abstract ideals, devoid of driving desire.

For example, no one draws a medical, political, and financial connection between cutting inflated Medicare Advantage capitation payments by, say $20 billion yearly, and using the saved sum to cover the full cost of a good new Medicare hearing aid benefit.[2339]

Today, threats that higher health spending will deprive other important sectors of adequate financing are just as abstract, as are threats that growth in health care costs are unsustainable.

Third, generally, opponents of cost control are more numerous, persuasive, and powerful than proponents. Some want all the medical care others are willing to finance. Some fear that failing to spend more money on health care would curtail lives or increase pain and disability. And some seek more money to boost their personal incomes or the revenues of the organizations they manage or own.

3. Shaping the configuration of caregivers to support efficient delivery of needed care and to redeem the promise of financial coverage

This is the second essential step to actually delivering equitable health care for all. Even if the U.S. built the first foundation by offering wide, deep, and equitable financial coverage to all citizens, that financial promise would be abstract, tantalizing, but unfulfilled were it not redeemed by adequate numbers of the right caregivers in the right places. A patient's insurance card remains only a piece of plastic unless enough good doctors or dentists or ERs or social workers or hospice programs are available nearby.

The word "configuration" refers to the numbers, types, and locations of doctors, nurses, dentists, hospitals, nursing homes, home health agencies, hospices, pharmacies, and other caregivers. Malconfiguration of hospitals or doctors or dentists or long-term care or mental health services—shortages, excesses, wrong types, wrong locations—all manifest anarchy in care delivery.

Governments in the U.S. do almost nothing coherent to shape caregivers' configuration by identifying shortages or excesses and working to remedy them. No one is accountable to address these problems. They are no one's job.

The medical care Americans get depends heavily on the caregivers we've got. Malconfigurations arise owing to comprehensive market failure. They persist because federal and state governments are unwilling or unable to act strategically to assess needs for caregivers and to implement programs to address malconfigurations. The nation does not have the right numbers of doctors, hospitals, and other caregivers. It lacks the right types of caregivers. And those we have are geographically maldistributed. These three problems boost cost, impair access, and undermine appropriateness and quality of care.

Only one state—Maryland—even has a list of the hospitals and emergency rooms that are essential to protect the health of the state's people. Created in 1971, the state's Health Services Cost Review Commission is obliged to constrain spending growth while protecting access to care and the financial stability of needed hospitals. This entails deciding which hospitals are needed to ensure access and then paying those hospitals enough to cover the cost of efficient delivery of needed care.[2340]

Elsewhere in the nation, no one payer or coalition of payers is obliged, able, or willing to identify needed hospitals. No entity has the job of learning the size of budgets adequate to efficiently deliver needed care. And, certainly, no entity is accountable for ensuring that the right amount of money goes to each hospital.

As discussed in chapter 9, a set of band-aid financial supports for politically persuasive hospitals has been only a weak substitute for open-eyed assurance of revenue sufficient to finance hospitals' efficient delivery of needed care.

For over four decades, a simple-minded, convenient, durable, but demonstrably false principle has shaped governments' and private payers' attitudes toward hospitals: total cost is lower when fewer hospitals and beds are operating. As summarized earlier in this chapter and as discussed in detail in chapter 11, some analysts thought that building more beds would induce higher use of hospitals. They concluded that closing entire hospitals was the most effective way to save money. Unfortunately, closing some hospitals allowed surviving institutions to raises prices and costs of care. Consequences include low bed-to-population ratios and low rates of hospital use, high per-person spending on hospital care, and excessive reliance on the costliest major teaching hospitals.

Public activity to shape doctor configuration is about as effective and useful as efforts to shape hospital configuration. But has done little to advance affordable high-quality care for all people. No state government even has a list of the numbers of primary care doctors, mental health clinicians, dentists, or other caregivers needed to protect the health of its people.

As will be shown in chapter 10, doctors' patient-by-patient decisions shape almost 90 percent of U.S. health care spending. In this sense, the care we get depends heavily on the doctors we've got.

As was shown in Exhibit 3-2, the U.S. provides only about two-thirds as many physician visits per person as the average rich democracy. Across rich democracies, we are third from the bottom in doctors per thousand people overall. We fare especially poorly in primary care physicians. Physicians' geographic malconfigurations—both across and within states—is substantial. These result in impaired access; reduced appropriateness, quality, and coordination of care; and higher cost.

No one has the job of ameliorating either the overall shortage of physicians in the U.S. or our low share in primary care.

Public actions to address these challenges, while often well-publicized, are almost always weak relative to the size of the problem. An exception is federal financing for community health centers to help deliver primary care, dental care, and mental health care in underserved urban and rural areas. They are platforms for perhaps one-twelfth of all doctor visits nationally, and a

substantially higher share of primary care visits, particularly to patients covered by Medicaid or who remain uninsured.[2341] But they typically lack secure arrangements to refer patients for specialized physician services or hospital care. Still, the CHC program is worth building on.

The National Health Service Corps recruits some 13,000 primary care physicians, dentists, and mental health clinicians to work in underserved urban and rural areas in exchange for a combination of salaries and debt forgiveness. Most serve in federally-financed community health centers; others are located in rural critical access hospitals, Indian Health Service sites, and various other settings.[2342]

These two complementary programs are enormously valuable to the patients they serve, but they are not remotely commensurate with need for care. They are patchwork, episodic, bandages that address symptoms of physician malconfiguration, not its causes.

Some state governments have built new medical schools or expanded existing ones in the genuine belief this would boost the supply of primary care doctors. Other states justified their investment in this way but did not expect more primary care doctors would result.

Medical schools train doctors indiscriminately. Focusing on them is like buying gasoline without specifying where the car should go. The specialty doctors choose for their residency shapes their subsequent practice.

State governments' support for medical schools is a spectacularly poorly targeted method of channeling more doctors into primary care. States find it hard to bind their medical schools' graduates to careers in primary care.[2343] Similarly, making medical school tuition-free may do little to divert more doctors into primary care.[2344] And medical school grads who enter primary care residencies in pediatrics or internal medicine are increasingly likely to depart for subspecialties: the share of internal medicine residents pursuing subspecialties was 81 percent in 2015, up from 62 percent in 2002.[2345] The money devoted to building new medical schools, subsidizing tuition, and similar steps does little to counter the higher incomes, higher prestige, greater control over time, reduced paperwork, and superior autonomy enjoyed by physicians who avoid primary care.

So—why the investment of billions of dollars in new medical schools, tuition subsidies, and the rest? One explanation is a triumph of hope over experience. A second is state governments' need to look like they are doing something about the shortages of primary care facing their citizens. And voters who don't discriminate among different types of physicians may see added medical school capacity as a way to expand access to care that had been in short supply. A third is that state governments might suppose that graduates of in-state medical schools may be more likely to practice in-state—even though site of residency training correlates much more closely with site of ultimate practice.

Adequate primary care capacity is widely recognized to be essential to supporting patient access to care, promoting continuity and coordination of medical services, and containing cost. Still, nation-wide shortages and geographic maldistributions of primary care are normal, not exceptions. Other rich democracies have sometimes responded to these challenges in serious and effective ways—surpassing U.S. actions. Their successes testify to the value of holding government accountable for strategic action to shape caregiver configuration.

In Ontario, family practitioners' share of new medical school graduates had fallen to half the desired level just before the new millennium. The province responded with substantial

organizational and financial changes. It sponsored interdisciplinary primary care teams to enhance practice capacity. It boosted family practitioners' incomes by 40 percent by adding salary and per-patient capitation payments to per-visit fees. About three-fifths of the shortfall in medical school graduates opting for family practice was made up in the five years following the changes in provincial policy.[2346] Still, this reform seems far from perfect. The primary care teams have been criticized for serving higher-income areas of the province and for failing to provide as much improvement in various quality and patient satisfaction measures as provincial government sought in return for its investment.[2347]

French President Macron announced in 2018 an effort to persuade and to pay 400 primary care physicians to practice in underserved rural areas and small cities.[2348] Salaries would be paid by the state. One step is to entice newly-retired general practitioners to work part-time.[2349]

4. Promoting equitable delivery of effective and high-quality care

This is health care for all's third foundation. Hard as they are to attain, financial coverage and appropriate configuration of caregivers are not enough. The third foundation, then, is to diagnose and treat inequities in the appropriateness and quality of care actually provided across the nation.

Inequitable care has three parents. One is the inevitable—perhaps random—differences across professional and institutional caregivers. The second is selective sorting or clustering of better caregivers in some parts of health care—hospitals above nursing homes, for example, and—more important, in some places but not others. This, in turn, manifests[2350] differences in insurance coverage and in prices paid by different payers, along with caregiver preferences. The third is failure to work harder both to narrow the inevitable randomness in inter-caregiver competence, and to counter the systematic and purposeful sorting and clustering of caregivers by type of service or type of patient or geography.

It is reasonable to expect that the professional competence, judgment, energy, and kindness of doctors, nurses, dentists, pharmacists, social workers, and other health care professionals are distributed normally, perhaps in something like the bell-shaped curve shown in Exhibit 5 – 5.

Clearly, one-half of health care professionals are above-average and one-half are below. Some paid closer attention during their clinical courses and residencies. Some have better memories. Some work harder and are more energetic. Some do better at organizing the information they have and at putting it to work when patients need it. Some are kinder and more deeply committed to patient well-being. Some are more resilient in crises.

An old question is, What is the title of the person who graduates at the bottom of their medical school class? "Doctor."

The same curve could be drawn for hospitals, ambulatory surgery centers, nursing homes, home health programs, hospices, and other institutional caregivers. Some are more generously financed. Some are better organized and managed. Some set higher standards of professional and compassionate patient care. Some attract better clinical and non-clinical workers.

For both professionals and institutions, the distribution of caregivers is neither random nor proportionate to need for medical care. Few individual citizens, for example, have entirely

unpredictable or random 50/50 chances of being served by or at an above- or below-average caregiver. Systematic patterns are at work. Lower income patients are more likely to be served by hospitals that are less-well-staffed and by professionals who are below-average in quality. So are members of several racial or ethnic groups. So are rural citizens or citizens of urban neighborhoods under-served by doctors, health centers, or hospitals. It appears, also, that patients who need long-term care services are particularly vulnerable to receiving low-quality care.

Looking beyond the question of adequacy of supply of caregivers, suppose that enough doctors and dentists could be attracted to rural counties or currently under-served low-income neighborhoods of large cities. Would they be as competent as their counterparts in urban counties or wealthier urban neighborhoods?

Suppose that all payers paid the same price for the same care. Would professionals shift toward currently under-served areas and people? And suppose that rural hospitals and those in low-income states or cities had budgets on a par with their urban and high-income counterparts. Would the technical quality, safety, appropriateness, and efficacy of their services become comparable?

For both professionals and organizations, the most extreme and dramatic quality problems, those near the far-left edge of the curve, receive the most visible attention.

Paid medical malpractice claims are highly concentrated. In one large study, about one-fiftieth of physicians accounted for almost two-fifths of paid claims [2351] and for over one-half of paid claims in a second study.[2352] Doctors hit by paid claims were found likelier to move to solo practice and also to gravitate to a few hospitals "staffed by physicians with unusually high numbers of paid med mal claims, disciplinary actions, or both." [2353]

Systematic exploitation of patients—particularly elderly patients—through unnecessary surgery, incompetent care, bribery, and theft characterized the for-profit Sacred Heart Hospital on Chicago's West Side before it was closed and malefactors jailed.[2354] A high share of services there were unnecessary, ineffective, dangerous, and incompetent.

For many years, King-Drew Medical Center in Los Angeles often provided inappropriate and low-quality care. Under these conditions, clinicians with higher standards of patient care could be expected likely to relocate to other hospitals. Crises became so grave and visible that comprehensive reform was finally undertaken.[2355]

After Washington's mayor and the city's Congressionally-mandated Financial Control Board forced D.C. General Hospital to close in 2001, its successor, United Hospital, encountered so many problems in its obstetrical service that OB was obliged to cease operating.[2356]

These three hospitals disproportionately served and, therefore, disproportionately harmed lower-income and Black or Latine patients.

