Osher Lifelong Learning Institute, Winter 2026

The Economics of Public Policy Issues

American University

April 6, 2026

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Course Schedule

Economics of Public Policy Issues

- Week 1 (3/02): Economic Update & Tariffs Geoffrey Woglom, Amherst College
- Week 2 (3/09): Trade and Globalization, Mina Kim, NEED
- Week 3 (3/16): Economics of Immigration, Robert Gitter, Ohio Wesleyan University
- Week 4 (3/23): Autonomous Vehicles, Arkadiusz Mironko, Kean University
- Week 5 (3/30): Climate Change Economics, Sarah Jacobson, Williams College
- Week 6 (4/06): **Health Care Economics, Robert Rebelein, Vassar College**
- Week 7 (4/13): Saving Social Security, Geoffrey Woglom

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Submitting Questions

- **Submit questions in the chat or by raising your digital hand.**
  - I will try to handle them as they come up.
- **We will do a verbal Q&A after the material has been presented.**
- **Slides will be available on the NEED website tomorrow (https://needelegation.org/delivered_presentations.php)**

Major Problems in the US

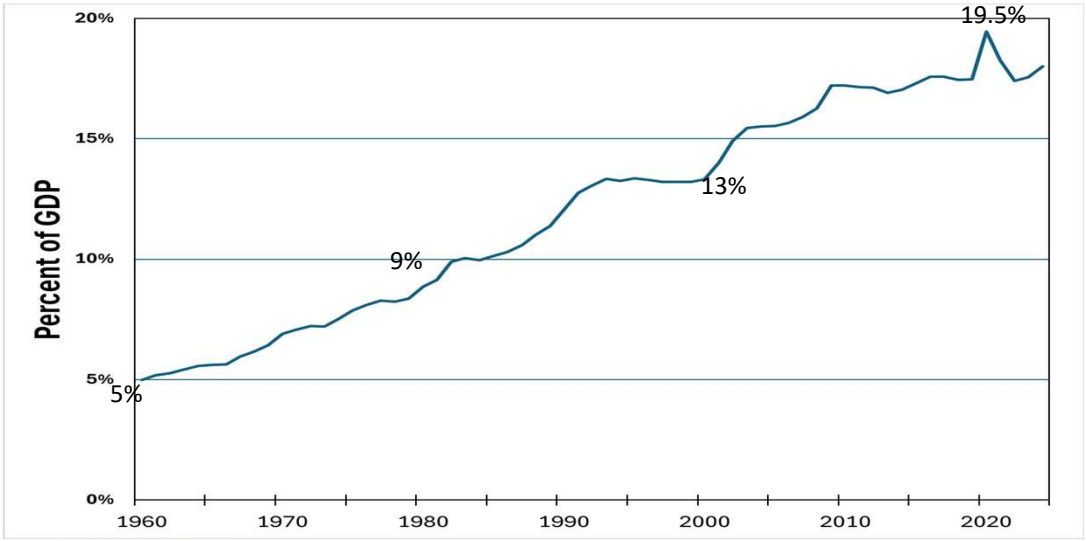
- Expenditure growth is unsustainable
- **ACCESS** to healthcare is not always great
- **QUALITY** of healthcare is not always great
- Increasing dependence on government payments
- Lack of competition in key markets

Healthcare expenditures in the U.S.

Health Economics is Big Business

- Healthcare is the biggest industry and the largest employer in the U.S.
- We spend **A LOT** on healthcare:
  - In 2024, U.S. national health expenditures were about **$5.3 trillion** -- approximately **18.0% of GDP** ($15,000 per person)
  - Expenditures grew 7.2% from 2023 to 2024

National Health Expenditure as Percent of GDP



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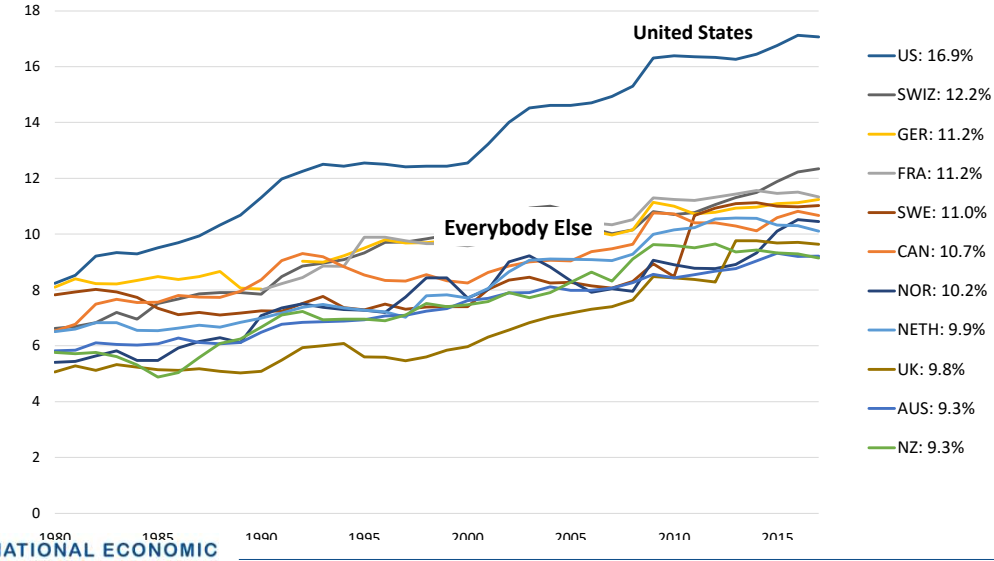
Source: Centers for Medicare and Medicaid Services (graph by NEED)

Health Care Spending as % of GDP, 1980–2018



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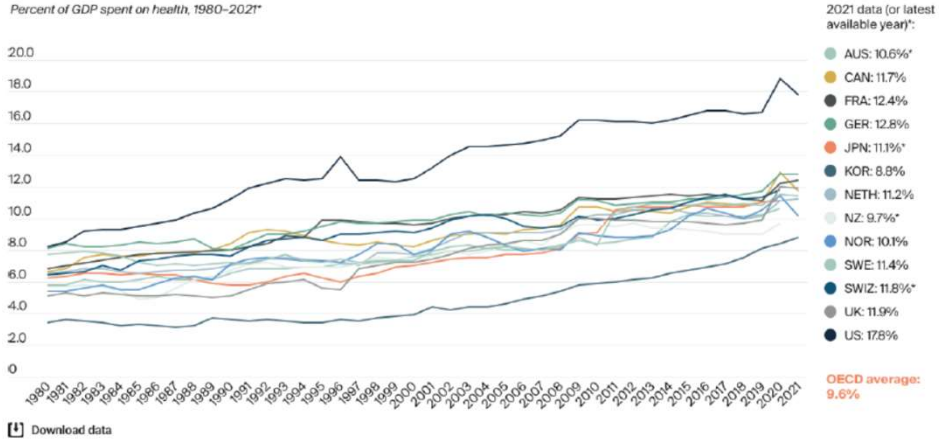
Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

The U.S. is a world outlier when it comes to health care spending.



Notes: * 2020 data. Current expenditures on health for all functions by all providers for all financing schemes. Data points reflect share of gross domestic product. Based on System of Health Accounts methodology, with some differences between country methodologies. GDP = gross domestic product. OECD average reflects the average of 38 OECD member countries, including ones not shown here.

Data: OECD Health Statistics 2022.

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/10.26099/8ejy-yc74

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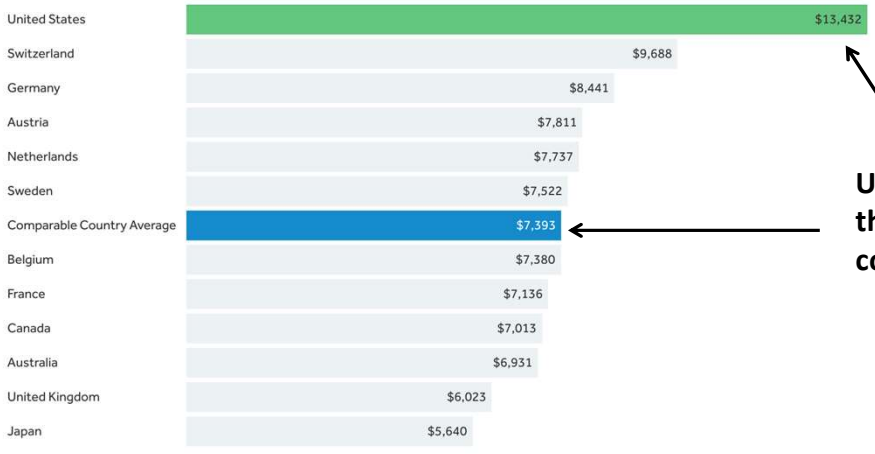
International Per Capita Healthcare Spending

Health expenditures per capita, U.S. dollars, 2023 (current prices and PPP adjusted)



US spends almost twice the comparable country average

Notes: Data from Australia, Belgium, Japan, the Netherlands, Switzerland, and United States are estimated. Data from Austria, Canada, France, Germany, Sweden and the United Kingdom are provisional.

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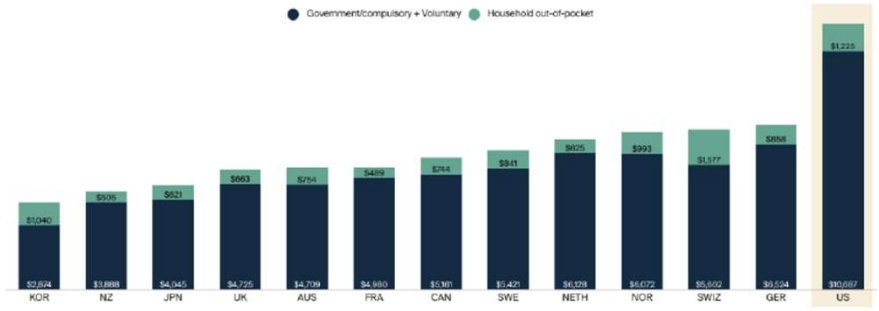
Source: Peterson-KFF Health System Tracker

The U.S. spends three to four times more on health care than South Korea, New Zealand, and Japan.

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. 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/10.26099/8ejy-yc74

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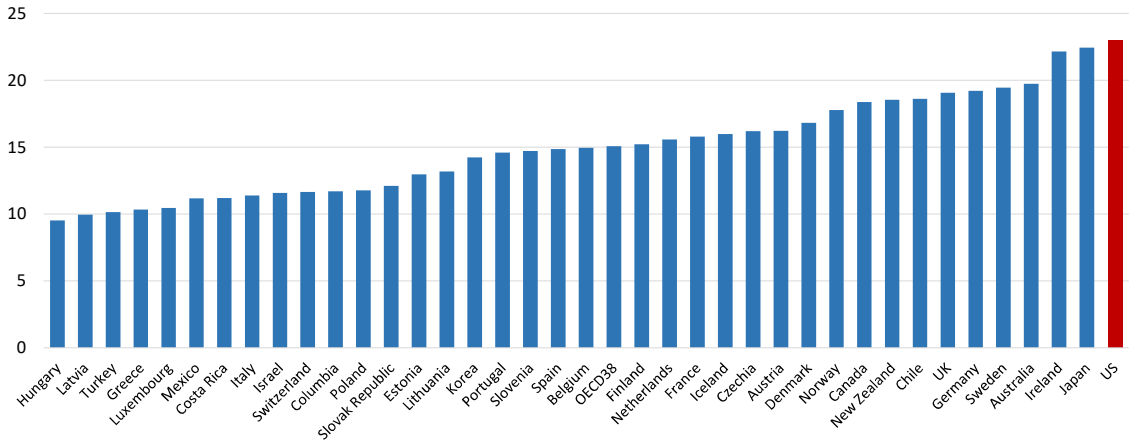
Government Healthcare Spending Share (2023)

Health Expenditure from Public Sources as a Share of Federal Government Spending (2023)



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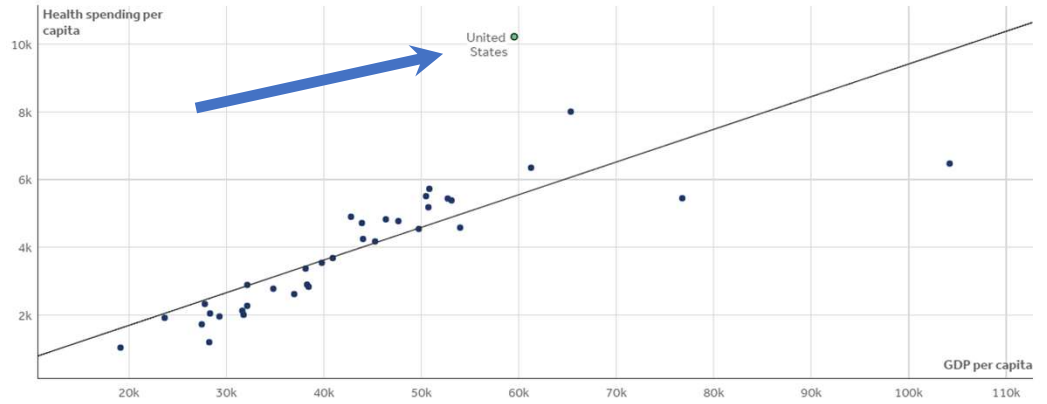
Source: *Health at a Glance 2025* (OECD); graph by NEED

GDP per Capita and Health Spending per Capita, 2017



Notes: U.S. value obtained from National Health Expenditure data. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of OECD and National Health Expenditure (NHE) data • Get the data • PNG

Peterson-KFF Health System Tracker

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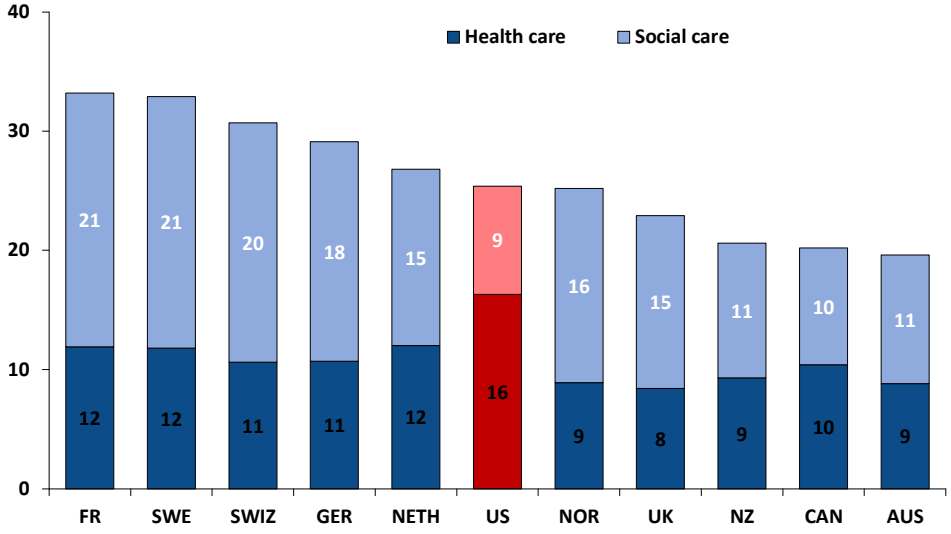
Health Care vs Social Services Spending



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Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

Health Care vs Social Care Spending

- A 2013 study by Bradley and Taylor found that the U.S. spent the least on social services—such as retirement and disability benefits, employment programs, and supportive housing—among the countries studied in this report, at just 9 percent of GDP.
- From 2000 to 2011, for every dollar the US spent on health care, the country spent another $1.00 on social services, whereas across the OECD, for every dollar spent on health care, countries spend an additional $2.50 on social services

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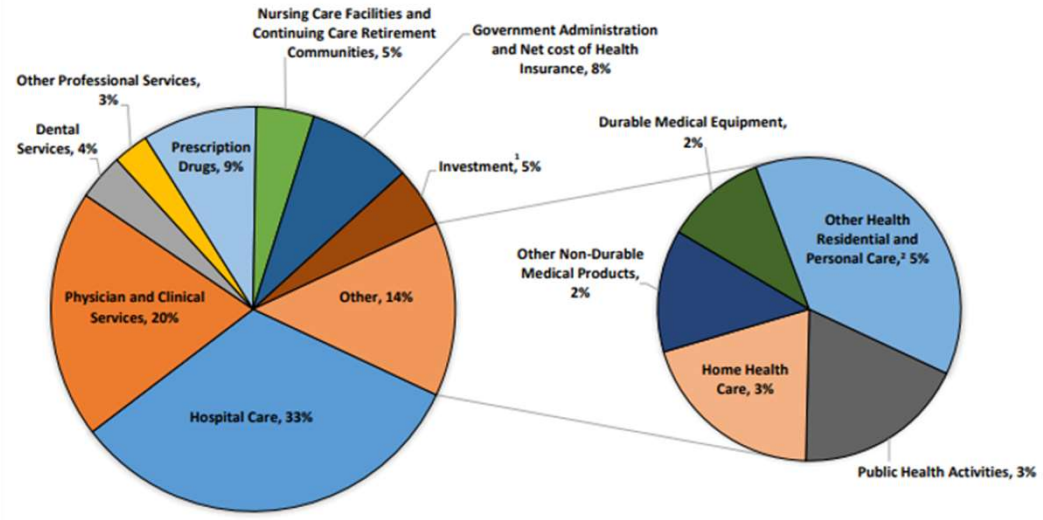
Where the money goes:



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Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group (2023).

