Healthcare Systems: Care, Cost, and Access

Figures current as of October 2026

How health care is paid for, delivered, and rationed, in the United States and around the world. The course covers what a health system does and the four ways countries build one; primary and specialist care; hospitals and emergency rooms; mental health and addiction care; long-term care; the doctors, nurses, and aides; insurance and the public programs; how providers are paid; prices, bills, and market power; how every system rations care; quality, safety, and outcomes; who goes without; the systems of other rich countries and of China, India, and the developing world; and the choices for reform. One patient's heart attack runs through it, from the ambulance to the last bill. A dated watch list closes the course.

MODULE 1 — The System in One Picture

Goal: Learn what a health system does, the four ways countries build one, and where America's money goes, and weigh whether America overspends.

What every system must do: raise money, pool risk, buy care, and provide it; Britain's tax-funded service, Germany's social insurance, Canada's single payer, and paying out of pocket, and the American mix of all four; where the money goes, by service and by payer; America against other rich countries; and why prices and administration explain most of the gap.

MODULE 2 — Primary and Specialist Care

Goal: Understand the doctor's office, from the front door to the specialist, and weigh whether new kinds of clinicians and clinics can stand in for the family doctor.

What primary care does and what the evidence says it buys; America's thin spending on it; nurse practitioners; the corporate clinics that opened and closed; telehealth; specialists, procedures, and surgery centers; and the regional variation that points to waste.

MODULE 3 — Hospitals and Emergency Care

Goal: Learn how American hospitals are owned, paid, and run, and weigh whether nonprofit hospitals earn their tax exemption.

America's hospitals and the systems that own them; their costs and margins; the emergency room and the 1986 law that makes it the safety net; rural closures and the rural fund; and the night a heart attack begins the course's running case.

MODULE 4 — Mental Health and Addiction Care

Goal: Follow how mental-health and addiction care is organized and paid for, and weigh whether its shortage is one of people or of payment.

How many need care and how many get it; shortage areas and directories of clinicians who never answer; the parity law; crisis lines, crisis clinics, beds, and jails; and the treatment of addiction as overdose deaths fall.

MODULE 5 — Long-Term Care

Goal: Understand who provides and pays for care in old age and disability, and weigh social insurance against Medicaid as the backstop.

Family caregivers and aides; nursing homes, assisted living, and care at home; what each costs and who pays; Medicaid's spend-down and waiting lists; the federal staffing rule; private insurance's decline; and the public programs of Washington State, Germany, and Japan.

MODULE 6 — The Workforce

Goal: Learn who delivers care and how they are trained and paid, and weigh whether America is short of doctors.

Doctors, nurses, nurse practitioners, and aides; the residency bottleneck and the doctors trained abroad; pay at home and abroad; burnout, unions, and strikes; and the software that writes doctors' notes.

MODULE 7 — Who Pays: Insurance and Public Programs

Goal: Understand how Americans are insured and who pays for it, and weigh whether Medicare Advantage is a better Medicare or an overpaid one.

Why health insurance is hard to sell; the coverage map and the uninsured; employer plans and their tax break; Medicare and its private plans; Medicaid and the 2025 budget law; the marketplaces after their extra subsidies expired; and how deductibles and coinsurance work.

MODULE 8 — How Providers Are Paid

Goal: Learn how the way providers are paid shapes the care they give, and weigh whether paying for value has worked.

Fee-for-service, payment by the day, the case, the episode, and the person, global budgets, and salaries; Medicare's fee schedule and the committee that values each service; hospital payment by diagnosis; accountable care and bundled payments; and Maryland's all-payer system.

MODULE 9 — Prices, Bills, and Market Power

Goal: Understand why American prices are high and how a bill is built, and weigh whether to cap prices or restore competition.

What private insurers pay against Medicare; consolidation, the employment of doctors, and private equity; price transparency; the anatomy of a bill; surprise bills and the 2022 law against them; denied claims and medical debt; and drug prices in brief.

MODULE 10 — Rationing: Queues, Prices, and Rules

Goal: See how every system limits care, and weigh whether waiting lists are the price of universal coverage.

Rationing by price, by queue, by rule, by paperwork, and by capacity; what cost-sharing does to care; waiting times across countries; cost-effectiveness thresholds and the American ban on them in Medicare; and prior authorization.

MODULE 11 — Quality, Safety, and Outcomes

Goal: Measure what the system produces, and weigh whether American medicine buys better care or only more of it.

Life expectancy and avoidable deaths against other countries; where American care excels; patient harm and diagnostic error; paying for quality; and public health, from the 2025-26 cuts to the return of measles.

MODULE 12 — Access and Inequality

Goal: Find who goes without care and why, and weigh whether health insurance saves lives.

The uninsured and the underinsured; the states that did not expand Medicaid; gaps by race, income, and place; rural maternity care; immigrants under the 2025 law; and the evidence from Oregon, Medicaid expansion, and a tax-office experiment.

MODULE 13 — The Rich World's Systems

Goal: Compare how other rich countries pay for and deliver care, and weigh single payer against regulated multipayer systems.