Lower-income patients are also much more likely to report lacking a usual source of medical care. In 2007, adults under 200 percent of the federal poverty rate said they were almost three times as likely to lack a usual source as those above 400 percent of the poverty rate.[2357]

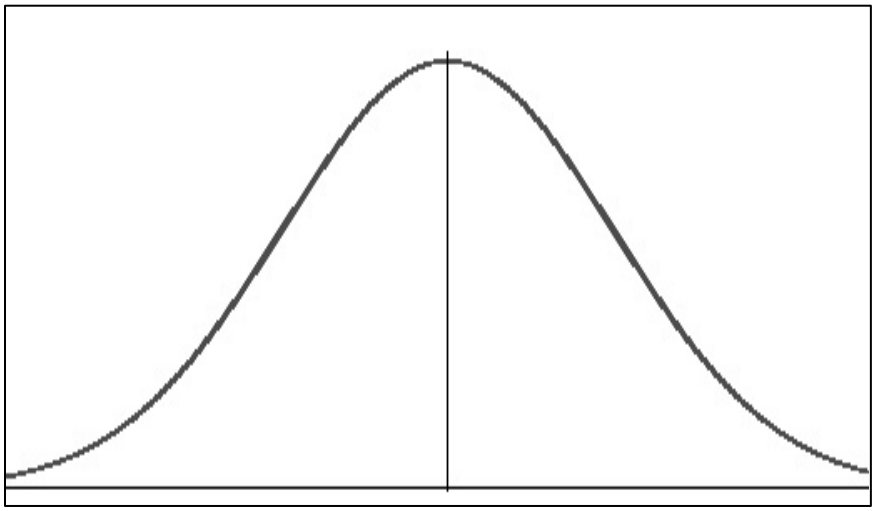
African-Americans and lower-income patients are more likely to rely on less experienced caregivers. In 2011, for example, about one-third of Black patients' visits to doctors were at

hospital outpatient departments or emergency rooms, where resident physicians are more likely to provide care. The share for Whites was one-fifth of visits.[2358]

Whites' rate of use of mental health services—outpatient visits or prescription medications—is about double that of Black or Latine citizens.[2359] It is likely that lower-income and Black or Latine patients are more likely than higher-income or White patients to receive care from less experienced mental health clinicians.

Exhibit 5 – 5

A Normal Distribution Curve



Problems of quality and appropriateness of care persist for a number of reasons. One background factor is that patients vary greatly in the revenue they generate to caregivers. Uninsured patients might face higher nominal charges but are generally able to pay the least. Medicaid programs pay higher prices, followed by Medicare. Private insurers pay the highest prices.

A second background factor pertains to the great variations in caregiver supply relative to population need for medical care.

A third is that less experienced, less well-trained, and less competent caregivers may serve lower-income or minority patients.

Fourth, many policy-makers' and caregivers' disproportionately focus on raising the ceiling—the best care that can be given to or afforded by some patients. This inevitably means less attention to raising the floor, the worst care patients are allowed to suffer.[2360]

Public and professional efforts rarely address any of these sources of gaps in quality or appropriateness of medical care. What might such efforts look like? One would financially cover all Americans. A second would have each payer pay the same price for the same care. A third, would undertake to address geographic gaps in caregiver capacity through effective tools—such as paying enough to attract the right numbers and types of caregivers to the right places, providing solid clinical and organizational support for caregivers working in formerly

underserved regions, and recruiting health care professionals who aim to work where caregivers are now in short supply. A fourth would be to invest in obtaining better evidence about ways to diagnose and treat the most common, damaging, and costly medical problems. A fifth would be to disseminate that evidence to all relevant clinicians.

These efforts, though, would be only a beginning. Much more thought and work will be required before appropriateness of care and its technical quality are raised to high and balanced levels throughout the nation.

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

This is essential in other rich democracies. Both conflicts are inevitable and persistent. Reconciling them rests on holding in mind two truths that are so obvious that we often ignore them.

One is that pathology is remorseless but resources are finite. The other is that spending more money on health care means spending less money on everything else. Therefore, other rich democracies must develop ways to choose what care to provide and pay for, and those choices must be made with an eye toward what is equitably affordable and effective for all.

Because these nations typically cap yearly spending on health care in various ways, it is clear that resources are finite. Doctors, hospitals, and other caregivers face pressures to care for patients efficiently in order to serve all without running out of money. That entails prioritizing effective and lower-cost care and avoiding ineffective and higher-cost care. This might be called “rationing” or it might be called deliberately working to win as much effective health care as possible with the clinical time and money available.

Reconciling access and cost also means shaping the supply of caregivers in accord with both patients’ clinical needs and payers’ financial realities. For example, numbers of hospital-based specialist physicians are typically capped while primary care is encouraged.

Doctors, hospital managers, unionized clinical and non-clinical workers, drug makers, and citizens—as both patients and voters—vary in their awareness of the two truths. This does not prevent workers from becoming angry if their real wages fall. It does not prevent some patients from becoming angry if a possibly valuable drug is not covered by a health plan. Political, financial, and clinical tensions are inevitable in each nation.

Trust and its foundations

Trust in health care’s fairness and adequacy goes far toward mitigating these tensions. Trust rests heavily on solid long-term relationships between patients and their family doctors. It also rests heavily on fair and adequate financing for appropriately configured caregivers. This includes the principle of financial neutrality. Doctors, hospitals, and other caregivers would be paid by financially neutral methods. Caregivers would act as fiduciaries—trustees—for U.S.

medical services and their financing. Adequate provision of good care builds trust, and that provision requires blasting loose a large share of the waste that pervades U.S. health care.

Absent a competitive free market, performing all these jobs rests on the foundations of competent and strategic government action. Building those foundations certainly has technical aspects. It main element, though, is to find ways to resolve inevitable conflicts among various aims and stakeholders.

In the U.S. today, we rarely try to reconcile the conflict between care for all and containing spending. Indeed, we tend to deny that the conflict even exists. Why do we do that?

First, Medicare and private insurance plans are almost always obliged to pay for all care that is given, as long as it has even the slightest clinical justification, without discriminating between care of great clinical value that costs little and care of little clinical value that's very expensive. There are few pressures to spend money carefully. This is a recipe for high costs but inferior health outcomes.

Second, to make this possible, spending is rarely capped in practice. Health maintenance organizations and capitated Medicare plans have sought to cap spending, but those caps have been overthrown or evaded. Spending remains largely unrestricted, open-ended. People are covered; doctors diagnose and treat; payers pay. If this year's spending is not adequate, taxes or premiums are boosted. An exception—for now—are the capped Medicaid plans for low-income citizens.

In the absence of effective public action to contain cost, insurance companies and employers have crafted alternatives. These generally work by suppressing access to care or its cost. They include narrow networks of caregivers, higher OOPs, and private bureaucratic constraints on care. The last include prior authorizations, step therapies for meds, downcoding, and retroactive denials of payment.

Enforcing these private constraints can be expensive. Insurers must hire people to administer them. They impose substantial monetary and time burdens on doctors, hospitals, and other caregivers. And they constitute effective barriers to using health care. Narrow networks can mean longer travel time to care or delays in obtaining appointments. Higher OOPs hit lower-income or chronically ill patients hardest. Prior authorization for prescription drugs might save money for insurers but can prevent patients from getting care or taking meds their doctors prescribe. In one study, over one-half of patients denied prior authorization ended up taking no meds at all. Effects on health could not be measured.[2361] [2362]

CMS has sought to streamline aspects of prior authorization by promulgating standards for electronic claims attached to prior authorization requests. Two different standards would need to be considered and reconciled. Administrative complexity associated with this effort (which was supposed to cut administrative complexity) prompted caregivers and private payers—the American Hospital Association, the American Medical Association, America's Health Insurance Plans, and the Blue Cross Blue Shield Association—to join to oppose the standards for electronic attachments.[2363]

Early in 2024, the AMA's president lauded CMS's final rule on prior authorization. It includes a requirement that Medicare, MA, Medicaid, and ACA exchange plans support prior authorization that is embedded in doctors' own EHRs. Insurers will be required to report on approval/denial

rates and time required to process requests for authorization of care.[2364] The AMA also pointed to 70 bills filed in 28 state legislatures that seek to reform prior authorization.[2365]

But all this is just another payer – caregiver skirmish over money and power. As long as a) cost controls are weak and b) payers perceive that doctors have financial incentives to give more care, payers will try to modulate the power of those incentives. In the face of tightening federal or state regulation of prior approval, payers will develop annoying new techniques that comply with the new regs but continue to frustrate doctors—and patients—and continue to waste money and effort.

Pre-empting conflict

Solid financial coverage for all Americans, sensible caregiver configuration, and a cap on spending will require different methods of pre-empting as many conflicts as possible and of resolving those that arise.

Some seven elements will be helpful.

Accountability. In U.S. health care, market failure plus government inaction and incompetence have combined to mean that no one is accountable for anything that happens outside the building where they work. Introducing accountability requires government, with other payers, to make strategic decisions—How to financially protect all American? How to cap revenue available to spend on health care? How to configure caregivers to redeem the promise of financial coverage? How to pay caregivers in ways that promote trust in their decisions and also work to squeeze out as much waste as possible? How to elevate and equalize appropriateness and quality of care by giving more attention to the floor than to the ceiling?

Adequacy. The first is adequate financing. Slashing a high share of waste and recycling it to pay for care should mean that the amount of money available will be widely deemed adequate.

Trade-offs. Finite dollars, remorseless pathology, and solid financial coverage for all combine to require establishing budgets for care. These are discussed in chapters 8, 9, and 10. Some care that might potentially benefit some patients would be denied, but only if other care for that patient or other patient is more cost-effective or has a higher benefit/cost ratio.

Primary care. A second is strong public efforts to boost the chance that each person has a family doctor, one whose trusted and, even, liked. One who has the time to learn what the patient wants, to understand the patient's medical diagnoses and treatments, to be available in emergencies to advise on where to go and what to do, to refer to specialists and coordinate their care, to assure continuity of care over time, and to assure the patient that care is clinically appropriate.

Financial neutrality. All caregivers would be paid by financially neutral methods. None would face financial incentives to give more care, less care, or different types of care. In the absence of a functioning competitive free market, for-profit caregiving would be outlawed.

Fiduciary duty and trusteeship. All professionals would have a fiduciary duty to put their patients' interests before their own. All caregiving organizations, their trustees, and their managers would have a fiduciary duty to put their patients' interests before their own. Identifying and recruiting altruistic physicians, other clinicians, and managers is feasible and

effective. As mentioned in chapter 1, Casalino and colleagues 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.[2366] Both professionals and organizations would accept stewardship of the nation's vast but finite clinical and financial resources.

Principles. It is valuable to develop reasonable guidelines for giving and denying care. Most will be principles, not rigid rules.

- ✓ Similarity: One would be the statement that people with similar problems will be treated similarly, up to a certain standard, unless they decline treatment.
- ✓ Priority: Another would be to assure that all patients are offered high-value/low cost care before any patient is offered low-value/high-cost care.
- ✓ This will require considerable investment in learning the efficacy and cost of different ways to diagnose and treat different problems.
- ✓ Since budgets for caregiving would be finite, the obligation to avoid waste and low-value care would fall on all health care professionals and organizations.
- ✓ Yet another would be for physicians, hospital administrators and trustees, and other parties to endorse the principles of similarity and priority.

Making the 5 big decisions well means better care and greater patient trust in our care. At the same time, it radically slashes the burden on government. It relieves government of the need to constantly sweep up after the circus parade—to make great numbers of small regulatory decisions—decisions that would inevitably be made badly

Governments in the U.S. have made few big health care decisions well. In recent decades, governmental failure has compounded market failure. Still, snowballing health care anarchy boosts pressure on governments to DO SOMETHING—to boost or protect coverage, contain cost, reconcile access-cost conflicts, shape caregiver configuration, or assure high-quality and appropriate care.

Failure to make big health care decisions well obliges Americans to make lots of smaller choices. They are so numerous that many are made badly. Governments, private payers, caregivers, and reformers are forced to devote energy to fighting energy-sapping skirmishes, not the big battles. When a house is badly built, it needs regular and costly repairs.

