

Healthcare in the United States: Status and Steps to Improve Outcomes and Reduce Costs

Summary

Healthcare costs in the U.S. are a primary driver of projected Federal Debt growth and consume almost one in five dollars of Gross Domestic Product (GDP). This level of spending is greater than all other, and about twice the average of, wealthy peer countries. Further, the U.S. generally has much poorer health outcomes (e.g., lowest life expectancy at birth, highest maternal and infant mortality rates). A more efficient and cost-effective U.S. healthcare system would allow greater investment in other areas of the U.S. economy and provide long-term economic benefits and fiscal stability as well as a healthier population. Healthcare system reforms that emphasize preventive care and eliminate waste (an estimated 25 – 30% of healthcare spending) are needed. All the peer countries, with better health outcomes and much lower healthcare costs, have universal government/compulsory healthcare coverage for all citizens. The U.S. should transition from the current fragmented public/private healthcare insurance system to a universal coverage system and achieve similar benefits.

The following sections include: 1.) a summary of U.S. healthcare outcomes and costs relative to peer countries; 2.) a discussion of the causes of high healthcare costs and poor health outcomes and a summary of the lifestyle characteristics of areas with long-lived populations; and 3.) a discussion of options for improving the health of U.S. citizens and reducing healthcare system costs. In this paper, explanatory footnotes are indicated by superscript roman numerals and referenced documents by superscript Arabic numerals and listed at the end of the document.

1.0 Healthcare Outcomes and Costs for U.S. and Peer Countries

A 2022 analysis by The Commonwealth Fund^I, using international data from the Organisation for Economic Co-operation and Development (OECD) and other sources, compared U.S. health system performance metrics (e.g., health outcomes, healthcare spending) relative to 13 peer countries^I and the averages for 38 high-income OECD countries^{II}. “Highlights” of the analysis, presented in greater detail in the following subsections, were:

- “• Health care spending, both per person and as a share of GDP, continues to be far higher in the United States than in other high-income countries. Yet the U.S. is the only country that doesn’t have universal health coverage.
- The U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and among the highest suicide rates.
- The U.S. has the highest rate of people with multiple chronic conditions and an obesity rate nearly twice the OECD average.

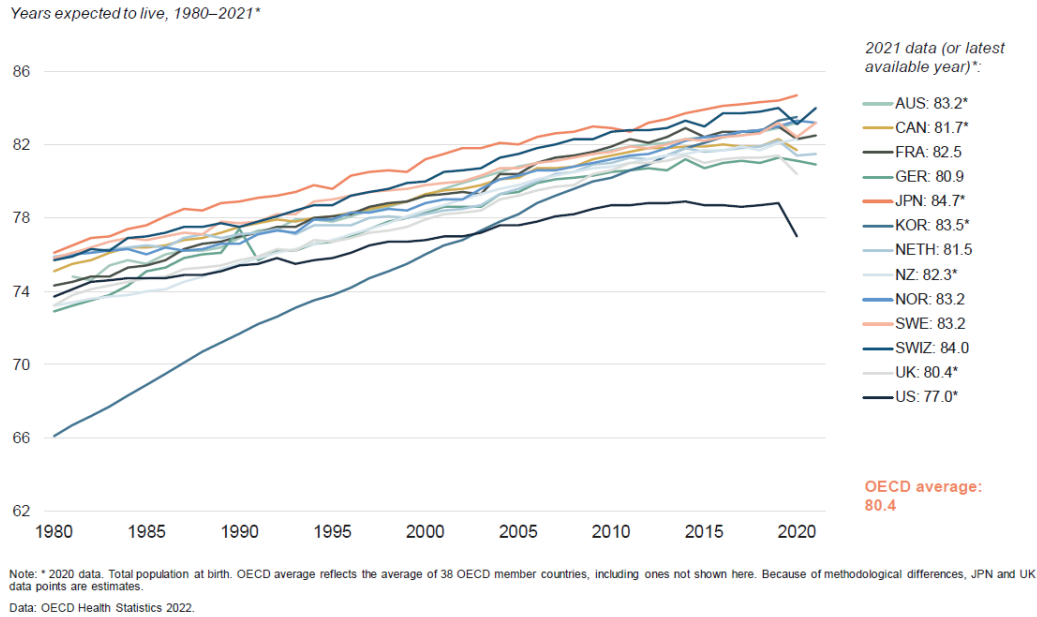
^I Australia, Canada, France, Germany, Japan, the Netherlands, New Zealand, Norway, South Korea, Sweden, Switzerland, and the United Kingdom

^{II} Australia, Austria, Belgium, Canada, Chile, Columbia, Costa Rica, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom, and United States.

- Americans see physicians less often than people in most other countries and have among the lowest rate of practicing physicians and hospital beds per 1,000 population.
- Screening rates for breast and colorectal cancer and vaccination for flu in the U.S. are among the highest, but COVID-19 vaccination trails many nations.”

1.1 Health Outcomes: U.S. Compared to Peer Countries and OCED Average

Life expectancy at birth in the U.S. is 77 years, which is lower than the life expectancy in all the peer countries and three years less than the OCED average (Figure 1).



Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). <https://doi.org/10.26099/8ey-yc74>

Figure 1. Life expectancy at birth: U.S., peer countries, and OCED average

The U.S. has 336 avoidable deaths per year per 100,000 people. This avoidable death rate is higher than in all the peer countries and the OCED average (Figure 2).

