The Three Trillion Dollar Trough

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Towards the end of his book *The Price We Pay: What Broke American Health Care and How We Can Fix It,* Dr. Marty Makary encounters Karen at a cancer fundraiser, and is curious when she declines a glass of wine.

She's taking antibiotics for a chronic sinus problem. "I had the balloon done and everything," she says, referring to the forty-five minute procedure in which her doctor inserted a small tube into her sinus and cleared it by inflating the material at the tip. It cost $21,000, of which $18,500 was covered by insurance.
Makary is hardly surprised to hear that Karen's sinuplasty hasn't really helped since, according to a focus group of Ear, Nose, and Throat specialists, "It's necessary for less than five percent of the patients who have it done." On the other hand, as evidenced by the invoice, it pays well. (Makary, pp. 239-239)
It's easy to get sucked into the quicksand of the United States Health Care System.
A RUNNER'S TALE

I'm familiar with the case of a seventy-two-year-old man who, when the pandemic strikes in March 2020 and shuts down his YMCA, has to shift his daily workout from a fifty-minute ride on an elliptical machine to a six-mile run -- at an admittedly slow pace. The consequences after one hundred days are not unexpected.

He experiences a sharp, persistent pain on the outside of his left knee which hampers even a moderate walk. He arranges an appointment with an orthopedist who has cured him twice previously of arthritic inflammation with cortisone injections only to be told, after an x-ray and a palpation, "There's nothing wrong with your knee other than mild bursitis." He is prescribed a topical gel called diclofenac which miraculously vanquishes both his skepticism and his affliction after three weeks of four-times-a-day application.

"But there's something else I want to show you," says the good doctor. "Do you see these white lines in your lower leg?" Not really, thinks the patient while nodding affirmatively. "They look like calcium deposits. I would mention them to your internist on your next visit."

Which he does after researching atherosclerosis and resolving to reduce drastically his consumption of carbohydrates. "We could perform a CT scan to measure your coronary calcium score," says the internist, "but absent other symptoms I don't recommend it. Instead I suggest a carotid ultrasound." It's harmless, speedy, paid for by Medicare, and shows up normal, much to the fellow's relief, since it enables him to resume his occasional binges of chips and ice cream.

All's well until a few weeks later he comes across this statement in Elisabeth Rosenthal's book *An American Sickness*: "The scientific consensus is that many of the new high-tech screening techniques being promoted to healthy patients, such as checking for 'low T' or getting an ultrasound to see if you have some narrowing of the arteries, are not much more useful than snake oil." (Rosenthal, p. 323) The web site "Very Well Health" lists the following conditions as prompts for the latter procedure: an increased risk of stroke; a blockage due to plaque or a blood clot; a narrowing of the artery; an abnormal sound;

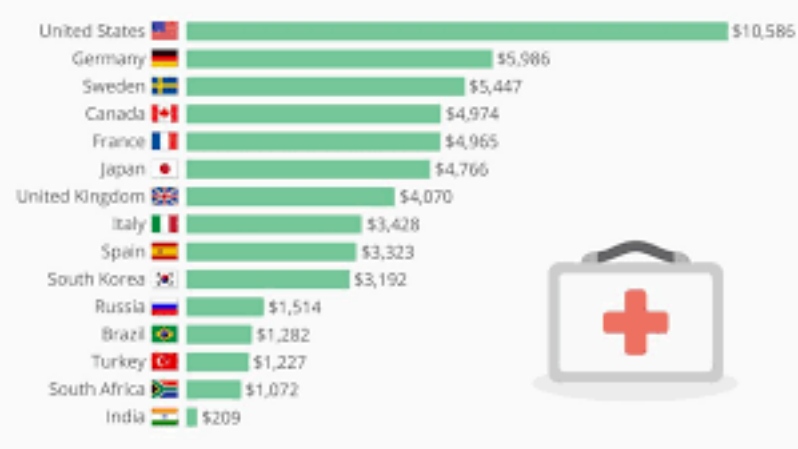
or a transient ischemic attack. The patient -- none other than your faithful scribe -- exhibited none of the above.

Shortly afterward, however, I incur a more mysterious ailment: a severe, intermittent pain in my upper back that spasms and moves from side to side depending on my position or activity. Three consultations with my internist, a urinalysis, and a chest x-ray yield no diagnosis or treatment other than a second prescription for diclofenac (the oral variant this time) and, "if that doesn't work," a recommendation that I try physical therapy. Disdaining both, I agonize for six months until magically the pain abates, leaving me to deduce that it too was the result of my moronic marathon and the incessant shock waves to which I insisted on subjecting my aging body.

I applaud my internist for steering me away from an MRI and an orthopedist. There are five times as many MRI machines and spine surgeries per capita in the U.S. as there are in England. A nationally renowned back specialist says that three quarters of the patients who come to him for a second opinion don't need surgery at all. The $85.9 billion spent in this country to treat back pain is more than its combined state, city, county, and town police force budgets. (Brill, pp. 4-5, Rosenthal, p. 253)

While physical therapy is a better option than going under the knife, a previous experience made me reluctant to return. I'm glad I waited.

THE UTILIZATION TRAP



In the state of New York, from 1995 to 2015, the cost of a physical therapy session jumped from $100 to $600 for post-hip replacement "therapeutic exercise, neuromuscular education, gait training, and an ice pack," all of which, research has shown, are irrelevant to the patient's recovery. From 2004 to 2014 the physical therapy industry grew from $18 billion to $27 billion, a pace that has accelerated to 7% a year since. Some of that can be attributed to Congress, at the behest of lobbyists, annually nullifying previously legislated Medicare reimbursement caps. (Rosenthal, pp. 160-163)

Another therapy which has become more widespread in recent years is Mohs surgery, the process by which skin cancer is removed in slivers or small cubes of flesh rather than in larger cuts in order to preserve as much healthy tissue as possible. The excised portion is examined under a microscope to determine if any malignant cells remain around the edges, which would require a second cut. "On rare occasions, a third stage may be necessary," which, not surprisingly, generates a heftier invoice. Establishing a threshold of 2.2 stages per operation, a Johns Hopkins research team advised a thousand surgeons who were regularly exceeding this benchmark that, compared to their colleagues, their deviation could be considered inappropriate. This assessment was confirmed when, within a matter of months, 83% of the outliers altered their behavior for the better. (Makary, pp. 100-105)

U.S. health care operates in a system where patients are charged a fee for every unique service they receive, thus creating a perverse incentive for physicians and hospitals to conduct more procedures. Since providers are compensated for volume, it's in their economic interest to adopt and promote the position that "We might as well order an extra scan." Says Dr. Harlan Kromholz, professor of health policy at the Yale School of Medicine, "Almost everything is more expensive here [than in other countries] . . .We have a higher utilization of a lot of different services." (Hohman, *today.com*. September 22, 2020)

The consumer is hardly innocent of complicity in this dysfunctional universe. In his desperate search for diagnosis, medication, and cure, he readily submits himself to a battery of tests, punctures, scopes, and treatments, all the while blithely oblivious to their necessity, side effects, and fees, ninety percent of which are borne by Medicare, Medicaid, or his employer.