England's NHS and its reorganization; Canada's provincial single payer; Germany's sickness funds; France; the managed competition of the Netherlands and Switzerland; Japan's fee schedule; and briefly South Korea, Taiwan, Australia, and Singapore.

MODULE 14 — Systems in Transition: China, India, and the Rest

Goal: Follow how middle- and low-income countries are building coverage, and weigh whether to start with hospital insurance or primary care.

The world's coverage gap and the hardship health costs cause; China's national insurance; India's national hospital insurance; Thailand, Rwanda, and Mexico; and global health aid after 2025.

MODULE 15 — Reform: The Choices

Goal: Lay out the paths for American reform, and weigh single payer, a public option, and the market.

What any reform must decide; single payer and its cost estimates; public options in three states; all-payer rate setting; market reforms and the White House plan of January 2026; price caps; and the politics ahead of the November 3 midterms.

MODULE 16 — Where Things Stand, and What to Watch

Goal: Close with the argument, the contradictions, and a dated watch list.

The course's argument on a page; the contradictions no single module states; what to watch from October 2026 on; and a last word.

A note on the sources: American spending comes from the National Health Expenditure Accounts of the Centers for Medicare & Medicaid Services (CMS), the federal agency that runs Medicare and Medicaid. Coverage comes from the Census Bureau and the National Center for Health Statistics (NCHS), and employers' premiums from KFF, a health-policy research organization. Much of the analysis of Medicare comes from the Medicare Payment Advisory Commission (MedPAC), which advises Congress, and from the Congressional Budget Office (CBO). International comparisons come mainly from the Organisation for Economic Co-operation and Development (OECD), a group of 38 mostly rich countries; from the Commonwealth Fund, an American foundation that surveys patients and doctors in ten of them; and from

the World Health Organization (WHO). Prices paid by private insurers come from RAND, a research organization, and the Health Care Cost Institute, which studies insurers' claims. Waiting times abroad come from the governments' own statistics, among them those of England's National Health Service (NHS).

Health statistics arrive late. National spending for 2024 was published in January 2026, the Census count of the uninsured for 2025 in September 2026, and many international comparisons describe 2023 or 2024. Each figure therefore names its source and the period it measures, and projections are labeled as projections. Where a figure comes from an advocate, a company, or an industry group, the course says whose it is. Amounts in other currencies are converted at the Federal Reserve's exchange rates for October 16, 2026.

One patient runs through the course: a 58-year-old woman with insurance through her job, who has a heart attack at 2 a.m. She is illustrative, but her prices and rules come from published sources. Module 3 takes her through the night, Module 8 shows how the main parties who treated her are paid, Module 9 follows her bills, Module 13 puts the same night in four other countries, and Module 14 in India.

The field argues over fifteen questions: spending, primary care, hospitals' tax breaks, the shortage of mental-health care, how to pay for long-term care, the supply of doctors, Medicare's private plans, paying for value, prices, waiting lists, quality, whether insurance saves lives, which foreign model works best, where poorer countries should start, and the choice of reform. On each, the course makes the cases as their advocates make them, gives the evidence, and then states its own reading once. The course explains how health systems work. It is education, not medical, legal, or financial advice, and it cannot know any reader's insurance, health, or finances.

Key Numbers, as of October 2026

The measurements the course relies on; the Terms after the Who's Who define the vocabulary

Measure	Figure	Period	Source and release
American health spending	$5.3 trillion, 18.0% of GDP and $15,474 a person, up 7.2% on the year	2024	CMS, National Health Expenditure Accounts, January 14, 2026
Spending, projected	About $5.7 trillion in 2025; $9.0 trillion, 20.6% of GDP, in 2034	2025-34, projections	CMS, June 24, 2026
Against other rich countries	17.2% of GDP and $14,885 a person in the US; an average of 9.3% and $5,967 across OECD countries, in dollars adjusted for purchasing power	2024	OECD, *Health at a Glance 2025*, November 13, 2025
What the money buys	Hospital care 31%, physician and clinical services 21%, retail prescription drugs 9%, nursing homes 4%	2024	CMS
Who pays it	Private insurance 31%, Medicare 21%, Medicaid 18%, patients out of pocket 11%	2024	CMS
Uninsured	26.7 million people, 7.9% of the population, for the whole year	2025	Census Bureau, September 15, 2026
Uninsured, projected	30.0 million in 2026, 35.3 million in 2028, 37.3 million in 2034	Projections	CBO, February 2026 baseline
Employer coverage	A family premium of $28,303, of which the worker pays $7,471; a single premium of $9,804; an average single deductible of $1,955	2026	KFF, Employer Health Benefits Survey, October 22, 2026
Medicare's private plans	35.2 million people in Medicare Advantage, 55% of those eligible	2026	KFF, June 5, 2026
Medicaid and the children's program	73.2 million people (66.0 million in Medicaid, 7.2 million in the Children's Health Insurance Program), 4.6 million fewer than a year earlier	June 2026	CMS, September 25, 2026
The marketplaces	23.1 million sign-ups; 19.2 million paying their premiums in February, 12% fewer than a year earlier	2026	CMS, March 27, 2026; KFF, July 28, 2026
Paid out of pocket	$556.6 billion, about $1,630 a person	2024	CMS
Medical debt	At least $220 billion owed; about 14 million adults owe more than $1,000	2021	KFF, analysis of Census data, February 2024
Primary care's share	4.5% of spending, counting physicians only; 12% counting nurse practitioners, physician assistants, behavioral health, and obstetrics	2023	Milbank Memorial Fund, February 12, 2026
Hospitals	6,100 hospitals, 907,216 staffed beds, 35.7 million admissions; 58% of community hospitals nonprofit	Fiscal 2024	American Hospital Association, February 5, 2026
Doctors' employers	82.0% of physicians employed by hospitals and health systems (59.7%) or other companies (22.3%)	January 1, 2026	Physicians Advocacy Institute and Avalere
Private prices	Private plans paid 254% of what Medicare paid for the same hospital services	2022	RAND, December 10, 2024
Prior authorization	52.8 million requests in Medicare Advantage; 7.7% denied; 80.7% of appealed denials overturned	2024	KFF, January 28, 2026