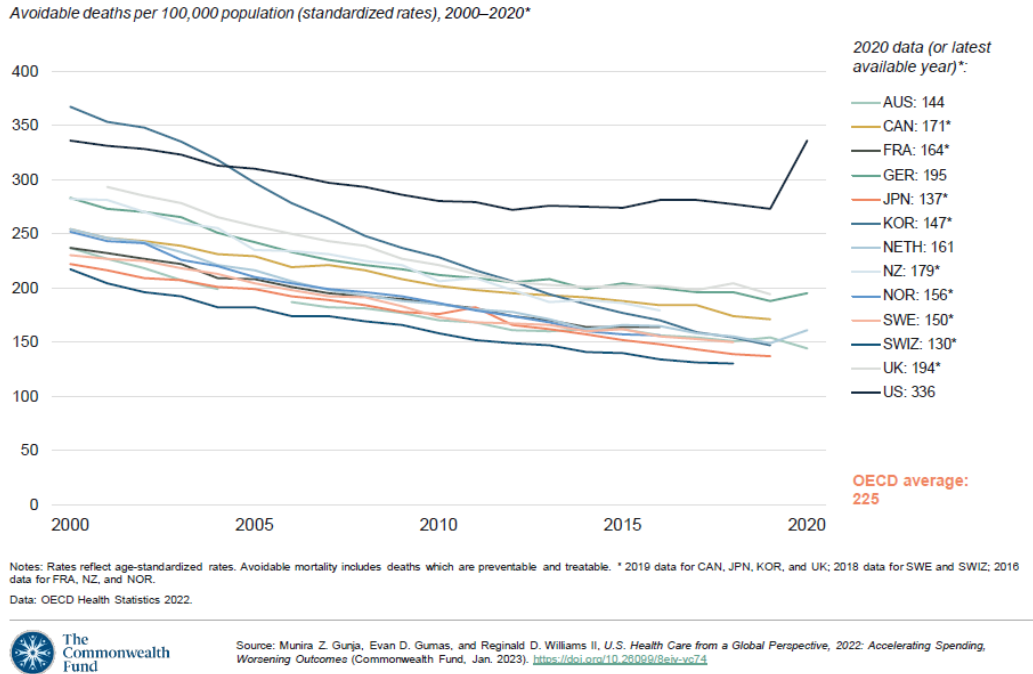


Figure 2. Avoidable deaths per 100,000 people: U.S., peer countries, and OCED average

Infant and maternal mortality rates in the U.S. are higher than in all the peer countries and the OCED averages (Figure 3).

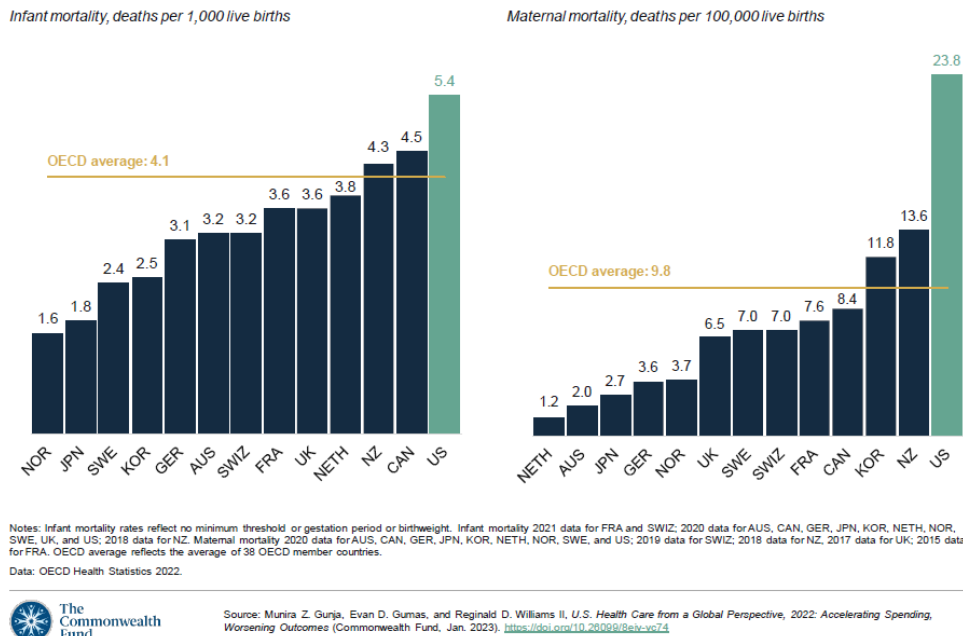


Figure 3. Infant and maternal mortality rates: U.S., peer countries, and OCED average

42.8% of the U.S. population is considered obese. This is higher than the obesity rates in all the peer countries and the OCED average (Figure 4).

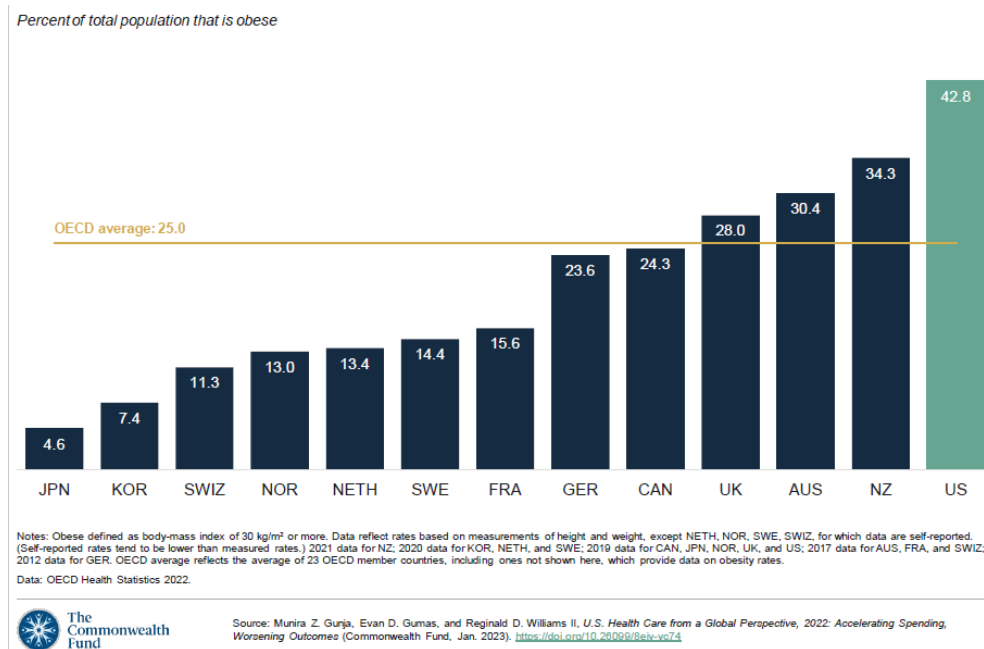


Figure 4. Obesity rates: U.S., peer countries, and OCED average

Table 1 summarizes other health outcomes for the U.S., peer countries, and the OCED average. The U.S. rank is the poorest or near the poorest for all these health outcomes.