U.S. Healthcare Expenditure Sources

	Total ($bill)	Out-of-Pocket	Medicare	Medicaid	Private & other Health Ins.	Other Third-Party Payers	GDP ($bill)	Total Expends as a share of GDP	Medicare & Medicaid share of Federal Budget
1960	**$27**	**48%**	**0%**	**0%**	**27%**	**25%**	**$543**	**5%**	**0%**
1980	**$255**	**23%**	**15%**	**10%**	**31%**	**22%**	**$2,863**	**9%**	**8%**
2000	**$1,369**	**15%**	**16%**	**15%**	**36%**	**19%**	**$10,285**	**13%**	**19%**
2023	**$4,866**	**10%**	**21%**	**18%**	**30%**	**21%**	**$27,800**	**17.6%**	**28%**

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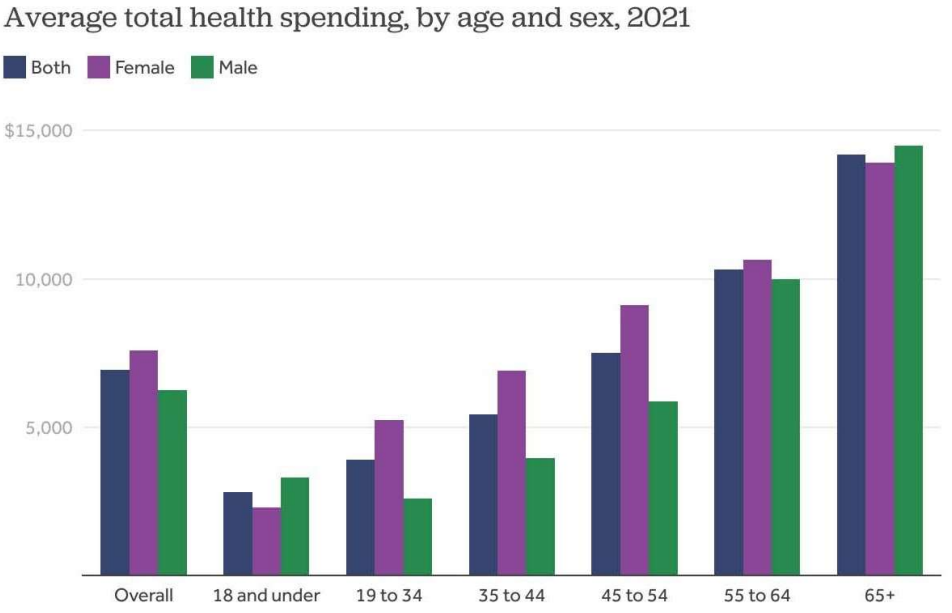

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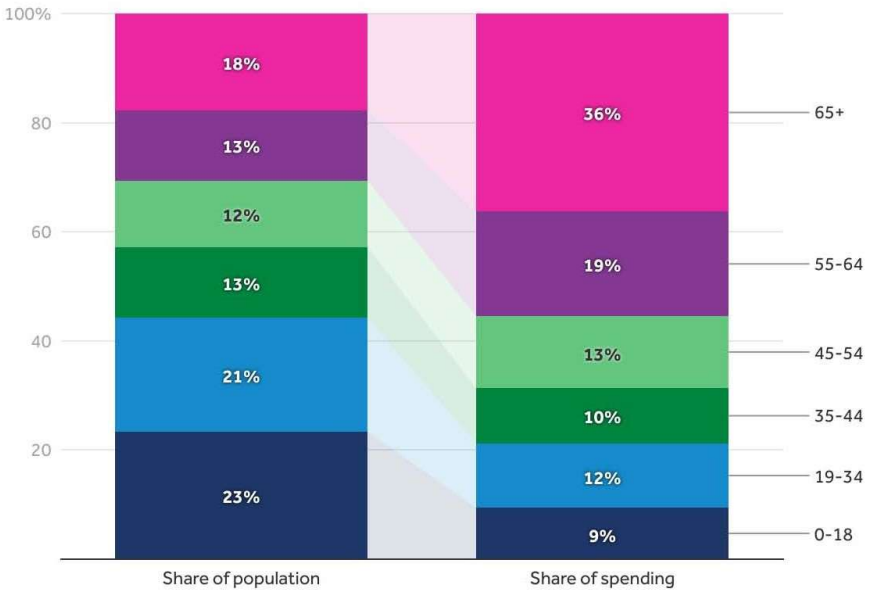
Share of total population and total health spending, by age group, 2021



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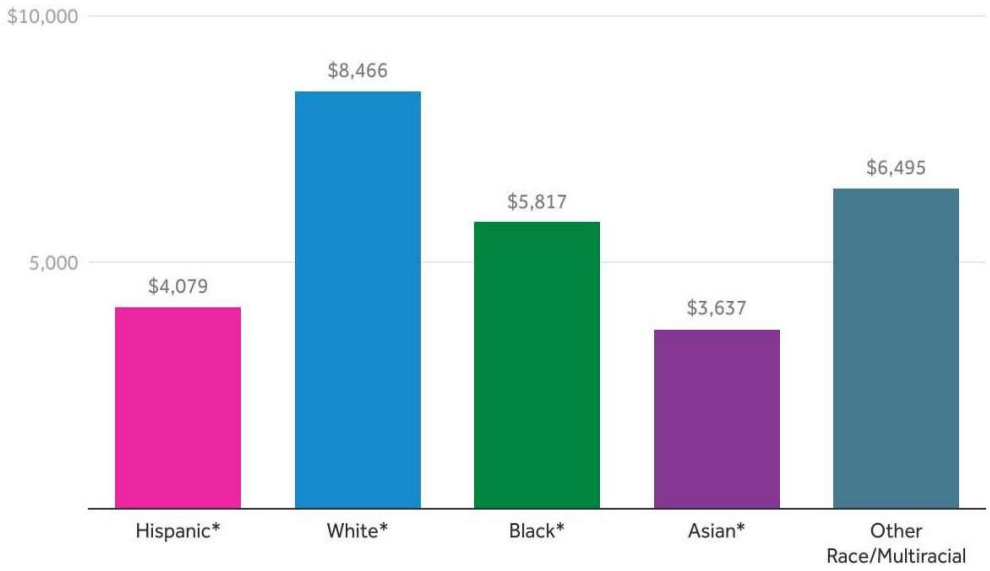
Average total health spending, by race/ethnicity, 2021



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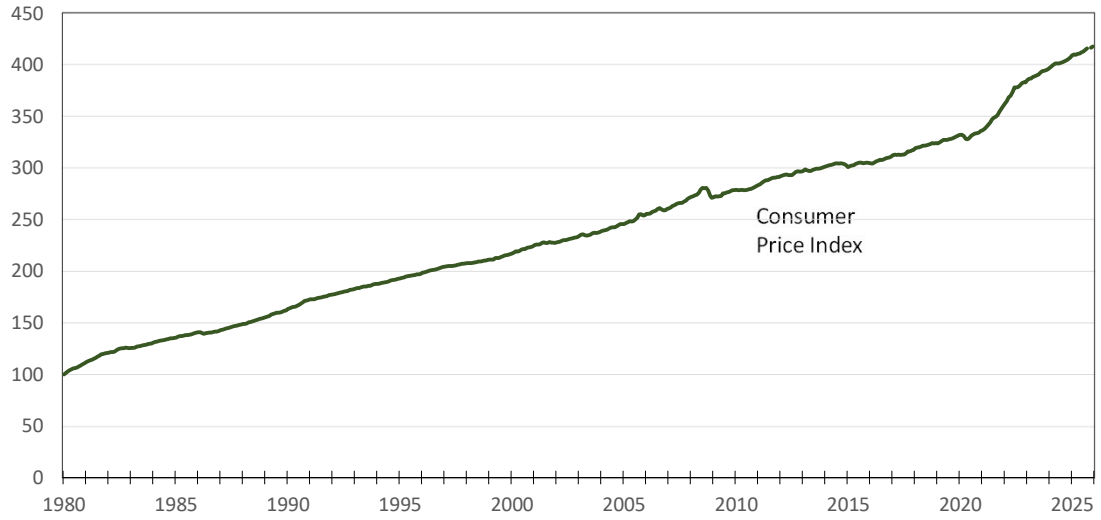
Inflation – CPI for all goods



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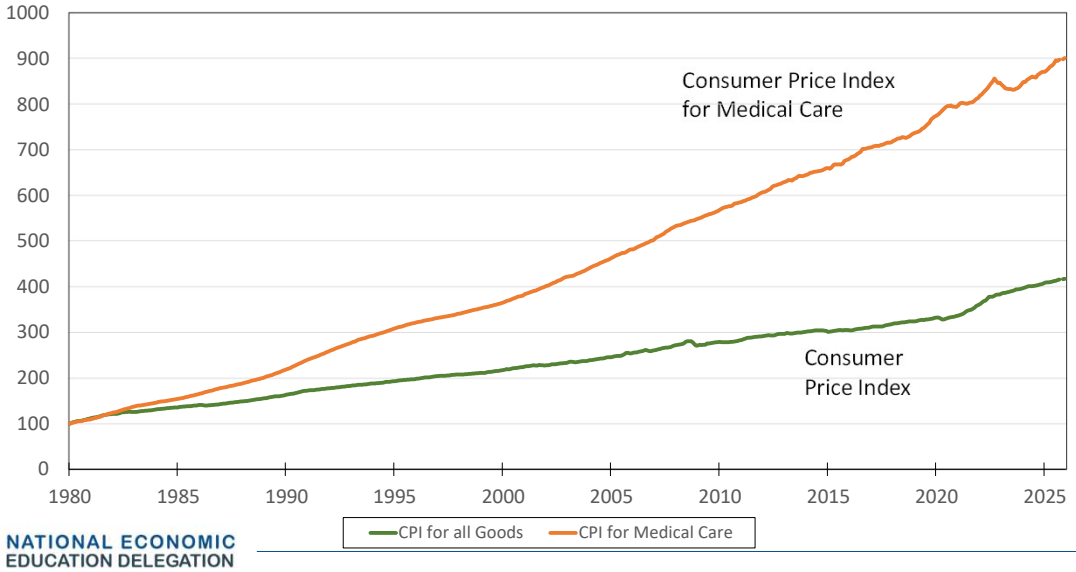
Inflation – CPI for Medical Care



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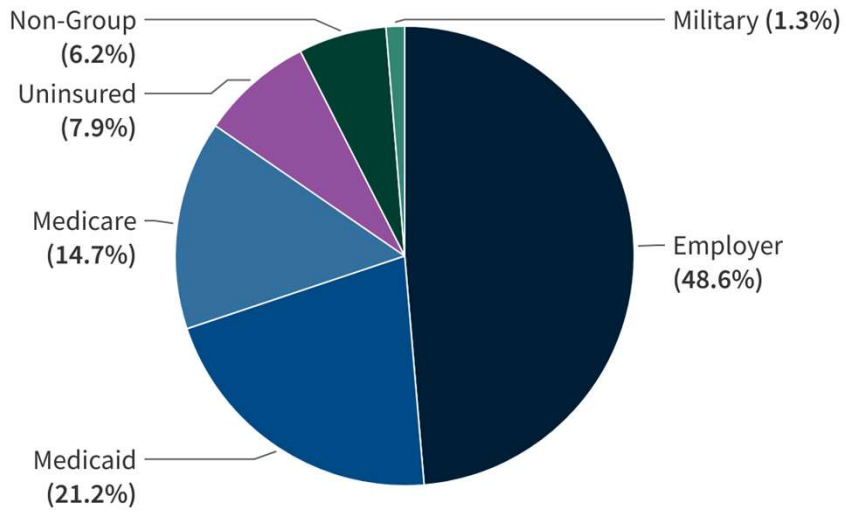
Assessing the U.S. Healthcare System:

Access to Healthcare Services

Health Insurance Coverage, 2023 – 92.1%



Source: KFF graph using 2023 American Community Survey

Health Insurance Coverage, 2022 – 92.1%

Countries with Less Than Universal Coverage

Country	% of Persons
Slovakia	94.5
Chile	94.3
UNITED STATES	92.1
Poland	91.5
Mexico	90.2
Algeria	90.9
Jordan	55.0

Countries with Universal Coverage

Countries	% of Persons
Australia	100
Canada	100
Czech Republic	100
France	100
United Kingdom	100
Greece	100
Hungary	100
And 21 more	**99+**

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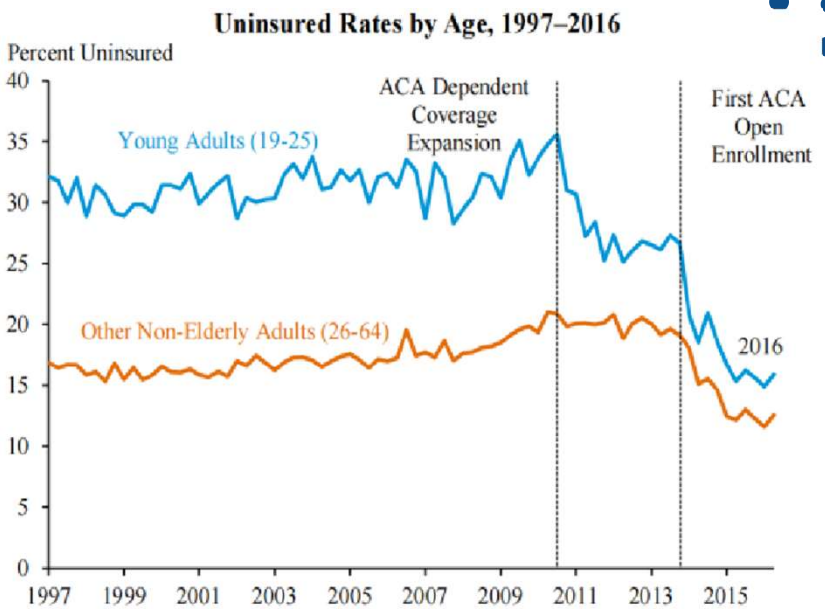
Source: Organization for Economic Cooperation and Development

Uninsured Rate dropped dramatically with the ACA; Drop was more significant for young adults



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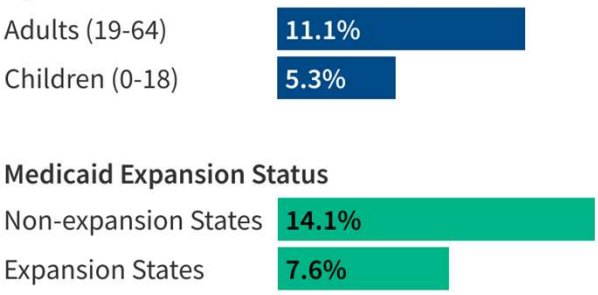
America's Uninsured

Uninsured Rates among the Population Ages 0-64 by Selected Characteristics, 2023

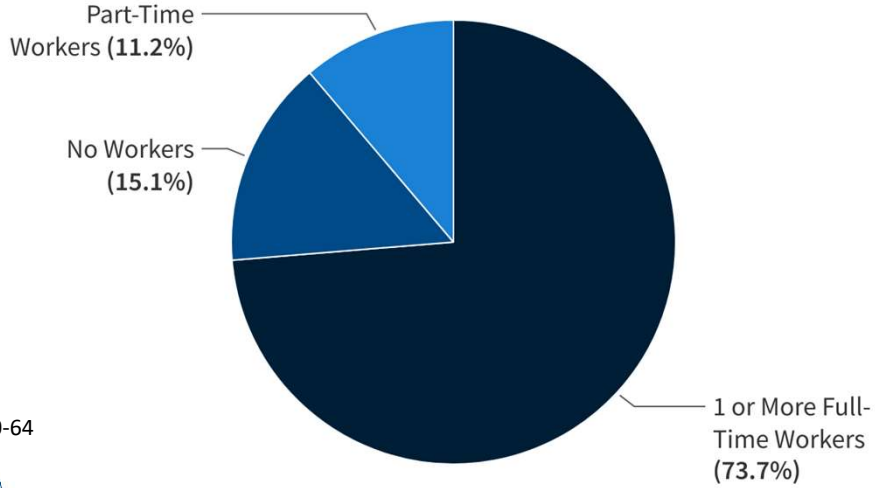


NATIONAL ECONOMIC EDUCATION DELEGATION

Source: KFF graph using 2023 American Community Survey

America's Uninsured

Family Work Status of Uninsured People Ages 0-64, 2023



Note: includes individuals age 0-64

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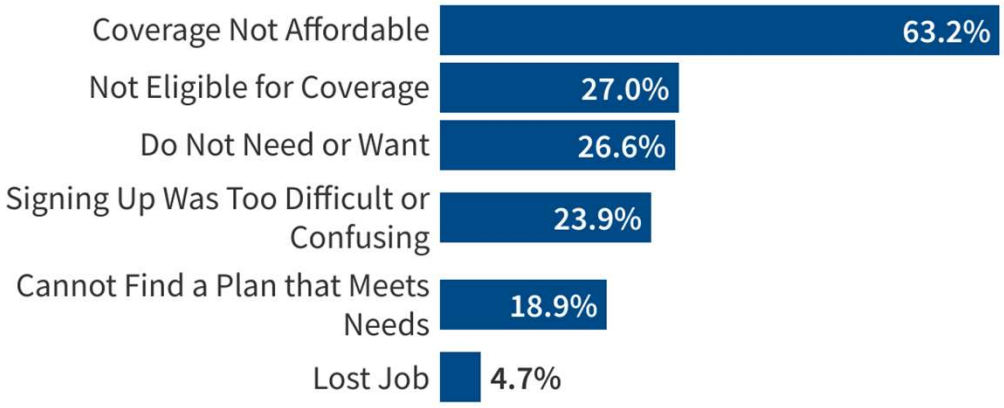
Source: KFF graph using 2023 American Community Survey

America's Uninsured

Reasons for Being Uninsured Among Uninsured Adults Ages 18-64, 2023



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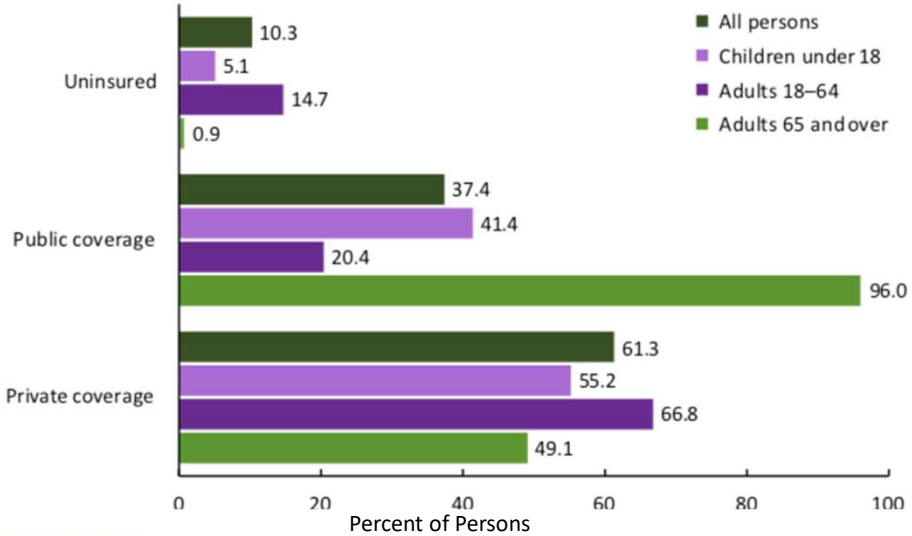
Source: KFF graph using data from the 2023 National Health Interview Survey