Governments need time and energy and legitimacy to think clearly about priorities, identify strategic choices, and take steps to overcome anarchy. This entails accumulating political support instead of dissipating it.[2367]

Governments need time to learn about health care, identify problems and analyze their causes, and devise remedies that are effective because they weaken the power of causes to undermine access, to boost cost, and the rest.

This brings us face-to-face with a chicken-egg problem. How can government win victories for competence and compassion in health care if it lacks political support or credibility to act? What

sort of a political coalition could be assembled to motivate and sustain effective public action? And if it enjoyed greater trust and political support, would it even know what to do?

Several potentially useful and effective approaches might guide government efforts. One would be to act in ways that make health care more self-regulating, where bigger decisions are made in better, more effective, more popular, and more durable ways—and in ways that cut the need for downstream government action instead of boosting need.

A second would be to begin strategically to build alliances. Doctors are vital politically and financially as well as medically. Today, they often complain about payers that limit their clinical freedom, financially-driven mistrust from payers and patients, growing administrative complexity and paperwork, and resentment and fear over exposure to malpractice suits.

C. Causes of weak government action

Strategic government actions could offer reasonable alternatives to anarchy. That is so in most of the world's rich democracies. Elsewhere, government actions are essential to protecting solid coverage for all people, containing cost, paying caregivers, and assuring reasonable configurations of care.

But not in the United States of America.

Little is expected of federal or state governments in health care. Less is delivered. While governments in the U.S. make some important decisions about health care well—such as financing coverage for many people who could not otherwise afford it—it is incompetent in most of its activities in health care. Even financing coverage is fraught with problems owing to the absence of effective controls on U.S. health care costs. Without cost restraints that work, governments have been complicit in suppressing use of care and cost of care in the worst possible way—via under-insurance—as discussed in detail in chapter 7.

It's useful to review the main over-arching reasons for governments' failure here to positively shape health care coverage, cost, care, and equity. Some 5 clusters of explanations are helpful. The relevance of individual explanations varies somewhat from issue to issue. And the explanations are sometimes complementary or overlapping. Understanding the different causes of governments' weak actions—and the forces underpinning them—may guide future efforts to do better. The 5 explanations are:

1. Widespread belief that market forces should shape most health care decisions—like containing cost, configuring caregivers, choosing which care to give and who should get it.

2. Americans have little confidence in governments. In health care, powerful caregivers and insurers desire more money from government and less public involvement in shaping how it is spent. Reformers typically seek incremental changes like added financing for unprotected citizens or badly-covered services, not greater attention to big problems.

3. Low government competence in addressing health care problems.

5. Government failure is the other source of anarchy

4. A history of poor government choices in addressing health care Why?

5. Accidents and distractions

1. Faith in markets

1. Widespread belief that market forces should shape most health care decisions—like containing cost, configuring caregivers, choosing which care to give and who should get it.

Free market advocates assert, with considerable justification, that genuine competition means that producers face strong pressures to lower costs, innovate, and make the goods and services that sovereign consumers wish to buy. Genuine markets self-regulate. They require little from government except breaking up monopolies and preventing false claims, adulteration, or other criminal behavior.

Advocates also assert that economies run from the top down become hidebound, corrupt, and undemocratic—and dictatorial.

A competitive free market is most Americans' first choice to do most economic jobs. That market may not work in health care, for reasons analyzed in chapter 4, but that failure is not widely acknowledged. One reason is that the case for market failure is complicated while the market's seductions and simple and visible. A second is that opponents of public action to improve financial protections, cut cost, configure caregivers, enhance equity of care, or rein in bad actors all trumpet market approaches and decry reliance on government. A third is that trust in market actors and mistrust of government run deep. The Gallup Poll's June 2022 inquired about the share of Americans with either a great deal of trust or quite a lot of trust in various institutions. Small business ranked highest at 68 percent. The presidency ranked 11th at 23 percent. Congress ranked 16th and lowest at 7 percent.[2368]

Federal and state governments don't wrap their arms around health problems, their causes, or possible remedies. They engage episodically and narrowly. They don't gain experience or build institutional memory. They fail to build political capital.

But the real-world validity of these assertions of efficiency, cost-cutting, innovation, and self-regulation rest on whether a free market is actually present.

As discussed at length in chapter 4, not one of the 7 requirements for functioning competitive free markets is remotely satisfied in health care. And efforts like empowering and motivating consumers, promoting choice, and fighting caregiver consolidation have been ineffective at best and wrong-headed smokescreens at worst.

Still, persisting faith in markets usually offsets or neutralizes pressure for government action—or simply crowds out opportunities for governments to act.

Free market economists help to influence continued reliance on competition. Large numbers of market-oriented judges strike down some legislation and identify constitutional or procedural requirements that paralyze implementation of others.

2. Little political pressure for competent government action in health care

Americans have little confidence in governments' competence, generally. In health care, powerful caregivers and insurers desire more money from government and less public involvement in shaping how it is spent.

Reformers rarely try to counter caregiver demands. Instead, they typically seek incremental changes like added financing for unprotected citizens or badly-covered services, not greater attention to any of the 5 big decisions discussed in the previous section of this chapter.

Frustrated reformers have sought some political and policy elbow room. This has led many to focus attention on sectors of health care where powerful caregivers, insurers, or free market ideologues are less likely to oppose public action. But weak opposition signals that reform—if enacted and implemented—would pose only weak threats to business-as-usual. Theoretical caps on state health spending are one example. Medicare drug price negotiations are a second. So opportunities for effective action have been rare. Reformers have been obliged to channel most of their energy into pushing policies and regulations that have generally proven unproductive.

3. Low governmental competence

Caregivers and insurers understandably prefer weak government action but generous government payments. Since governments have never been obliged to engage seriously with any of the 5 big decisions, they have not needed to develop broad and deep understanding of the 5 problems or their causes. They have not needed to become competent to develop policies at address those causes or to implement them effectively.

Federal and state governments have not put their arms around health care. Governments haven't taken ownership or accountability for competently making the 5 big decisions. Instead, they have usually been kept busy reacting to problems or abuses.

One reason is that high elected officials rarely know much about health care problems, their causes, or possible remedies. In other rich democracies, prime ministers must understand health care because health care errors can be politically fatal when they result in skyrocketing costs, tax increases, denials of needed care, or caregiver shortages.

Because governments operate top-down, ignorance at the top tends to suffocate innovative reforms from the bottom-up.

Ignorance of health care and weak political pressure to act have led governments to fail to forge tools they'd need to competently intervene when problems arise. For example, Steward and Prospect were allowed to buy financially troubled hospitals—mainly non-profit institutions—in Massachusetts, Connecticut, Rhode Island, Pennsylvania, Florida, Texas, Utah, California, and

elsewhere. Closings of the hospitals or substantial infusions of state- or privately-financed revenue. The buyers promised to turn around the hospitals through efficient management and targeted capital investments,

Those improvements rarely materialized. Instead, capital improvements, repairs, and even routine maintenance were deferred. Needed equipment sometimes became unavailable. Buildings and land were sold off and leased back. In Massachusetts, it is likely that only 5 of 10 Steward hospitals will continue operating—and even this will cost the state many hundreds of millions of dollars. State money is replacing money extracted by venture capitalists and plundering executives.

The for-profit ownership proved to be only an imaginary rest stop on the hospitals' downward slides.

What could state governments have done instead? First, inventoried hospital bed and ER capacity, and individual services like peds, OB, psych, and others. Second, compared capacity with need, current and projected. Third, designated needed hospitals and services. Fourth, gauged revenue required to finance efficient delivery of needed care. Fifth, assured needed hospitals that revenue via all-payer budgeting. Sixth, passed robust receivership statutes that would allow responsible state officials to petition a court to appoint a receiver to quickly take control of a hospital that is being mis-managed or financially plundered. The receiver should be empowered to petition the court to write off improperly-acquired financial obligations—such as rent required to use land/building sold offer by profiteers. Seventh, established a Hospital Stabilization Trust Fund, financed by yearly payments from hospitals themselves (equal to perhaps 0.25 percent of patient care revenue and 1.0 percent of non-operating revenue). This money would serve as a mutual aid or insurance reserve, available to underwrite short-term operating losses and also to hire skilled turn-around technical assistance.

These things did not happen and they have not happened. One reason may have been that Steward's CEO became a major donor to Massachusetts politicians.

Instead, we now see legislation aiming to make it harder for new private equity-backed actors to repeat the bad deeds of the past decade. This is called shutting the stable door after the horse has bolted. It is a disheartening to read that Tsai and colleagues call a 2025 Massachusetts law "perhaps the most far-reaching state legislation in the United States aimed at curtailing the influence of private equity (PE) in health care." [2369]

States did not anticipate any of the problems accompanying for-profit take-overs of financially distressed hospitals. Even so, their after-the-fact responses have been surprisingly narrow, weak, and rare.

An important aspect of anarchy and unaccountability in U.S. health care is governments' preoccupation with fighting health care fires. Failure to make big decisions well means that governments are bombarded by incessant demands to make many (many) small decisions. But they lack the money, political support, or even the information and analyses required to make those small decisions competently. Besides, those small decisions are so numerous as to dissipate governments' attention and energy.

Even worse, it is usually not possible to make good small decisions well because of the prior failure to build a foundation of good decisions. One reason is that even small matters are enmeshed in complicated tangles of earlier laws, regulations, financing methods, and other

barriers. Progress through a jungle is hard when the foliage is dense and no one has a machete. Judges occasionally plant legal kudzu that impede definitive regulatory action—often for many years.

Problems of financial coverage, cost, quality and appropriateness, and caregiver configuration in the U.S. have been allowed to burn for decades, much like a network of fires in a vast abandoned underground coal mine. Confidence in putting out the fires wanes steadily.

Still, health care problems are widely publicized, pushing politicians to act—or to appear to be acting. Unfortunately, the laws that can pass are unlikely to work well, and the laws that might work well are unlikely to pass.

This makes public action look incompetent. That undermines support for subsequent action. Defeat demoralizes and drives desertions.

Government actions lack competitive free markets' simple test of success—profitability. Governments are therefore sometimes tempted to cut corners.

One option is to rename a problem. So VD become STD and then STI. Addiction becomes OUD.

A second option is to move the problem to a new site, usually without remedying it. So hospital length-of-stay is cut and post-acute nursing home days rise. Older residents of state mental hospitals are discharged to nursing homes; some younger people suffering mental illnesses obtain supportive housing and outpatient meds if lucky but other younger people live on the street or in jails if unlucky.

A third option is to write a plan. This is valuable if it is a guide to action by governments seeking to actually act. The Vermont state plan for shifting long-term care resources and patients from nursing homes to alternative settings is a good example.[2370]

Sadly, though, most plans are designed to serve as alternatives to effective action. The federal action plan for heart disease and stroke,[2371] for example, mainly describes calls for meetings. It was, therefore, followed by a paper on translating the action plan into action.[2372] Influenza immunization preparation,[2373] disaster management, and electronic health records[2374] are unhappy examples.

4. A history of poor government choices in health care

Federal and state governments have faced little political pressure to act effectively to anticipate and address health care problems. Efforts to improve financial coverage requires finding new money—since it is so hard today to cut health care waste. But finding new money is hard for several reasons. Current spending to cover most Americans is very high. Buying coverage for currently uncovered citizens can be expensive. Unequal income distributions mean that most of the new money must be extracted from relatively small numbers of high-income and wealthy Americans. They may resist. But not in ways that would actually squeeze out wasted dollars and recycle them to cover all Americans.

5. Government failure is the other source of anarchy

Doctors, hospitals, drug makers, and insurance companies have helped press governments to make poor health care choices. All are financially addicted to more money for business-as-usual. None want governments to pursue reforms that threaten this.

Government action in health care suffers from a particular chicken – egg problem. Public trust and confidence in government's capacity for competent action is low. A history of policy missteps and regulatory failures weakened governments' self-confidence.