Table 1. Summary of Other Health Outcomes in the U.S., Peer Countries, and OCED Average

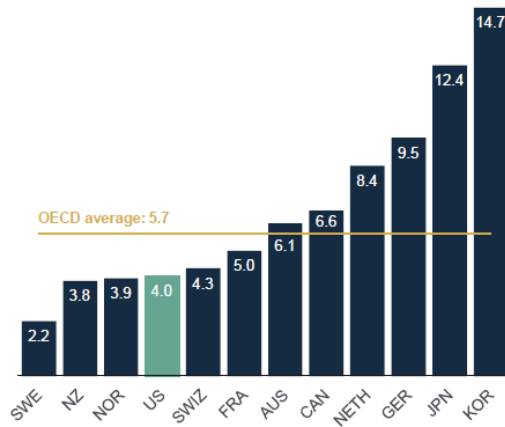
Health Outcome	U.S. Rank
Deaths from gun violence and other assault	Higher than all peer countries by a factor of 5 or more and OCED average by a factor of 3
Suicide rates	Third highest of peer group and higher than OCED average
Multiple chronic conditions	Higher than all peer countries
COVID-19 death rates	Higher than all peer countries

1.2 Health Care System Capacity and Use: U.S. Compared to Peer Countries and OCED Average

The U.S. has very low rates of practicing physicians and physician consultations per capita (Figure 5). Amongst peer countries, the U.S. is essentially tied for the lowest number of practicing physicians per 1,000 population and is lower than the OCED average. Physicians would prefer to spend less time on insurance and administrative tasks and more time practicing medicine, and waning job satisfaction in the medical community could be contributing to the low rate of practicing physicians in the U.S. An analysis of the U.S. healthcare system in *The Lancet*² notes

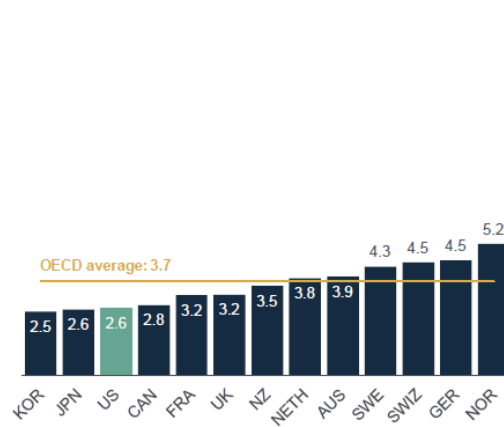
“overwhelming paperwork is a primary factor in physician burnout.”

Physician consultations in all settings per capita



Notes: Data for UK not available. 2021 data for AUS and NOR; 2020 data for FRA, GER, KOR, NETH, and SWE; 2019 data for CAN and JPN; 2017 for NZ and SWIZ; 2011 data for US. OECD average reflects the average of 37 OECD member countries, including ones not shown here.
Data: OECD Health Statistics 2022.

Practicing physicians per 1,000 population



Notes: 2021 data for CAN, GER, NZ, NOR, SWIZ, and UK; 2020 data for AUS, FRA, JPN, KOR, and NETH; 2019 data for SWE and US. OECD average reflects the average of 31 OECD member countries, including ones not shown here.
Data: OECD Health Statistics 2022.

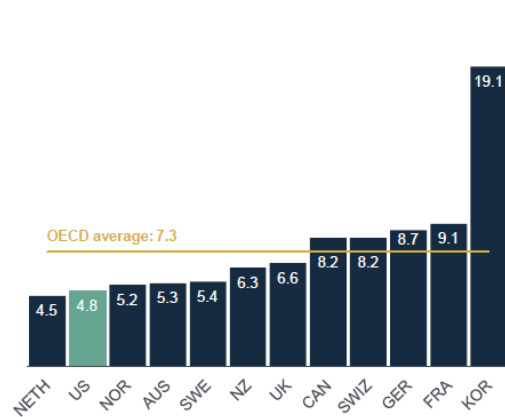


Source: Munira Z. Gurja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). <https://doi.org/10.28099/9eiv-vc74>

Figure 5. Rate of visits to physicians and number of practicing physicians per 1,000 population: U.S., peer countries, and OCED average

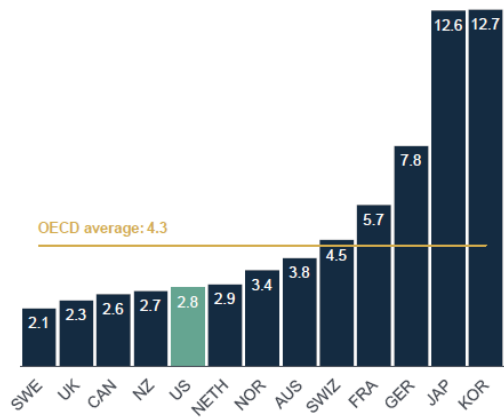
The U.S. has short hospital stays and a low number of hospital beds per capita relative to peer countries and the OCED average (Figure 6).

Average length of stay for inpatient care (days)



Notes: Data reflect average length of stay for inpatient care for all hospitals. 2021 data for NOR; 2020 data for CAN, FRA, GER, KOR, NETH, SWE, and SWIZ; 2019 data for AUS and NZ; 2018 data for UK; 2010 data for US. Data for JPN not available. OECD average reflects the average of 38 OECD member countries, including ones not shown here, where data are available.
Data: OECD Health Statistics 2022.

Number of total hospital beds per 1,000 population



Notes: 2021 data for NZ and UK; 2020 data for CAN, FRA, GER, JPN, KOR, NETH, NOR, SWE, and SWIZ; 2019 data for US; 2016 data for AUS. OECD average reflects the average of 38 OECD member countries, including ones not shown here, with available data.
Data: OECD Health Statistics 2022.



Source: Munira Z. Gurja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). <https://doi.org/10.28099/9eiv-vc74>

Figure 6. Average length of hospital stays and number of hospital beds per 1,000 people: U.S., peer countries, and OCED average

The U.S. has high screening rates for breast cancer and colorectal cancer relative to peer countries and the OCED average (Figure 7).