During the past ten years, reported David Goldhill in the Washington *Post* in 2013, "the number of CT and MRI scans [paid by Medicare] more than doubled; hip replacements increased by more than thirty-six percent. One out of three beneficiaries has at least one surgery in the year of his or her death. The average seventy-five-year-old takes five prescription drugs."

A 2017 study by H. Lyu et.al. revealed that a representative sample of doctors believe that 21% of all medical care delivered in the U.S. is unnecessary. That number rose to 45% in a report issued by the state of Washington Health Alliance; it found that in one year 600,000 patients in the state consumed services they didn't need at a cost of $282 million. The current high volumes of knee replacements, appendectomies, and thyroid surgeries have all been questioned by articles in the *New England Journal of Medicine*. (Makary, pp. 144-147)

Overtreating and overmedicating have other costs besides the profligate squandering of dollars. Opioid addiction and the ensuing tragic death toll are consequences of the uncontrolled and unwarranted distribution of the drug. The antibiotic and anti-

microbial crises are the result of the overuse of antibiotics both in medicine and animal food production. (Makary, p. 146)

In 2018 the U.S. spent $3.65 trillion on health care, almost 18% of its Gross Domestic Product and more than $11,000 per person, which is two times higher than the amounts reported by high-income countries like the U.K., France, Canada, Australia, and New Zealand. The latter pair's 9.3% of GDP devoted to health care is about half that of the U.S.

Despite their inordinate spending, Americans experience worse health outcomes than their international peers. In 2017 life expectancy at birth in the U.S. -- 78.6 -- was more than two years less than the average of countries submitting data to the OECD (Organization for Economic Co-operation and Development) and five years lower than Switzerland, which has the longest lifespan. (Tikkanen and Abrams, *The Commonwealth Fund*, January 30, 2020, pp. 2-3)

The U.S. had the highest number of suicides per capita in the cohort. U.S. adults were diagnosed with two or more chronic conditions -- such as asthma, diabetes, heart disease, or hypertension -- at a level 15% higher than in the other countries. The incidence of obesity in the U.S. was twice the OECD average. Hospitalizations for diabetes and hypertension were 50% higher in the U.S., and among OECD countries the U.S. had the highest rate of amenable mortality (1.12 per 1000) -- that is, premature deaths from conditions which are considered preventable with timely access to quality care, such as diabetes, hypertensive disease, and some cancers. (Tikkanen and Abrams, *The Commonwealth Fund*, January 30, 2020, pp. 3-6)

Excessive utilization is the foundation upon which rises one departmental floor after another, each one piling on more exorbitant costs to support the bloated edifice housing the U.S. health care system.

HUNGRY HOSPITALS

The fastest growing component has been hospital services. From 1997 to 2012 those costs increased 149% compared to 55% growth on the physician side. By 2013 the average hospital cost per day in the U.S. reached $4300, three times the charges in Australia and ten times those in Spain. (Rosenthal, p.23)

An aggressive campaign of revenue enhancement has yielded huge dividends.

Once it became evident to hospitals that private insurers and Medicare would reimburse them for goods and services like operating room time, oxygen therapy, and prescription drugs but not for items like gauze rolls, they adjusted their price lists -- called chargemasters -- accordingly. Such strategic billing assigns prices for pills, plastic surgery, transport, and tests that bear no relationship to their actual costs. (Rosenthal, pp. 34-35)

Hospitals offer financial incentives to physicians to encourage them to up code diagnoses -- that is, amplify their severity and complexity -- in order to generate higher insurance reimbursements. They employ specialists trained in anatomy, physiology, and pharmacology who are equipped to decipher the abstruse coding languages and system. Armed with their professional advice, physicians and nurses know that they can charge $1200 for a steroid injection by classifying it as surgery, that an "acute systolic heart failure" diagnosis is worth thousands more than simple "heart failure," and that administering a narcotic painkiller for a finger fracture or inserting two separate IVs for chemotherapy and dehydration makes a big difference in the patient's bill. (Rosenthal, pp. 37-37, 174-175)

Medical coding and coders like this essentially don't exist in any other healthcare system. A detailed itemized statement for hip replacement in Belgium consists of three pages and totals about 2500 Euros. The same operation in the U.S. will likely cost over $100,000, detailed in dozens of pages, each filled with medical terminology and numerical codes the unintiated could not possibly comprehend. (Rosenthal, pp. 172-173)

Another money maker for hospitals are facility fees -- charges imposed for the use of their rooms and equipment. Not reimbursable in Europe, they became widespread in the U.S. after improvements in anesthesia, pain medicine, minimally invasive surgery, and biopsy techniques greatly reduced the frequency of overnight stays. Imagine the outcry from their customers should other businesses -- like retailers -- brazenly attempt to pass on their rent and utility expenses in the form of surcharges. (Rosenthal, pp. 38-39)

Hospitals have further driven revenue to their bottom lines by shedding perennial losing departments -- like dialysis and drug treatment -- and focusing on more lucrative ones -- like orthopedics and cardiac and cancer care -- often by purchasing existing practices or constructing grandiose new facilities. They have invested heavily in highly profitable services like bariatric surgery and proton beam therapy (for which the machines cost $100 million each) even though the latter offers "no long term benefit over traditional

radiation therapy," according to a survey of thirty thousand prostate cancer patients. (Rosenthal, pp. 40-41)

Every year hospitals in aggregate pocket in excess of $15 billion in subsidies to support graduate medical education, or about $100,000 per resident physician, which covers 75% of his or her cost including salary. These subsidies have a multiplier effect. Besides serving as the primary teachers of students assigned to their wards, residents supply much of the hospital's on-the-ground manpower -- seeing patients in the ER, assisting in the OR, drawing blood -- work which has been calculated to have a value of $233,000 annually. (Rosenthal, p. 43)

In recent years hospitals have latched on to a new profit generator: trauma center designation. Since 2008, when Medicare authorized reimbursements for trauma activation -- that is, the assembly of a skilled team of surgeons and nurses upon notification of severe injury from a rescue squad -- the number of Level I and Level II centers has grown from 305 to 567. Trauma fees can run anywhere from $9000 to $50,000, even when the patient is never admitted, which has become increasingly common. (Hancock, Jay, CNN health, July 17, 2021)

"The portion of Florida trauma activation cases without an admission rose from 22% in 2012 to 27% in 2020." At Broward Health Medical that number was almost 50%. Oregon Health and Science reported that 24% of patients treated under trauma alerts over a twelve-month period ending in April 2021 were not admitted. Unwarranted trauma alerts are costing health and auto insurers and their customers millions of dollars annually in expenses and higher premiums. (Hancock, Jay, CNN health, July 17, 2021)