Health Insurance Coverage By Age, 2019



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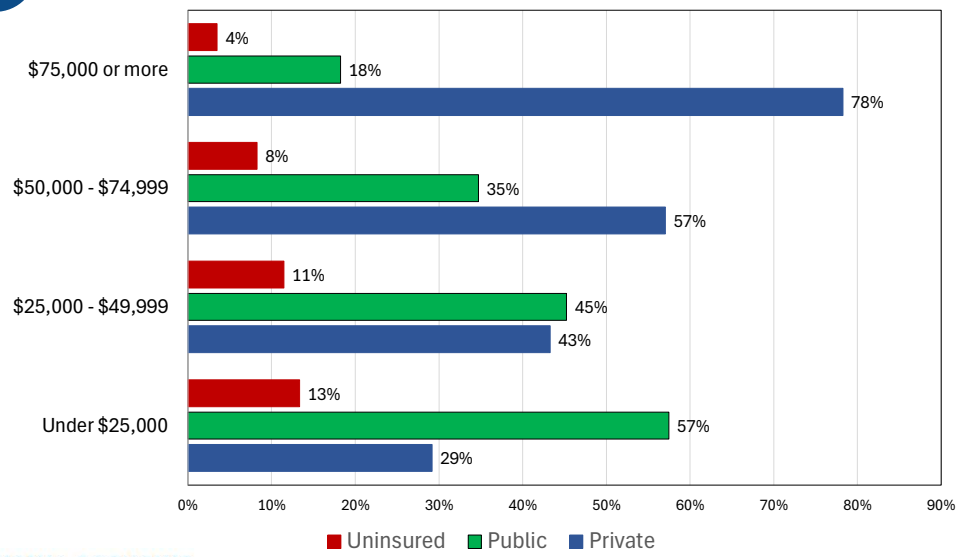
Source: National Center for Health Statistics

Health Insurance Coverage by Income, 2023



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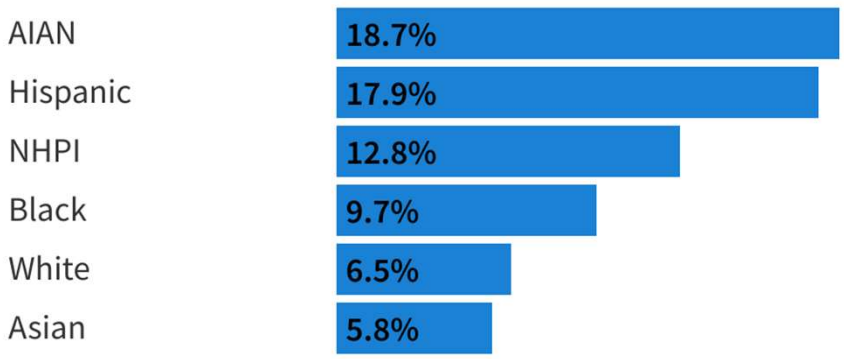
Source: NEED graph using data accessed via SHADAC from the American Community Survey

Insurance Non-Coverage by Race/Ethnicity, 2023



AIAN refers to American Indian/Alaska Native; NHPI refers to Native Hawaiians or Pacific Islanders

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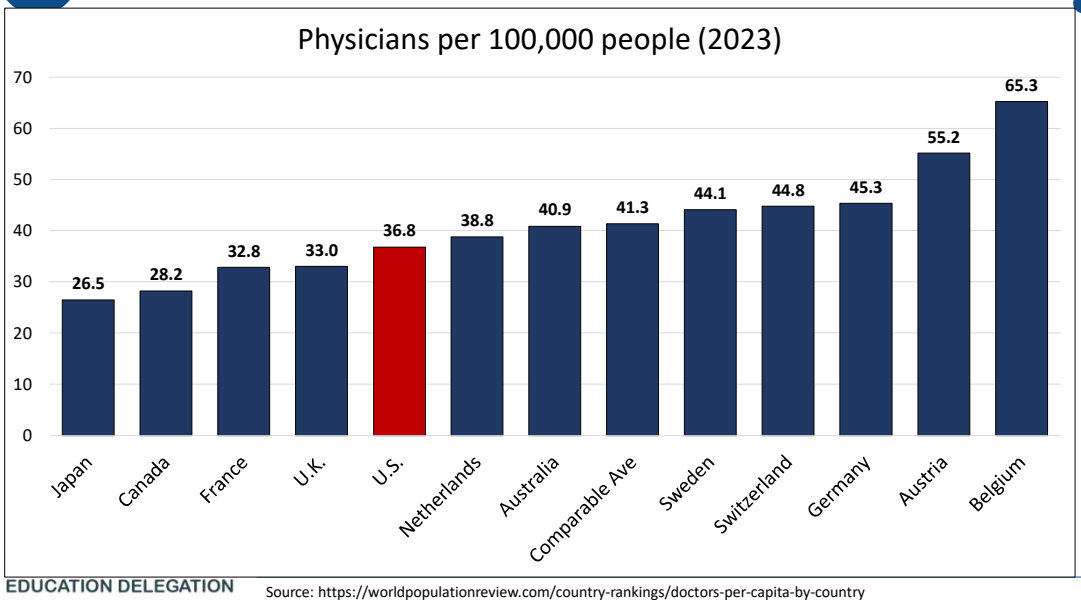
Source: KFF graph using 2023 American Community Survey

Physician Supply



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Source: https://worldpopulationreview.com/country-rankings/doctors-per-capita-by-country

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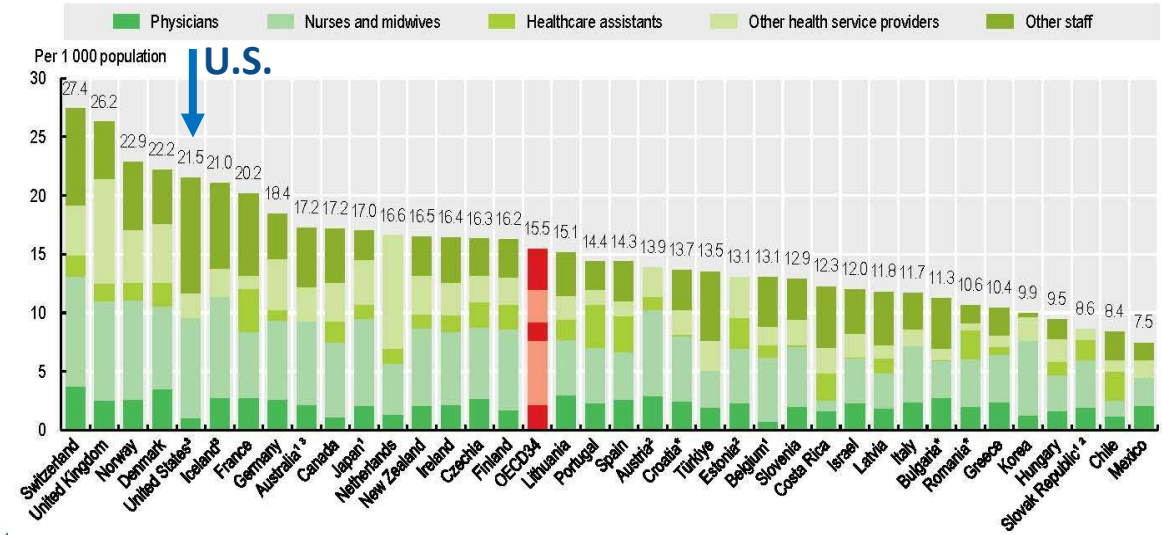
Hospital Staff per 1,000 population (2023)



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Source: *Health at a Glance, 2025* OECD

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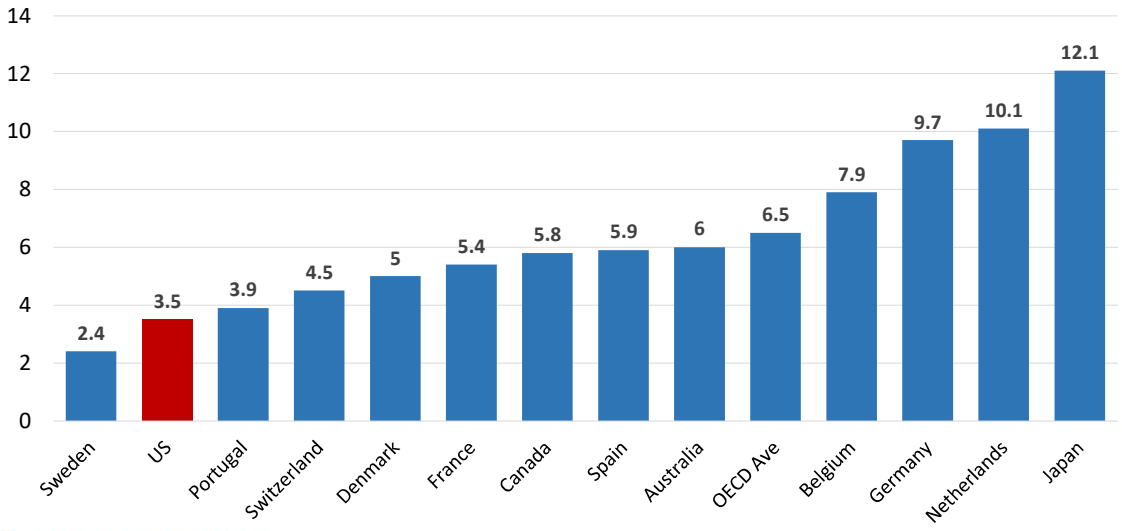
Physician Visits per capita (2023)



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Source: *Health at a Glance, 2025* OECD

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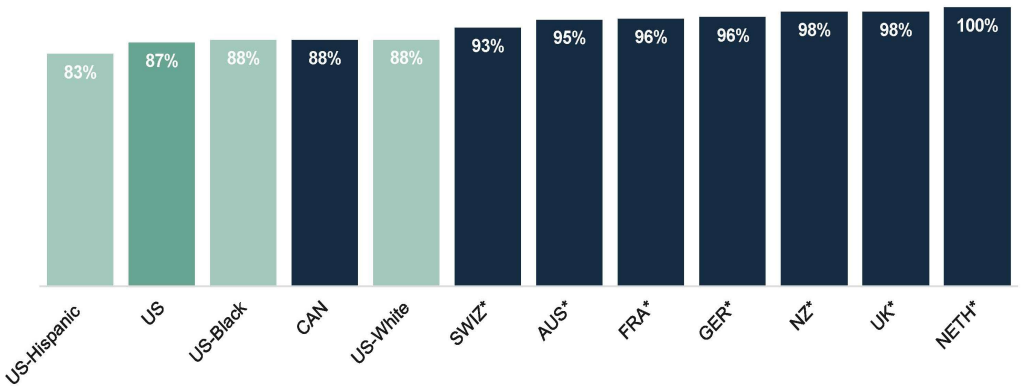
Percent of Women Ages 18–64 Who Reported Having A Regular Doctor/Regular Place of Care



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Source: Commonwealth Fund 2023 International Health Policy Survey

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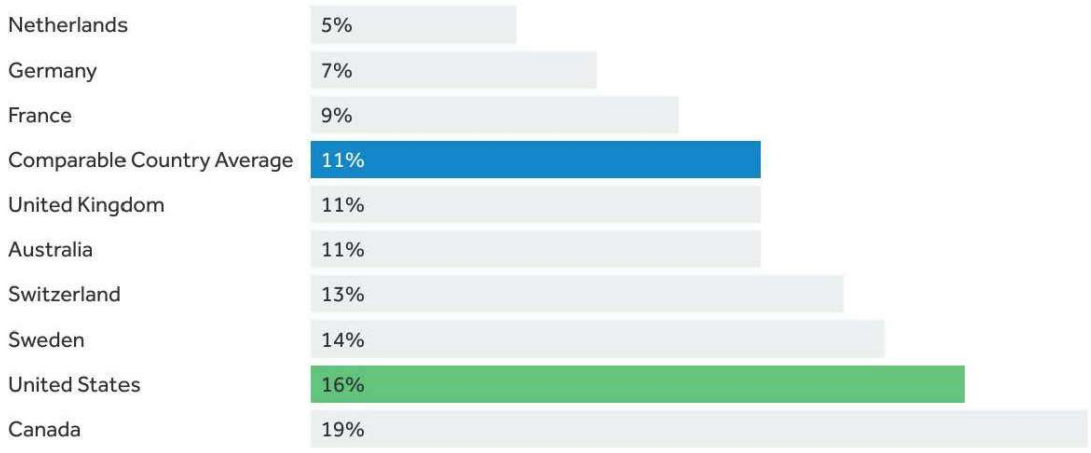
Percent of adults who used the emergency room either for care which could have been provided by a regular doctor or because they did not have a regular doctor, 2023



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Source: KFF, using data from Commonwealth Fund International Health Policy Survey (2023)

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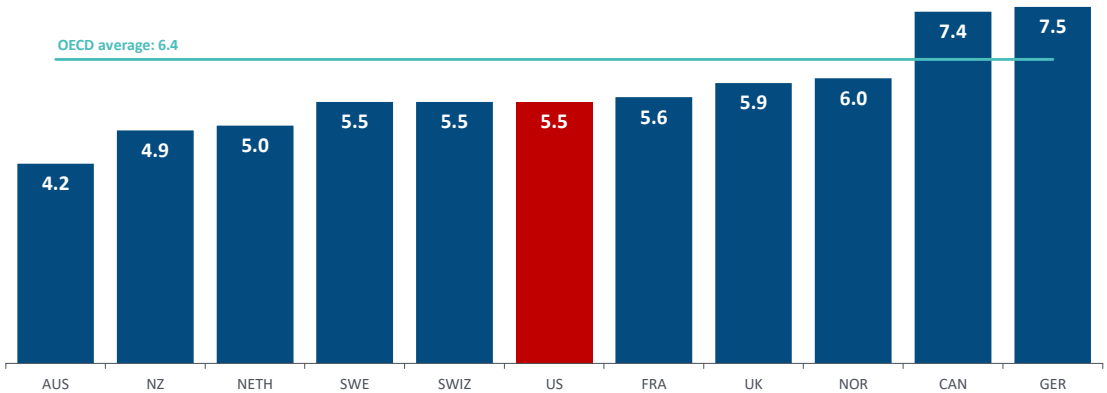
Hospital Acute Care Average Length of Stay

Average length of stay for acute care (days)



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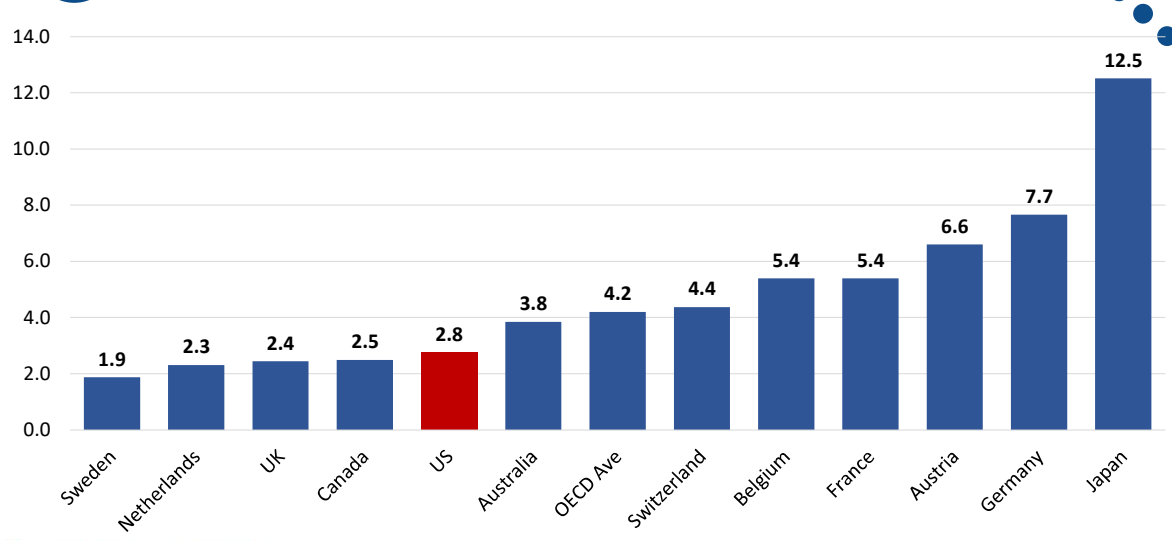
Hospital Beds per 1,000 People (2023)



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Source: *Health at a Glance, 2025*, OECD (graph by NEED)

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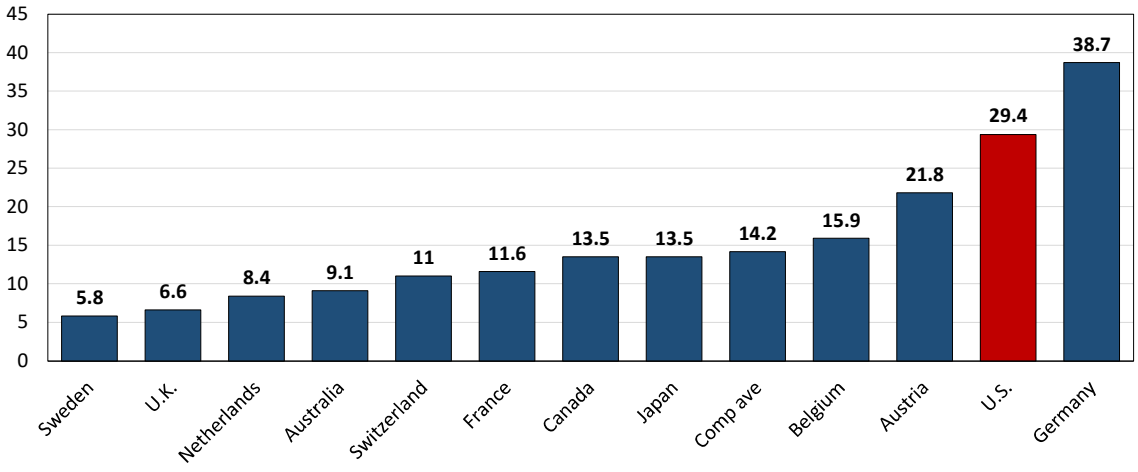
Acute Care Hospital Beds per 100,000 People (2025)



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Source: World Population Review; graph by NEED

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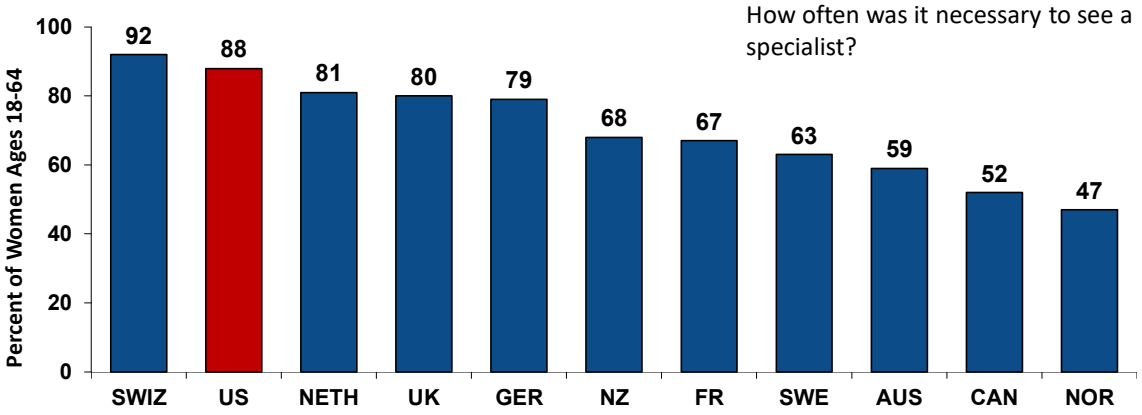
Waited Less Than a Month to See A Specialist

But how much time did they spend with the specialist?