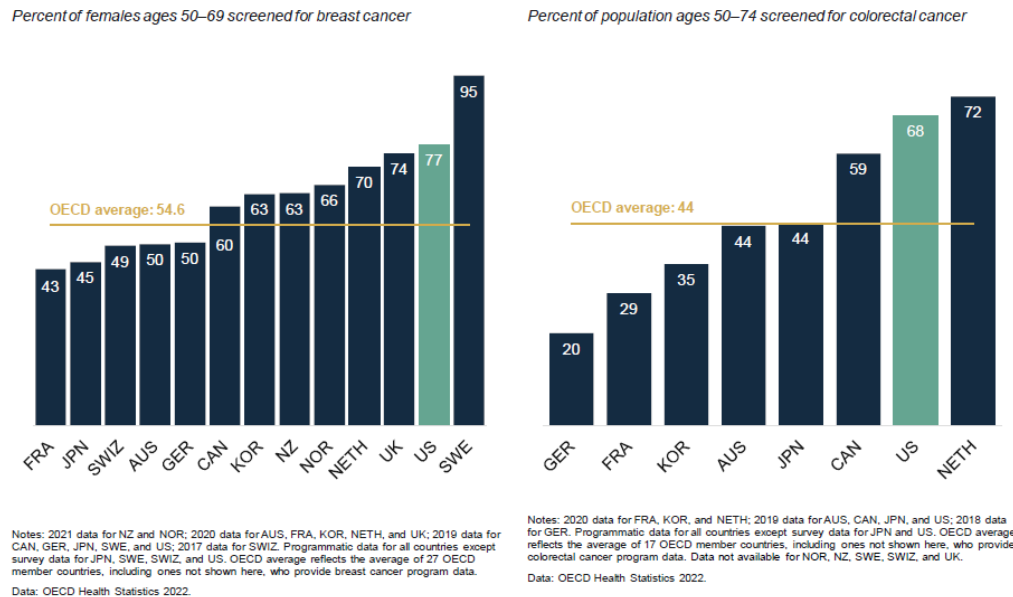


Figure 7. Screening rates for breast cancer and colorectal cancer: U.S., peer countries, and OCED average

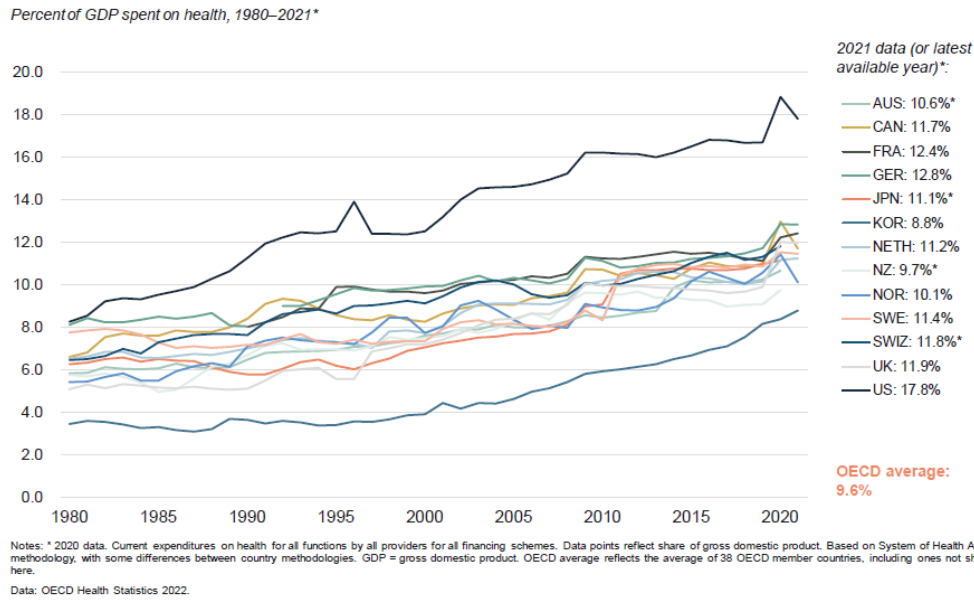
Table 2 summarizes other health care system capacity and use data for the U.S., peer countries, and the OCED average.

Table 2. Summary of Other Health Care System Capacity and Use Data for the U.S., Peer Countries, and OCED Average

Parameter	U.S. Rank
Vaccination rate for influenza	In the top 50% of peer countries, greater than OCED average
Vaccination rate for COVID-19	Third lowest of peer countries and equal to OCED average
Magnetic resonance imaging (MRI) scans	About the 50 th percentile for peer countries and greater than OCED average
Hip replacements	Second highest of peer countries, greater than OCED average

1.3 Relative Health Care Costs and Health Insurance Coverage: U.S. Compared to Peer Countries and OCED Average

The U.S. spends a much greater share of its economy, measured as percentage of GDP, on healthcare than peer countries and the OCED average (Figure 8). The U.S. spends nearly 18% of GDP on health care compared to the OCED average of 9.6%. The next highest peer country is Germany at 12.8% of GDP.

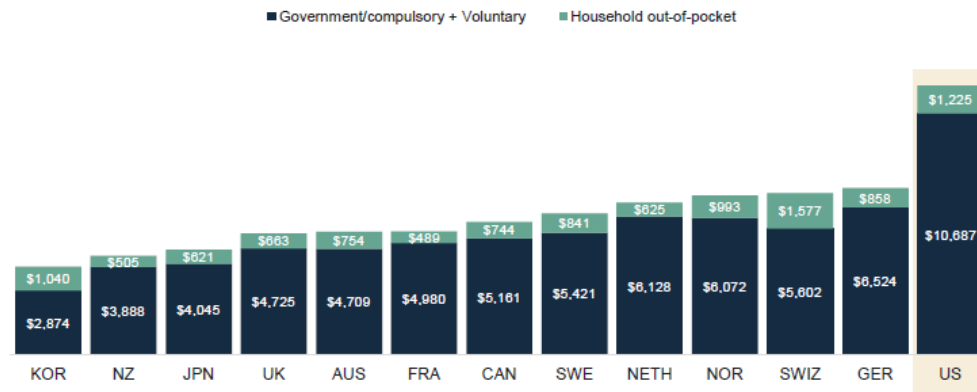


Source: Munira Z. Gurja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). <https://doi.org/10.26098/8eiv-vc74>

Figure 8. Healthcare spending as percent of GDP: U.S., peer countries, and OCED average

The U.S. spends much more per capita on healthcare than peer countries (Figure 9). The U.S. spends almost \$12,000 per year per person on health care. The next highest peer country is Germany at about \$7,400 per year per person, about 40% less than the U.S. per capita spending rate. Per capita healthcare spending in Korea is about one-third of U.S. spending. Healthcare spending in the U.S. includes public government programs (e.g., Medicare, Medicaid, Affordable Care Act, Children’s Health Insurance Program (CHIP), and for military personnel); private insurance provided to employees by employers; other forms of private insurance; and out-of-pocket. As shown in Figure 10, the U.S. is the only peer country that does not have government/compulsory healthcare coverage for all citizens. Residents in many of the peer countries purchase private insurance in addition to the public coverage. Over 95% of the population in France has public and private insurance.