In 1969 the IRS ruled that in order to maintain their not-for-profit status -- and their ability to avoid income and property taxes, issue tax-exempt bonds, and solicit deductible donations -- hospitals had to devote a portion of their resources to "charity care and community benefit." Abuses of this mandate are widespread. "A 2015 survey of 990 Forms conducted by the California Nurses Association concluded that 196 hospitals received '$3.3 billion state and federal tax exemptions and spent only $1.4 billion on charity care' . . . Three-quarters of the hospitals got more in tax breaks than they spent on benefiting the communities they serve." (Rosenthal, pp. 49-50)

One egregious example is the University of Pittsburgh Medical Center, one of the nation's biggest hospital systems, with 2020 revenues of $23 billion, earnings of $836 million, and a 60% market share. According to the Pittsburgh *Post Gazette*, UPMC is " 'Allegheny County's largest property owner, with 656 acres,' 86 percent of which is tax-exempt. If it were not classified as a nonprofit, 'UPMC would owe the city $20 million more in taxes every year.' On its 2014 IRS Form 990, UPMC claimed that about 11 percent of its costs went to charity care and community benefit." Some of those benefits were hardly credible, like boosting the economy through construction jobs, promoting diversity by hiring minority contractors, and improving the environment by creating a healing garden. (Rosenthal, p. 51)

DOCTORS' DILEMMA

Alongside hospital revenues physician income has risen consistently since 2009. Doctors make more in the U.S. than in other countries. "The gap is particularly striking in the specialties." While primary care doctors in the U.S. make about 40% more than their peers in Germany, that figure rises to over 100% for orthopedic surgeons. Twenty-seven percent of U.S. physicians fall into the upper one percent of all wage earners, which exceeds the percent of attorneys and corporate executives in that category. (Rosenthal, pp. 56-57)

In 1986, attempting to curb escalating physician costs, Congress, in cooperation with the American Medical Association, developed a currency of measurement for a roster of services and procedures. These relative value units were based on (1) the time spent on the visit or intervention; (2) the overhead incurred in rendering the service; (3) the cost of training for the service; and (4) the related cost of malpractice insurance. (Rosenthal, p. 61)

Several poorly-conceived aspects of the plan ultimately undermined its good intentions.

In 1997 a ceiling was applied to overall Medicare payments. Consequently, in order to maintain budget neutrality, a higher valuation for one procedure had to be offset by a lower valuation elsewhere -- or reimbursements for all procedures would be adjusted downward. Medical groups spent hundreds of millions of dollars every year for two decades lobbying Congress to postpone any reductions until the law was rewritten in 2015. (Rosenthal, pp. 61, 65)

Further, because the concept more highly valued physician time and training, it tended to favor mechanical procedures over cognitive analysis and diagnosis. Radiologists, for example, would be rewarded while neurologists would be penalized. (Rosenthal, p. 62)

Finally, Medicare delegated the responsibility for annually reviewing the payment system to an arm of the AMA, the Relative Value Scale Update Committee. In "vituperative meetings," advocates for every specialty -- which had equal representation

regardless of its actual percentage of the total universe of doctors -- fought bitterly for shares of the pie. The result, of course, was higher prices for insurers and premium payers. (Rosenthal, pp. 63-64)

Specialists have been contributory to and prospered from the spiraling costs of medications. For years oncologists have skimmed millions by "buying chemotherapy drugs from manufacturers and infusing them in the office, generally with a hefty markup, a practice known as 'buy and bill' . . . Drugs and biologicals make up 80% of all medical oncology charges submitted to Medicare each year." The general public is blind to the outrageous profit margins involved. Betty Glassman's insurers paid $23,000 (less her co-payment and deductible of $3564) for two rounds of three drugs to treat her breast cancer; the same cycle in Italy was estimated to cost $1500. (Rosenthal, pp. 78-80)

PHARMA'S FOLLIES

The outlandish volume of dollars rolling off the pharmaceutical industry's printing presses engulfs not just oncologists' practices.

Consider the case of Hope Marcus. To control her ulcerative colitis, she has spent much of her adult life on a decades-old drug called mesalamine. Unstable in the intestines, mesalamine is manufactured with a protective coating under the trade name Asacol. With its patent set to expire in 2013 and her Medicare Advantage plan committed to reimbursing the full cost of a generic, Ms. Marcus was anticipating a significant drop in her $750-a-month payment. (Rosenthal, pp. 87-88)

But the savings never materialized. Having acquired the rights to mesalamine from Warner Chilcutt in 2009, just prior to its date of expiration Procter and Gamble introduced two "new, improved products": Asacol HD, a once-a-day long-lasting variant, and Delzicol, a gel-coated version of the old 400mg pill, which it removed from the market. Both were covered by new patents, and carried a price tag of $800 per month. (Rosenthal, p. 88)

To make matters worse, by 2015 Ms. Marcus saw a 500% increase in the price of the rectal formulation of mesalamine, called Rowasa, after two companies ceased manufacture of its generic without warning. (Rosenthal, pp. 89-90)

"It is very hard for me to understand why these medicines are so expensive" in the United States, says Dr. John Mayberry, a professor of gastroenterology at the University of Leicester in England. In the United Kingdom, patients who get their mesalamine through the National Health Service pay about $12 a month, those with private prescriptions about $55 a month. Many versions of the drug are available, and pharmacists dispense them interchangeably. (Rosenthal, p. 89)

Perversely, despite their good intentions, numerous efforts to regulate the drug industry have only exacerbated the problem.

In 1962, in response to the thalidomide birth defect scare, the Kefauver-Harris Act invested the Food and Drug Administration with the authority to approve, postpone, or reject new drugs using a quantitative approach to evaluating new applications and clinical testing. However, while companies had to demonstrate that their products were safe and effective, the FDA standards of approval omitted any consideration of price and any measurements of cost-effectiveness and comparative utility, that is, whether the drug was more effective (and less costly) than other treatments already on the market. (Rosenthal, p. 93)

In 1984 the Hatch-Waxman Act expedited the rollout of generic drugs by allowing manufacturers to forgo fresh clinical trials and rely on prior studies. But in order to appease the brand makers, lawmakers introduced a number of lucrative patent extensions: six-months for pediatric trials; three years for trials to support a change in dosage; five years for time lost in regulatory review; and seven years for a drug whose usage was limited to 200,000 patients. (Rosenthal, p. 95)

In 1991, in order to accelerate the availability of HIV "miracle drugs," the FDA relaxed its rules for verifying the effectiveness of a drug. Instead of having to prove that the symptoms of an illness were actually cured, drug makers could utilize surrogate measures -- like blood markers -- which had been shown to correlate with such benefits. (Rosenthal, pp. 98-99)

Before long abuse was rampant. According to Thomas R. Fleming, professor of biostatistics at the University of Washington, "sponsors of drugs and biologics . . . are getting marketing approval much sooner and with much less research expenditure . . . for products that are likely biologically active but less likely to provide truly important effects." As evidence, "an in-depth investigation by the Milwaukee *Journal Sentinel* and MedPage Today in 2014 revealed that, thanks to surrogate endpoints, seventy-four percent of cancer drugs approved by the FDA during the previous decade ultimately did not extend life by even a single day." (Rosenthal, p. 99)

Manipulating patent law and FDA policies to extend their products' value has become a strategic objective of pharmaceutical companies.