One policy misstep was Medicare's adoption of DRG payment by the discharge for hospital inpatient care in reaction against hospitals' abuses of cost-reimbursement. Another was adoption of resource-based relative value scale (RBRVS) payment as a reaction against doctors' abuses of usual, customary, and reasonable fee-for-service payments. A third has been the evidence-free adoption of value-based payments as reaction against perceived abuses of pay-for-volume. A fourth has been to boost HMOs' managed care, Medicare Advantage, Medicaid managed care, and accountable care organizations as shallow mechanical remedies for deep problems. A fifth has been to tolerate access suppression as a main cost control technique. A sixth was to enact Medicare Part D prescription drug coverage without regulating drug prices—making for a program with high OOPs. Subsequent caps on OOPs have resulted in higher premiums and exclusion of many meds from coverage.[2375]

These policies share several characteristics. Each was the best policy that could be crafted in its day—and the best law that could pass. Each rested on weak analysis and evidence. To win legislative support, each was over-sold. None lived up to promised value or even worked very well. The law that can pass can't work, and the law that could work couldn't pass.

Governments' over-riding policy principle might be called DALAP – do as little as possible.

Governments haven't crafted remedies commensurate with problems. They have refused to analyze causes of problems or to address them. Feeble scattershot federal and state efforts on primary care exemplify this frailty. Governments set no clear objective and formulated and financed no policies or programs commensurate with the importance of winning primary care for all Americans.

At the same time, most reformers have focused on single payer as their remedy. They have given little attention to devising detailed plans for implementing access for all while containing cost; they have given little attention to caregiver configuration.

Much of the political pressure on governments to act in health care has focused on boosting financial coverage.

One chronic illness plaguing government has been expanding financial coverage without capping spending. Therefore, as described in chapter 7, cuts in the number of uninsured Americans have been paralleled by efforts to hold down costs of care by suppressing actual use of care by insured Americans.

The ACA is a good example. It was the best bill Congress could pass in the early spring of 2010. It has roughly halved the number of uninsured Americans. But the heavy lifting to expand coverage exhausted the political oxygen available to Congress. None was left for cost control. Besides, attempts to build in effective cost controls would have cleaved the creaky coalition supporting the law.

Still, work to contain cost must seem visible. Unsurprisingly, that work has meant ineffective and annoying cost controls that punish patients with high OOPs or that caregivers can often game or evade. These controls often raise high financial and other barriers between patients and their needed medical care. Spending more for less care is the main symptom of the systemic diseases ravaging U.S. health care.

The realities of political support for expanded coverage but weak support for cost containment have not deterred some who detest the ACA from blaming it for many of the ills of U.S. health care.[2376]

Health care is remarkably costly. Access is spotty for many rural, urban and other citizens. Money is one problem and lack of nearby caregivers is another. Appropriateness, quality, and outcomes of care are also very uneven.

These problems very often result in demands for government intervention—usually in the form of regulation. But those who fear their freedom of action (or revenue) will be constrained by that regulation fight to defeat it or water it down.

Absent strategic, coordinated government actions—back by understandings of real problems, their causes, and effective remedies—most government efforts devolve into childish whac-a-mole efforts to suppress individual instances of bad behavior. It is hard to imagine a more effective method of undermining Americans' faith in the competence of our elected officials.

Federal and state governments are constantly called upon to prepare detailed regulatory responses to harms stemming from market failure. But these band-aids are generally impractical, unenforceable, complicated, annoying, incommensurate with the size of the problem, and widely ignored. The evoke scorn and ridicule. And contempt.

Regulatory failures have been even more common than policy failures. These include certificate of need regulations of health care capital investments, regulations designed to protect care and safety of nursing home residents, regulating approval of new meds, regulations governing payment of caregivers for out-of-network services under the No Surprises Act, regulation of brokers' fees in ACA plans, regulations setting capitation payments for MA plans, federal regulation of state recertification of citizens' Medicaid eligibility, and regulation of adequacy of narrow networks for Medicaid, MA, and ACA plans.

The types of failures of regulations vary.

- ✓ Sometimes, the regulated actors are powerful enough to craft the rules to suit themselves, not the public interest.
- ✓ Other times, the frequency and severity of violations of the regs overwhelm the regulators. This may happen because law and regulation seek to push the regulated actors to change substantially or at great cost to themselves, thereby violating Curran's standard that most regulated actors must be already in compliance with the rules, minimizing the number of violators who must be spotted and sanctioned.
- ✓ Sometimes, those regulated deem themselves to be above the law. If profit-making, they may consider that their profits are blessed by some imaginary market, and that government actions that cut profits are therefore illegitimate.
- ✓ More often, the cost of complying with regulations exceeds what regulated actors are able or willing to spend. Unfunded mandates are widely denounced—and flouted.
- ✓ Reliance on competition in the absence of functioning markets regularly results in unacceptable harms—low access, low caregiver availability, and low quality. When

insufficient primary care capacity drives patients to ERs, insurance companies' main private regulatory response is to boost co-payments for ER visits. These regulations clearly punish victims.

Weak public trust, low political pressure for public action, and low competence and self-confidence have undermined governments' willingness and capacity to act effectively to address health problems. Governments haven't built up strong, capable, politically neutral, experienced groups of employees who understand health care problems, their causes, possible remedies, and ways to implement them competently and with political support.

5. Accidents and distractions

Accidents

A number of unplanned military, political, financial, and social events and forces propelled most rich democracies to craft financial protections for all citizens, design ways to contain health spending, and negotiate generally acceptable and adequate ways to pay caregivers.

Very different unplanned events and forces led to very different evolutions in U.S health care. These left U.S. governments politically weak and largely unable to make the big health care policy decisions competently. And that incompetence obliged governments to confront lots of small decisions that could rarely be made well—and that often left U.S. governments paralyzed by distractions.

In one sense, it is no accident that all the world's other rich democracies cover all people and contain cost. Other nations cover all people through various mixes of single payer and coordinated all payer methods, with varying public shares of spending, reliance on non-profit insurers, and methods of actually raising the money. Those nations contain cost through single central public budgets, negotiated caps on spending, and different methods of paying doctors and hospitals.

The world's other rich democracies employed such different methods but not accidentally happen to attain the same results of coverage for all and cost control. They intended to win those results.

In another sense, the failure in the U.S. to cover all and contain cost is a product of a series of accidents or what was then seen as good fortune.

Other rich democracies confronted and suffered the Depression of the 1930s, the fascist threat, the Second World War's murderous devastation, and the post-War Russian imperial threat. Comprehensively or incrementally, they made commitments to affordable health care for all.

Most were impelled to do so by one or more forces. Rebuilding their societies and factories after the War, they saw that protecting all citizens against the cost of medical care could be an important social glue. And an anti-communist one. A welfare state guaranteeing social security aimed to protect all citizens from threats from the recent past and also current ones. Some

nations, like the U.K., covered all people at once immediately after the War. Others, like France and Germany, took several decades to gradually expand coverage to different groups by age or occupation or income. At different speeds, all rich democracies outside the U.S. secured health care for all. But whether incrementally or all at once, it was obvious to politicians, employers, unions, and caregivers that covering everyone was impossible unless costs were contained.

During the four decades from 1930 to 1970, massive economic, political, and military threats undermined rich democracies' traditional reliance on mixed but uncoordinated methods of raising money to cover citizens who were sick or injured, and to pay doctors, hospitals, or drug makers.

In most nations, higher public spending was deemed essential to cover all people and pay caregivers. But the resulting heavy demands on scarce tax revenue reinforced pressures to contain spending on health care. With most nations financing the great bulk of health care spending through taxes, higher health spending meant tax increases. Tax increases could defeat politicians in the next election. In this climate, most nations' doctors and hospitals accepted some restraints on the prices they were paid. They saw public financing as the most dependable source of revenue they could expect. In some nations, it was the sole source. They therefore understood that a social, political, financial, and medical compact required compromise. Employers, unions, and politicians shared that general understanding.

Some had hoped that universal health care access would contain cost. This proved unrealistic. Indeed, aging populations, difficulties in boosting productivity in health care—as in other service industries, and medical advances meant surging pressure for higher health care spending.

Economic difficulties during the last quarter of the 20th century meant growing competition for scarce public revenues. For these reasons, sustaining the continuing commitment to covering all citizens meant that other rich democracies constantly confronted cost control challenges in health care.[2377]

The post-War evolution of U.S. health care rested on economic, political, and medical foundations that were radically different from those prevailing in other rich democracies.

Through a series of accidents and uncoordinated decisions, U.S. health care evolved in a nutrient-rich financial environment to cover most people through private insurance, but without either a commitment to contain cost or a political deal with doctors and hospitals.

The main five accidents are best considered chronologically. The first was the origin and design of the main original forms of private health insurance during the 1930s. The second was the unintended spur to health insurance coverage during the Second World War. The third was the U.S. economy's strength in 1945. The fourth was the growth of private health insurance through collective bargaining in the 1950s and 1960s. The last was the structure of private health insurance itself, one that left it incapable of containing health spending.

The *first* accident was the origin and design of the first two large U.S. health insurance enterprises. Blue Cross plans were initiated by state hospital associations and Blue Shield plans by state medical societies. Both sets of plans functioned as money-raising arms of caregivers. This was widely recognized as necessary and even desirable during the parlous

1930s but proved a dangerously financially congenial arrangement during the prosperous quarter-century that followed the Second World War.

During the Depression of the 1930s, state hospital associations created non-profit Blue Cross hospital insurance plans. These were designed to protect individuals and groups of employees against hospital costs. And to provide hospitals with a steady flow of revenue. The BC plans were controlled by the state or regional hospital associations that established them.

As these plans slowly grew, state medical societies created Blue Shield plans to pay for care by surgeons and other specialists.[2378] Other nations saw some efforts by caregivers to secure a steady flow of revenue, but the decades of caregiver dominance of these large-scale non-profit insurance entities in the U.S. is remarkable.

The *second* accident was that, during the Second World War, wage and price regulations prevented employers from raising wages to attract workers to expand productions of needed weapons. But employers could add fringe benefits like health insurance or pensions. According to Morrissey, the share of Americans with any form of private health insurance grew from 9 percent in 1940 to 23 percent in 1945.[2379]

Third, the U.S. emerged from the Second World War with its factories and economy intact. In 1950, for example, the U.S. had 151 million people, up from 132 million in 1940. World population was 2.5 billion in 1950, up from 2.3 billion in 1940. So the U.S. had roughly 5.8 percent of the world's people. But U.S. 1950 GDP of $300 billion was fully 40 percent of estimated world GDP of $750 billion.

This contrasts powerfully with the post-World War II conditions in the nations today we number among the world's rich democracies. The U.K., France, Germany, Italy, Spain, and all of the rest of Europe west of the then-Iron Curtain suffered difficult economic, political, and social circumstances. All faced various pressures to improve security of residents.

Medical coverage was one opportunity to do so. Financially protecting citizens against health costs in a weak economy made the necessity of three policies obvious to everyone involved. One was greatly enhanced public financing. A second was strong controls on health spending. The third was to crafting methods and levels of paying doctors and hospitals that would support them in caring for all patients while containing total spending. Indeed, caregivers typically embraced public financing because no other money was available. They did so in the years that most U.S. doctors rallied to oppose the "Socialized Medicine" that evolved into Medicare.

In other rich democracies today, politicians, employers and workers, and caregivers generally continue to perceive the vital need to juggle the three elements of coverage, cost, and caregiver payments. That need was not perceived in the 1940s in the U.S. and it remains largely unimagined here to this day. So far.

After 1945, the U.S. enjoyed a prosperous subsequent quarter-century. Real per-person GDP—adjusted for inflation and population growth—rose by 70 percent from 1947 to 1970.[2380]

In these years, higher health spending was seen as desirable, not as a problem. As Exhibit 8 - 4 shows, defense spending was greater than health spending in 1950 and doubled health spending in 1955 owing to the Korean War and Cold War.

Subsequently, health care's share of the economy rose steadily, especially after enactment of Medicare and Medicaid in 1965. Cost containment was on no one's agenda during the prosperous quarter-century ending in 1970. During the post-War years, interest in boosting financial protections for citizens, doctors, and hospitals paralleled aggressive disinterest in controlling health care costs.

The prosperous time was interrupted by Vietnam-era inflation in the late-1960s and the two oil shocks of the 1970s. These were accompanied by various proposals and actions to slow the rise of health spending. None proved effective. Nor have their successors.