Dollars (USD) per capita spend on health expenditures



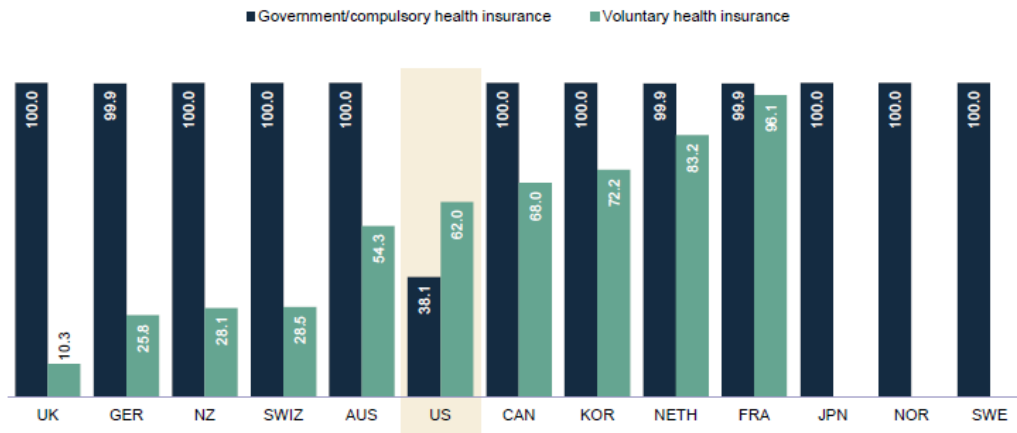
Notes: Data reflects all financing schemes on all functions of current expenditures on health by all providers. The OECD considers the vast majority of ACA marketplace plans in US to be "government/compulsory spending" because of the individual mandate, despite its repeal in 2018. See here for more information: <https://www.oecd.org/health/spending-on-private-health-insurance-brief-march-2022.pdf>. Government/compulsory spending data: 2021 data for CAN, GER, KOR, NETH, NOR, SWE, and UK; 2020 data for AUS, FRA, JPN, NZ, SWIZ, and US. Voluntary spending data: 2021 data for CAN, GER, KOR, NETH, NOR, SWE, and UK; 2020 data for FRA, JPN, SWIZ, and US; 2019 data for AUS; 2018 data for NZ. Household out-of-pocket spending data: 2021 data for CAN, GER, KOR, NETH, NOR, SWE, UK, and US; 2020 data for FRA, JPN, and SWIZ; 2019 data for AUS; 2018 data for NZ.
Data: OECD Health Statistics 2022.



Source: Munira Z. Gurja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). <https://doi.org/10.26099/8ely-yc74>

Figure 9. Per capita healthcare spending as percent of GDP in the U.S. and peer countries

Percent of total population with health insurance coverage



Notes: Government/compulsory health insurance data: 2021 data for AUS, CAN, FRA, NZ, and NOR; 2020 data for GER, KOR, NETH, SWE, SWIZ, UK, and US; 2019 data for JPN. Voluntary health insurance coverage data: 2021 data for AUS, CAN, and NZ; 2020 data for GER, KOR, NETH, and US; 2019 data for UK; 2017 data for FRA and SWIZ. Government health insurance refers to public benefit basket covering a minimum set of health services. Voluntary health insurance refers to payments for private insurance premiums, which grant coverage for services from private providers. See more information on definitions here: <https://www.oecd.org/health/spending-on-private-health-insurance-brief-march-2022.pdf>.
Data: OECD Health Statistics 2022.



Source: Munira Z. Gurja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). <https://doi.org/10.26099/8ely-yc74>

Figure 10. Healthcare coverage in the U.S. and peer countries

The combination of high costs and poor outcomes makes clear that there are inefficiencies in the U.S. healthcare system and opportunities for improvement. The Commonwealth Fund analysis concluded:

“The findings of our international comparison demonstrate the importance of a health care system that supports chronic disease prevention and management, the early diagnosis and

treatment of medical problems, affordable access to health care coverage, and cost containment — among the key functions of a high-performing system. Other countries have found ways to do these things well; the U.S. can as well.”

and

“ While the United States spends more on health care than any other high-income country, the nation often performs worse on measures of health and health care. For the U.S., a first step to improvement is ensuring that everyone has access to affordable care. Not only is the U.S. the only country we studied that does not have universal health coverage, but its health system can seem designed to discourage people from using services.”

2.0 Causes of High Healthcare Costs and Poor Health Outcomes, and Lifestyle Characteristics of Areas with Long-lived Populations

Causes of high health care costs and poor health outcomes in the U.S. are analyzed in The Commonwealth Fund¹ paper, presentations on the Peter G Peterson Foundation³ and the Bipartisan Policy Center⁴ websites, and papers published in the Journal of the American Medical Association⁵ and The Lancet². Causes of high health care costs include:

- Excessive healthcare system waste. An estimated 25 – 30% of U.S. healthcare system spending is on services that are “unnecessary, ineffective, overpriced, and wasteful”.^{3,5} Table 3 lists six waste domains in the healthcare system and estimated annual cost of the waste. Pricing failure (unreasonably high prices) plus Administrative complexity account for almost 60% of the wasteful expenditures.

Table 3. U.S. Healthcare System Waste Domains⁵

Waste Domain	Estimated Cost (2019 \$Billion/yr)	Percent of Total ^A
Failure of care delivery (execution of care processes)	\$102.4 – \$165.7	15.8%
Failure of care coordination	\$27.2 – \$78.2	6.2%
Overtreatment or low-value care	\$75.7 – \$101.2	10.4%
Pricing failure (unreasonably high prices)	\$230.7 – \$240.5	27.8%
Fraud and abuse	\$58.5 – \$83.9	8.4%
Administrative complexity	\$265.6	31.3%
Total	\$760 – \$935	100.0%

A. Based on average of low and high estimates.

- High Administrative overhead costs for insurance companies. The analysis presented in The Lancet paper estimated that administrative overhead costs for health insurance providers are 12.4% of spending compared to 2.2% for the Medicare program.
- The complex and fractured U.S. healthcare system that includes public government programs (e.g., Medicare, Medicaid, Affordable Care Act, Children’s Health Insurance Program (CHIP), and for military personnel); private insurance provided to employees by employers; other forms of private insurance; and out-of-pocket expenses.