Measure	Figure	Period	Source and release
Life expectancy	79.0 years in the US, a record; 82.7 years on average in comparable rich countries	2024	NCHS, January 29, 2026; Peterson-KFF Health System Tracker, March 31, 2026
Avoidable deaths	217 preventable and 95 treatable deaths per 100,000 people in the US, against OECD averages of 145 and 77	Latest year in the 2025 edition	OECD, *Health at a Glance 2025*
Mothers' deaths	17.9 deaths per 100,000 live births: 44.8 for Black women and 14.2 for white women	2024	NCHS, March 4, 2026
Mental illness	54.6 million adults (20.6%) with a mental illness, of whom 50.9% received treatment	2025	Substance Abuse and Mental Health Services Administration, July 27, 2026
Long-term care's price	A private nursing-home room $129,575 a year; home care $35 an hour	2025	CareScout, Cost of Care Survey, March 2, 2026
Waiting abroad	England: 7.37 million cases on the waiting list, about 65% waiting under 18 weeks; Canada: a median 28.6 weeks from a family doctor's referral to treatment	August 2026; 2025	NHS England data, via the British Medical Association, October 8, 2026; Fraser Institute, December 9, 2025
The world's coverage gap	4.6 billion people without full coverage of essential health services; 2.1 billion facing financial hardship from health costs	2023 and 2022 data	WHO and World Bank, December 6, 2025

CMS's national accounts and the OECD measure spending differently, so the American share of GDP is 18.0% on the first and 17.2% on the second. The course uses CMS for American totals and the OECD for comparisons between countries.

Who's Who

The people who lead the institutions the course describes, as of October 25, 2026

The federal government

Name	Who they are	Why they matter
Donald Trump	President since January 20, 2025, his second term; age 80	Sets the administration's health agenda, from its budget for public health to its plan for subsidies (Modules 11 and 15)
Robert F. Kennedy Jr.	Secretary of Health and Human Services (HHS) since February 13, 2025; age 72	Runs the department that oversees Medicare and Medicaid, public health, and the approval of drugs (Modules 7 and 11)
Mehmet Oz	Administrator of the Centers for Medicare & Medicaid Services (CMS) since April 2025; age 66	Runs Medicare, Medicaid, and the marketplaces, and the rules on payment and prior authorization (Modules 7, 8, and 10)
Chris Klomp	Deputy administrator of CMS and director of Medicare since April 2025; nominated in June 2026 as HHS deputy secretary	Oversees Medicare's payment rules and private plans; his nomination awaits a vote of the full Senate
Abe Sutton	Director of the CMS Innovation Center since January 2025	Runs Medicare's payment experiments, among them the model that brought prior authorization into traditional Medicare (Modules 8 and 10)
Dan Brillman	Director of the CMS center for Medicaid and the Children's Health Insurance Program (CHIP)	Oversees the states' Medicaid programs as the 2025 law's work requirements begin (Module 7)
Erica Schwartz	Director of the Centers for Disease Control and Prevention (CDC), confirmed on August 5, 2026; age 54 at confirmation	Leads the public-health agency through proposed budget cuts and the return of measles (Module 11)
Jay Bhattacharya	Director of the National Institutes of Health since April 1, 2025, and acting head of the CDC from February to August 2026	Leads federal medical research and ran the CDC between its directors
Kyle Diamantas	Acting commissioner of the Food and Drug Administration (FDA) since May 15, 2026, after Marty Makary resigned; age 38	Leads the agency that approves drugs and devices; the nominee for the post, Heidi Overton, awaits a Senate vote

Congress, its advisers, and the reform debate

Name	Who they are	Why they matter
Michael Chernew	Chair of the Medicare Payment Advisory Commission (MedPAC)	Leads Congress's advisers on Medicare payment, whose estimates of what Medicare Advantage costs the course uses (Module 7)
Phillip Swagel	Director of the Congressional Budget Office (CBO) since June 3, 2019	His office estimates the cost and coverage effects of health laws, including the 2025 budget law (Module 7)
Bernie Sanders	Independent senator from Vermont; age 85	Sponsors the single-payer bill in the Senate (Module 15)