The *fourth* accident was that, after the War, unions were permitted to bargain with employers over health insurance and seized on this as one effective organizing tool. In seeking privatized health coverage, unions explicitly opposed concerted public action to cover all citizens. Non-unionized businesses often offered health insurance voluntarily to try to forestall unionization. The share of Americans with any private health insurance rose steadily from 23 percent in 1945 to 51 percent in 1950 and to 73 percent in 1965.[2381]

The company-by-company insurance coverage had the effect of fragmenting private buying power. That is, it cut buyers' ability to win lower prices from caregivers. Fragmentation grew as more insurers began providing health coverage. Early growth was dominated by non-profit Blue Cross and Blue Shield plans. These were financially friendly toward hospitals and doctors but did retain some restraints on payments. Over time, dozens of for-profit commercial insurance companies gradually enrolled more than half of privately insured people.

Anti-trust laws prohibited Blue Cross plans and the various for-profit health insurers from uniting to present a common front when negotiating prices or other payment policies with hospitals or doctors. Only rarely has the federal government permitted coordination of all payers' payments. (One exception is Maryland's waiver for paying hospitals.[2382])

Fifth, private health insurance could neither cap spending centrally through budgets nor build in mechanisms to put brakes on spending. One reason is that Blue Cross, Blue Shield, and the emerging for-profit insurance plans were all designed in accord with traditional insurance principles. This meant that individuals were covered for various services, with no caps on volumes of care.

Insurance thereby creates an entitlement. Should this year's payouts exceed premium income, premiums rise next year. For-profit insurers typically covered only small shares of a region's patients. They therefore enjoyed little leverage over caregivers' prices or volumes of care. They typically paid doctors' and hospitals' posted charges. With no effective built-in cost controls, and unable to restrict spending, private insurance has meant blank-check financing.

Private health insurance pumps huge sums to caregivers through wide underground—and therefore invisible—aqueducts. Financing a large share of higher spending through premiums buffers politicians because it slashes the share of the health care dollar that must be raised through taxation. Few Americans perceive connections between higher health spending and the need to increase revenue to pay for it. Health care cost control in the U.S. therefore lacks the automatic braking system (hold down health care costs to make coverage for all people affordable while minimizing tax increases) that works in other rich democracies.

5. Government failure is the other source of anarchy

This is one of the most powerful forces enabling higher U.S. health spending (and costs). Yet it is widely ignored in health policy discussions. In power and insidiousness, it resembles other underground pipelines, the Nordstream 1 and 2 projects that came close to the edge of making Europe vulnerable to Russian energy blackmail.

An important factor is that Blue Cross's dominant method of paying hospitals, cost reimbursement, was designed in the 1930s to be financially neutral but was widely implemented in the 1950s and 1960s when all of the foundations of financial neutrality were sundered. In the 1930s, reasonable experts could expect that a Blue Cross plan—that covered at most 10 or 20 percent of a hospital's patients—could not affect hospital behavior by reimbursing costs of serving BC's patients. The great bulk of hospital care was given in non-profit or public hospitals that simply—and often desperately—sought money to cover their legitimate costs. The economy of the 1930s was fragile. Hospitals were uncomplicated and inexpensive places. Technology typically meant an x-ray machine or a simple laboratory. A small share of U.S. doctors were specialists and medicine could not offer many costly forms of treatment.

But in the prosperous years after the War, most patients had some insurance. Hospitals could build, borrow money, and hire workers with greater confidence that insurance revenue would rise to cover their higher costs. Cost reimbursement thus unintentionally enabled much higher spending. Its effect was magnified when, in 1965, Medicare adopted cost reimbursement explicitly as the method of paying hospitals for inpatient care. It did so to ensure that hospitals would serve Medicare patients.

Similarly, Blue Shield evolved toward a common policy of paying doctors their usual, customary, or reasonable charges.[2383] [2384] This meant that specialists' incomes skyrocketed—especially for those performing surgical procedures.

These doctors had previously often charged patients by a sliding fee schedule, one that sought higher fees from richer patients. This was either informal social justice, Robin Hood-style, or revenue maximization, charging each patient as much as they would be willing and able to pay.

In practice, the usual, customary, and reasonable policy invited doctors to raise their prices. The power of this method to magnify health spending grew enormously because, when Congress enacted Medicare Part B in 1965 to cover physicians' services and other outpatient care, it copied the common Blue Shield method.

Desiring to win hospitals' support for enacting Medicare, and hoping to neutralize many doctors' passionate opposition to Medicare, and unworried by possible cost increases, Medicare's designers declined to incorporate effective controls on spending on either hospitals or doctors.

This sequence of five accidents has meant that no government or private actions in the U.S. have been adequate to financially cover all Americans or act effectively to contain health care costs. The coverage and cost control neurons remain disconnected in the brains of legislators, caregivers, employers, unions, and the public at large.[2385]

By contrast, other rich democracies evolved toward much greater reliance on public financing to both cover people and pay caregivers. As a result, the union of coverage for all with cost control was baked into post-War health reforms from the beginning. Public and private payers, politicians, caregivers, and the public at large generally understood this connection. And its

correlate—that higher health spending means less of other things. Doctors and hospitals generally understood that the alternative to public payment or coordinated public-private payment was inadequate income, so they accepted restrictions on income as part of the combined coverage – cost control – caregiver payments arrangements.

In the U.S., though, accidental reliance on open-ended insurance financing means no effective cost controls; those that are retrofitted are weak, unfair, and—usually—both.

Although evil actors and bad motives are common, they don't explain the anarchy and lack of accountability that pervade U.S. health care.

The accidents and the often-well-intentioned decisions just described are sufficient explanations. At heart, the accidental reliance on private health insurance, open-ended entitlements and decades of unrestricted flows of money to caregivers, a weak commitment to covering everyone, and the failure to weld a strong and visible connection among cost control and coverage expansions and caregiver payments have combined to leave governments in the U.S. unaccountable for containing health care costs. Indeed, governments, private insurers and employers, and caregivers are excused from thinking seriously about health care problems, their causes, or possible remedies. Caregivers' beliefs that they are financially entitled have has grown to substantial levels.

Distractions

Persistent distractions magnify accidents' effects. They incessantly elbow the important problems, their core causes, and realistic remedies off the public stage. They diminish attention to the heart of health care—affordable and high-quality health care for all and carefully negotiated payment arrangements with caregivers. They thereby reinforce the harm done by anarchy, unaccountability, and accidents.

This allows U.S health care to continue to deliver less care at much greater cost to fewer people, who live shorter lives.

The four main types of distractions are politicization that undermines government accountability for addressing causes of health care problems, a focus on the ceiling and not the floor, reliance on painless panaceas like consumer choice or financial incentives or various O's to fix care, and on slogans like "pay for value, not for volume, and other escapist fantasies.

Politicization

The federal government must address a wide range of important challenges. This is seen in, for example, the matters addressed by fourteen individual committees of the House of Representatives—agriculture, armed services, education and labor, energy and commerce, financial services, foreign affairs, homeland security, judiciary, natural resources, science and technology, small business, transportation and infrastructure, veterans' affairs, and ways and means. Health care is addressed mainly by subcommittees of both energy and commerce and ways and means.

5. Government failure is the other source of anarchy

Anarchy and unaccountability in U.S. health care mean that new symptoms of access, cost, quality, and caregiver configuration problems arise each year. Federal and state government efforts to deal with these symptoms resemble the children's Whac-a-mole toy. New and often severe symptoms frequently pop up in public awareness and cry out for attention.

Alone among rich democracies, the U.S. government does not act to contain health care costs to make care affordable for all citizens. This stems from the failure, to-date, to agree on protecting all citizens against costs of medical care and from the persisting failure to coordinate multiple public and private payers' financing of care. This releases Congress and the president from the need to be accountable for either access or cost control. That lack of accountability reverberates throughout health care politics.

It is magnified by the high level of polarization and personal mistrust prevailing among many members of the two parties. Health care was once less partisan. Almost one-half of congressional Republicans—83 of 168) voted to create Medicare in 1965.[2386] But not one voted for the Affordable Care Act's coverage expansions in 2010.

Failure to focus on the two cores of coverage and cost control renders federal health policy chaotic and incoherent. Individual pressures and demands—to regulate insulin prices, to protect nursing home residents from natural disasters, to fight fraud in the hospice program, to pay doctors or hospitals more money, to investigate Medicare Advantage plans' exploitation of complicated risk adjustment methods, to enhance primary care or mental health services, to raise or rein in reliance on financial incentives to boost access or contain spending, to regulate state Medicaid managed care plans, and much more—push and pull federal action.

Organized parochial interest groups set agendas for public action. They lobby, make campaign contributions, write reports, and demand attention to their demands. Federal actors receive lots of sensory input but suffer from weak cranial capacity to conceive and execute coordinated policy. That's because, on most issues and most of the time, both political parties, and most congressional committees and federal health agencies lack independent, integrated ideas about health care problems, their causes, or their remedies.

This is one reason why more money for business-as-usual has become the well-trodden political path of least resistance. Add-ons, not trade-offs are common. Spending more may be financially promiscuous, but it politically easier than tough cost control love that is in a durable and monogamous relationship with affordable health care for all.

Capped spending, risk-adjustment, and pay-for-value. One reason why motives to contain cost are weak is that no one imagines that containing any cost, anywhere in health care, might benefit them.

Politicians boost Medicare Advantage plans that seem to cap previously open-ended financing and thereby cap spending. Politicians suppose that capping revenue will induce insurers running MA plans, hospitals, and doctors, to rein in costly care of low value. But it is vastly easier to boost revenue than to contain cost.

MA plans grab undeservedly high revenues by manipulating the enrollees' risk scores by which the plans are paid. After the 2010 ACA included a provision to roll back some of their extra revenue, the plans and their members successfully lobbied Congress to repeal the rollback.

5. Government failure is the other source of anarchy

It is not possible to pay MA plans fairly—by giving them fixed sums of money in advance—without building an accurate, easy-to-administer, and difficult-to-manipulate method of adjusting for risk—for the likely average cost per patient of those enrolled in a particular MA plan.[2387] Similarly, it is impossible to build a fair and trustworthy set of incentives for any caregivers without robust risk-adjustment.

Because no such risk-adjustment method is available, efforts to "pay for value," to incentivize caregivers to contain cost, boost quality, or to otherwise behave differently have not succeeded. Witness the 20 percent added cost of MA plans (up to $75 billion in 2023 alone).[2388]

A recent suggestion to risk-adjust payment to primary caregivers urged learning from errors the U.K. risk-adjustment by failing to include factors like income and deprivation that may be associated with greater need for primary care. This is a step in the right direction.[2389] Still, it builds on a very shaky foundation of weak knowledge of how to adjust for risk. Further, it relies on financial incentives to influence caregiver behavior. Each is a dangerous flaw, probably a fatal one.

Horn and Navathe are very smart and very well-intentioned critics of current risk coding. They have called for "clinically meaningful" risk coding that "should not foster a culture of gaming." [2390] They decry the bureaucratic and financial pressures doctors face to include information that boosts payment, partly because these violate doctors' commitment to truth, and partly because these magnify alienation and burnout. They denounce the diversion of substantial resources to manipulate sums hospitals harvest via up-coding. They mock "value-based" care that engenders administrative waste to harvest undeserved revenue.

But risk coding does not foster a culture of gaming. Rather, the culture of financial games in health care motivates, sustains, and grows risk coding. At work here is a toxic combination of a) aggressive revenue-seeking by both for-profit and non-profit hospitals and insurers; b) the widespread belief that the bottom line registers a legitimate market judgment, so whatever is done to boost that bottom line is legitimate by derivation; c) a belief that "we must do this to survive because all our competitors are doing it"; d) light punishments for cheaters who are caught; and e) more.

Setting budgets fairly requires two things. One is mechanical and political: a clearer, simpler, more reasonably objective, and independent method of risk-adjusting. Reinhardt notes that to fairly community rate all insurers in Switzerland, Holland, and Germany, it is essential to risk-adjust their members' revenue.[2391] He asserts this is done competently, simply, and without litigation or politicization in each nation.