- A tax code that subsidizes health insurance provided to employees by employers and shields patients from the true cost of much healthcare.
- About 71% of total U.S. health spending is to treat patients with multiple chronic conditions. This treatment also requires about 93% of total spending by Medicare.⁴
- Fee for service payment structures that disincentivize lowering costs and improving the quality of care. This is a perverse incentive in that improved care efficiency can reduce the number of services and revenue.
- Consolidation of hospitals reducing competition.³

Causes of poor health outcomes include:

- Many Americans do not have health care insurance due to the high cost and miss or defer preventative or other necessary care. High co-payment costs also cause many adults to miss or defer preventative or other necessary care.¹
- Inadequate prevention and management of chronic conditions and reduced primary care access caused, at least in part, by an insufficient number of health care providers.¹
- Other factors that contribute to poor health outcomes in the U.S. (and no doubt in other countries) include a sedentary lifestyle, poor diet (e.g., high calorie, low nutrition ultra-processed foods^{III} that have been linked to weight gain and greater risk of other health issues such as cardiovascular disease, heart attacks and strokes^{7 8}), chronic stress, smoking, excessive alcohol use, and obesity (related to sedentary lifestyle and diet).⁹

Conversely, factors that contribute to longer healthier lives were identified by studying the lifestyles of people living in “blue zones”, five areas in the world where people live to be over 100 years old at a rate 10 times greater than in the U.S.^{IV} The common lifestyle characteristics of these areas, often referred to as “the Power 9” are:

“ Activity

- **Move Naturally** The world's longest-lived people do not “exercise.” In blue zones, Buettner's^V team observed that people were nudged into moving about every 20 minutes. For example, they were gardening, they kneaded their own bread, and they used hand-operated tools; their houses were not full of conveniences. When they did go out (e.g., to school, work, a friend's house, a restaurant, or to socialize), it was almost always on foot. Movement is engineered into their daily lives.

Outlook

- **Down Shift** Stress is part of the human condition, Buettner said, and people in blue zones suffer the same stresses that others do. However, the people living in blue zones have

^{III} “Ultra-processed foods are packaged foods that have been made by food companies using many manufactured ingredients, rather than actual foods. Those ingredients are combined in some way to make something that is edible, but it in no way maintains the integrity or nutritional content of the original foods.”⁶

^{IV} Loma Linda, CA USA, Nicoya Costa Rica, Sardinia Italy, Ikaria Greece, and Okinawa Japan

^V Dan Buettner is the author of “Blue Zones, 9 Lessons for Living Longer from the people who have lived the longest” and was the leader of the team that studied the blue zones communities.

daily rituals that reduce stress and reverse the inflammation associated with stress. Rituals varied and included activities such as prayer, ancestor veneration, napping, and happy hour.

- **Purpose** In the blue zones, people have vocabulary for purpose. Buettner described a recent study from Canada that followed 6,000 people for 14 years and found that those people who could articulate their sense of purpose had a 15 percent lower risk of dying. Another study, this one from the National Institute on Aging, found that people who could articulate their sense of purpose were living up to 7 years longer.

Diet

- **Wine at 5** Except for the Adventists, people in blue zones consumed moderate amounts of alcohol (most commonly two glasses per day, but as much as four glasses per day).
- **Plant Slant** A meta-analysis by Buettner of 154 dietary surveys in all five blue zones found that 95 percent of 100-year-olds ate plant-based diets, including plenty of beans. Beans are inexpensive, full of fiber and protein, and nutritionally rich, Buettner said. The 100-year-olds also eat a lot of carbohydrates, but in the form of whole grains and sourdough breads rather than in breads leavened with yeast.
- **80 Percent Rule** The longest-lived people have strategies to keep themselves from overeating, Buettner said (such as the Confucian mantra some Okinawans use to stop eating when they feel 80 percent full). There is clinical evidence that strategies such as stopping to say a prayer before meals, eating slowly so that the full feeling can reach the brain, not having televisions in kitchens, or eating with family lead to a decrease in food intake. In all five blue zones, people eat a large breakfast and a smaller lunch, and dinner is the smallest meal of the day.

Connections

- **Loved Ones First** Centenarians spend a lot of time and effort working on their relationships with their spouses and children. Children are likely to keep their aging parents nearby and to consider them to be fountains of wisdom that will favor their own survival.
- **Belong** People in blue zones tend to belong to a faith-based community. Individuals of faith who regularly attend a faith-based service live 4 to 14 years longer than their counterparts who do not, Buettner said.
- **Right Tribe** Health behaviors are contagious, Buettner said. Deleterious behaviors (e.g., obesity, smoking, excessive drinking, loneliness, unhappiness) are also contagious. The world's longest-lived people “curate” social circles around themselves that support healthy behaviors.”¹⁰

3.0 Policies and Incentives for Better Health and Lower Costs for the U.S.

Section 2 listed some factors that contribute to poor health in the U.S. including inadequate preventative or other necessary healthcare, sedentary lifestyle, poor diet, chronic stress, smoking, excessive alcohol use, and obesity. It also listed lifestyle characteristics shown to lead to long lives such as an active lifestyle, a moderate plant-based diet, a purpose in life, and community and

relationships. Unsurprisingly, many of these are the opposite of lifestyle characteristics that contribute to poor health. These indicate that to address the underlying causes of many preventable health issues and improve the health and longevity of U.S. citizens, the policies should:

- Provide access to annual checkups and other primary and preventative care.
- Encourage less sedentary lifestyles; for example, by redesigning cities and towns to promote more walking (e.g., install sidewalks). Such changes would also increase a sense of community.
- Support for volunteer groups that give many people purpose.
- Encourage better diets through outreach and public education programs. The consumption of ultra-processed foods, which has been linked to obesity and other serious health problems, could be comparable to smoking 50 years ago, a common public health concern. Smoking rates dropped after public education about the hazards of smoking became ubiquitous and high excise taxes were applied to cigarette purchases. A similar approach could be used to reduce consumption of ultra-processed foods.

Insurance options to improve the U.S. healthcare system and promote better health outcomes and lower costs fall into two broad categories: 1.) institute single-payer universal healthcare coverage, discussed in Section 3.1, and 2.) improving the current public/private healthcare coverage system, discussed in Section 3.2.

3.1 Single-Payer Universal Healthcare

All the U.S. peer countries included in the Section 1 analysis have better healthcare outcomes than the U.S., much lower healthcare costs than the U.S., and universal healthcare systems with 99.9 or 100% of the population having government/compulsory health insurance. This strongly indicates the U.S. should be considering a comparable system. However, politics and vested interests, such as the pharmaceutical industry and health insurance companies, are potential roadblocks.