When, in the early 2000's under the Montreal Protocol, CVC propellants were banned from aerosolized products, drug manufacturers leaped into the breach, obtaining new patents for redesigned asthma inhalers, removing generic ones from the shelf, and boosting the price from $10 to over $100. (Rosenthal, pp. 105-106)

In 2010 Purdue Pharma was able to "evergreen" -- extend the life of -- its patent on the its billion-dollar pain medicine OxyContin by introducing an "abuse-resistant" substitute. Unlike the original pills -- which, in order to unleash a mammoth hit, users would crush into a fine powder of pure oxycodene and then snort, ingest, or inject -- these were shatter-proof. It was a cruelly ironic ruse; having denied for years any culpability in the drug's trail of addiction and death, Purdue not only brazenly trumpeted the new version's more protective coating, it successfully lobbied the FDA to prohibit the manufacture and sale of a generic formulation of the original on the grounds that it was no longer safe. (Keefe, pp. 222, 306-308)

In 2014, when Sanofi Aventis's monopoly on its brand of insulin, Lantus, which carried a price tag of $300 a month, was threatened by a generic from Eli Lilly, it sued, claiming Lilly was violating four patents. The ensuing twenty-month waiting period invoked by law enabled Sanofi to siphon off two more years of exorbitant profits before the case was settled. (Rosenthal, pp. 106-107)

When Warner Chilcott's patent on its popular Loestrin 24 Fe contraceptive pill -- for which it was charging four times the international price of $20 -- was set to expire in 2011, it employed similar tactics, gaining thirty months protection by a lawsuit and then offering financial incentives to two drug makers, Watson and Lupin, to delay their applications for generics. Afterwards, it invented a chewable form of the pill, patented it, renamed it Minastrin Fe 24, upped the price to $140, and removed its predecessor from the market. (Rosenthal, p. 108)

U.S. law prevents a drug from being sold both by prescription and over-the-counter, and grants a company three years exclusivity on a prescription drug that it takes over-the-counter. When GlaxoSmithKline saw its profits on its popular allergy medication Flonase being undermined by a generic, it began selling Flonase off drugstore shelves for $40 a bottle; manufacturers of the generic -- which they had been offering for half that price -- had six months to deplete their inventory and cease production. At the same time Glaxo introduced a new, patented, branded, and higher-priced nasal spray -- Veromyst -- for sale by prescription to customers who didn't want to fork over $40 but who could get their insurance to pay for it. (Rosenthal, p. 112)

In 2008 Glaxo came under scrutiny when two generic anti-nausea drugs -- prochlorperzine and droperidol -- suddenly disappeared from the marketplace, enabling the company to reap lucrative profits from its branded product Zofran. Two disturbing occurrences were too timely to be dismissed as pure coincidence. The plant making all

the prochloroperzine and droperidol had been purchased, and shut down. And a report surfaced linking droperidol to incidents of life-threatening arrhythmia. Conspiracy theorists were vindicated when it was revealed that the patients cited had received doses fifty to one hundred times higher than those typically prescribed in the U.S. (Rosenthal, pp. 120-121)

In 2011 Horizon Pharma, a start-up venture, invented a new painkiller, Duexis -- a combination of the anti-inflammatory ibuprofen and the stomach-lining protector famotidine -- and began selling it for $1600 a month, even though, says Patrick Crutcher of Chimera Research Group, "there is no benefit to using Duexis over the two generics." When another manufacturer, Par Pharmaceutical, sued to be allowed to make a generic of Duexis, claiming the drug was not really new, Horizon paid it an undisclosed amount to defer such action until 2023. (Rosenthal, pp. 112-113)

The number of such pay-for-delay agreements has increased dramatically over the past decade. The resulting scarcity of cheap alternative versions of brand-name drugs costs taxpayers and consumers $3.5 billion every year, according to the FTC. (Rosenthal, p. 113)

Aiding and abetting the pharmaceutical companies in their drug-pricing schemes is a second villain, the pharmacy benefit manager or PBM. Contracted directly by employers or through their insurers, these intermediaries purchase drugs from manufacturers, sell them to pharmacies, and then invoice the employer's health plan as prescriptions are filled. Those charges can run five to twenty times what the PBM is paying for the drug. Often the patient himself contributes to the bloated markup in the form of a co-pay. Should the drug maker offer a rebate to promote a specific medication or particular brand -- a common practice -- the PBM usually pockets most or all of it. (Makary, pp. 191-194)

PBM's take extreme measures to conceal their actual costs. Every month the health care manager in a typical mid-sized company will receive a list of medications numbering in the thousands, whose itemized names, generics, schedules, dosages, fees, rebates, and discounts are indecipherable to a layman. These managers have no recourse other than to authorize payment and file the invoice. (Makary, p. 194-195)

DEVICES AND DELIVERY

Another contributor to the high cost of a hospital stay -- sometimes even exceeding the facility fee, physicians' invoices, and pharmacy charge -- is the piece of medical hardware that may have been inserted in the patient's body, either permanently or temporarily. (Rosenthal, p. 129)

Stretching between the implant manufacturer and a new hip is a chain of cash registers that includes a broker who tallies ten percent, a distributor who rings up thirty percent, a salesman who pockets fifteen percent, and the hospital which tacks on a one hundred percent mark-up. All of a sudden, what should rationally sell for a few hundred dollars, according to orthopedist Blair Rhodes, has been transformed into a $36,800 metal knee implant at NYU's Hospital for Joint Diseases, a $4000 set of screws at Lenox Hill Hospital in New York City, or a $33,000 stabilizing rod screwed into the fractured leg bone of a child hit by a car in Atlanta. (Rosenthal, p. 129)

A handful of device manufacturers monopolizes the global market. Stryker, Zimmer Biomet, DePuy Synthes, and Smith and Nephew make virtually all knee and hip implants available in the United States. (Rosenthal, p. 130) Medtronic is the primary supplier of insulin pumps, neurostimulators, coronary stents, and defibrillators. Its gross profit margin on these products is seventy-five percent, one reason it has delivered an annualized compound return of 15% to shareholders for over the past twenty years. (Brill, p. 109)

Favorable regulatory policies have enabled these giants to maintain their dominance and their profit margins. In 1976 amendments to the Food, Drug, and Cosmetics Act defined as Class Two any device which was deemed substantially equivalent in design and purpose to one currently in use, and allowed its introduction with a minimum of testing and red tape. Before long investigators determined that the average evaluation period for Class Two applications had fallen to twelve hours compared to twelve hundred for Class Three applications. When asserting "substantial equivalence,"

manufacturers were not required to conduct clinical trials nor prove their Class Two devices were safe and effective. Many weren't. (Rosenthal, pp. 132-133)