How often was it necessary to see a specialist?



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Source: 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults in Eleven Countries.

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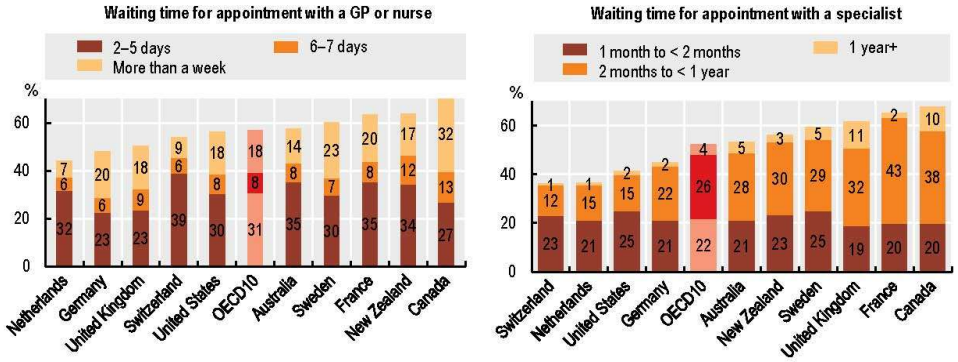
Figure 5.13. Waiting times for appointment with a GP or nurse, or a specialist, 2023



Note: Data include teleconsultations and exclude visits to hospital emergency departments.
Source: Commonwealth Fund 2023 International Health Policy Survey.

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Source: *Health at a Glance, 2025* OECD

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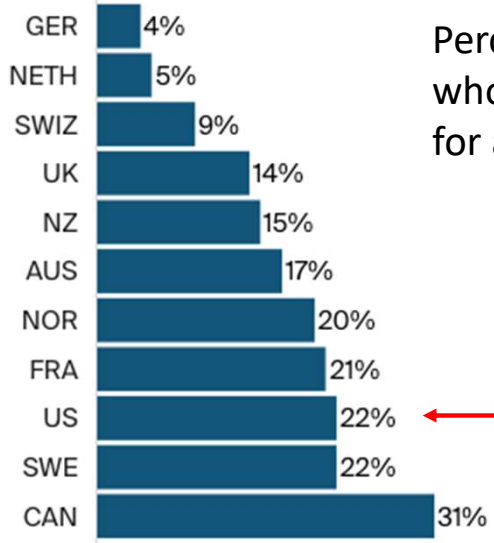
More About Wait Times



Percentage of adults aged 65+ who waited more than 6 days for an appointment when sick.

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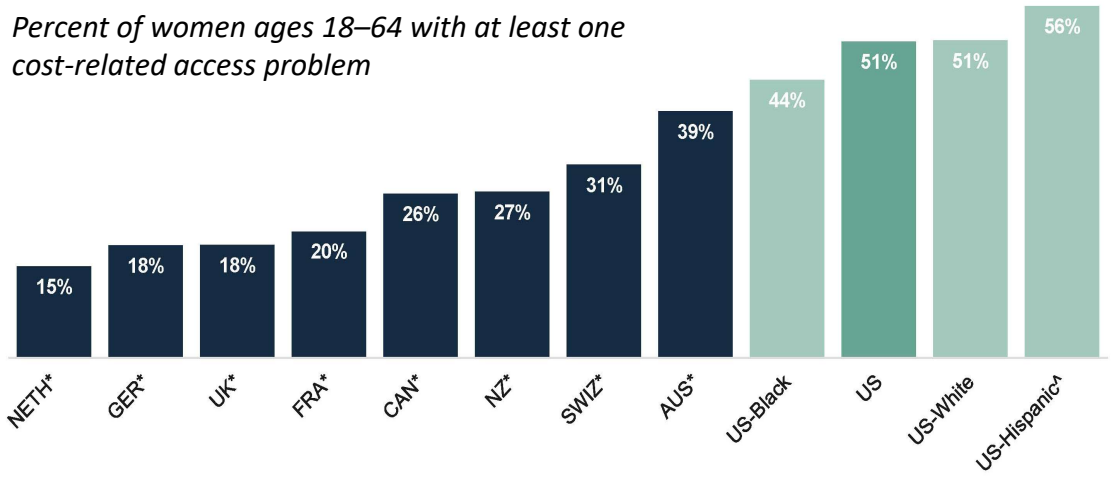
Source: Commonwealth Fund, Comparing Nations on Timeliness and Coordination of Health Care, 2021

Skipped Care Because of Cost (2022)

Percent of women ages 18–64 with at least one cost-related access problem



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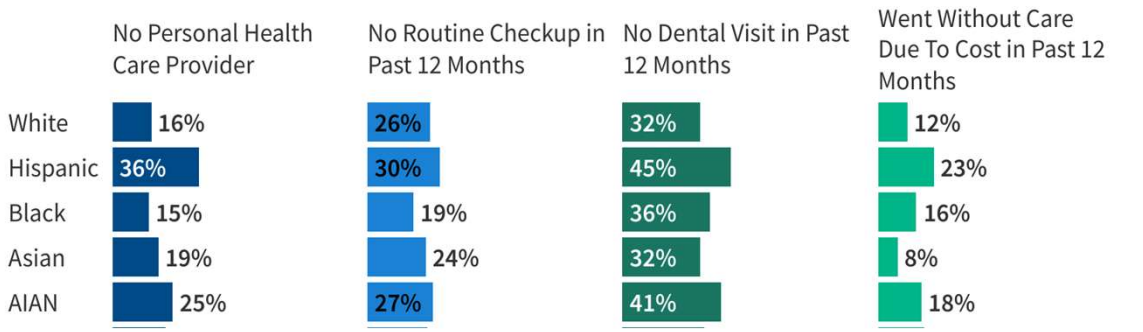
Source: Munira Z. Gunja, Relebohile Masitha, and Laurie C. Zephyrin, *Health Care for Women: How the U.S. Compares Internationally* (Commonwealth Fund, Aug. 2024).

Having a regular care provider

Having a Health Care Provider and Use of Care Among Adults Under Age 65 by Race and Ethnicity, 2024



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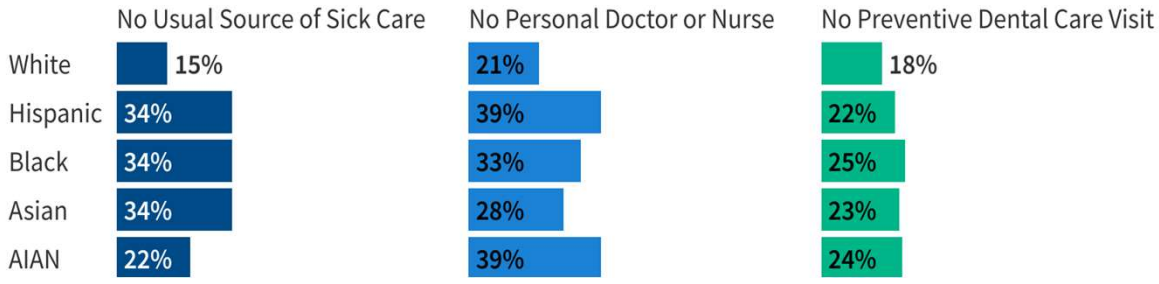
Source: KFF analysis of 2024 Behavioral Risk Factor Surveillance Survey

Children's access to Health Care

Percent of Children Without a Usual Source of Care, Personal Doctor, and Who Did Not Have a Dental Visit by Race and Ethnicity, 2023



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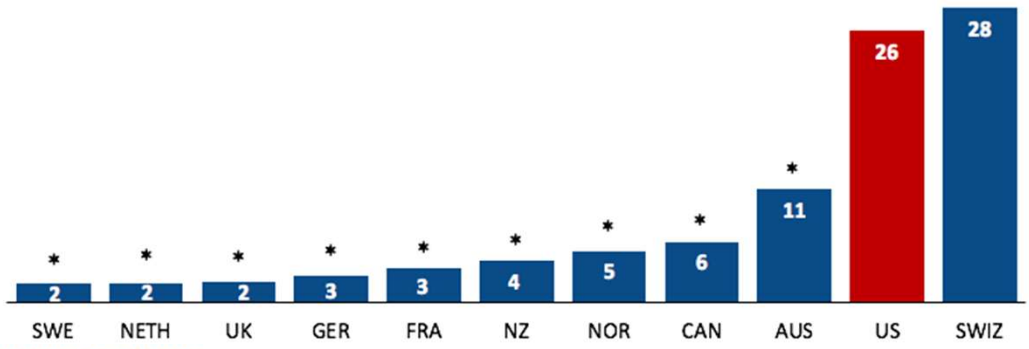
Source: KFF analysis of data from NSCH, HRSA, and MCHB

Out-of-Pocket Costs

Percent of women ages 18–64 with out-of-pocket costs of $2,000 or more.



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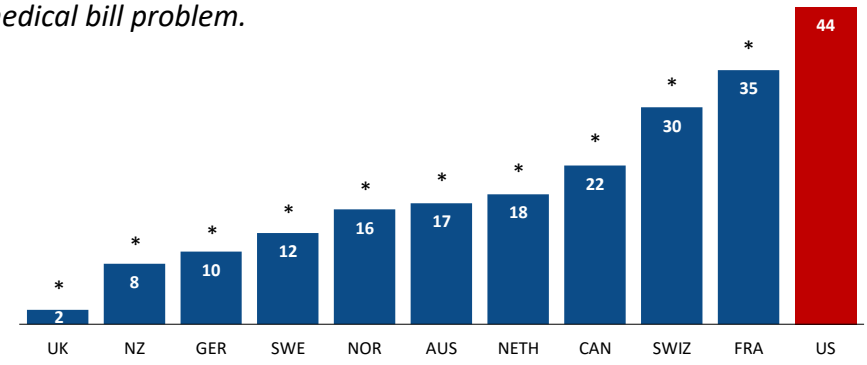
Source: Munira Z. Gunja et al., *What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?* (Commonwealth Fund, Dec. 2018).

Medical Bill Problems

Percent of women ages 18–64 with at least one medical bill problem.



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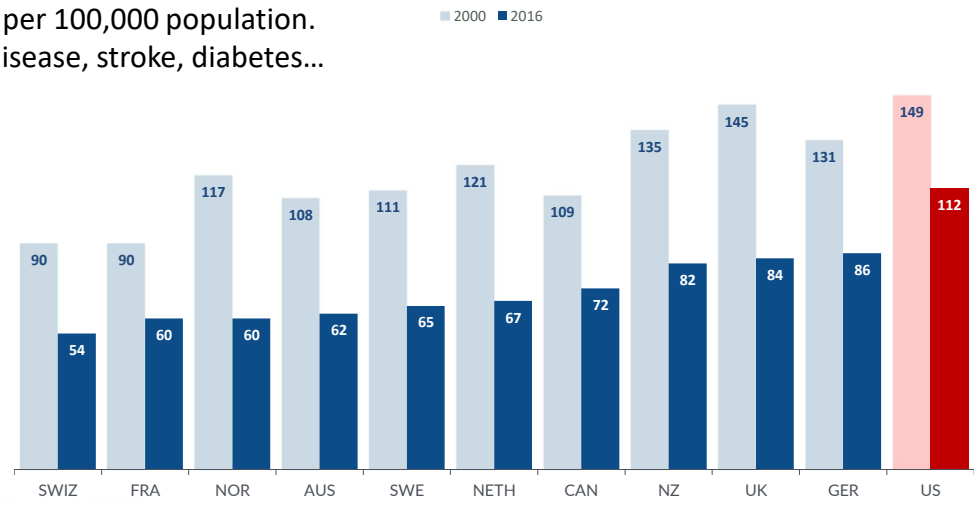
Source: Munira Z. Gunja et al., *What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?* (Commonwealth Fund, Dec. 2018).

Avoidable Deaths

Deaths per 100,000 population.
Heart disease, stroke, diabetes…



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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

Notes about Healthcare Access

- **Insurance coverage in the U.S. is not universal.**
  - Is universal in most other developed countries.
- **Wait times are not necessarily lower in the U.S.**
- **Supply of medical personnel and equipment is lower than some comparable countries**
- **Emergency room use is higher in the U.S. than elsewhere.**
- **Specialized medicine more accessible in the U.S.**
- The U.S. has **fewer physicians** and **fewer physician visits** than most peer countries

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Assessing the U.S. Healthcare System:
Quality of Healthcare Services

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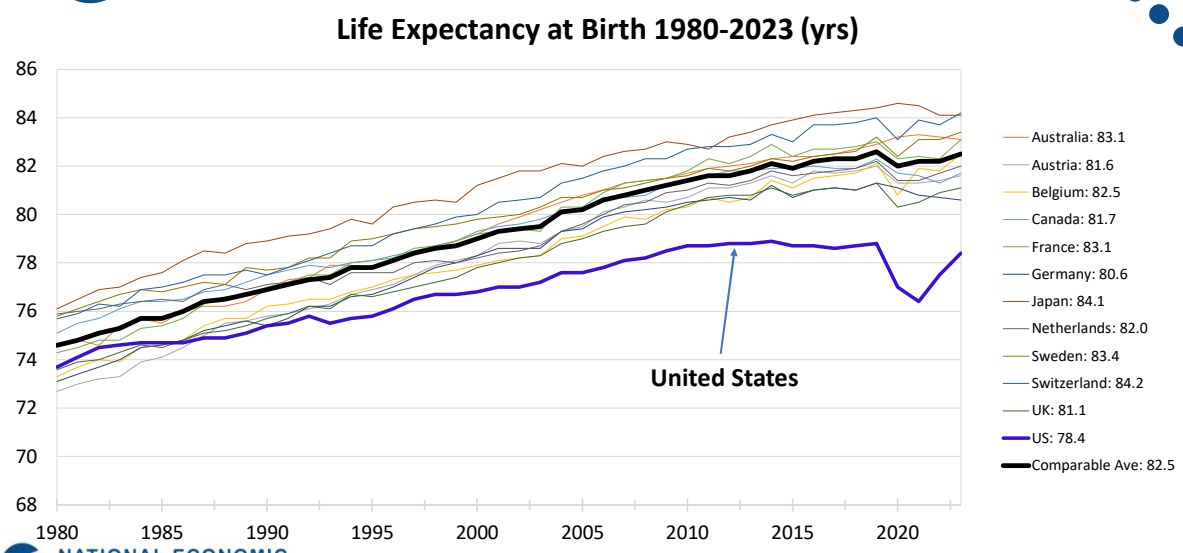
Life Expectancy: How Does the US Compare?



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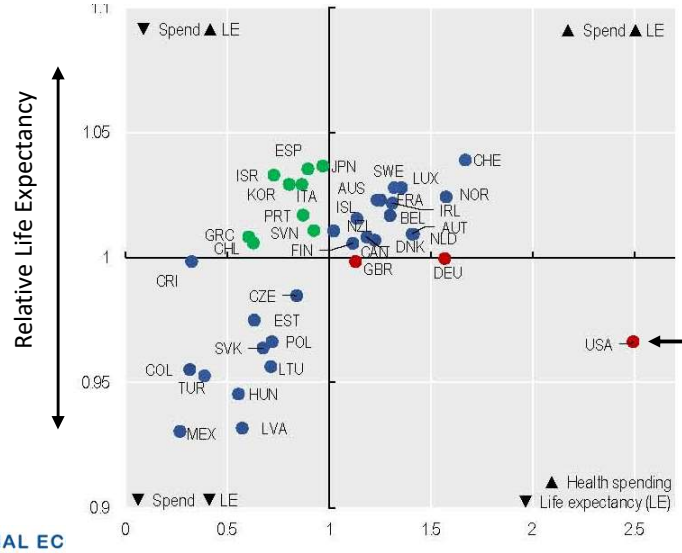
Source: KFF data collection. https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/

Health Expenditure vs. Life Expectancy (2023)



US has highest spending per capita and below average life expectancy

Source: *Health at a Glance, 2025* OECD

Life Expectancy at Birth by Race/Ethnicity, 2019

Race/Ethnicity	Life Expectancy (Years)
All Races	78.8
White	78.8
Black	74.8
Hispanic	81.9
Asian	85.6

Source: KFF, Key Data on Health and Health Care by Race and Ethnicity

Income Also Matters – Reflecting Access?