If that's so, why has the U.S. not chosen to adopt one of the methods that work elsewhere? Interested people in Congress, on committee staffs, and in CMS must be aware of the options. Yet when the first MA risk-adjustment method was discredited, Congress adopted a new method that seems to have enabled gaming at unprecedented levels. Did insurers or other interested parties play a role in this, or were other forces at work? This is worthy of attention.

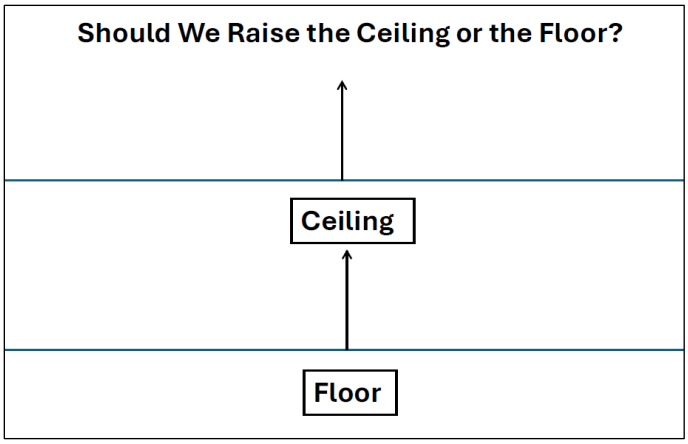
The other is cultural and financial: demotivating financial game-playing by insurers, managers, and caregivers. This could be advanced in several ways: a) ceasing to allow for-profit caregiving; b) legally requiring organizations like hospitals, nursing homes, and hospices to act as fiduciaries that marshal inevitably scarce dollars to do as much clinical good as possible; c) legally requiring doctors, dentists, and other decision-makers to act professionally, with patients' best interests at heart; d) paying all caregivers in ways that are financially neutral; e) adopting

the principle that no one is denied care unless doing so liberates money to give care to another person, who'd derive greater benefit.

Ceiling

The second distraction stems from health care's greater attention to the ceiling, not the floor—on improving the best care available for some, not on elevating the least good (worst) care suffered by others.[2392] The two are pictured in Exhibit 5 – 6.

Exhibit 5 – 6



This is a distraction. It means indiscriminate development of new types of care. Rarely are their incremental benefits or costs compared. Even less consideration is given to the downstream affordability of equitably delivering new types of care. Many of these new ideas will be so expensive that they can't be afforded by or for all who could benefit from them.

Proton beam therapy is one. Costly new cancer meds are another.

Trade-offs between floor and ceiling are rarely perceived in U.S. health care. Reasons for this blindness are clearly visible. The U.S. doesn't cap spending nationally. Hospitals, nursing homes, and other organizational caregivers rarely have fixed budgets. To contain cost indirectly, U.S. payers rely chronically on high OOPs, malconfigured caregivers, administrative friction, and other care suppressors. Patients vary greatly in their financial protections against health care costs and in their abilities to pay privately.

Similarly, U.S. medical care's floor is simply not defined. What are the lowest acceptable standards of care and coverage—the levels below which we won't allow anyone to fall? Standards might include, for example, availability of primary care, travel time to an ER or waiting time in the ER, or maximum OOPs as a percentage of yearly income.

In this environment, care that generates revenue in excess of its cost is more likely to be delivered. Innovations in diagnosing or treating nursing home patients, widely covered by Medicaid, are less likely than other innovations for patients covered by Medicare or private insurance.

Pushing back frontiers of the medically possible is vastly more prestigious than cutting cost of existing care or evaluating and discrediting ways to diagnose or treat patients. No one wins a Nobel Prize in medicine for improving efficiency of care.

Failure to discriminate is exemplified in the premise of state certificate of need legislation, which required hospitals or other caregivers to obtain state-issued licenses before they could undertake substantial capital investments or initiate new services. These laws did not establish capital budgets or require caregivers to compete for scarce permissions. One unmet need was as good as another. Hospitals that had accumulated enough savings or could demonstrate capacity to repay money borrowed by selling bonds could gain access to capital needed to invest in new buildings or programs. Hospitals with lower operating margins or less accumulated wealth would usually be locked out of capital markets, unable to sell bonds to rehab or replace deteriorated buildings.

Because caregivers rarely competed by price but often competed by reputation, investments to cut costs were rarely prioritized over investments to boost capacity or acquire new technology.

While it would be difficult to separate the share of National Institutes of Health Investments going to push back frontiers of medical knowledge from the share going to cut costs of existing care, it is likely that the former dominates overwhelmingly. Pushing back frontiers can sometimes cut cost, but probably less often than would intentional investments in making medical care more affordable for all.

One smart way of doing just that would be to ensure that all Americans could have a good primary caregiver. Primary care demonstrably cuts cost while improving both access and appropriateness of care. As will be discussed in chapter 10, investing in good primary care for all citizens would raise the medical floor, below which no American would fall.

Another smart way would be to finance development of effective new medications in a manner that made them affordable for all Americans. Please refer to chapter 14.

A third smart way would be to establish fixed budgets for caregivers like hospitals or for clusters of citizens. These would press doctors and other caregivers to make trade-offs—to spend inevitably finite dollars to do as much clinical good as possible. This would oblige doctors to weed out care that was expensive and had little clinical benefit to patients.

Panaceas

A number of putatively painless panaceas flourish in an unaccountable environment.[2393] The main ones are boosting patients' out-of-pocket costs, offering numerous, confusing, and meaningless coverage choices, trying to cap spending through capitation and private budgeting, shifting care from one setting to another, and investing in social determinants of life instead of medical care.

OOPs. Insurers and employers have few effective tools to contain costs of the health care they finance. They have been happy to boost out-of-pocket payments by the weakest party—sick or injured citizens. They piously rationalize this with words about empowering consumers or overcoming moral hazard. The federal government has endorsed this approach by pushing

high-deductible health plans and health savings accounts. The health savings accounts are excellent ways to enable high-income Americans to shelter substantial sums each year from income taxation [2394] but they are not a useful way to contain health care costs.

Capitating to combine coverage and care. The health maintenance organization or HMO was the first major reform slogan with bipartisan pretensions. It merged the liberal non-profit prepaid group practices' salaried physicians and budgeted hospitals with the conservative fee-for-service doctors of the independent professional associations. HMO membership grew rapidly for several decades, mainly in the fee-for-service networks, before encountering roadblocks.

Some resistance to further growth stemmed from the increasingly for-profit share of HMOs and resulting fear that investors or caregivers could make more money when patients got less care. Many patients were reluctant to switch doctors or hospitals in order to join an HMO. Some workers and families resented employer mandates to join an HMO in order to retain health insurance through the job.

Preferred provider organizations (PPOs) were seen as a fall-back or substitute managed care option. Patients' would enjoy freedom of choice. They'd pay less out-of-pocket if they saw an in-network caregiver, one that had negotiated a lower price with the insurance company organizing the PPO. But patients could go out-of-network if they were willing to pay more out-of-pocket. PPOs soon became more popular than HMOs, and this has persisted. The lines between HMOs and PPOs have become blurred in many instances.

As PPOs grew, insurers worked harder to create narrow networks of doctors and hospitals that would be given preference. This has not visibly saved money. But it is something insurers can do; it is a putative cost control tool they can wield. One response by some doctors and hospitals has been to aggressively identify out-of-network patients and send them very high bills. As discussed earlier, those bills engendered state and federal legislation to protect patients.

Still, some patients have complex and costly medical needs and have come to rely on specific doctors and hospitals. They disliked restrictions on their choice of caregivers.

Also, proponents of capitated or managed care were frustrated that payments to HMOs or PPOs were not conditioned on cost or quality of patient care. They wanted to incentivize better quality and lower cost.

Accountable care organizations (ACOs) were created by the Affordable Care Act of 2010. They aimed to incentivize more efficient and also more appropriate care for Medicare patients by sharing money saved with the ACOs that served those patients. ACOs were virtual organizations in that patients were enrolled without their consent or even knowledge. Patients were free to seek services from non-ACO caregivers. Since patients did not know which doctors or hospitals were in an ACO, or even that they as patients were enrolled, it was easy to do that. So patient choice was not restricted. To discourage an ACO from withholding needed care, they were permitted to share in any savings only if the ACO scored high on a number of measures of quality and appropriateness of care.

ACO proponents have been among those embracing the "pay for value, not volume" theme that has been voiced frequently in U.S. health care. Paying fees to doctors for individual services

and paying hospitals for individual discharges do seem to incentivize higher volumes. But one of the many remarkable things about U.S. health care is how often theory and reality are at odds. Despite these incentives, U.S. inpatient hospital days and physician visits are at only 60 percent of the levels recorded in the typical rich democracy—as was shown in Exhibit 3-2.

Despite massive enrollment and despite repeated claims that HMOs, PPOs, or ACOs save money, evidence on those savings has proven to be transient and weak—especially when administrative costs and payouts are considered.[2395]

All of these approaches purport to rein in spending by establishing budgets for groups of patients,

Medicare Advantage plans are told to enroll patients, accept monthly risk-adjusted capitation payments for each patient, and keep any savings. Many MA plans find it easier to make their patients look sicker by identifying remunerative diagnoses, thereby boosting revenue, than to make money by containing costs of care.[2396]

Medicaid managed care plans have a decades-long history of saving or making money by giving less care. Medicaid managed care plans in California proliferated when Reagan was governor. Many took the money and gave little care. Congress therefore required that Medicaid patients could be enrolled only in HMOs with 50 percent or more privately-insured patients—patients who had freely chosen such HMOs. That share was subsequently cut to 25 percent and then back to zero. Medicaid managed care inherently means rationing care for low-income people. Medicaid managed care's seductive words are that financial incentives to over-serve associated with paying for doctor visits or hospital admissions are a big reason for high costs. So are lack of primary care and, generally, disorganization and poor care management. The notional remedy is to make organizations accountable for delivering care and for paying for it from fixed budgets.

Medicaid managed care has the added advantage of shifting cost and quality and access problems from state Medicaid programs to private contractors—insurers, HMOs, PPOs, and sometimes city or county governments.

A shift with wide, deep, and durable consequences has been the growth of for-profit businesses throughout U.S. health care. The for-profit share of acute care hospitals doubled from 13 percent in 1975 to 25 percent in 2018.[2397] In 2010, fully 13 million visits for surgical procedures were made to free-standing ambulatory surgery centers,[2398] 95 percent of which were operated for-profit, [2399] compared with 16 million visits for ambulatory surgery at hospitals. In the long-term care sector, 69 percent of U.S. nursing homes were operated for-profit in 2016, as were 63 percent of hospice programs, 45 percent of adult day health programs, 81 percent of residential care communities, and 81 percent of home health agencies.[2400] It appears that well over one-half of people with private health insurance were covered by for-profit companies in 2008, even before the conversion of many formerly non-profit Blue Cross plans to for-profit status.[2401]

For-profits have grown for a number of reasons. One is the diminished role of professionalism and charitable impulses in health care. A second is the hope that free market competition could exist in health care and that it would help to contain costs. A third is that health care is increasingly "where the money is."[2402] With almost one-fifth of the nation's economy, health care is seen by many businesses as offering substantial opportunities to earn high profits.

Because—as shown in chapter 4—nothing close to a functioning free market exists or can exist in health care, profits do not signal efficiency, innovation, or satisfaction of consumer demand. But those who garner those profits doubtless believe otherwise, and will lobby and make campaign contributions to try to sustain their profits. Those businesses may also be motivated to resist, water down, or hijack reforms that actually would contain cost, protect all people, reconfigure caregivers, and boost quality. Non-profit caregivers threatened by reforms might try to do the same, but for-profit actors might be more strongly motivated and incentivized, and more clever. At minimum, the widely-disseminated for-profit businesses in health care can be expected to impede design, passage, and implementation of reforms. This will be an important factor to hold in mind in subsequent chapters.

Failed innovations. One set of distractions are the badly-crafted or foolish remedies that create more problems than they solve, but that subsequently absorb energy that might better have been used to attack actual causes of problems. The energy instead is devoted to patching leaky boats that are sailing in the wrong direction. These remedies are devised to substitute for those that might actually work to contain cost—but that are today politically or legally unavailable in the U.S.