Boston Scientific's ProtoGen Sling -- a vaginal mesh used to support a "dropped" bladder or uterus -- was taken off the market in 2002 after a spate of internal injuries and lawsuits. Similar products remained available from other makers although by 2015 one hundred thousand claims had been filed. (Rosenthal, pp. 134, 146)

When first marketed in 2008, the Stryker Rejuvenate hip implant had been touted as more durable (and more expensive) than the decades-old model it was replacing, even though, says orthopedist Rory Wright, the latter "worked great. It has one percent failure . . . The majority of our patients should be getting tried-and-true method. We're not oncologists -- there's no benefit to the newest. In fact, it's often worse." (Rosenthal, pp. 137,139)

Dr. Wright's reservations were well-founded. When the Rejuvenate's "novel chromium, cobalt, and titanium components ground against each other, the metals leached into the surrounding muscle and blood, leading to joint failure, local tissue and bone death, and, potentially, to damage to other organs." (Rosenthal, p. 137)

Like drug makers, device manufacturers' disputes over intellectual property rights have fueled price escalation. In 2010 Edwards Lifesciences sued Medtronic over a new prosthetic aortic valve that is placed in the heart via catheter rather than by open heart surgery. Medtronic's CoreValve infringed on its patents, Edwards argued. When a jury ruled in Edwards's favor in 2014, in order to keep the product on the market, Medtronic agreed to pay Edwards $750 million plus ongoing royalties on its sales of CoreValve. (Rosenthal, p. 145)

An ancillary business raking in outrageous profits related to health care is transport. When Hugh Sparks of Plano, Texas, pulled off the road to snap some close-up photos of a rattlesnake, it sank its fangs in his wrist, and sent him speeding to the nearest hospital, where he was treated with antivenom. His doctor recommended an immediate transfer to an Abilene hospital fifty miles away -- by helicopter. After two days of observation, Hugh was released and feeling much better -- until he received an ambulance bill of $43,514, of which only $13,827 was paid by insurance. Owing $29,687 was more traumatic than being bitten by a poisonous snake, he reported. (Makary, p. 73)

In the 1980's private investors began buying air ambulance services from hospitals, moving into smaller markets across the country regardless of need, and driving up prices. The number of air ambulance companies and the number of helicopters they operate have both increased one thousand percent. Three companies control 75% of the market; one of them, Air Methods, now charges almost $50,000 compared to $13,000 in 2007. (Makary, pp. 71, 78)

THE INSURANCE CONUNDRUM

The final and perhaps most gluttonous beast feeding at the three trillion dollar trough is the insurance industry. Invented over one hundred years ago at the Baylor University Medical Center in Dallas, Texas, to provide hospitalization coverage to a local teachers' union, the original Blue Cross Plans' "goal was not to make money but to protect patient savings and keep hospitals -- and the charitable religious groups that funded them -- afloat." (Rosenthal, p. 19)

During and after World War II, the concept swept across the country as a result of two dubious government policies. First, the National Labor Relations Board froze salaries, which motivated businesses to offer health insurance in order to attract workers. The IRS added a second incentive when it ruled that such insurance was both a tax-deductible expense to the employer and a non-taxable benefit to the employee, a ruling that was codified in the Revenue Act of 1954. (Hughes, Gareth, *U.S. Policy Gateway,* July 12, 2009)

As the demand for employer-funded health insurance exploded, for-profit companies like Aetna and Cigna aggressively moved into the market, underwriting risk, offering a variety of plans, and adversely selecting younger, healthier members. By 1993 Blue Cross and its physician component Blue Shield, burdened by an older, sicker population, were hemorrhaging money; they shed their non-profit status, went public, renamed themselves WellPoint, and, now answerable to shareholders and investors, began raising prices. (Rosenthal, p. 18)

Prior to that date the Blues' and most other insurers' "medical loss ratio" -- the percent of premiums spent on medical care as opposed to marketing and administration -- was about 95%. That number had fallen to 80% by 2010, when the Affordable Care Act mandated loss ratios no lower than 85%. While CEO's wailed in protest, their credibility was suspect in the face of Medicare's reported spending of 98% of its funding on medical services. In fact, when the cost of catastrophic stop-loss insurance is included, commercial carriers' overhead is close to 30% compared to Medicare's two percent. (Rosenthal, pp. 19-20)

Insurance is "the most complex and distorted method of financing any activity," writes David Goldhill in *The Atlantic* (September 2009). "Its use to fund nominal and routine as well as large and expected expenses is a major cause of health care's huge cost," and also the underlying reason "why innovation and technological advancements never generate efficiencies or savings."

For every two doctors in the United States, there is one health insurance employee. In 2017, the U.S. spent $800 billion dollars on health care administration, or $2500 per person, compared to $550 per person in Canada; the insurer overhead alone (characterized as "useless bureaucracy" by Dr. David Himmelstein, a distinguished professor of public health) was $844 per person versus $146 in Canada. (Carroll, Linda, *Reuters*, January 6, 2020). Inefficient claims processing wastes $210 billion annually, according to Price Waterhouse Coopers Health Research Institute. Businesses large and small expend precious payroll dollars on human resource staffing to advise and assist employees in navigating plans and filing claims.

In cooperation with providers, health insurance doubly insulates the consumer from the high cost of his care: first, by relieving him of any responsibilities except his deductible and copay; and secondly, by serving as his agent and remitting hospitals and physicians directly, the only form of insurance that leapfrogs the beneficiary. With little of his own money at stake, moral hazard -- the tendency for people to make less careful decisions when risk has been minimized -- prevails.

But the sad truth about health care is that everybody foots the bill. While a worker may be discomfited by the annual announcement that his premium is rising, he is secure in the knowledge that should a severe illness strike him or a family member, much of the burden will be borne by someone else. Doesn't he realize that his employer may be stifling his wages to offset the high cost of insurance? Or that when he purchases a new sofa or refrigerator, embedded in the price is an amount allocated to the retailer's expense of insuring his own employees? Or that, if he is fortunate enough to avoid any hospitalizations, physician visits, or medications for an entire year, his premiums may be used to pay for a coworker's hip replacement?

Aside from his premiums, he's paying a Medicare tax, which is not for future insurance coverage on himself after he retires, but to pay the drug costs of someone like his elderly neighbor who may be undergoing chemotherapy. And probably neither he nor his employer understands how commercial insurance premiums are inflated in order to offset the discounted hospital and physician Medicare reimbursements that both claim are not sufficient to cover their operating costs; the industry-wide practice is nothing less than an insidious hidden tax known as cost-shifting.

The Centers for Medicare and Medicaid Services projects that health spending will grow at an average annual rate of 5.4 percent, and reach $6.2 trillion by 2028. Since this rate is 1.1 percentage points higher than the projected growth of gross domestic product, the health share of the economy will rise from 17.7 percent in 2018 to an almost unsustainable 19.7 percent in 2028.

With that bleak picture staring citizens and policymakers in the face, are there any potential strategies that might facilitate a bending of this daunting curve? With the Medicare Trust Fund expected to become insolvent by 2024, which would pile even more debt upon an already encumbered populace, it would seem imperative that key

players set aside or at least be willing to compromise their self-interest and commit to a serious discussion about our nation's most pressing problem.