Sex	Income Category	Life Expectancy (Years)	Difference High vs Low
Women	**Highest** Incomes (top 1%)	88.9	10.1 years
	Lowest Incomes (bottom 1%)	78.8	
Men	**Highest** Incomes (top 1%)	87.3	14.6 years
	Lowest Incomes (bottom 1%)	72.7	

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Source: https://healthinequality.org/documents/paper/healthineq_summary.pdf

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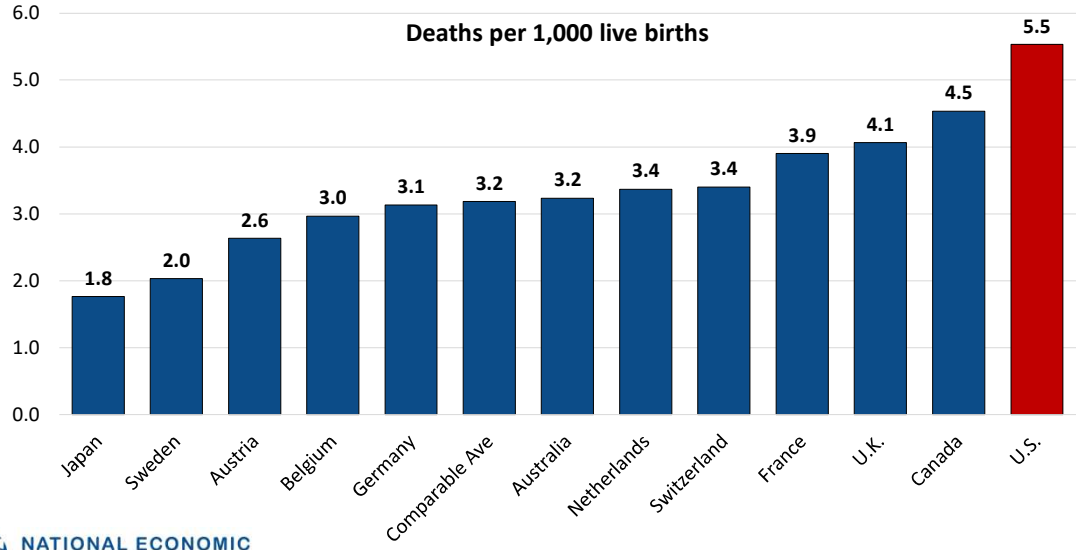
Infant Mortality Comparison(2023)



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Source: *Health at a Glance, 2025* OECD; graph by NEED

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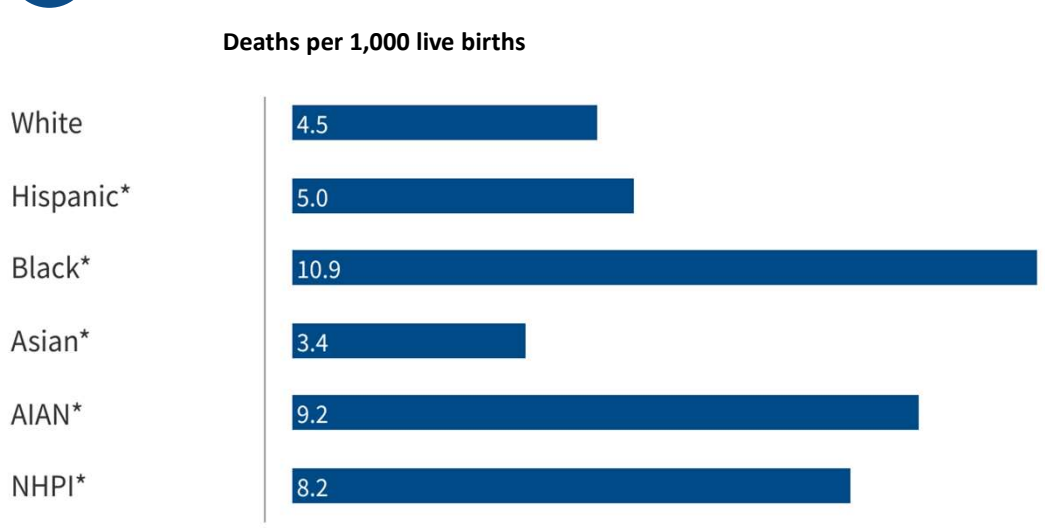
Infant Mortality by Race/Ethnicity (2023)



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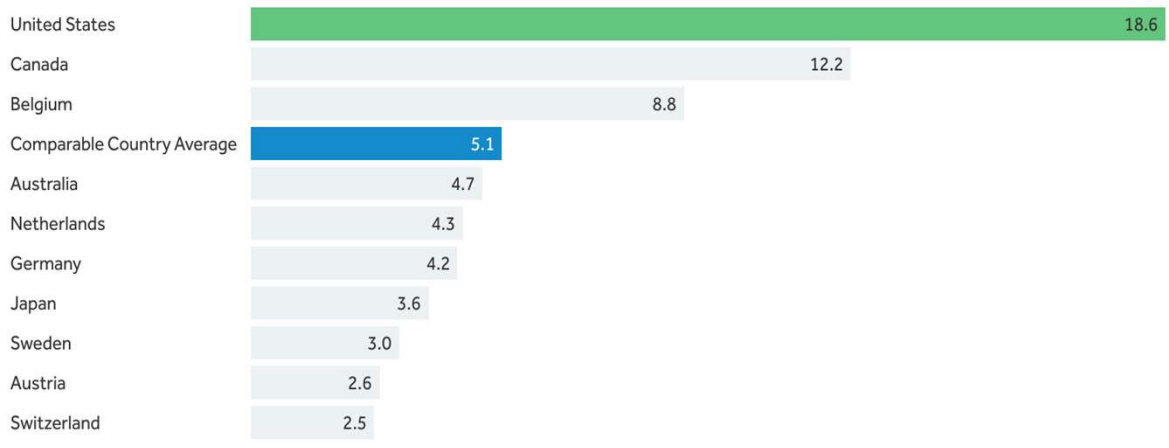
Source: Ely, DM, Driscoll, AK. *Infant mortality in the United States, 2023*, CDC

Maternal Mortality Rates per 100,000 live births (2023)



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Source: KFF analysis of OECD data

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Maternal Mortality Rates by Race

Pregnancy-Related Mortality Rate per 100,000 Births and Number of Deaths by Race and Ethnicity, 2023

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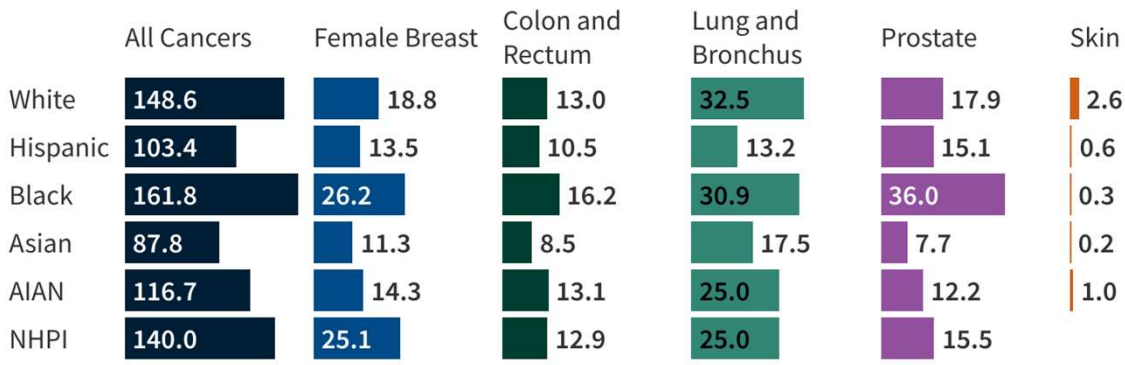
Source: *Pregnancy-Related Deaths by Race-Ethnicity*, 2023, CDC

Age-Adjusted Rate of Cancer Mortality per 100,000 by Race and Ethnicity, 2023

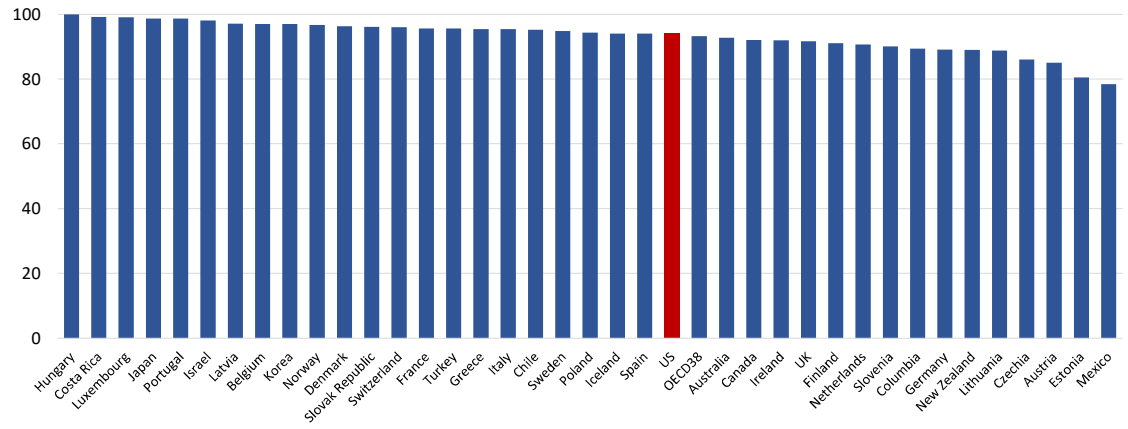


NATIONAL ECONOMIC EDUCATION DELEGATION

Source: KFF analysis of CDC data

Measles Immunization (2024)

Percentage of eligible children receiving two doses of measles vaccination

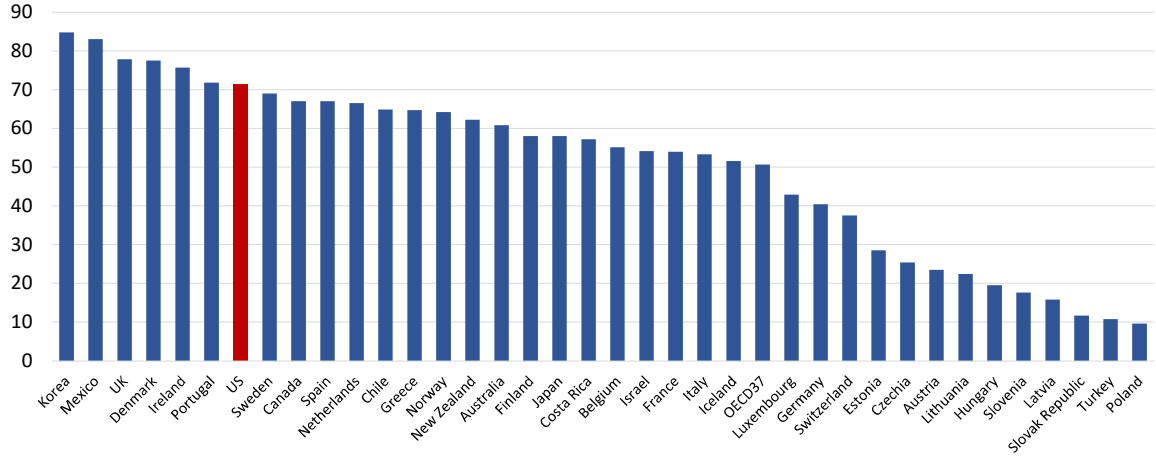


NATIONAL ECONOMIC EDUCATION DELEGATION

Source: *Health at a Glance, 2025* OECD; graph by NEED

Flu Immunizations (2024)

Percentage of population aged 65 and over Vaccinated against Influenza

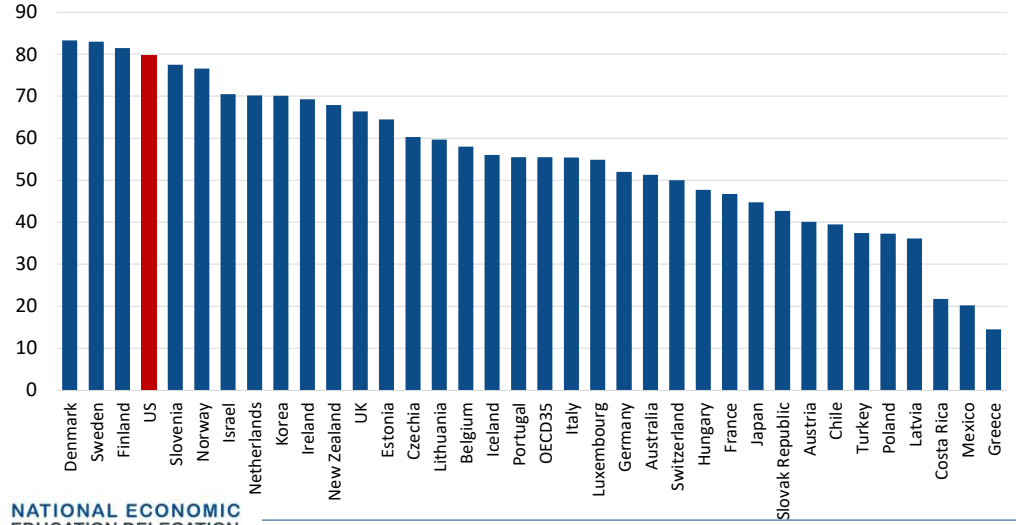


NATIONAL ECONOMIC EDUCATION DELEGATION

Source: *Health at a Glance, 2025* OECD; graph by NEED

Breast Cancer Screening (2023)

Portion of Women aged 50-69 receiving Mammograms within prior two years (%)

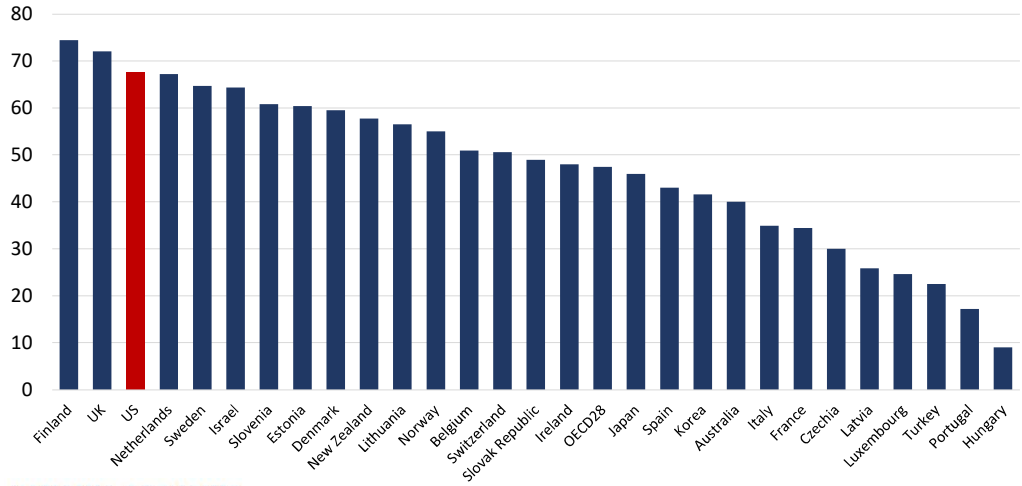


NATIONAL ECONOMIC EDUCATION DELEGATION

Source: *Health at a Glance, 2025* OECD; graph by NEED

Colorectal Cancer Screening Coverage (2023)

Percentage of Target Population Screened



NATIONAL ECONOMIC EDUCATION DELEGATION

Source: *Health at a Glance, 2025* OECD; graph by NEED

Prevention and Screening

- The U.S. excels in several prevention measures
  - including **vaccinations** and **cancer screenings**.
- Among OECD countries, the U.S. has
  - The highest average five-year survival rate for breast cancer,
  - but the lowest five-year survival rate for cervical cancer.