The 2020 article in *The Lancet* “Improving the prognosis of health care in the USA”² noted

“Single-payer universal health care has the potential to improve the quality, cost-effectiveness, and accessibility of medical services”

and evaluated the anticipated impact of the Medicare for All Act (MAA) for

“a single-payer system of universal health care for every American”

that had been proposed by Senator Bernard Sanders. A discussion of this article follows as a means of estimating the impact of a single-payer system.

The authors note that over 37 million people in the U.S. lacked any health insurance and another 41 million had inadequate health care access and that

“a universal system, such as that proposed in the Medicare for All Act, has the potential to transform the availability and efficiency of American health-care services. Taking into

account both the costs of coverage expansion and the savings that would be achieved through the Medicare for All Act, we calculate that a single-payer, universal health-care system is likely to lead to a 13% savings in national health-care expenditure”

The expected 13% savings indicates the increased costs required to provide healthcare coverage to everyone in the U.S. would be less than the cost reductions resulting from a universal health-care system. The authors point to Medicare as a

“real-world test for the viability of single-payer, government-funded health care” that “has significantly and cost effectively improved the health of older people”

and is viewed as an important program by most Americans.

Table 4 lists and discusses the expected impacts of implementing the single-payer MAA including benefits such as expanded access to insurance, improved administrative efficiency, lower pricing of pharmaceuticals, and service improvements.

Financing a single-payer MAA program would involve a restructuring of healthcare expenditures. The authors discuss an option that would institute a payroll tax to replace insurance premiums paid by employers and an income tax for households to replace insurance premiums paid by households. Estimates provided in the paper estimate that employers could pay a lower payroll tax than current insurance premiums. In addition, employers would no longer be responsible for managing benefits for employee healthcare and see a cost reduction. The paper also notes that reduced administrative tasks/paperwork with a single-payer system would reduce burnout of physicians, nurses, and other medical professionals and increase career satisfaction.

“As providers reduce their administrative workload, they free time for patient care, which will bolster career satisfaction”

Other considerations of the single-payer system analysis included:

- Lives saved every year. An estimated 68,531 U.S. lives would be saved each year, mostly young people who currently do not have healthcare coverage.
- Improved quality of life. Better health from better primary and preventative healthcare would improve quality of life and productivity and prosperity for many people.
- More efficient lifelong healthcare. Because

“a single-payer system would be financially responsible for health care throughout the lifespan of all Americans, it becomes efficient to incur a small cost in the present with the purpose of avoiding more serious and costly health conditions in the future. By contrast, private insurance companies, within which patients are most often transiently enrolled, maximise profit by minimizing short-term costs. This practice reflects the fiduciary responsibility of health insurance corporations to their shareholders; it also inherently disincentivises the prioritisation of long-term health. Shortsighted costcutting can catalyse a cascade of longer-term health and financial repercussions over the lifespan of a patient.”

Table 4. Estimated Impacts of Medicare for All Act Changes to U.S. Healthcare System²

Healthcare Spending Change	Δ\$Billion/yr (2017 \$)	Notes
Eliminating uncompensated hospitalization fees	+\$38B	Each year, it is estimated that hospitalization fees of \$38.3B are not collected. All legitimate health care would be reimbursed under the MAA, thus increasing spending for hospital services. This would be a benefit for hospitals, physicians, and clinical services.
Eliminating avoidable emergency room visits and hospitalizations	-\$78B	Increased primary care for people who currently lack insurance would reduce emergency room and hospitalization costs.
Reducing reimbursement rates for hospitals, physician, and clinical services	-\$100B	Reimbursement rates comparable to rates paid by Medicare would be established. These are about 30% more than Medicaid and 22% less than private insurance. This lower compensation would be offset by “Eliminating uncompensated hospitalization fees” and “Reducing overhead expenditures”
Reducing pharmaceutical prices via negotiation	-\$188B	By adopting the Department of Veterans Affairs negotiating approach, about a 40% reduction in pharmaceutical prices paid by Medicare is projected.
Reducing overhead expenditure	-\$219B	Administrative overhead costs for private health insurance providers are 12.4% of spending compared to 2.2% for the Medicare program. Paperwork for physicians would be reduced.
Improving fraud detection	-\$102B	Changing to a single healthcare payment system and database would increase detection of provider claims with irregularities.
“insurance expansion	+\$191B	Spending on healthcare spending for previously uninsured people is projected to double, and spending by currently underinsured people is projected to increase about 14%.
Total	-\$458B	-13.1%

- Increased and uninterrupted patient choice of healthcare providers.
“A single-payer system integrates all providers under a unified financial framework. This restructuring erases in-network and out-of-network distinctions and the issue of health-care providers declining to accept individuals based on their insurance status. Patient choice will be dramatically expanded if a universal health-care system is adopted.”
- Uninterrupted healthcare coverage.
“Universal single-payer coverage eliminates the danger of losing health care when it is needed most. For many Americans, a serious illness precipitates the simultaneous losses of income and employment-based health insurance.”

3.2 Improve the Current Public/Private Healthcare System

Until a single-payer universal healthcare coverage system can be implemented in the U.S., improvements to the existing public/private healthcare coverage system should be pursued. The analyses posted by the Peter G Peterson Foundation³ and the Bipartisan Policy Center⁴ listed the following general federal actions to reduce health care costs and improve healthcare service.

- Change incentives to encourage healthcare providers to deliver more value – better care at a lower cost. Options include transition from a fee-for-service model to a pay-for-performance model including
“alternative payment arrangements for patient care such as bundled payments and accountable care organizations, and expanded use of capitated payments to Medicaid’s long-term care beneficiaries.”³
- Improve healthcare system information and data transparency for patients
“to encourage them to be more involved in healthcare decisions. For example, by designing co-payments and deductibles to make patients more aware of costs, by using different amounts of co-pays and deductibles to encourage patients to select higher value care options, and by prohibiting “first dollar”^{VI} coverage so patients have some out-of-pocket cost exposure.”³
- Reduce subsidies for federal healthcare to limit government costs. Table 5, from the United States Annual Budget Deficits and Federal Debt paper, presents options for reducing federal outlays and subsidies for healthcare.
- Redesign the federal programs for healthcare. Options include: combine Medicare Parts A and B; improve financing for high-cost, long-term care patients “dually eligible” for Medicare and Medicaid; change Medicare to a program that supplements beneficiary payments for private insurance, and change Medicaid to a state block grant program.