Insurers, hospitals, and their associations

Name	Who they are	Why they matter
Stephen Hemsley	Chief executive of UnitedHealth Group since May 2025, after leading it from 2006 to 2017	Runs the largest health insurer and its physician groups (Modules 7 and 9)
Gail Boudreaux	Chief executive of Elevance Health since November 2017	Runs the largest operator of Blue Cross Blue Shield plans (Module 10)
David Joyner	Chief executive of CVS Health, the owner of Aetna, since October 2024	Runs a company that combines an insurer, a pharmacy-benefit manager, and pharmacies (Module 9)
Brian Evanko	Chief executive of Cigna since July 1, 2026, succeeding David Cordani	Runs an insurer and the pharmacy-benefit manager Express Scripts (Module 9)
Jim Rechtin	Chief executive of Humana since July 2024	Runs the second-largest Medicare Advantage insurer (Module 7)
Sarah London	Chief executive of Centene since March 2022	Runs the largest insurer in the marketplaces and a leading Medicaid insurer, the programs the 2025 law cuts (Module 7)
Greg Adams	Chair and chief executive of Kaiser Permanente	Leads the largest integrated system, which insures its members and employs its doctors (Module 8)
Sam Hazen	Chief executive of HCA Healthcare since January 2019	Runs the largest for-profit hospital chain (Module 3)
Wright Lassiter III	Chief executive of CommonSpirit Health since August 2022	Runs one of the largest nonprofit systems, the kind whose tax exemption Module 3 weighs
Eduardo Conrado	Chief executive of Ascension since January 1, 2026, succeeding Joseph Impicciche	Runs one of the largest Catholic hospital systems (Module 3)
Mike Tuffin	President and chief executive of AHIP, the insurers' trade group, since January 8, 2024	Speaks for the insurers in Washington, including on prior authorization (Module 10)
Rick Pollack and Steve Walsh	Pollack, long-serving president of the American Hospital Association (AHA), retires by the end of 2026; Walsh, head of the Massachusetts hospital association, was named his successor on June 30, 2026	Lead the hospitals' main lobby, whose figures on underpayment and community benefit the course weighs (Module 3)
Willie Underwood III	President of the American Medical Association (AMA) since June 9, 2026; a urologist in Buffalo	Leads the largest doctors' group, whose committee proposes most of Medicare's fee values (Module 8)

Abroad

Name	Who they are	Why they matter
Yvette Cooper	Britain's Health and Social Care Secretary since July 20, 2026, when Andy Burnham became prime minister; age 57	Oversees the NHS through the abolition of NHS England (Module 13)
Sir Jim Mackey	Chief executive of NHS England since April 1, 2025	Runs the body that the Health Bill now before Parliament would abolish (Module 13)
Carsten Linnemann	Germany's health minister since July 29, 2026; age 49	Oversees Germany's sickness funds as they cut costs (Module 13)
Marjorie Michel	Canada's health minister since May 13, 2025	Leads the slow rollout of national pharmacare (Module 13)
Stéphanie Rist	France's health minister since October 12, 2025	Oversees France's national health insurance (Module 13)

Name	Who they are	Why they matter
Sophie Hermans	Health minister of the Netherlands since February 23, 2026; age 45	Oversees the Netherlands' regulated private insurance (Module 13)
Elisabeth Baume-Schneider	Swiss federal councillor in charge of the Department of Home Affairs, which covers health; age 62	Oversees Switzerland's regulated private insurance and its premiums (Module 13)
Kenichiro Ueno	Japan's Minister of Health, Labour and Welfare since October 21, 2025; age 61	Oversees Japan's national fee schedule (Module 13)
Jeong Eun-kyeong	South Korea's Minister of Health and Welfare since July 21, 2025; age 61	Oversees the smaller expansion of medical schools that followed the doctors' walkout (Module 13)
J. P. Nadda	India's Minister of Health and Family Welfare since June 9, 2024, as he was from 2014 to 2019; age 65	Oversees the national hospital insurance scheme (Module 14)
Zhang Ke	Head of China's National Healthcare Security Administration since February 1, 2024	Runs China's national insurance and its drug tenders (Module 14)
Tedros Adhanom Ghebreyesus	Director-general of the WHO since 2017; his second term ends on August 15, 2027; age 61	Leads the WHO after America's departure; members choose his successor in May 2027 (Module 14)
Ong Ye Kung	Singapore's Minister for Health since May 15, 2021; age 56	Runs the system built on personal medical savings accounts (Module 13)