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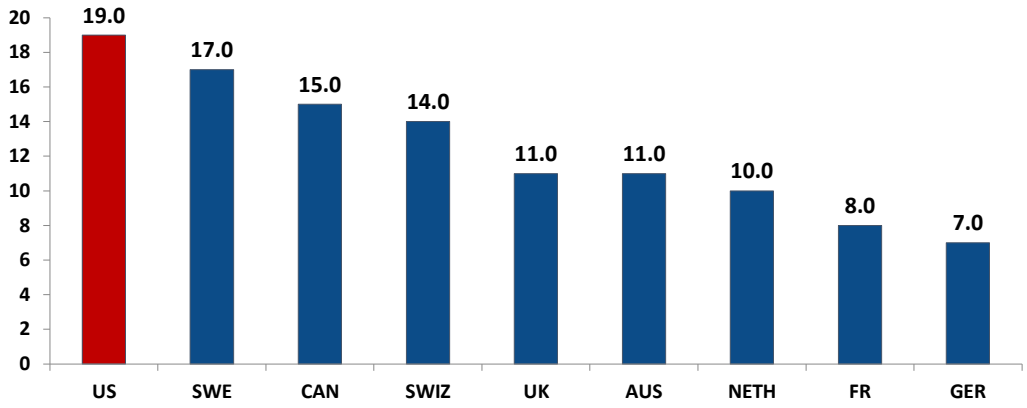
Percent of adults who have experienced medical, medication, or lab errors or delays



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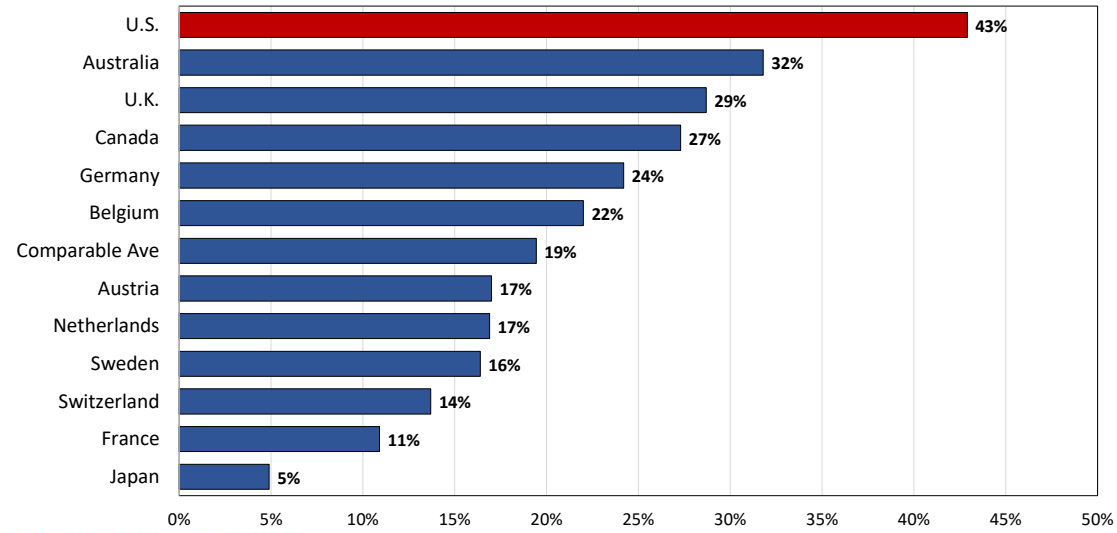
Source: 2016 Commonwealth Fund International Health Policy Survey.

Obesity Rates (2022)



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Source: The World Population Review; graph by NEED

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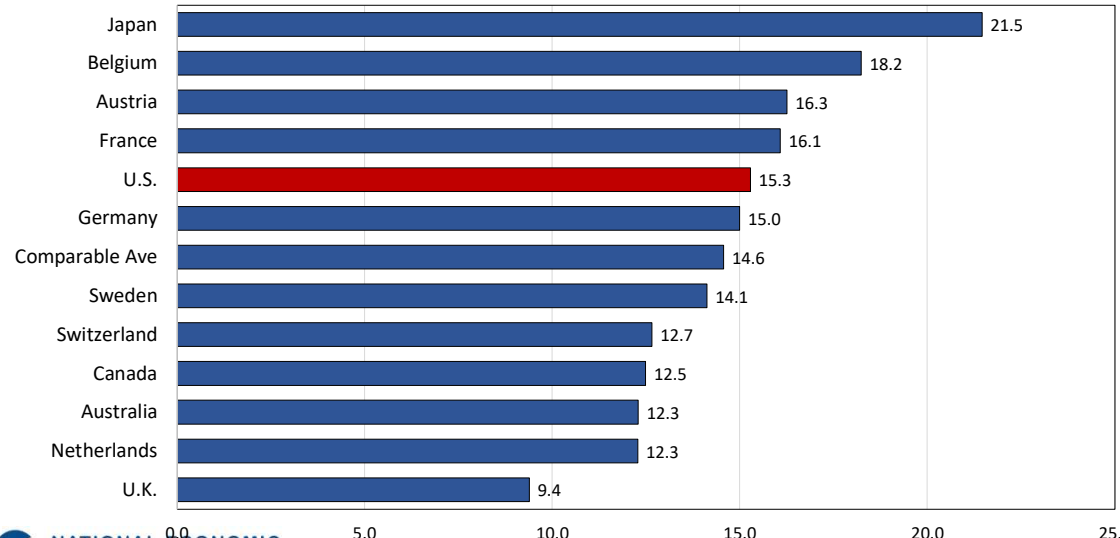
Suicides per 100,000 people (2023)



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Source: NEED graph using data from the World Population Review

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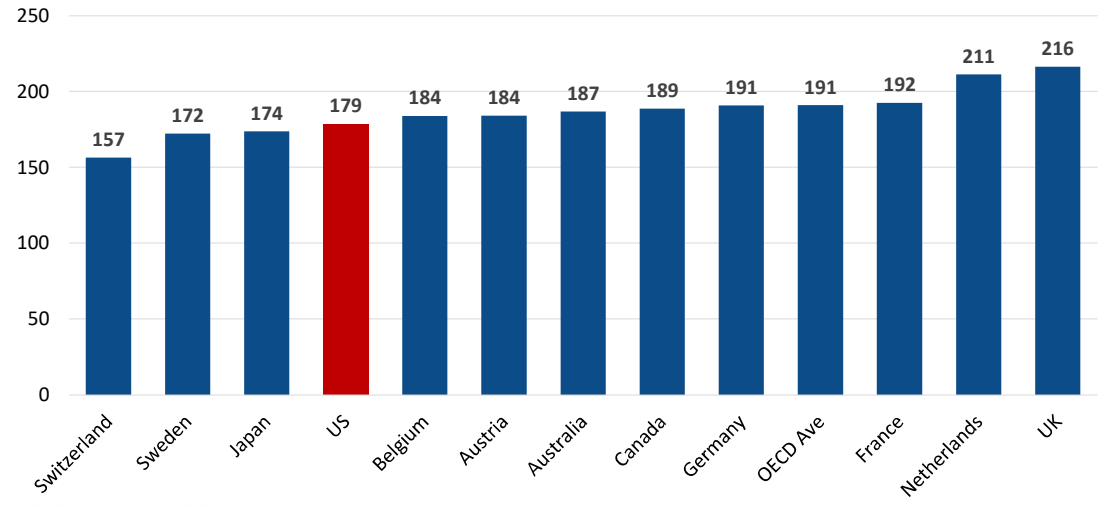
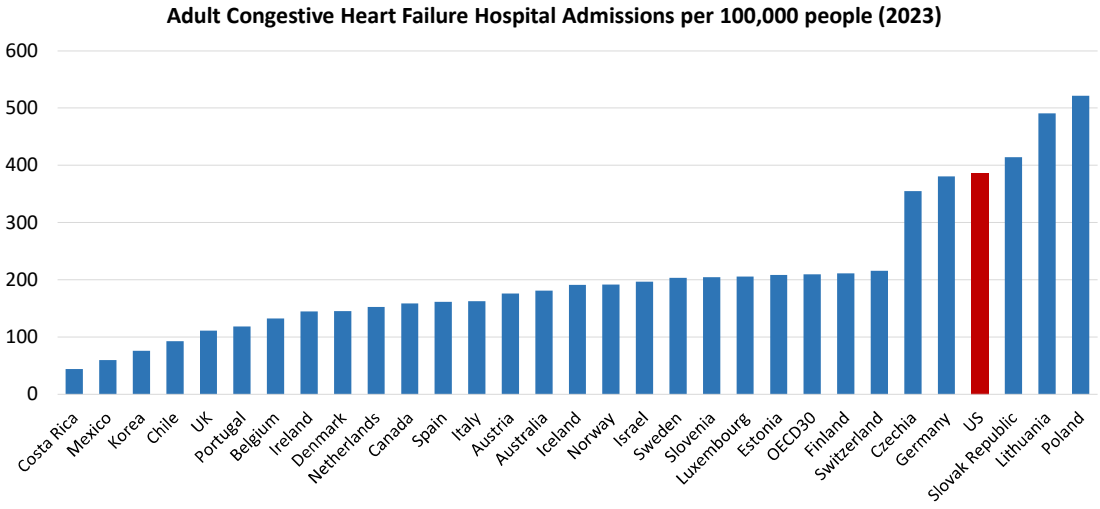
Cancer Mortality, Deaths per 100,000 (2023)



NATIONAL ECONOMIC EDUCATION DELEGATION

Source: *Health at a Glance, 2025* OECD; graph by NEED

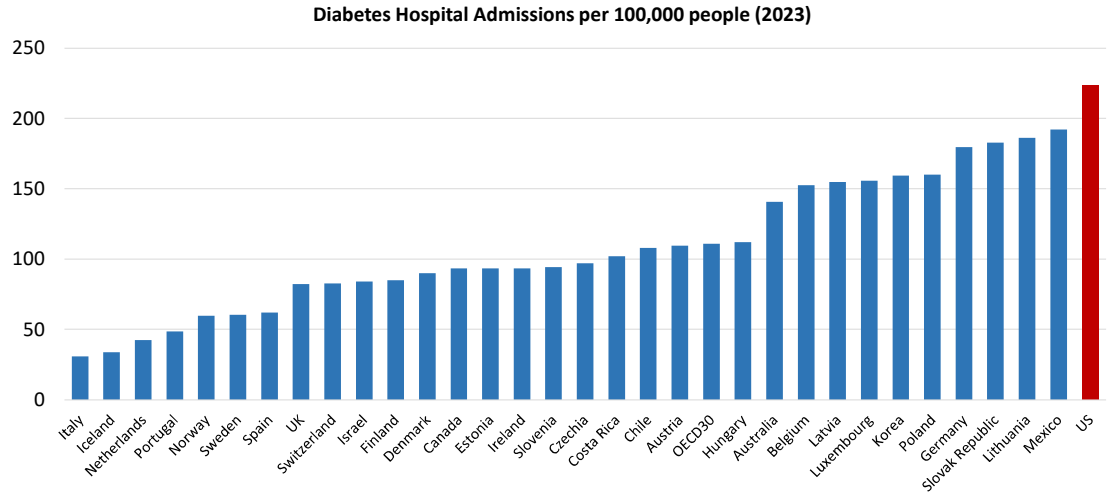
Hospital Admissions, Congestive Heart Failure



NATIONAL ECONOMIC EDUCATION DELEGATION

Source: *Health at a Glance, 2025* OECD; graph by NEED

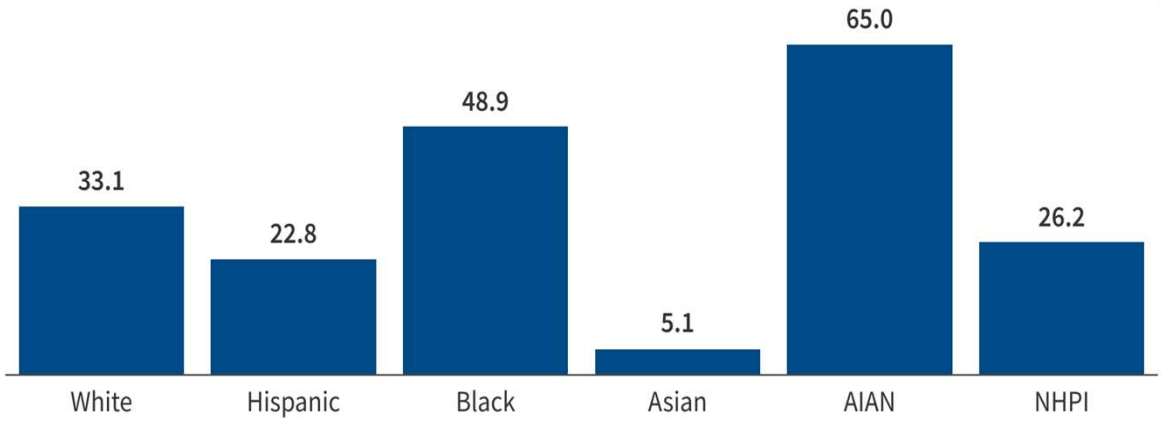
Hospital Admissions, Diabetes (2023)



NATIONAL ECONOMIC EDUCATION DELEGATION

Source: *Health at a Glance, 2025* OECD; graph by NEED

Drug Overdose Deaths per 100,000 (2023)



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Source: KFF analysis of CDC data

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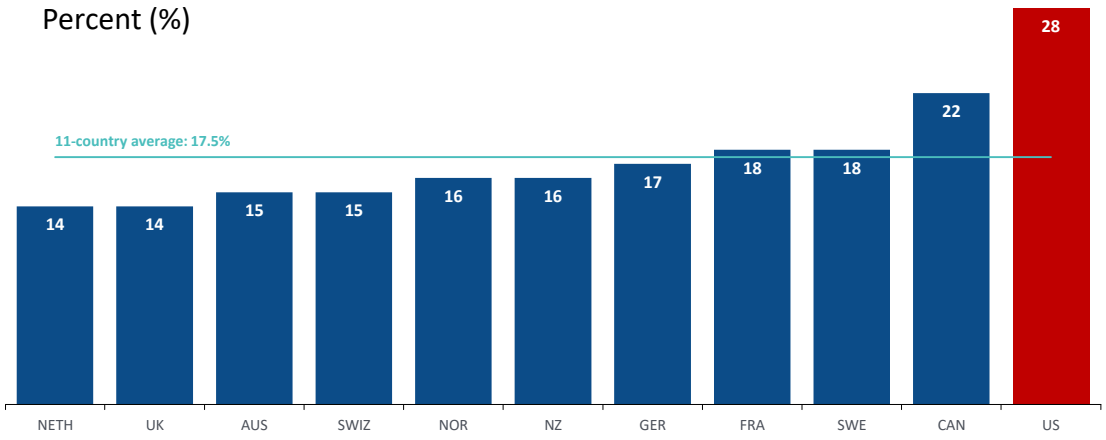
Adults with Multiple Chronic Conditions, 2016



NATIONAL ECONOMIC EDUCATION DELEGATION

Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

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Notes About U.S. Healthcare Quality

- The U.S. has the **highest chronic disease burden**
  - and an obesity rate that is two times higher than the OECD average.
- The U.S. has the **highest rate of avoidable deaths** and one of the highest rates of hospitalization for avoidable causes.
- Americans use more **expensive technologies** and **specialists**
  - MRIs, and specialized procedures, such as hip replacements, more often than our peers.
- The U.S. outperforms its peers in terms of many **preventive measures**
- **Avoidable deaths are higher in U.S., perhaps indicating less access to care**

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The Economics of Healthcare

An Economic View

The Healthcare system consists of many markets:

- Medical services
- Physicians
- Nurses
- Other care providers
- Hospital facilities
- Pharmaceuticals
- Health Insurance
- Medical supplies (e.g., diagnostic and therapeutic equipment)
- Nursing homes
- Rehab facilities
- Other?

Medical Services Unlike Other Products

- For most products, the price reflects the good's value to buyers and the cost to sellers for producing the good; prices adjust to balance supply and demand.
  - ➔Market prices guide economic decisions and help to allocate society's scarce resources.
- Third-party payment system separates buyers (and many sellers!) from the true cost of the products/services they are consuming
- Many healthcare products/services are heterogeneous across consumers
  - ➔Buyers are poorly informed and ask suppliers what they need

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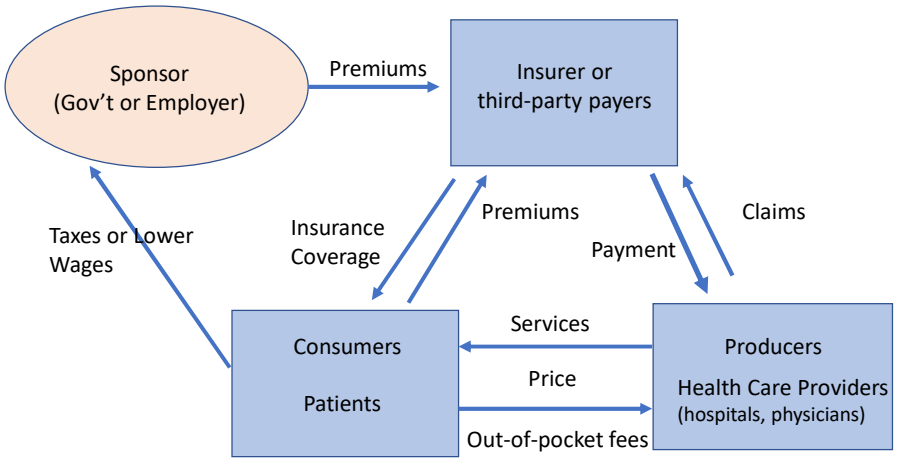
Health Care Markets are Different



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How much does an office visit cost to produce?

- Any ideas? Includes cost of facility and supplies, wages for doctors and nurses and other staff, their utilities and insurance, etc. (Do the doctors know???)
- We pay a small co-pay
- One result is that we consume more healthcare than we would if we had to pay its full cost (moral hazard)

Rising HC Expenditures: Demand factors

- Rising incomes
  - health care is a “normal” good
- Aging population
- Unhealthy lifestyles
- Over-indulgence in specialized care
  - 2 in 5 adults in the U.S. get general care from specialists

Rising HC Expenditures: Demand factors (cont.)

- Role of providers:
  - Supplier induced demand (?)
  - Defensive medicine (?)
- **Third-party payer system separates consumers from the cost of services**

  ➔Prices can't properly signal surpluses or shortages, etc.

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Rising HC Expenditures: Supply Factors

- Limited supply of physicians
- Changes in medical technology
  - improved quality of tests, procedures, drugs, etc.
- Slow productivity growth
- Complex payment systems
- High administrative costs & lack of price control
  - Health care payers and providers spend $496 billion per year on billing/insurance costs

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Two Comments

1. The United States has the only profit-motivated healthcare system in the world.
2. We have a health RESTORATION system, not a health **CARE** system.

Another Difference: "Right" or Moral Imperative

- **Health care as a product is often viewed as a "right" or moral imperative.**
  - This view argues for greater government interaction in the market, primarily to promote access.
    - ➔Subsidies for insurance and care.
    - ➔Market regulations to reduce inequities.
- **Unfettered free markets are unlikely to achieve social goals with respect to health care.**

Consequences of Rising Expenditures

- Reduced access to care
  - Waiting for treatment increases costs
- Slower wage growth
- Personal bankruptcies
- Impact on government budgets

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Tradeoffs

Tradeoffs take place among access, quality, and cost:

- Increasing quality in health care may lead to higher health care costs.
  - This could mean a compromise in access (affordability).
- I.e., with increasing quality, access may suffer.
- By increasing access, quality and cost may suffer.
- By decreasing costs, quality may suffer.

In healthcare in the United States, there are potential opportunities to improve all three simultaneously.