Prominent examples include bundling or aggregating units of payment in hopes of lowering spending, reversing financial incentives in hopes of rewarding provision of less care, shifting care from notionally higher-cost sites to notionally lower-cost sites, a preference for closing hospitals, boosting patients' out-of-pocket burdens, allowing insurers to form narrow networks of caregivers, and relying on pharmacy benefits managers to hold down drug spending. Four specific examples illustrate this problem. The first two illustrate the theme of moving the problem; all are examples of the failure to confront causes of problems.

One common theme of U.S. health care panaceas has been one of moving a problem instead of confronting and solving it. Examples include shifting care from acute inpatient hospitals to ostensibly lower-cost settings like skilled nursing facilities [2403] [2404] or free-standing ambulatory surgical centers or even in-home care.[2405]

First, some reformers have long sought to allow "death with dignity," to allow patients to choose less care, calming care, and comfort and pain relief over aggressive surgical or other death-delaying interventions. Hospices began as reforms that offered compassionate comfort and kind end-of-life care that did not subject patients to ineffective and unwanted treatments. When for-profit hospices were allowed into the program, spending rose along with accusations of profiteering from unnecessarily long stays in hospice and of failure to provide essential care and comfort during patients' last days.[2406] It has proven pragmatically and politically difficult to set and enforce high standards of quality on the new hospice industry. Efforts to rationalize payment for MA enrollees who became hospice patients proved highly profitable to the MA plans.[2407]

Second, during the middle of the 20th century, reformers in the mental health field rightly denounced most of the huge state mental hospitals as irredeemable snakepits. They demanded community-based care—supported by new medications—and deinstitutionalization as remedies. States saved money by cutting capacity at mental hospitals by 95 percent. Many older residents of state mental hospitals were transinstitutionalized and shifted to nursing homes where federal Medicaid dollars improved financing. Many newly liberated younger patients found vastly better lives. But adequate non-institutional care for the many liberated people

requiring substantial support was not forthcoming. Those people ended up homeless on the street, vulnerable to victimization, and likely to be re-institutionalized in jails and prisons.

Third, private insurance companies bid to cover workers employed by both private and public employers. They do the same for groups of Medicaid and Medicare patients. But individual private insurers have few tools to hold down costs of care for these groups of patients. As noted elsewhere, they are almost always legally prohibited from joining together to bargain with physician or hospital groups.

One method, not yet legally prohibited, is for many insurers to contract with businesses like MultiPlan to conduct coordinated price negotiations with hospitals and other caregivers. This has sometimes been called an illegal hub, spoke, and rim conspiracy in restraint of trade. MultiPlan, at the hub, contracts with insurers individually along each spoke of the wheel. The insurers separately contract with one another, along the rim. Advent Healthcare has recently sued what it calls the "Multi-Plan Cartel" for coordinating and controlling prices for out-of-network care.[2408] [2409] An earlier suit along these lines was filed by bankruptcy trustees for the hospital chain Verity Health in 2021.

What firms like MultiPlan can do is to invite some doctors and hospitals to become preferred providers who accept lower prices in exchange for promises of higher volumes of patients.

If this approach succeeds in legally boosting private insurers' leverage over hospitals and doctors, those caregivers will complain more forcefully to Congress, state legislatures, and the courts. They'll argue that they require high payments from commercial insurance companies to offset low Medicare and Medicaid prices. In the absence of clear measures of adequate revenue, the finger-pointing, lawsuits, and chronic unaccountability will persist.

Fourth, pharmacy benefits managers (PBMs) have been touted as a substitute for national price regulation or price negotiation. PBMs allow employers and insurers to believe that someone is doing something to rein in spending on medications. But while PBMs appear to function as substitutes for payer-imposed or –negotiated price restraints, they do not appear to be an effective way to restrain spending on meds. They are not found in other rich democracies that enjoy lower prices for meds. PBMs rarely disclose how they operate. They have been accused of violating their fiduciary duties to clients—employers, union health funds, or insurance companies—and of enriching themselves instead. They are alleged to have done so in part by channeling patients to costlier brand-name drugs in response to bribes from manufacturers of brand-name drugs thinly-disguised as buying data on drug use,

Some drug makers, pharmacies, employers, and insurers have pushed state legislation to rein in some PBM practices. It is unlikely that such legislation will do much good.

Slogans

Health care is rife with positive slogans. These include prevention not treatment, pay for value and not volume, public option, and single payer. Negative slogans like socialized medicine or rationing or death panels are less common.

5. Government failure is the other source of anarchy

Slogans dissipate energy that might push competent public action because they embody proposals that are divisive or unrealistic. Some are offered by conservatives, others by liberals, and still others by both groups.

Beginning in the 1940s and continuing for decades, proposals for national health insurance or coverage of older people provoked some opponents to decry these ideas as "socialized medicine." Opponents of cost controls say these will lead to "rationing" of care. Some people who disliked the 2010 Affordable Care Act seized on the provision that would pay doctors to converse yearly with Medicare patients about their preferences for care and decried it as calling for "death panels." Defenders of drug makers denounce restraints on prices of new meds as inhibitors of research, leading to preventable deaths.

One reform slogan has long been "single payer." This emphasizes a mechanism for containing cost, one adopted formally in the U.K. and Canada, and informally through all-payer coalitions in other rich democracies. But it is defective as a slogan because one of its words emphasizes payment instead of coverage while the other manifests monopsony buying. Far better to use the slogan, "health care for all," which also has four syllables but emphasizes actual delivery of medical care to everyone.[2410]

A second has been the "public option" proposal to allow all who wish to buy in to Medicare coverage.[2411] This is a smart and positive idea for expanding coverage and retaining freedom of choice of caregivers, but it is very optimistic in its hope of relying on Medicare's regulatory mechanisms to hold down costs of covering more people. Hospitals and doctors fiercely oppose the public option's plan to substitute lower Medicare prices for higher private insurance prices. Stepping back, one of the main cost control challenges is how to negotiate politically and financially agreeable prices and payment methods. The public option tries to finesse this challenge but that is impossible. Desired—or adequate—revenue is too important to doctors and hospitals for them to allow it to slide by. Gimmicks are no substitute for learning how much we need to pay for the care we require. And to develop fair, adequate, and simple methods of moving the money.

A third has been the wide range of efforts to reduce volumes of care. The obsession with cutting volume is one of the main distractions afflicting government efforts to cut U.S. health costs. Noting that payment by any unit of care offers a financial temptation to make money by boosting volume (since revenue rises faster than cost as volume goes up, as long as price exceeds variable cost), some reformers support proposals to cut volume. These include cutting capacity by closing hospitals, aggregating payments, capping revenue, or paying more money for less care. So far, not one has been effective in containing costs. Closing hospitals, for example, does not save if the less costly hospitals are likelier to close and if displaced patients obtain care at surviving costlier institutions. Despite the financial incentives to give more care, Americans use both hospital and physician care at much lower rates than their counterparts in other rich democracies.

A fourth has been public action to improve competition or slow the drift toward consolidation. Many conservatives and liberals agree on anti-trust enforcement or consumer empowerment. Conservatives see anti-trust enforcement like opposition to hospital mergers as a useful tool to enhance market competition. To empower consumers, conservatives usually rely on higher out-of-pocket payments and flimsier insurance coverage. Liberals cleave toward organizing patients to give them a voice in clinical, financial, or political decisions.[2412]

A fifth has been state proposals to slow increases in health care spending. As discussed earlier in this chapter, Massachusetts legislation in 2012 created the state's Health Policy Commission. It empowered the HPC to set a benchmark for rises in health care spending. Some laud its pioneering efforts.[2413] Other states have followed.[2414] [2415] But the HPC's actual effectiveness in holding down health costs is doubtful. It has few practical tools, has been reluctant to use those it does have, and lacks political support.

A sixth has been giving increased attention to upstream social determinants of life (SDL), as discussed at length in chapter 2. Emphasis on prevention, not treatment, and on addressing the SDLs, are two of the largest forces to distract government from taking effective action to ensure medical security for all Americans. Those urging greater attention to prevention and to SDLs invariably seek better and more equitable health. But, I fear, they are unlikely to attain what they seek.

Noting higher health spending and inferior health outcomes in the U.S., and claiming that health care explains only about one-fifth of the differences in health outcomes—longevity, illness, or disability—some advocates of more effective and equitable health assert that much greater attention should be given to the non-medical social determinants.

One of the promises of the health maintenance organization was better health and lower cost through prevention, particularly early detection of illness.[2416] It is reasonable to assert that prevention is more equitable than treatment if prevention aims to help broad groups of people indiscriminately—free of discrimination—and since current treatment quantity and quality improve with income and vary with insurance coverage.[2417]

Some experts and advocates assert that higher spending on SDLs would do more to improve health outcomes than higher spending on health care services. Some also assert that doing so would be more equitable. And some believe that spending more on SDLs would prevent many health problems from developing, thereby saving money now spent on medical care.
These three assertions are seductive. The main reason is that the first two are simply true. But the third is not. And that is a big problem. Prevention may be effective than treatment for many problems. But it is a complement, not a substitute. That's because prevention has a 100 percent failure rate. (So does medical care, but that's a separate matter.)

Prevention is not durable. When illness or injury hit us, medical care is a reasonable response. It is rarely cheap. Indeed, if the illnesses and injuries that kill us quickly or cheaply are -targeted by preventive interventions, prevention would lead to higher spending on medical care.

There is a danger that, if health becomes everything, then it becomes nothing.

Since social determinants are very powerful, they should be addressed. Doing so will require money. Where will it come from? Should it be squeezed out of current or future health spending? Should it come from new taxes? Should it come from within each sector of the economy or society?

The things others call social determinants of health determine much more than health; they are determinants of life and of well-being generally. As argued in chapter 2, they should probably be called SDLs—social determinants of life. This signals a broad emphasis on overall well-being and happiness, on economic, social, and personal security—not only on health.

Often, sadly, just as social factors influence health, so does health influence social factors. We have a two-way street. For example, people who suffer debilitating chronic illnesses suffer lower incomes.[2418]

If we wish to spend more on the SDLs, we should note the very real possibility that failure to assure health security for all Americans and failure to contain health care costs are the two biggest political and financial barrier to spending more—to finding the money to finance more effective attention to SDLs. That's because, today, health care spending rises by hundreds of billions of dollars yearly.

In this view, substantial boosts in public spending on SDLs are almost inconceivable before the U.S. attains medical security for all combined with health care cost control.

And worse, talk about SDOHs and SDLs has the effect of letting health care off the hook. If health care explains only one-fifth of health outcomes, maybe health care doesn't matter very much, and we should devote our substantial but finite energies to touting the social determinants.

But allowing U.S. health care to continue business-as-usual would be a terrible mistake. It would permit perpetuation of high-cost, unequal, and often ineffective medical care. And that, in turn, would absorb money that might otherwise be available to address the various SDLs.

Worse still, stripping money from health care might be most likely to harm the very people who are already the most vulnerable to deprivation of needed medical services.

Politically, it would be very difficult to safely cut today's health spending absent systematic reforms. Patients and caregivers would be likely to resist. Even harder would be the job of capturing any cuts in health spending in a bucket and carrying that money to another sector. How could health dollars be transferred to improve education, nutrition, housing, the environment, or other sectors?

Some might propose that hospitals, HMOs, physician groups, and drug makers be obliged to spend some of their own money to house homeless people, feed hungry people, and do other vitally important things.[2419] UnitedHealth, for example, touted $11.1 million in "empowering health" grants to address social determinants in 2023.[2420] The money would address problems like nutrition, isolation, behavioral health, and health literacy. This spending may signal virtue, offer good publicity, and make hospitals or insurers feel good about themselves, but it is dubious for several reasons.

Millions of dollars might be involved, but they are tiny sums in proportion to the size of the large social problems they purport to address. When Medicaid pays for these things, the result is likely to be less adequate Medicaid payments for actual medical care, which can make fewer doctors willing to care for Medicaid patients. Also, hospitals, doctors, drug makers, and other parties inside health care face enough challenges in actually delivering health care. They are not experts in housing, nutrition, transportation, or other sectors. Finally, if caregivers were to shift spending from medical care, to which sector should they shift it? No one knows whether spending more on education and job training, for example, would do more good than spending on housing or the environment.