Terms

The vocabulary of health systems

Term	Meaning
Premium	What is paid each month or year for insurance, whether or not care is used. In employer plans the employer pays most of it (Module 7)
Deductible	What a patient pays each year before the insurer begins to pay for most services
Copayment and coinsurance	A copayment is a fixed charge for a service, such as $30 for a visit; coinsurance is a share of the price, such as 20%, paid after the deductible
Out-of-pocket maximum	The most a patient pays in a year for covered care inside the plan's network, after which the plan pays in full
Network	The doctors and hospitals that have contracts with an insurer. Care outside the network costs the patient more, and an out-of-network provider may bill the patient for the difference between its charge and what the insurer pays, which is called balance billing
Gross charge, allowed amount	A hospital's gross charge is its list price, kept in a file called the chargemaster; the allowed amount is what an insurer has agreed to pay, which is usually far lower
Explanation of benefits	The statement an insurer sends after a claim, showing the charge, the allowed amount, what the plan paid, and what the patient owes
Prior authorization	An insurer's approval, required before some services or drugs, without which the plan will not pay
Adverse selection	The tendency of people who expect to need care to buy insurance, and of healthy people to skip it, which drives premiums up
Moral hazard	The tendency of insured people to use more care because they pay less for it at the time
Risk adjustment	Paying insurers or providers more for sicker patients and less for healthier ones, so that no one gains by picking healthy customers
Medical loss ratio	The share of premiums an insurer spends on care rather than on administration and profit; the Affordable Care Act (ACA) of 2010 sets minimums (Module 7)
Self-funded plan	An employer plan in which the employer pays the claims itself and hires an insurer only to run the plan (Module 7)
Health savings account (HSA)	A tax-free account for medical costs, open to people in a high-deductible health plan
Medicare	The federal program for people 65 and over and some younger disabled people. Part A covers hospital care, Part B doctors and outpatient care, and Part D drugs; Part C, Medicare Advantage, lets private plans provide all of it
Medicaid and CHIP	Medicaid is the joint federal-state program for people with low incomes; the Children's Health Insurance Program (CHIP) covers children in families just above Medicaid's limits
The marketplaces	The ACA's government-run websites, such as HealthCare.gov, where people without job-based coverage buy regulated plans, with premium tax credits that scale with income
Fee-for-service	Paying a provider for each visit, test, and procedure
Capitation	Paying a provider or plan a fixed amount per person per month, whatever care that person uses
Diagnosis-related group (DRG)	A category of hospital stays with similar diagnoses and treatments, each paid a set rate by Medicare whatever the length of the stay
Relative value unit (RVU)	Medicare's measure of the work, practice expense, and malpractice cost of a physician's service; a conversion factor turns RVUs into dollars
Bundled payment	One payment for all the care in an episode, such as a hip replacement and the 90 days that follow
Accountable care organization (ACO)	A group of doctors and hospitals that shares in the savings, and sometimes the losses, if the total cost of its patients' care comes in under a target

Term	Meaning
Global budget	A fixed annual budget for a hospital or a region, set in advance, in place of payment per service
All-payer rate setting	A system in which a state sets the prices every payer pays a hospital, as Maryland does (Module 8)
Site-neutral payment	Paying the same for a service whether it is done in a doctor's office or in a hospital's outpatient department, which can charge an extra facility fee
Consolidation	The merging of hospitals into systems, and the purchase of physician practices by hospitals, insurers, and investors
Private equity	Investment funds that buy companies, often with borrowed money, aiming to sell them at a profit within a few years
340B	A federal program that lets hospitals and clinics serving many low-income patients buy outpatient drugs at deep discounts
Pharmacy benefit manager (PBM)	A company that runs drug coverage for insurers and employers: it sets which drugs are covered, negotiates rebates from drugmakers, and pays pharmacies
Single payer	A system in which one public insurer pays for everyone's care, as in Canada's provinces
Social health insurance	A system of compulsory insurance funded by contributions from wages, usually through nonprofit funds, as in Germany, France, and Japan
National health service	A system in which the government both pays for care and owns much of it, funded by taxes, as in Britain and Spain
Managed competition	A system of compulsory insurance sold by competing private insurers under strict rules, as in the Netherlands and Switzerland
Gatekeeping	A rule that patients see a family doctor first, who refers them to specialists
Health technology assessment	The formal judgment of whether a drug or treatment is worth its price, as done by England's National Institute for Health and Care Excellence (NICE)
Quality-adjusted life year (QALY)	A year of life in full health; a year in poorer health counts as a fraction of one. Cost-effectiveness is measured as the cost of gaining one
Avoidable deaths	Deaths that good public health could have prevented (preventable) or that timely, effective care could have averted (treatable), counted before age 75
Underinsured	Insured, but facing out-of-pocket costs or deductibles that are high relative to income
Catastrophic health spending	Out-of-pocket health spending large against a household's budget: on one measure, above 10% or 25% of its total spending; on the measure the WHO and the World Bank use for financial hardship, above 40% of what it has left after basic needs
Universal health coverage	Everyone able to get the health services they need without financial hardship, the goal the WHO and the United Nations set for 2030
Sickness fund	One of Germany's nonprofit health insurers, which collect contributions from wages and pay for their members' care
Long-term services and supports	Help with the tasks of daily life, such as bathing, dressing, and eating, for people with disabilities or frailty, at home or in a facility
Graduate medical education	The years of paid training in a hospital, called residency, that follow medical school; Medicare pays much of its cost
Scope of practice	The legal limits on what each kind of clinician may do, set by each state

Module 1 — The System in One Picture

What a Health System Does, and Where America's Money Goes

Recommended Reading / Reference

Book: Victor R. Fuchs, *Who Shall Live? Health, Economics, and Social Choice* (1974; expanded edition 2011), the classic short account of the choices every health system must make

Reference: CMS's National Health Expenditure Accounts (January 14, 2026), and the Peterson-KFF Health System Tracker's comparisons with other rich countries

1a. What a Health System Does

A health system does four things. It raises money, from taxes, payroll contributions, premiums, or patients' own pockets. It pools that money, so that the healthy pay for the sick. It buys care, deciding which services to pay for, from whom, and at what price. And it provides care, through doctors, nurses, clinics, and hospitals. Behind those functions lie three questions that run through this course: who pays, who provides, and who decides what care is worth. A country's answers decide what its people pay, what they wait for, and what they go without.