^{VI} “First Dollar Coverage is an insurance policy in which the insured does not have copays or out-of-pocket expenses required before coverage begins. Instead, the insurer begins payment from the very moment an insurable event occurs, so there is no financial pressure placed on the insured.”¹¹

Table 5. CBO Options For Reducing the Deficit and Projected Savings^{VII}

No.	Deficit Reduction Option	Savings, 2023-2032 (\$B)	Outlay ↓ or Revenue ↑
1.1	<p>“Establish Caps on Federal Spending for Medicaid”^{VIII}</p> <ul style="list-style-type: none"> Federal & state governments co-finance Medicaid. Federal funding is proportional to state funding and currently most federal funding is not capped if a state funding increases. Deficit Reduction Option(s): Set Federal caps and/or growth rates on overall spending or per enrollee spending and could apply for different spending and eligibility categories 	501 to 871	Mandatory Outlay ↓
1.2	<p>“Limit State Taxes on Health Care Providers” (that treat Medicaid patients)</p> <ul style="list-style-type: none"> Federal & state governments co-finance Medicaid. Federal funding is proportional to state funding. Some states use a “hold harmless” strategy where, for example, Medicare providers are taxed at higher rates than similar providers and the taxes are returned to the Medicare providers through higher Medicaid payments that result in higher Federal payments. These arrangements are allowed when providers are taxed at 6% or less of their net revenues from Medicaid patients Deficit Reduction Option(s): reduce the hold harmless arrangements threshold from 6% to 5%, 2.5% or 0% and thereby reduce Federal payments 	41 to 526	Mandatory Outlay ↓
1.3	<p>“Reduce Federal Medicaid Matching Rates”</p> <ul style="list-style-type: none"> Federal and state governments co-finance Medicaid. The federal share of medical services and administrative expenses varies by state based on per capita income, and is higher for ACA enrollees Deficit Reduction Option(s): 1.) Reduce the federal share of administrative expenses; 2.) Reduce the federal share of medical services for non-ACA enrollees for high per-capita income states; 3.) Make the federal share of ACA-enrollees medical services the same as for non-ACA enrollees 	68 to 667	Mandatory Outlay ↓

^{VII} The information in the table is from “Options for Reducing the Deficit”, Posted by Phill Swagel, CBO Director, on March 6, 2023. www.cbo.gov/publication/58981

^{VIII} Medicaid is a joint federal-state program that covers health care for groups of low-income people including families with dependent children, elderly people (65+), non-elderly people with disabilities, and, at states discretion, other non-elderly low-income (incomes below 138% of federal poverty guidelines) adults eligible for Medicaid under the Affordable Care Act (ACA)

No.	Deficit Reduction Option	Savings, 2023-2032 (\$B)	Outlay ↓ or Revenue ↑
1.4	<p>“Increase the Premiums Paid for Medicare^{IX} Part B”</p> <ul style="list-style-type: none"> Physician and other outpatient services for Medicare patients are covered under Part B. Enrollees pay a basic premium of about 25% of Part B costs. Higher income enrollees also pay an income-related premium (IRP) Deficit Reduction Option(s): 1.) increase the basic premium from 25% to 35% of expected costs; 2.) freeze IRP high-income thresholds from 2024 to 2032; and 3.) a combination of 1 and 2 	57 to 448	Revenue ↑
1.5	<p>“Reduce Medicare Advantage Benchmarks”</p> <ul style="list-style-type: none"> The Medicare Advantage program allows beneficiaries to enroll in private Medicare coverage plans rather than the Medicare fee-for-service (FFS) program administered by the government Federal payments to Medicare Advantage providers are based on local cost-adjusted FFS beneficiary spending benchmarks and other parameters such as patients’ health conditions Deficit Reduction Option(s): reduce Medicare Advantage program benchmarks by 10% 	392	Mandatory Outlay ↓
1.6	<p>“Reduce Tax Subsidies for Employment-Based Health Insurance”</p> <ul style="list-style-type: none"> Employer paid premiums for employee health insurance are excluded from income & payroll taxes, and most worker premium payments for such plans are excluded from income & payroll taxes This favorable tax treatment is a large tax expenditure Deficit Reduction Option(s): limit the exclusion from income and payroll taxes to the 50th or 75th percentile of employment-based health insurance premiums, or only limit exclusion from income taxes at the 50th percentile 	500 to 893	Revenue ↑

^{IX} “Medicare is a federal health insurance program for people 65+ and for younger people with long-term disabilities or end-stage renal disease”

References

1. “U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes”, M.Z. Gunja et al, The Commonwealth Fund Issue Brief, January 31, 2023. www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022
2. “Improving the prognosis of health care in the USA” A.P. Galvani et al, The Lancet 2020, Volume 395, February 15, 2020. [www.thelancet.com/article/S0140-6736\(19\)33019-3/fulltext](http://www.thelancet.com/article/S0140-6736(19)33019-3/fulltext)
3. Peter G. Peterson Foundation / Finding Solutions / Healthcare Reform www.pgpf.org/finding-solutions/healthcare
4. “Containing the Growth of Health Care Costs”, B. Ritz, Bipartisan Policy Center, October 3, 2016. <https://bipartisanpolicy.org/blog/containing-the-growth-of-health-care-costs/>
5. “Waste in the US Health Care System, Estimated Costs and Potential for Savings”, W.H. Shrank et al, Journal of the American Medical Association, October 7, 2019. <https://jamanetwork.com/journals/jama/article-abstract/2752664>
6. “What are ultra-processed foods?”, H. Alexander, The University of Texas MD Anderson Cancer Center, March 16, 2022 www.mdanderson.org/cancerwise/what-are-ultra-processed-foods.h00-159538167.html
7. Harvard Health Blog – What are ultra-processed foods and are they bad for our health?” www.health.harvard.edu/blog/what-are-ultra-processed-foods-and-are-they-bad-for-our-health-2020010918605
8. “Ultra-processed foods: how bad are they for your health?” British Heart Foundation. www.bhf.org.uk/information-support/heart-matters-magazine/news/behind-the-headlines/ultra-processed-foods
9. “Your Heart is in Your Hands”, M. Lee, MD, RHG Media Productions, 2020.
10. “Business Engagement in Building Healthy Communities: Workshop Summary, Lessons from the Blue Zones®” National Library of Medicine, National Center for Biotechnology Information. www.ncbi.nlm.nih.gov/books/NBK298903/
11. www.hubinternational.com/insurance-glossary/f/first-dollar-coverage/