That said, it is useful to distinguish small-scale from large-scale investments in SDLs. Health care organizations could develop competence in the former, and devise ways to afford them. A

cancer clinic may offer to help patients navigate their care.[2421] An emergency room might offer a frequent visitor who is homeless a path to temporary or permanent housing. A pediatric clinic might refer a family suffering inadequate nutrition to a weekly visit to the hospital's food pantry. Patients suffering ill health compounded by poverty-related problems might be helped by a community health worker who is expert in securing income and social supports.

Advocates of greater investment in SDLs often seem to conflate two very different sorts of interventions. This retail-level help to individual patients differs enormously in ambition, scope, and cost from the large wholesale-level interventions to address community-level homelessness, inter-person violence, family and behavioral challenges, food insecurity, environment, and other problems. Health caregivers can be very reasonable resources for addressing the retail SDLs that are closely tied to specific health outcomes that caregivers understand. But there is no reason to suppose that health caregivers have any expertise in addressing community-level housing challenges for hundreds or thousands of homeless humans, for dozens of thousands suffering food insecurity or personal/family/neighborhood-level personal insecurity and danger, and for all who suffer from lack of job skills and other sources inadequate income.

If it is true that four-fifths of health outcomes are attributable to forces outside medical care, it does not follow that the most practical way to improve health outcomes is to shift money from health care to other sectors.

In this sense, health care and health reform are surprisingly strategic.

An important related idea is that each problem needs to be confronted individually and head-on. Most of the following chapters of this book are devoted to examining problems in individual health care sectors, analyzing their causes, and suggesting specific remedies.

In the same spirit, it may be that each sector of the U.S. economy and society will benefit from greater efficiency, effectiveness, and equity—and can make its own contributions to enhancing life chances, overall well-being, and health.

For example, as Exhibit 5-7 shows, housing is about 15 percent of the U.S. economy. On a given day in 2020, some 580,000 Americans were identified as homeless. Three-fifths were in shelters or transitional housing and the others were on the street or in cars or abandoned buildings.[2422] But, at the same time, Americans owned some 8.2 million second homes.[2423] This is fully 14 times the number of homeless Americans. Clearly, geographic, financial, political, and legal barriers preclude simply housing today's homeless people in today's second homes. But, as a matter of policy, the U.S. might consider steps to ensure that each person has one home before anyone has two or more homes.

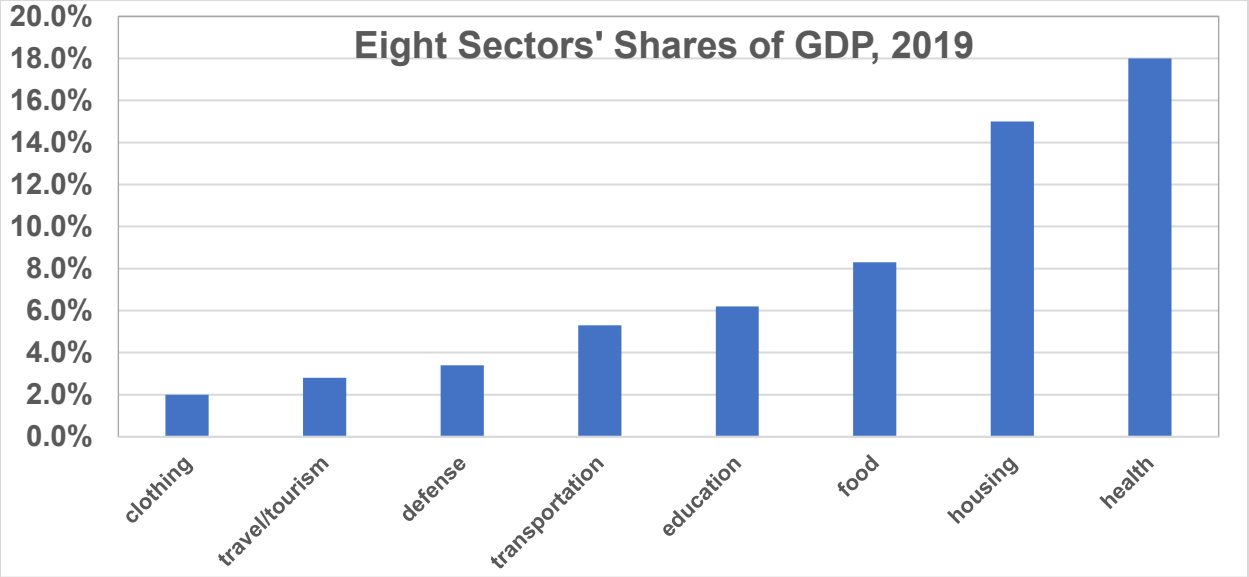
The challenge of confronting equity problems inside each sector can probably be more easily addressed for food security than for homelessness. Food is just over 8 percent of the economy, as shown in Exhibit 5-7. In 2021, pre-recession GDP was $23 trillion;[2424] total food spending that year was $2.12 trillion, fully 55 percent ($1.17 trillion) of which was for food away from home.[2425]

In 2021, about 42 million Americans received Supplementary Nutrition Assistance Program (SNAP) benefits averaging almost $220 per person per month, for a yearly total program cost of $114 billion, including the federal share of administrative costs.[2426]

Suppose that a federal 5 percent food assistance tax (FAT) were imposed on food away from home costing more than $10, and that such costs were about one-half of food away from home. That tax would raise about $30 billion yearly, enough to boost monthly SNAP payments by about one-quarter—or to cover an added 10 million people monthly.

This specific program to advance food security may not be optimal or even desirable. But it is offered as an example of intra-sector redistribution. It asks the food sector to improve equity of nutrition, addressing an important social determinant of life.

Exhibit 5 - 7



Addressing each problem head-on is superior to hoping that some magical or escapist notion will bail us out. In 1942, according to Blanpain:

> There was a strong conviction, and it was one of the tenets of Lord Beveridge's blueprint for the National Health Service in the United Kingdom, that enabling early access to hospital care would reduce the onset of irreversible and costly disease. It was predicted and believed that this would eventually lead to a substantial reduction in health expenditures in the near future.[2427]

Similarly, HMOs touted primary prevention or early detection. Promises to "pay for value, not volume" and other painless panaceas have pervaded U.S. health care for decades.[2428] Those who call for diverting vast sums from health care to address SDLs are assuredly driven by the most positive and sincere motives. Doubtless, they are daunted by the difficulty of reforming U.S. health care and to attain medical security for all.

Nonetheless, end-runs around health care problems surely won't work. Confronting those problems head-on just might.

Racial, ethnic, and religious bigotry, sexism, ableism, and other types of discrimination or exclusion are partly responsible for unequal use of medical care and unequal health outcomes. All should be overcome as quickly as possible.[2429]

But doing so is no substitute for full and equal coverage for medical care for all Americans, the right caregivers in the right places to redeem financial coverage through actual health care, paying caregivers by methods that are trustworthy and enable and motivate caregivers to spend finite dollars carefully, and equalizing quality and appropriateness of medical care for all people and in all places. Overcoming discrimination and winning medical security for all Americans are complements, not substitutes for one another. It would be sad if a focus on securing rhetorical endorsement of abstract ideals were to allow U.S. health care off the hook—if it allowed words of equality to substitute for deeds of equality.

Given the real advantages of competitive free markets, when they actually function, it is not surprising that most Americans preferred to rely on them to make decisions about health care in place of inevitably politicized government action. In the real world, though, an attainable second-best is often better than an unattainable best choice. Actual competition in health care works terribly. In the U.S., traditional public action works only a little better.

Perhaps.

In other rich democracies, strategic public decisions about coverage and cost control, plus unified payer negotiation with caregivers, combine to shape health care that delivers better outcomes at lower cost. And they seem, generally, to do so with substantially lower levels of public and private bureaucracy than those prevailing in U.S. health care. These strategic decisions, then, appear to build foundations for self-regulating and trustworthy health care. Foundations vastly more solid than U.S. reliance on failed markets and incompetent government.

Viewed in another way, even government can out-perform failed health care markets. If government limits itself to doing things it can actually do competently. In health care, that amounts to making a fairly small share of the decisions—the big ones—and then getting out of the way.

So we can do better. What are the key steps forward?

D. Remedies for weak government action

In 2003, Schoenbaum and others called for strong federal government leadership in health care. They had in mind mobilizing "action to set national priorities for quality; develop and promulgate standards for care; and stimulate implementation of performance measures and standards for providers." A new federal agency would take on these three jobs. The federal government would pay caregivers in light of the new "performance standards, invest in needed information technology, and invest in research" to improve care and to train professionals.[2430]

Some—but certainly not most—of this has happened in the succeeding two decades. Quality measures for ACOs have been prescribed. Medicare ostensibly adjusts doctors' payments for

reported quality and cost measures, and money was poured—quickly and fairly recklessly—into financing EHR purchase by hospitals and doctors.

These actions aim to press caregivers to spend money more carefully by weeding out low-value care. But the focus on quality can go only so far.

Can federal action from the top, down engage doctors and hospitals in squeezing out clinical waste? What would be done about administrative waste, high prices, and theft? Can effective cost controls be crafted, legislated, and implemented? How to design methods of paying caregivers that enable patients and payers to trust caregivers to spend vast but finite dollars as well as possible? Can the huge sums inside health care be mobilized to ensure solid financial protection for all Americans? How can the numbers, types, and locations of caregivers be much better matched with patients' health care needs? Can appropriateness and quality be heightened and made much more equal?

Absent a large and visible crisis, it is hard to imagine powerful political pressure for effective federal and state government action in health care.

Chapter 1 described a possible financial crisis for health care. Late in the 2020s, international, economic, political, and social challenges from outside health care propel a freeze in federal spending for Medicare, Medicaid, ACA subsidies, and other programs. Health care's financial addiction to substantial new revenue each year is deeply disrupted. Hospitals and other caregivers face bankruptcy. Doctors, dentists, nurses, and other professionals face lower incomes and even unemployment. Established patients face disruption of treatment as caregiver capacity shrinks. New patients are threatened with delayed or denied diagnosis and treatment.

This crisis might mean pressure for relief, recovery, and reform. Even though frozen, revenue will remain enormous. It will be enough to deliver all needed care. But not if one-half of the dollars continue to be wasted. Crisis might provide the ingredients to blast loose much of the money that's been wasted year after year. But focusing the explosive in the right places—and capturing and repurposing the resulting savings will be challenging.

Responding to crisis will have many moving parts. Stakes will be high. Preparation will be essential.

It would be useful to cease debating the nature of U.S. health care's problems, their causes, possible remedies, and how to implement them.

It would be even more useful to prepare detailed plans to deal with the contingency of a crisis—to think through what might be done to salvage what's good and reform and repurpose what' bad. To identify allies who could persuade colleagues to get on board with implementing reforms. To begin training the caregivers who'll be needed to deliver needed medical care to all Americans.

It would be equally valuable to begin to test better ways to cover all Americans, deliver needed care, contain cost by recycling waste and spending available money carefully, pay caregivers in trustworthy ways, and the other vital jobs.

Those who disagree with the possibility of crisis should continue to over-sell trivial reforms, to develop arguments for continuing business-as-usual, and to protect current arrangements.

5. Government failure is the other source of anarchy

That makes it vital to prepare to act when a crisis is deemed politically to have arrived. This preparation entails an analysis of the problems haunting U.S. health care, their causes, and possible remedies. Coordination of remedial interventions will be essential.

The second half of this book—chapters 7 through 17—will suggest ways to prepare.

The short list of government jobs

1. Since crisis is probable, prepare to address it.
2. Develop detailed analyses of ways to make the 5 strategic decisions.
3. Prepare political and public relations campaigns to implement those decisions.
4. Obviate regulatory micro-responses to problems.
5. Build foundations for trusting caregivers to self-regulate and serve all of us within budgets.
6. Make it clear to all citizens and caregivers that “theft kills and waste kills.”

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5. Government failure is the other source of anarchy