1b. Four Ways to Build a System

The rich world has settled on a few designs, which the reporter T. R. Reid sorted into four. In a national health service, as in Britain, the government raises money from taxes, owns most hospitals, and employs many of the clinicians. In social insurance, as in Germany, France, and Japan, workers and employers pay contributions into nonprofit funds that buy care from mostly private providers; managed competition, as in the Netherlands and Switzerland, is a variant that requires everyone to buy regulated private insurance. In a single payer, as in Canada, one public insurer funded by taxes pays private doctors and nonprofit hospitals. The fourth design is the absence of one: in much of the poor world, patients pay out of pocket, and those who cannot pay go without.

The United States uses all four at once. Veterans have a national health service: the Veterans Health Administration owns its hospitals and employs its doctors. Most workers and their families have insurance through their employers, paid for from wages like social insurance but bought from private insurers. People aged 65 and over have a single payer, traditional Medicare, run by the federal government, though more than half now choose private plans within it (Module 7). And the uninsured pay out of pocket, as patients do in poor countries. Medicaid, for people with low incomes, and the marketplaces, for those buying their own insurance, add two more channels (Module 7).

1c. Where the Money Went

Americans spent $5.3 trillion on health care in 2024, $15,474 a person and 18.0% of gross domestic product (GDP), the value of everything the economy produced, according to the National Health Expenditure Accounts that CMS published on January 14, 2026. Spending grew 7.2%, after 7.4% in 2023, faster than the economy. Hospitals took the largest share and doctors and clinics the next.

What the money bought	2024 spending	Share
Hospital care	$1,634.7 billion	31%

What the money bought	2024 spending	Share
Physician and clinical services	$1,109.7 billion	21%
Retail prescription drugs	$467.0 billion	9%
Other health, residential, and personal care	$320.5 billion	6%
Nursing homes and continuing-care communities	$219.9 billion	4%
Dental services	$189.2 billion	4%
Other professional services, such as therapists	$184.9 billion	4%
Medical products and equipment	$215.1 billion	4%
Home health care	$169.4 billion	3%
Administration, insurers' costs, public health, and investment	$768.2 billion	15%

CMS, National Health Expenditure Accounts, January 14, 2026. The last line is total spending less the care itemized above. Shares are rounded.

Private insurance paid 31% of the total, Medicare 21%, Medicaid 18%, and patients out of pocket 11%; other public and private programs and investment made up the rest. Who ultimately bore the cost is a different question, since employers' share of premiums comes largely out of pay (Module 7) and governments' money from taxes, and the worked example at the end of this module follows it to the household.

CMS projects spending of $5.7 trillion for 2025, a rise of 7.3%, and growth averaging 5.4% a year through 2034, against 4.1% for the economy, so that health care reaches $9.0 trillion and 20.6% of GDP in 2034 (June 24, 2026). The 2025 budget law's cuts to Medicaid slow the growth in 2027 and 2028. Over the decade the federal government's share of the total still rises, from 31% to 33%, as Medicare grows.

1d. America Against Other Rich Countries

For comparisons across countries the OECD's figures are the standard (Key Numbers). In 2024 the United States spent $14,885 a person, at purchasing power parity, the rate of exchange that equalizes what money buys in each country, against an OECD average of $5,967. It spent 17.2% of GDP against 9.3%. Switzerland, the next most expensive of its peers, spent about $5,000 less a person (Peterson-KFF Health System Tracker, March 11, 2026).

Country	Share of GDP	Per person (US$ at purchasing power parity)
United States	17.2%	$14,885
Switzerland	11.8%	$9,963
Germany	12.3%	$9,365
Netherlands	10.0%	$8,436
Australia	10.3%	$7,469
France	11.5%	$7,367
Canada	11.3%	$7,301
United Kingdom	11.1%	$6,747
OECD average	9.3%	$5,967
Japan	10.6%	$5,790
South Korea	8.4%	$4,797

OECD, *Health at a Glance 2025* (November 13, 2025); 2024 figures, many estimated or provisional.

1e. Why America Spends More

The clearest answers come from studies that compare what Americans buy with what others buy. Irene Papanicolas, Liana Woskie, and Ashish Jha compared the United States with ten rich countries, using data mostly from 2013-16 (*JAMA*, March 13, 2018). Americans had fewer doctors per person than the others, 2.6 per 1,000 against an average of 3.3, about as many nurses, and fewer hospital discharges, 125 per 1,000 people against 150, although they had more scans. What differed were prices and administration. Americans spent $1,443 a person on drugs against $466 to $939 elsewhere, paid their doctors and nurses more (Module 6), and spent 8% of the total on planning, regulating, and managing the system, against 1% to 3%.