E.g., it is possible that increasing quality can reduce costs.

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Concentration in specific markets:

1) Pharmaceuticals

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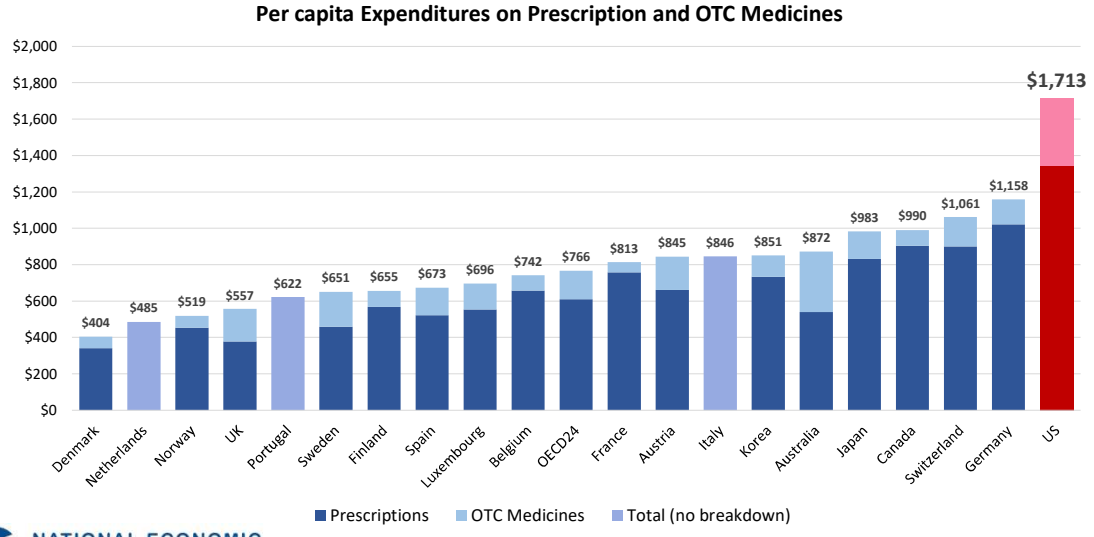
Spending on Pharmaceuticals (2023)



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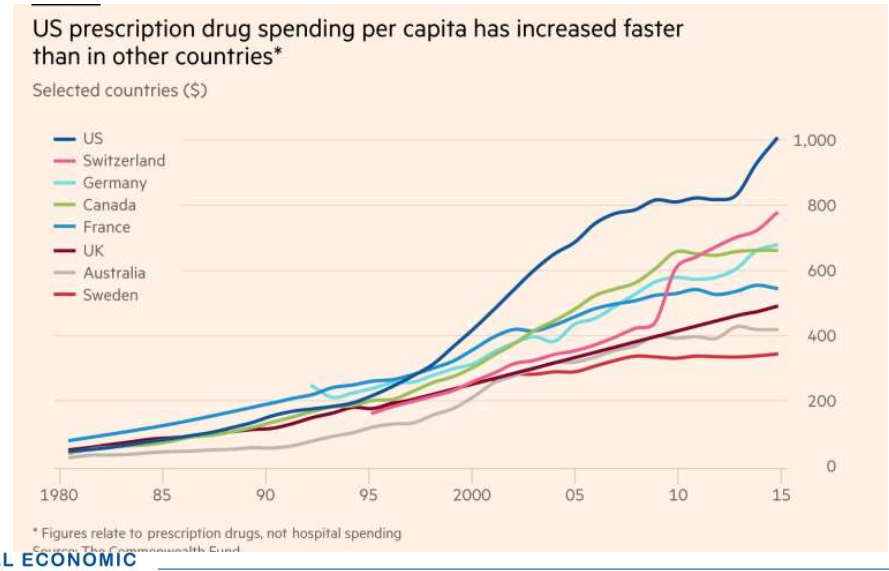
Source: *Health at a Glance, 2025* OECD; graph by NEED

Spending on Pharma: Trends Over Time



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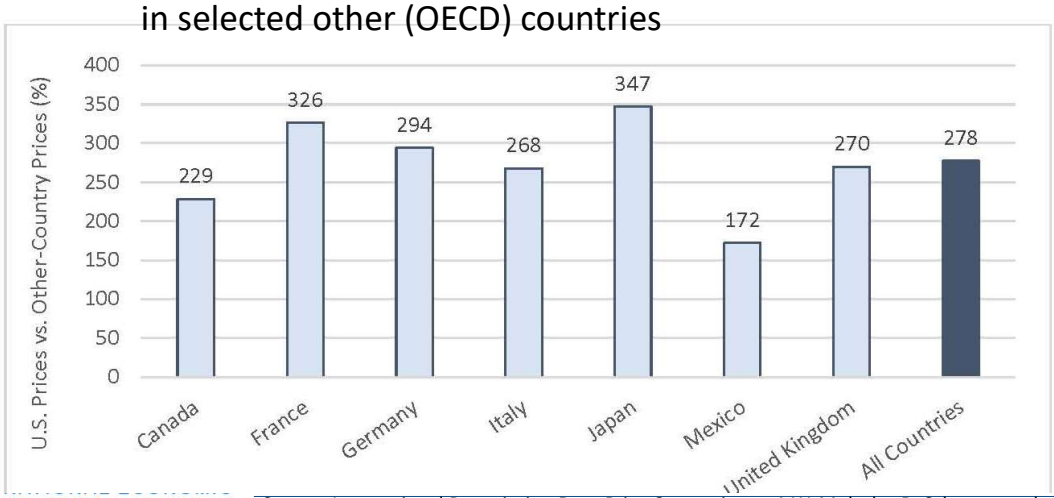
Comparing Prescription Drug Prices (2022)

U.S. Prescription Drug Prices as a Percentage of Prices in selected other (OECD) countries



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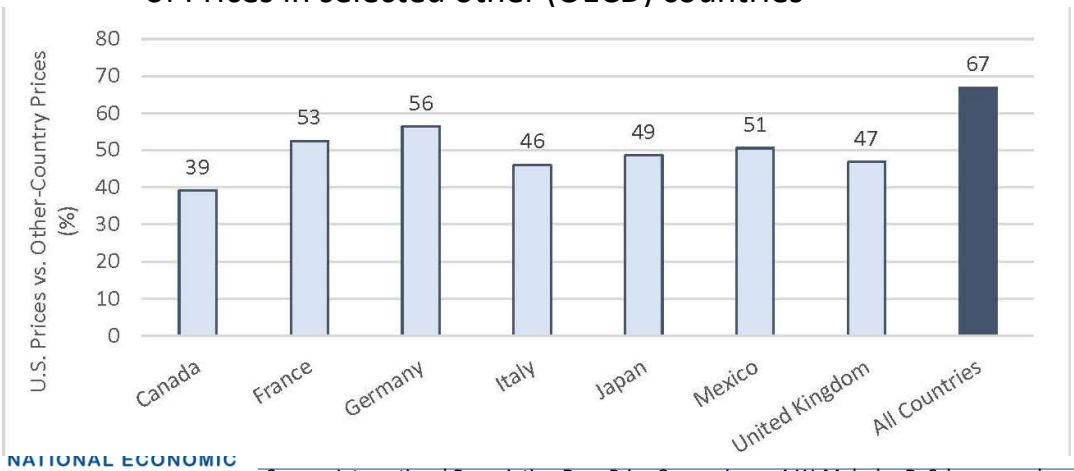
Source: International Prescription Drug Price Comparisons, A.W. Mulcahy, D. Schwam, and S.L. Lovejoy, RAND, 2024

Comparing Generic Drug Prices (2022)

U.S. Unbranded Generic Drug Prices as a Percentage of Prices in selected other (OECD) countries

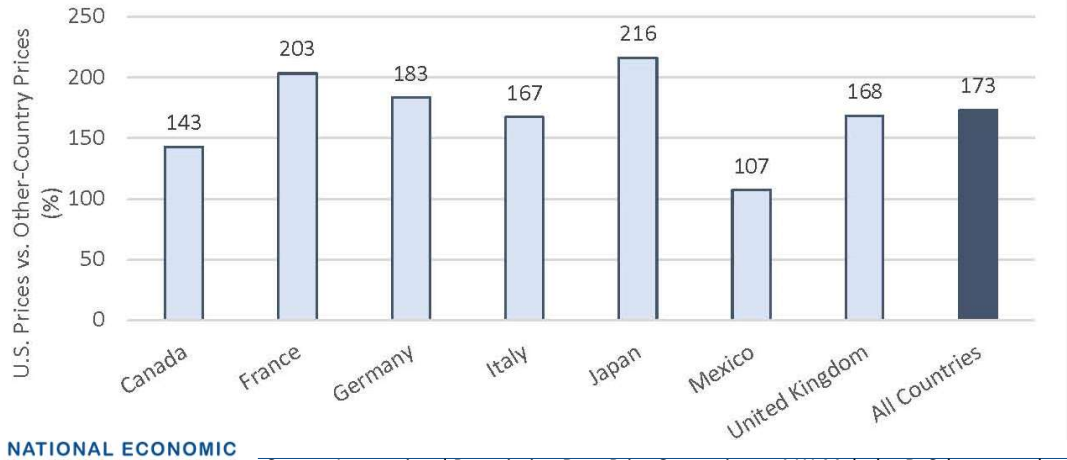


NATIONAL ECONOMIC EDUCATION DELEGATION

Source: International Prescription Drug Price Comparisons, A.W. Mulcahy, D. Schwam, and S.L. Lovejoy, RAND, 2024

Comparing Drug Prices (2022)

U.S. Prescription Drug Prices as a Percentage of Prices in selected other (OECD) countries when including U.S. price adjustments



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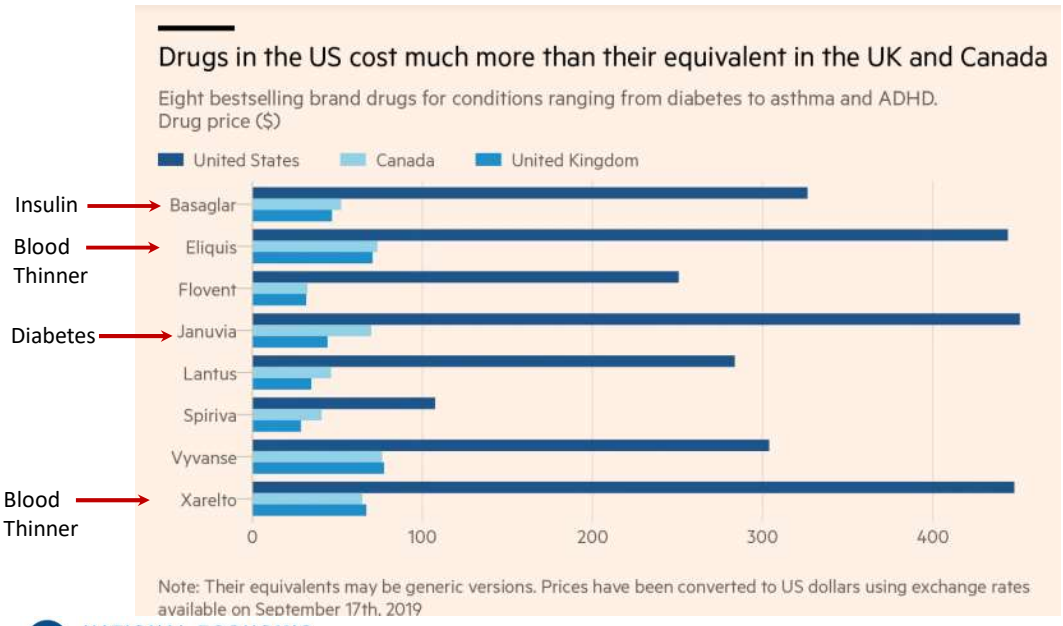
Source: International Prescription Drug Price Comparisons, A.W. Mulcahy, D. Schwam, and S.L. Lovejoy, RAND, 2024

- **In 2022, only 24% of global volume of prescription drugs was sold in the U.S., but U.S. sales accounted for 62% of sales dollars**

NATIONAL ECONOMIC EDUCATION DELEGATION

Source: International Prescription Drug Price Comparisons, A.W. Mulcahy, D. Schwam, and S.L. Lovejoy, RAND, 2024



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Reasons for higher drug prices

- **By law**, Medicare Part D was unable to negotiate drug prices like other insurance programs do. The Inflation Reduction Act of 2022 began to change this, starting 1/1/2026
- In 2023, Medicare spent nearly $36 billion on 10 diabetes drugs.
  - Researchers found that if Medicare were allowed to negotiate drug prices like the U.S. Department of Veterans Affairs (VA) can, Medicare could **save about $4.4 billion/year *just* on insulin**.
- Growing concentration of pharmaceutical companies.

Reducing Medicare Drug Spending

- Under the Inflation Reduction Act (2022), Medicare began negotiating drug prices with manufacturers
  - Beginning January 1, 2026, negotiated prices for 10 drugs were implemented. Estimated savings of:
    - $6 bill/year for Medicare; and,
    - $1.5 billion/year in out-of-pocket savings for participants.
  - Starting 1/1/27, another 15 drugs will see negotiated prices. Then another 15 in 2028 and 20 more drugs per year after that.
- The One Bill Beautiful Bill (2025) included provisions that limit which drugs can be considered for future price negotiations

Medicare Price Negotiations

Drug Name	Clinical use(s)	List price, 2024	Big Four price, 2024	Medicare negotiated price, 2026
Eliquis	*Blood thinner*	$594	$402	$249
Jardiance	*Diabetes, Heart failure*	$611	$434	$204
Xarelto	*Blood thinner*	$542	$392	$206
Farxiga	*Diabetes, Heart failure*	$582	$420	$182
Januvia	*Diabetes*	$547	$392	$117
Entresto	*Heart failure*	$668	$478	$314
Enbrel	*Psoriasis, Rheumatoid arthritis*	$7,402	$4,775	$2,335
Imbruvica	*Blood cancers*	$17,018	$10,669	$10,619
Stelara	*Crohn's disease, Psoriasis*	$26,517	$9,472	$4,490
NovoLog/Fiasp	*Diabetes*	$140	$138	$134

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Source: KFF analysis of VA National Acquisition Center, Centers for Medicare and Medicaid Services (CMS), and the Texas Prescription Drug Price Disclosure Program

Medicare Price Negotiations

Drug Name	Clinical use(s)	Medicare negotiated price, 2026	Average price among comparable countries, 2024	Medicare price per (%) above average pr comparable countr
Jardiance	*Diabetes, Heart failure*	$204	$52	289%
Farxiga	*Diabetes, Heart failure*	$182	$54	236%
Eliquis	*Blood thinner*	$249	$76	228%
Enbrel	*Psoriasis, Rheumatoid arthritis*	$2,335	$734	218%
Januvia	*Diabetes*	$117	$39	204%
NovoLog /Fiasp	*Diabetes*	$134	$50	169%
Xarelto	*Blood thinner*	$206	$82	153%
Entresto	*Heart failure*	$314	$139	125%
Imbruvica	*Blood cancers*	$10,619	$5,670	87%
Stelara	*Crohn's disease, Psoriasis*	$4,490	$2,822	59%

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Source: KFF analysis of VA National Acquisition Center, Centers for Medicare and Medicaid Services (CMS), and the Texas Prescription Drug Price Disclosure Program and KFF analysis of national drug formularies and pharmacy webpages

How Much is Negotiation Worth?

- The CBO estimated that drug pricing negotiation could reduce federal spending by $456 billion and increase revenues by $45 billion over 10 years. This would include:
  - direct savings for Medicare Part D **($448B** over 10 years**)**
  - lower spending for the Affordable Care Act's subsidies for commercial health plans
  - lower spending for the Federal Employees Health Benefits Program
  - more government tax revenue because employers using savings from reduced premiums to fund wage increases for their workers.

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Source: Congressional Budget Office, https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf

Concentration in Pharmaceutical Companies

- Between 1995 and 2015, 60 drug companies merged into 10.
- The number of mergers and acquisitions involving one of the top 25 firms more than doubled, from 29 in 2006 to 61 in 2015
- Research indicates that fewer competitors are associated with higher prices -- Especially in the market for generics.
- Mergers have a varied impact on innovation: R&D spending, patent approvals, and drug approvals.
  - Some studies have found a negative effect.

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Concentration in specific markets:

2) Hospital Consolidations

Hospital Consolidation

- Reductions in competition in health systems, hospitals, medical groups, and health insurers has surged in recent years.
- Between July 2016 and January 2018:
  - Hospitals acquired 8,000 more medical practices.
  - 14,000 more physicians left independent practice to become hospital employees.
- Between 1999 and 2018, hospital profit margins soared!
  - From 100% in 1999 to 317% in 2018.
- Evidence suggests that with more government oversight and restraining mergers, health care costs would have been lower.

Potential Benefits of Consolidation

- **Consolidation could lead to potential benefits**
  - Better coordination of care; Investment in care quality; reduction of costly, unnecessary duplication; Savings from scale, etc.
- **But, …**
  - **Consolidation isn't integration.**
  - **Evidence doesn't support the claims.**
    - Consolidation has not led to lower costs, better quality, or coordinated care.