Unfortunately, that appears to be wishful thinking, considering the bitter political environment, the obscene amount of money at stake, and the inherent flaws of three approaches currently in vogue: capitation; regulation; and nationalization.

CAPITATION

For a number of years Medicare had tested a strategy called "bundling," that is, paying hospitals a fixed amount for various therapies rather than a separate fee for each component of the therapy. The experiment demonstrated significant savings in the reimbursements for dialysis (mainly because the expensive drug Epogen was included in the bundle), for knee and hip replacements, and for the treatment of simple pneumonia. (Rosenthal, pp. 296-297)

Having witnessed success, some thoughtful people proposed building upon it: scrapping the fee-for-service template altogether and replacing it with a system called "capitation," whereby providers receive fixed lump-sum payments annually to manage population health and treat members for specific illnesses. Years ago, for example, the Mayo Clinic pooled its total revenues, put all its physicians on salary, and created one of "the highest-quality, lowest-cost" operations in the country. (Guwande, Atul, *New Yorker*, June 1, 2009) More recently, in 2015, the Boeing Company contracted to pay two Washington State hospitals a set yearly per capita fee for all the care for its 27,000 employees. (Rosenthal, p. 297)

The federal government has attempted to promote capitation by incentivizing the formation of Accountable Care Organizations: groups of doctors and hospitals that work together to coordinate and deliver high quality care for Medicare patients. Those that lower costs will share in the savings.

Capitation is unlikely to meet its objectives, write Clayton Christensen, Jeffrey Flier, and Vineeta Vijayaraghaven, in the *Wall Street Journal* (February 19, 2013) because it is based on flawed assumptions about personal and economic behavior.

First, doctors whose attitudes have been shaped by years of interactions with hospitals, insurance companies, and colleagues will find it difficult to reconcile what they consider appropriate medicine with cost reduction measures and evidence-based protocols. Second, the necessary cooperation and engagement of patients may not be forthcoming; their noncompliance with recommended treatments and lifestyle changes and their refusal to share claims or medical data will pose significant roadblocks. Finally, unless ACO's are able to build a clear wall around what's included in the bundled coverage and prevent providers from imposing additional charges, a problematic assumption, anticipated savings will not materialize.

Early returns seem to have confirmed the experts' prognostications. The Congressional Budget Office estimated the impact of the largest ACO option, the Medicare Shared Savings Program, on total Medicare spending from 2013 to 2018 at less than one percent.

REGULATION

As for any hope that skyrocketing health care costs might be curbed by regulation -- which in this context is defined as legislation past, present, and prospective and its attendant interpretation and application -- history suggests otherwise.

The well-documented missteps of Congress and the FDA in this effort date back fifty years. But perhaps the most blatant example of government's inability to effectuate meaningful reform is its most recent, when in 2010, during the deliberations that led to the passage of the Affordable Care Act, or Obamacare, it squandered a generational opportunity.

Medicaid expansion, the elimination of preexisting conditions as grounds for denial of coverage, and the subsidizing of policies for low income families were expected to create

twenty million new consumers (from a total uninsured population of 45 million) for the four main sectors of the health care industry: device makers, hospitals, insurance companies, and pharmaceuticals. It was only reasonable for lawmakers to insist that each of them participate in an overall cost containment program and share a portion of its revenue windfall with the federal government, which would be spending an estimated $75 billion on expanded coverage in 2014 (rising to $100 billion in 2018).

Staffers working for the Senate Finance Committee, which was drafting the legislation, originally penciled in a 5% annual tax, equivalent to $6.5 billion a year, on medical device revenue. When the bill reached the Senate floor, pressure from Evan Bayh of Indiana and Amy Klobuchar and Al Franken of Minnesota, two states where major device manufacturers like Medtronic, Boston Scientific, and Zimmer Biomet are large employers, convinced Majority Leader Harry Reid to cut the tax in half. In 2014 the industry spent $32.8 million lobbying Congress to repeal the tax, which it did permanently in the 2019 bipartisan budget deal following a four-year suspension. (Brill, pp. 110, 175; Rosenthal, p. 130)

The most recent figures available to the Senate Finance Committee in 2009 indicated that the 4300 non-profit hospitals in the U.S. (75% of the total) were claiming $36 billion in uncompensated care, most of which would be paid going forward by expanded Medicaid coverage and by insurance policies subsidized by the government. Confronted by this argument, hospitals agreed to give back $155 billion over ten years, mostly through mechanisms designed to slow the increase in Medicare reimbursements. Not surprisingly, the purported savings never materialized. (Brill, pp. 102-103)

A provision to cut Medicaid's Disproportionate Share Hospital payments by $1.4 billion annually -- based on an assumption of fewer subsidies for the uninsured -- has been repeatedly postponed by Congress due to intense lobbying by states and hospitals. (Antos and Capretta, *HealthAffairs*, April 10, 2020)

An Independent Payment Advisory Board was constituted and invested with the authority to recommend and implement cost-cutting policies if Medicare spending exceeded a target growth rate. Political indifference and opposition from the health care industry left the Board in limbo, as no appointments were made, and Congress allowed it to disappear in 2018. (Antos and Capretta, *HealthAffairs*, April 10, 2020)

The bulk of the $155 billion was to accrue from tying Medicare payment updates to an economy wide productivity measurement. But the metric widened the disparity between Medicare and commercial reimbursements to such an extent that many institutions found themselves on the brink of bankruptcy. As a result, another linchpin of affordable care suffered a quiet death. (Antos and Capretta, *HealthAffairs*, April 10, 2020)

As controversy over the ACA swirled over the air waves and in public forums, advocates attempted to deflect ire away from "government bureaucrats taking over healthcare" towards "villainous insurance companies preying on the sick and helpless."

Under the new law greed would be restrained, and discriminatory underwriting reformed. "The high profits reaped from administering certain Medicare programs would be cut." (Brill, p. 143) Insurers could no longer exclude persons with preexisting conditions, nor impose limitations on their lifetime coverage. Plans must include emergency, maternity, and mental health care, preventive services such as mammograms and colonoscopies, and prescription drugs. In order to minimize their premium costs, at least theoretically, older subscribers could be charged no more than three times their younger counterparts.

Once again, the reality fell far short of the rhetoric.