Gerard Anderson and colleagues reached the same conclusion in a paper titled “It’s Still the Prices, Stupid” (*Health Affairs*, January 2019). The United States had fewer physicians, nurses, and hospital beds per person than the median OECD country, but spent $737 a person on administration against $94. Counting the time that hospitals and doctors spend billing many insurers makes the gap wider still. David Himmelstein, Terry Campbell, and Steffie Woolhandler, who are advocates of single payer, estimated that administration took 34.2% of American health spending in 2017, $2,497 a person, against 17.0% and $551 in Canada (*Annals of Internal Medicine*, January 2020).

Not all of the extra spending is price. William Shrank and colleagues put waste of every kind at $760 billion to $935 billion a year, about a quarter of spending, from care that fails or is poorly coordinated, care of little value, fraud, administrative complexity of about $266 billion, and pricing failures of about $231 billion to $241 billion (*JAMA*, October 2019).

1f. Does America Overspend, or Spend as a Rich Country Would? The Cases as Their Advocates Make Them

The case that it overspends: many health economists, among them the authors of the studies in 1e, argue that the comparisons of what is actually bought find similar use of most services and much higher prices and administrative costs. Some countries with higher incomes per person, such as Switzerland and Norway, spend far less. And the outcomes do not show the extra money buying better health (Module 11).

The case that it spends as a rich country would: a pseudonymous analyst who writes as Random Critical Analysis, the economist Alex Tabarrok, and Ed Dolan of the Niskanen Center, a research group, argue that health care is a luxury. As people grow richer they spend a rising share of their income on it, about 1.6% to 1.8% more for each 1% more income. Measured against GDP, American spending is an outlier, but Americans consume far more than people elsewhere, and measured against household consumption the United States sits close to the trend, within the normal range on Dolan’s count. On this view the extra money buys more and more intensive care, such as scans and procedures, and the studies of prices, which count visits and stays, miss how much more is done in each.

What the evidence says: richer countries do spend a larger share of their income on health, and America’s high consumption explains part of its lead, though household consumption includes health spending itself, so measuring against it partly assumes the answer. But the comparisons of what is bought, by different authors using different years, agree that Americans use about as much care as people in other rich countries, pay much more for it, and spend much more to administer it.

The course’s reading: America spends more partly because it is rich, but mostly because it pays higher prices for the same care and spends more to administer it. On the evidence, it overspends.

Worked example — A Family’s Real Health Bill

The family is an average one. In 2024 national health spending came to $15,474 a person, or $61,896 for a family of four. CMS divides the total by who ultimately paid it: households 28%, through premiums, out-of-pocket costs, and payroll taxes for Medicare; private businesses 18%, mostly employers’ share of premiums; the federal government 31% and state and local governments 16%, from taxes and borrowing; and other private sources about 6%. For the average family of four that is about $17,300 paid directly, $11,100 through employers, and $29,100 through governments ($61,896 × 0.28, 0.18, and 0.47). Only the first part looks like a health bill. The employers’ part comes largely out of wages (Module 7), and the governments’ part arrives as taxes and borrowing. A family with employer coverage sees a narrower slice still: Milliman, an actuarial firm, estimates that the care of a family of four with such coverage cost $37,824 in 2026, premiums and out-of-pocket costs together, up 7.2% in a year. Employers paid 58% of such costs; workers paid 27% through their share of the premium and 15% out of pocket.

Module 1 Key Points

The System in One Picture

• Every system raises money, pools risk, buys care, and provides it; America does each in several ways at once.

• America spent $5.3 trillion on health in 2024, 18.0% of GDP; CMS projects 20.6% of GDP by 2034.

• Hospitals took 31% of the money and doctors and clinics 21%; private insurance paid 31%, Medicare 21%, and Medicaid 18%.

• The OECD puts American spending at $14,885 a person in 2024, about two and a half times the OECD average.

• Americans use about as much care as their peers but pay higher prices and far more for administration.

Module 1 Quiz

Check Your Understanding

1. Which model of health system does the United States use?

A) Single payer

B) All four at once: a national service for veterans, insurance through employers, a single payer for the old, and cash for the uninsured

C) Social insurance only

D) A national health service

2. How much did the United States spend on health care in 2024?

A) About $530 billion

B) About $15 trillion

C) $5.3 trillion

D) About $1.6 trillion

3. What share of GDP did the OECD put American health spending at in 2024?

A) 17.2%, against an OECD average of 9.3%

B) 9.3%

C) About 25%, a quarter

D) 11.2%, about the same as Switzerland and Germany

4. What do comparisons of what America buys find?

A) Americans use far more care.

B) Americans pay lower prices but see doctors twice as often as people in other rich countries.

C) Americans have many more doctors and hospital beds per person than people in other rich countries.

D) Americans use similar care but pay higher prices.