Source: Martin Gaynor, NIHCM.org, Supersized: The Rise of Hospital Giants

Effects of Hospital Consolidations

- **Consolidation could lead to potential benefits**
  - Better coordination of care; Investment in care quality; reduction of costly, unnecessary duplication; Savings from scale, etc.
- **But Consolidation isn't integration, and**
- **Evidence doesn't support the claims; a review of studies of hospital consolidations reveals that:**
  - 13 of 14 price studies find that prices rose after consolidation
  - 13 of 16 cost studies find that costs rose after consolidation
  - 20 of 26 quality studies find that quality of care fell or remained the same after consolidation

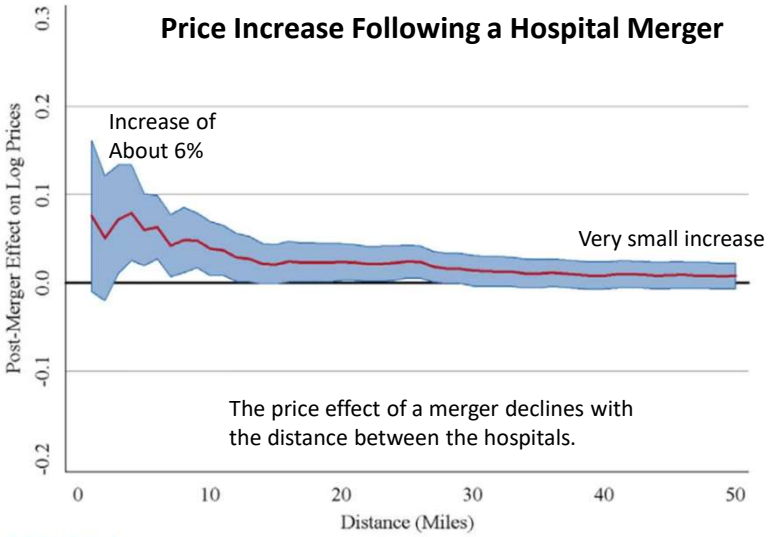
Source: A Systemic Review of Integration Strategies across the U.S. Healthcare System: Assessment of Price, Cost, and Quality of Care By Satiani, Bhagwan, David P. Way, David B. Hoyt, and Christopher E. Ellison, Journal of the American College of Surgeons, May 2025

Effects of Hospital Consolidations

- **Cost savings depend on whether the entity taken over is a small, independent organization (potential for sizeable savings) or an organization that is already part of a system (then no discernable cost savings)**

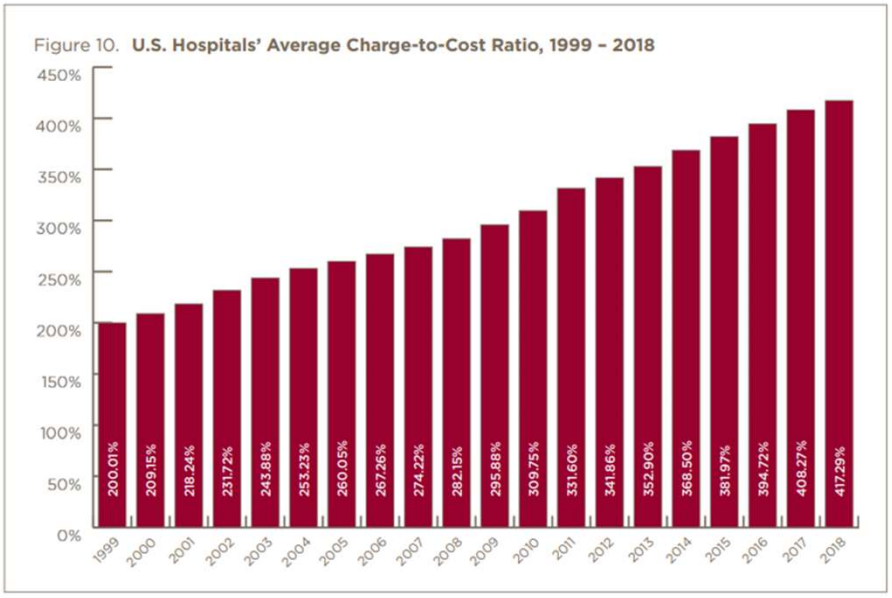
Source: The Corporatization of Independent Hospitals, by Andreyeve et al., Journal of Political Economy Microeconomics (2024)

Evidence on Consolidation

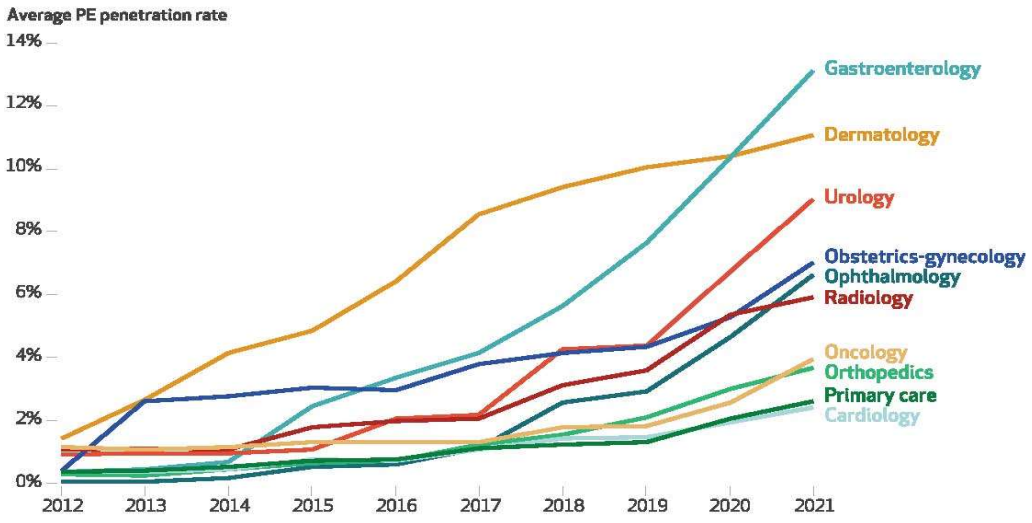


Hospital Monopolization Across the Nation

- Hospitals Charge Patients More Than Four Times the Cost of Care
- The most expensive hospitals cost of care range from 1,129% at the low end to 1,808% at the high end.
- Most of the top 100 most expensive hospitals are located in states in the south and west.
  - Florida had the highest number, with 40 hospitals.
  - Other top states included Texas with 14 hospitals, Alabama with eight, Nevada with seven, and California with six.



PE Penetration Rate by Physician Specialty



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Source: Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012-2021, by Abdelhadi, Ola, et al., *Health Affairs* (2024)

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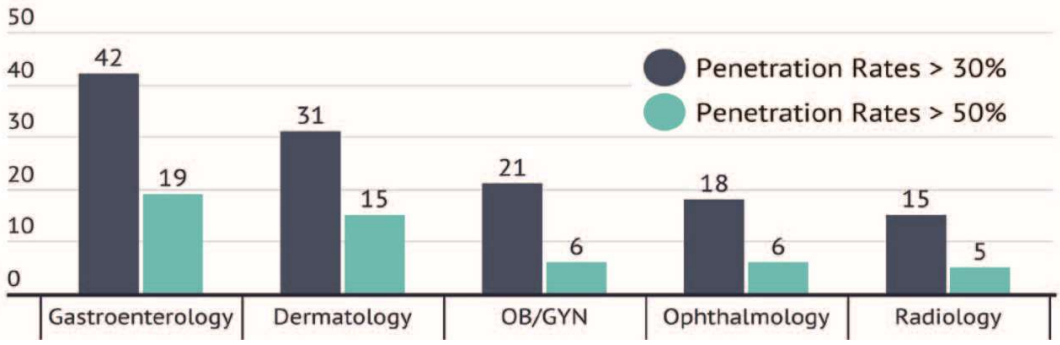
Private Equity Penetration in selected markets

Number of MSAs with Private Equity Market share >50% and >30% in 5 most-concentrated physician specialties (2021) (out of 120 MSAs)



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Source: Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012-2021, by Abdelhadi, Ola, et al., *Health Affairs* (2024)

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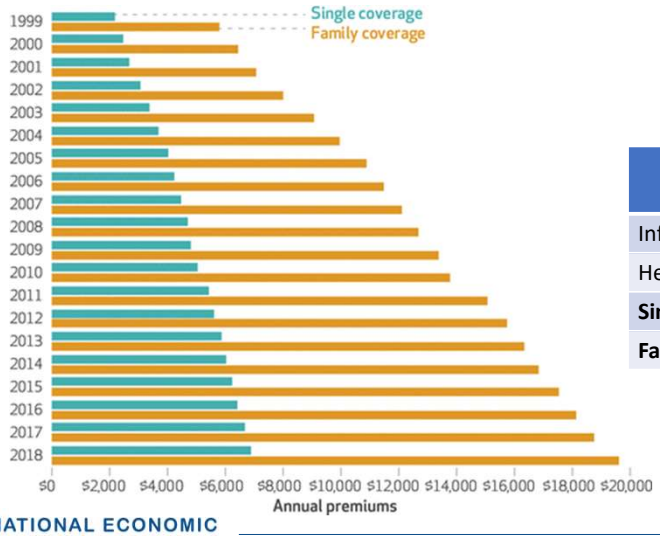
Concentration in specific markets:

3) Health Insurance

Average Annual Insurance Premiums, 1999-2018

Employer provided, Not Adjusted for Inflation

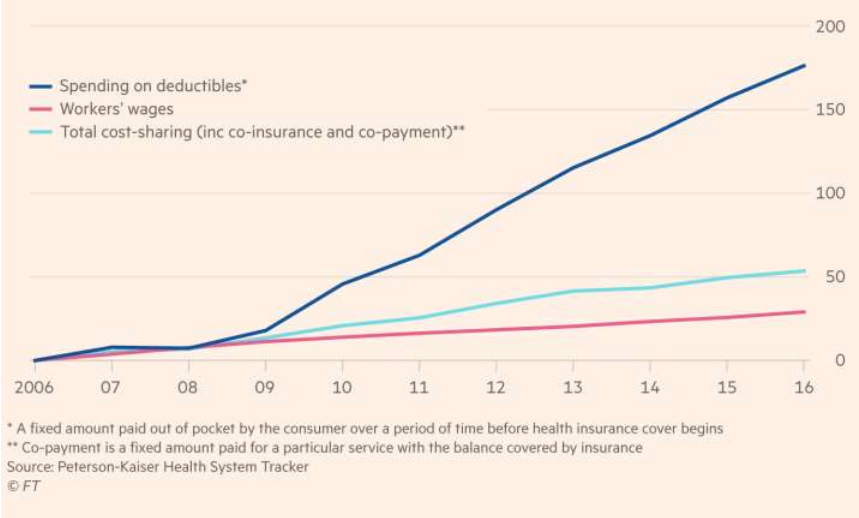


Single: ~$2,000 to ~$7,000
Family: ~$5,900 to ~$19,500

	Average Annual Rate of Change
Inflation	2.19
Health Care CPI	3.68
Single coverage	**6.51**
Family coverage	**6.52**

Source: The Commonwealth Fund

Spending on Deductibles



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Reason for Higher Health Insurance Rates

- Rising prices in the health sector
- Advances in medical technologies
- Increased demand for services
- Decreasing competition in health insurance markets

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Consolidation in Health Insurance Markets

- As of 2011, there were close to **100 insurers** in **Switzerland** competing for consumer health care dollars, **forcing firms to compete** by setting prices to just cover costs.
- In the United States, **markets are state specific;** consumers can choose only from plans available in the state in which they reside.
- In 2019, of the 50 states and the District of Columbia:
  - 21 had only 1 or 2 insurers (up from 11 in 2014)
  - 14 had 3 or 4, and
  - 16 states had 5 or more. (CA had 11)

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Source: KRR, Number of Issuers Participating in the Individual Health Insurance Marketplaces

What the Affordable Care Act did:

- Created Insurance "exchanges" where individuals could buy insurance
  - Premium could be subsidized by federal government (depends on person's income)
  - Subsidies expanded during the pandemic
- Significantly expanded Medicaid eligibility, now up to 138% of poverty level
  - Fed pays 90% of the cost for these people
  - Many Red (21) and Blue (20) states have accepted this expansion
  - Added about 20 million people to Medicaid
- Required insurance companies to cover children up to age 26
- Required people to have insurance and companies to offer insurance to employees (many exceptions allowed)
- Prevented insurance companies from excluding preexisting conditions

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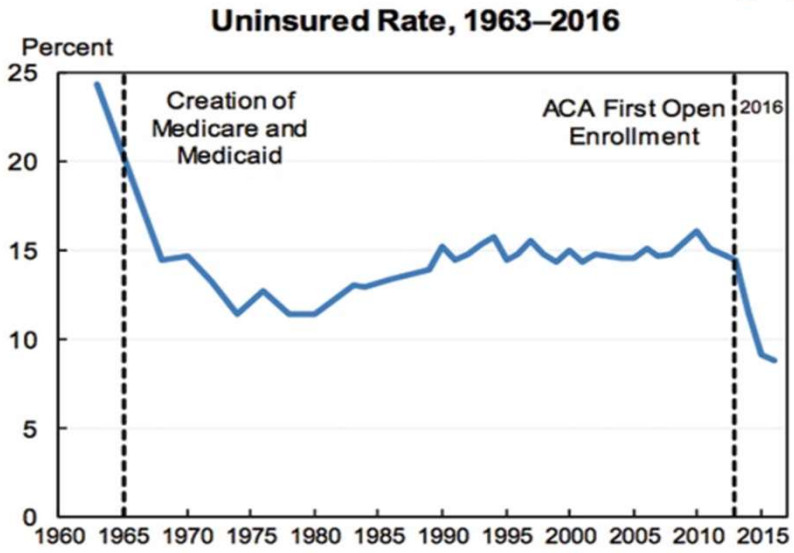
Uninsured rate dropped dramatically after first ACA open enrollment in 2016



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What the One Big Beautiful Bill did:

Imposed additional requirements for Medicaid-expansion people:

- Tougher work requirements (many participants already working)
- Additional eligibility verifications (2x per year); may be difficult for many recipients to follow
- Multiple groups estimate about 10 million people will lose Medicaid eligibility and hundreds of rural hospitals will have to close
- Savings of around $1 trillion expected over next 10 years

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Fact vs Fiction

- Illegal immigrants are not eligible for Medicare or Medicaid
  - Exception: States can offer emergency care to illegal immigrants; this comprises less than 0.5% of all Medicaid spending

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Alternative Health Care Structures

Definition: Universal Coverage

- **Universal coverage –** refers to a healthcare system in which ***all*** individuals have the same insurance coverage.
- Generally, this coverage includes:
  - Access to all needed services and benefits.
  - Protects individuals from excessive financial hardships.
    - Medical indebtedness is the #1 cause of bankruptcies in the United States.

Definition: Single-Payer

- **Single-payer** - refers to financing a healthcare system by making one entity solely and exclusively responsible for paying for medical goods and services. (Not necessarily the government.)
- Only the financing component is nationalized.
  - The money for the payment can be either collected by:
    - Taxes collected by the government
    - Premiums collected by National or Public Health Insurance
- **Single-payer systems: 17 countries**
  - Norway, Japan, United Kingdom, Kuwait, Sweden, Bahrain, Brunei, Canada, United Arab Emirates, Denmark, Finland, Slovenia, Italy, Portugal, Cyprus, Spain, and Iceland.

Definition: Socialized Medicine

- **Socialized medicine** – this model takes the single-payer system one step further.
  - Government not only pays for health care but also operates the hospitals and employs the medical staff.
- **This is NOT, and has NEVER been, part of the debate in the United States.**

Potential pros and cons of national insurance

- **Potential Pros**
  - Universal coverage
  - Government controls quality of care
  - No medical bills or co-pays (or debt!)
  - Consolidated medical records (lower administrative costs; fewer errors)
  - Higher wages/wage growth
- **Potential Cons**
  - Higher taxes
  - Long wait times for elective services
  - Government determines service eligibility
  - May reduce incentives for innovation

Consequences of Rising Health Expenditures

- Reduced access to care
  - Waiting for treatment increases costs
- Slower wage growth
- Personal bankruptcies
- Impact on government budgets

Summary/closing thoughts

- **Healthcare is a very complex issue**
- **The U.S. HealthCare system is not performing well.**
  - Very expensive with mixed results regarding quality and coverage.
- **Third-party payment system is inefficient**
  - Separates buyers and sellers from the price
  - For other goods, prices signal resource shortages or surpluses
  - High administrative costs
- **One reason for rising expenditures is reduced competition in healthcare markets.**

Closing Thoughts…

- **Is health care a right or a privilege?**
  - If the former, this argues for greater government involvement
- **Someone must decide how to ration healthcare services.** Currently, health insurance companies do this
- The United States has the only profit-motivated healthcare system in the world; **changing the focus from maximizing profits to maximizing health would help.**

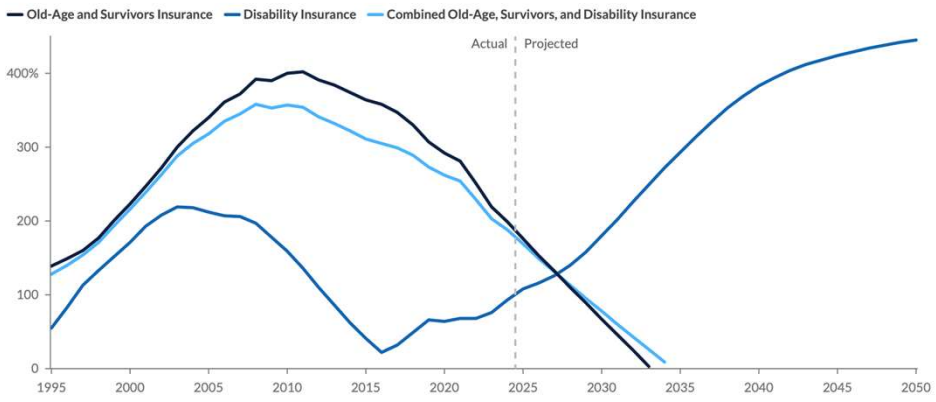
Resources for further exploration

- **The Kaiser Family Foundation (www.kff.org) is a great source for health care data**
- **For international comparisons: *Health at a Glance 2025*, OECD**
- **Centers for Medicare and Medicaid Services (cms.gov)**
- **For info on hospital and physician consolidations (including the rise of venture capital) see the National Institute for Health Care Management at NIHCM.org**

Trust Finds Are Running Out

Social Security's retirement fund will be depleted in eight years

Asset Reserves at the Beginning of Calendar Year (% of Annual Cost)



Source: Social Security Administration • Embed • Download image

Note: Under law, a trust fund cannot incur a negative balance. The OASI Trust Fund will be depleted in 2033 while the DI Trust Fund will not be depleted within the 75-year long-range projection period. Combined, the trust funds would be depleted in 2034.

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Source: https://www.pgpf.org/article/social-security-faces-serious-financial-shortfalls-and-other-takeaways-from-the-trustees-report/

Thank you!

Any Questions?

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