Hoping to raise $102 billion over ten years, legislators enacted a health insurance tax on each company's net premium revenue above $25 million. It managed to garner $30 billion from 2014 to 2016 before some astute analysts pointed out that the insurers weren't actually paying the tax; their customers were. And because the tax was not a deductible expense and any premium increase was subject to a 21% federal tax rate, one study determined that insurers were charging an extra $1.27 for every dollar in tax owed, or an average increase of 2.2%. After suspending the tax in 2017 and 2019 (it was allowed to return in 2018), Congress sunset it permanently effective January 1, 2021. (*Center Forward Basics*, March 2019)

The ACA established a medical loss ratio of 85% in the large group market (80% in the small group market), and required insurers who did not spend that percentage of their premium revenue on health care claims or quality improvement to rebate the difference to their enrollees either by credit or check. This initiative appears to have been successful; insurers returned $1.37 billion to consumers in 2018 and $2.46 billion in 2019. (Keith, Katie, *HealthAffairs*, November 17, 2020)

Naysayers have argued that these numbers are merely a reflection of the industry's extreme profitability. They have questioned whether insurers could be gaming the system by shifting expenses from the administrative category to the care or improvement categories. And they have alleged that the penalty has perversely incentivized carriers in noncompetitive markets to forgo deep discounts from providers in order to realize higher administrative revenue. (Brill, pp. 120-121)

The ACA's centerpiece, and the justification for its title, was the subsidy provided to lower-income families and individuals to enable them to purchase health insurance in the open market. Indeed, for anyone not covered by Medicare, Medicaid, or his employer and eligible for a subsidy, health insurance became very affordable. Depending on one's income, or lack of it, the federal government could be paying 70% of his premium. Surprisingly, even for shoppers not eligible for a subsidy, premiums seemed to be reasonably priced, as insurers were eager to entice new customers, especially the young and healthy, who might lower their risk. (Brill, pp. 316-317)

If the ACA can be deemed initially a success -- once the disastrous rollout of its web site was fixed -- the progress it made was unsustainable. By 2015, one year after the ACA's

reforms went into effect, membership in the open market had grown from 13 million to 18.8 million, about half of whom were receiving government support. Four years later, however, after a steady decline, that number was back where it started, with the subsidized population unchanged at around nine million. The exodus was in full force well before the repeal of the individual mandate in 2019. (Antos and Capretta, *HealthAffairs*, April 10, 2020)

"The reason for the collapse is clear: high premiums and deductibles have made this market unattractive to consumers who do not qualify for federal assistance." Insurance companies are in business to make money, and they cannot provide the coverage mandated without the revenue to offset claims. In 2019 the average monthly premium per enrollee in the open market was $515, up from $217 in 2011. Deductibles have risen commensurately over the same period, from $2425 for a silver plan offered on healthcare.gov. in 2014 to $4500 in 2020. (Antos and Capretta, *HealthAffairs*, April 10, 2020)

As premiums have risen, so also has the cost to the taxpayer of subsidizing them. In 2018, according to the Congressional Budget Office, the government paid out an average of $6300 to every subsidized enrollee, up from $3000 in 2014, an increase of 114%. (Anton and Capretta, *Health Care Blog*, April 10, 2021)

Over the same period federal expenditures increased from $21 billion to $45 billion per year. The recently passed American Rescue Plan Act will tack on another $22 billion in 2022 (and annually if renewed) by subsidizing 100% of the premiums of individuals/ families below 150% of the poverty level and not on Medicaid and by capping all others' maximum outlay for health insurance at 8.5% of their adjusted gross income and subsidizing the rest. (Chang, Ellen, *Forbes Advisor*, March 26, 2021)

The consequences of all these generous handouts are distressingly predictable: costs will continue to escalate; insurance companies will get richer; and the government will sink deeper in debt.

Salivating the most at the prospect of instant enrichment -- $200 billion over ten years, as calculated by analysts working for the Senate Finance Committee -- was the fourth member of this exclusive club of trough feeders: the pharmaceutical companies. In their opening salvo, the Committee negotiators asked for $130 billion back in the form of price reductions on drugs paid through Medicare and a tax on revenues. (Brill, p. 98)

They were up against one of the shrewdest lobbyists in the business: Wilbert Joseph (Billy) Tauzin II. Elected to the House of Representatives in 1980 as a conservative Democrat from Chockbay, Louisiana, Tauzin employed his abundant charm and political savvy to elevate himself to majority whip and chair of the powerful Energy and Commerce Committee. He retained the position even after switching parties in 1994 following the Republican takeover. Voters didn't care; they continued to reelect him. (Brill, p. 49)

In 2003 Tauzin engineered the drug bill that funded Medicare's drug purchases for seniors but forbade the agency from negotiating discounts. Tauzin felt indebted to the industry: diagnosed with colorectal cancer the previous year and told he had a one percent chance of surviving, he claimed his life was saved by a newly developed drug. Within months he left Congress, and took over as CEO of the Pharmaceutical Manufacturers Association of America (PhRMA) for a salary of $2 million a year. (Brill, p. 50)

Not only was Tauzin faced with the $130 billion demand, a liberal caucus in the House of Representatives led by California Congressman Henry Waxman was clamoring for additional measures which were certain to impair his clients' profits. These consisted of (1) giving Medicare the authority to negotiate prescription drug prices; (2) allowing consumers to buy drugs from Canada; (3) funding research on the "comparative effectiveness" of various drugs so insurers could make more economical purchasing decisions; and (4) continuing the moratorium on any patent-like protection for biologics (medicines created by living organism rather than by chemicals). (Brill, pp. 98-99)

The Obama Administration had staked its credibility on getting health care (or health insurance) reform passed; it was not willing to let the Waxman faction or Senate Committee staffers stand in its way, regardless of any concessions it might have to make to Tauzin and his cabal. When PhRMA came to the table with $70 million to fund anonymously two political action committees which would buy television ads endorsing senators in favor of the bill and attacking those who were against it, the pressure was too intense for the opposition to persist. (Brill, pp. 100-101)

By the time the smoke cleared, Tauzin had orchestrated a complete sellout to his domestic cartel. "There would be no prescription drug importation. Medicare would not be set loose to negotiate drug prices. There would be no draconian cuts in Medicaid payments . . . There would be twelve years of protection for biologics." The givebacks had been whittled down to $8 billion a year in Medicaid discounts and in subsidies for senior citizens when their prescription drug bill exceeded their Medicare reimbursement. (Brill, p. 127)

The final coating of lipstick was splashed on the pig. Not only had the four pillars of the United States health care industry suffocated any and all attempts to address the cost issue, they had also avoided any impactful assumption of the obligations being borne by the government (or its taxpayers) in bringing them twenty million new customers through Medicaid expansion and a subsidized open market.

Also sliding into the trillion dollar trough as the process played out were the promises made by President Barack Obama. On April 30, 2009, his leading economic advisors said: "For every 5% we can reduce health care over the next ten years we will save families $2500." On May 11, acknowledging the industry executives standing beside him, he distributed a fact sheet to the press announcing that they "had agreed to two trillion in cost cuts over the next ten years." On June 15 he told the American Medical Association convention that he would honor his pledge to the American people: "If you

like your doctor, you will be able to keep you doctor, period. If you like your health plan, you will be able to keep your health plan, period." (Brill, pp. 117, 123, 126)

It was *The Audacity of Hope* revisited. And it leaves me not sanguine about the future.

NATIONALIZATION

I can't help but think that the same toxins that undermined the good intentions of the Affordable Care Act -- corporatism and cowardice, plus a new one, complacency -- will ultimately reduce to an academic exercise any consideration of the last best hope of controlling this runaway spending: the nationalization not of hospitals and physician practices but of the instrument by which they are funded. Nevertheless, it's obligatory, because unless this titanic changes course and embraces Universal Health Insurance, Medicare for All, or whatever other label might be applied, calamity looms on the horizon.

The United States is the only one of thirty-three developed countries that does not have universal health care. Thus, models are already in place that, except for a few outliers, are saving these countries fifty percent of the U.S. per capita expenditures on health care. Granted it would take years, maybe decades, for the U.S. to realize similar savings, yet even a start down this path could begin to moderate the frightening trend.
If one rejects the British single-payer model whereby providers are government owned as too radical for the U.S., two viable options remain. Under the social insurance hybrid that was developed in Germany and has been copied by other European countries, workers pay a tax or premium through their employers into a national fund. Private insurers manage benefits, and private doctors and hospitals provide care, but prices are strictly monitored by the government. The Canadian system is similar except there is one government-operated insurance company, which pays for all private practice care. (Amadeo, Kimberly, *The Balance*, March 13, 2020)

Most of the arguments I hear dismissive of universal insurance are anachronistic, illogical, or ill-founded.

Many folks are quick to denounce the evils of "socialized medicine" until one takes the time to explain to them that we are halfway there. Currently, about 42% of the U.S. is covered by Medicare, Medicaid, or the Veterans Administration. Since employee-funded health insurance is tax-deductible, the 56% of the population who fall in this category are being subsidized by the federal government in an amount equivalent to the corporate tax rate, not to mention another ten percent whose generous subsidies enable them to obtain insurance on the open market.

Others bemoan the loss of freedom or lack of choice that might follow in the wake of expanded government control. Don't they realize that, if they are getting coverage through their employer, he is selecting their insurance company and designing their plans, and they have no other options? Nor is it practical for them because of the additional cost to seek care outside the network of hospitals and physicians under contract with their insurance company. Medicare and Medicaid patients are under no such restrictions.

The contention that "U.S. health care is superior to that offered by countries with universal care" is easily rebutted by the painful statistics that clearly show more favorable outcomes for the latter. Friends of mine who formerly lived in Canada recently informed me that Princess Margaret in Toronto is one of the top five cancer centers in the world.

They also refuted the frequently heard claim that patients have to wait longer for procedures in places like Canada than in the U.S. "That's only true for some elective surgeries," they said. Indeed, according to the Peterson-Kaiser Health Tracker, in some cases the wait times in the U.S. are longer, as insurance companies waste hours securing referrals and approvals for urgent treatments. On average, residents of Germany, France, the UK, Australia, and the Netherlands reported shorter waiting periods than those in the U.S. (Sousa, Lorie, et.al., *U.S.News*, May 13, 2020)

Even the staunchest defenders of the status quo seldom assert that universal care would cost more; the numbers clearly demonstrate otherwise. But they do raise a valid point when they question how a transformation could be financed.

I can't speak macro-economically, but I can pose an hypothesis based on my company's experience. Schewel Furniture Company offers coverage to its employees and their family members through a self-insured plan; that is, Schewel pays all claims and administrative expenses, while employees contribute about 20% of this amount as payroll-deducted premiums. Thus, in an average year, if Schewel's claims for it six hundred employees total $4 million, the employees are being charged $800,000 (about $110 per month per capita), leaving Schewel's expenditure at $3.2 million. Since health insurance is tax-deductible, Schewel's net cost at a 25% tax rate is $2.4 million.

Assume the federal government imposes a health insurance tax on my company equal to my after-tax costs: $4000 per employee, or $2.4 million. Assume also that each employee is assessed a premium equal to what he is paying Schewel: $110 per month, or $800,000. These two taxes together would generate enough revenue to pay all hospitals and physicians the sum of $3.2 million, which is $800,000, or 20%, less than Schewel is paying its insurer. Anthem's administrative costs are closer to 30%, which would leave 10% available to cover a national insurance company's overhead (which is considerably higher than Medicare's current rate).

Once such a plan is in place, the national insurance company could begin negotiating larger discounts from providers and drug companies. Genuine system-wide savings would ensue.

Cost control, universal access, eliminating the middlemen, less paperwork, better outcomes: what's wrong with this scenario? Nothing except for the three immovable obstacles blocking the way forward.

The U.S. health care system is the only one in the world based on corporatism. Pharmaceutical manufacturers, insurance companies, hospital conglomerates, device makers, even some specialty practices, like dialysis, are big businesses. In most sectors, a few giants dominate the market. Profit-driven and publicly owned, they are primarily beholden to their shareholders, face weak competition, have little interest in a value proposition, and engage in cost-saving stratagems that often engender hardship and frustration among patients and caregivers. For them, the risks of reform are huge. In order to preserve their franchises, every year they spend millions of dollars to manipulate public opinion and influence legislators. (Arno and Caper, *HealthAffairs*, March 25, 2020)

When it comes to resisting the blandishments and deep pockets of the industry's powerful lobbies, it's clear that on Capitol Hill and in the White House, regardless of the occupants, cowardice trumps courage. Every four years or so, Bernie Sanders and his ilk manage to ramp up the rhetoric, but truthfully in the halls of government there's little appetite for meaningful change. Lawmakers are too intimidated by dire warnings of factory closings, job losses, hospital insolvencies, and thwarted research to look past the next election cycle. If they lacked the political will to enforce the industry's meager sharing of its ACA slush fund, how can one ever expect them to rise to a much higher level of disinterested statesmanship?

That relegates any hope of reform to the two stakeholders who really have the most to gain but are too indifferent or complacent to advance the conversation: employers and employees. As for the latter, aside from sporadic complaints about rising premiums, deductibles, and co-pays, most seem content with the devil they know, one who competently manages their health care with minimal effort on their part. Restructuring the current system is far down on their hot-button list, which is headed by gun and abortion rights.

In my view, the only body that could thrust the conversation into the public arena and bring the power brokers to the table would be an alliance of major employers, the CEO's of companies like Google, Amazon, General Motors, Exxon, and Whole Foods. But apparently they are satisfied, even pleased, to be able to offer insurance to their thousands of workers and absorb most of the cost. They have the resources to manage their risk. For them, health insurance is a valuable benefit which can be used to attract and retain key executives. Most are reluctant to involve themselves in controversial political issues. Absent a dramatic event in the current environment, they are unlikely to champion a revolutionary movement.

We are left with no recourse other than to make the best of a bad situation. As a seventy-two-year old male who has been gifted with excellent health all his life and is now waiting for the inevitable shoe to drop, I have a few suggestions: get an annual physical; exercise every day; don't smoke anything; never drink alone; eat a peanut butter and jelly sandwich for lunch; be wary of elective surgery; observe the speed limit; always cycle with a helmet; don't take yourself too seriously; don't cross the street while looking at your phone; limit your consumption of coffee to one cup a day except on vacations; stay out of the sun; and, last but not least, inherit the genes of a ninety-five-year-old mother.

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