5. What is the course's reading on whether America overspends?

A) No, it spends as a rich country would

B) Only on drugs

C) Yes, mostly because Americans see doctors and stay in hospitals far more often than people elsewhere

D) Yes, mostly because it pays more for the same care

Module 2 — Primary and Specialist Care

The Front Door and What Lies Behind It

Recommended Reading / Reference

Book: Jerome Groopman, *How Doctors Think* (2007), a physician's account of how doctors reason, and misreason, in the office and the clinic

Reference: Milbank Memorial Fund, *The Health of US Primary Care: 2026 Scorecard* (February 12, 2026), the annual measure of primary care's share of spending, workforce, and use

2a. What Primary Care Does

Primary care is the part of medicine a person sees first and most: the family doctor, the general internist, the pediatrician, and the nurse practitioner who treats ordinary illness, manages chronic disease, gives vaccines and screenings, and decides when a specialist is needed. Barbara Starfield, a physician at Johns Hopkins whose research defined the field, named four features that set it apart. It is the first contact for most problems; it follows the same patients over years; it handles most of what they need; and it coordinates the care they get elsewhere.

The evidence that these features matter is consistent, though most of it is observational. Starfield and her colleagues found that places and countries with stronger primary care had lower death rates and lower costs. A 2019 study of American counties by Sanjay Basu and colleagues found that each 10 additional primary-care physicians per 100,000 people was associated with about 51.5 more days of life expectancy, against about 19 days for each 10 additional specialists. Such studies cannot rule out that healthier, richer places attract more doctors, though no study has found that more primary care goes with worse health.

2b. America's Thin Front Door

The United States spends little of its health money on primary care. The Milbank Memorial Fund's 2026 scorecard found that 4.5% of all spending went to primary care in 2023 when only physicians are counted, down from 4.6% in 2022. Counting nurse practitioners, physician assistants, behavioral health, and obstetrics and gynecology, the share was 12%, down from 13%. In Medicare it was 3.7% on the narrow measure.

The workforce has stopped growing. America had 67 primary-care physicians per 100,000 people in 2023, a figure that has barely moved, against an average of about 80 in peer countries. Only 26% of American physicians practice primary care, and 22% of new physicians entered it in 2023. The number of primary-care residents reached a decade high of 17.73 per 100,000 people, but many leave for hospital medicine or specialties after training. Federal research on primary care received $115 million in 2024, 0.31% of federal health research.

The patients notice. In 2023, 29.7% of American adults had no usual source of care, a regular clinic or clinician they would go to when sick, slightly fewer than the 30.9% of 2022. People without one are more likely to use the emergency room for problems a clinic could handle, and less likely to be screened for cancer or to have their blood pressure controlled.

The reasons are mostly about money. Primary-care doctors earn far less than most specialists (Module 6), because Medicare's fee schedule, which private insurers largely copy, pays more for procedures than for

the time spent talking to patients (Module 8). Students who leave medical school with large debts choose accordingly. The work is also heavy on paperwork, since primary-care doctors handle most of the prior authorizations, referrals, and forms that the rest of the system generates.

2c. Nurse Practitioners and the New Front Door

Much of the growth has come from nurse practitioners (NPs), registered nurses with graduate training who diagnose, treat, and prescribe. Their association counted more than 461,000 licensed nurse practitioners in its 2025 count, up 7% from 2023, and most are certified in primary care. Yet the Milbank scorecard found that only 29% of nurse practitioners actually work in primary care, down from 34% in 2021, as hospitals and specialty practices hire them.

The states decide what they may do. Under their association's 2025 classification, 27 states and the District of Columbia let nurse practitioners practice without a physician's supervision or collaboration, a status called full practice authority; other trackers count 29 to 34, depending on how they treat transition periods. A New Jersey law signed on March 30, 2026 lets experienced nurse practitioners practice independently. Physicians' groups have fought most of these changes, state by state (2g).

2d. The Corporate Clinics

Between 2018 and 2023 several of America's largest companies bet that they could rebuild primary care, and most of the bets failed. Walmart opened 51 Walmart Health centers and announced on April 30, 2024 that it would close them all, saying it had found no sustainable business model. Walgreens invested in VillageMD, closed about 160 of its clinics in 2024, and wrote down $5.8 billion; after Sycamore Partners took Walgreens private in August 2025, VillageMD was spun off and began selling clinics. CVS Health, which bought Oak Street Health in 2023, said in October 2025 that it would close 16 centers, about 7%, leaving 230 in 27 states, and took a $5.7 billion impairment. Amazon bought One Medical in 2023 for about $3.9 billion.

The lesson most analysts drew is that primary care, paid visit by visit, does not earn enough to cover the clinics' costs. The companies that bought clinics serving older patients were betting on Medicare Advantage, in which a private plan is paid a fixed amount per enrollee (Module 7), so that a clinic that kept patients out of the hospital could keep the savings. When Medicare tightened those payments in 2024-26 and patients proved costlier than expected, the arithmetic turned.

2e. Telehealth

Video and telephone visits, rare before 2020, became a lasting part of care during the pandemic. Medicare's temporary permission to pay for them at home, anywhere in the country, lapsed on October 1, 2025 during the government shutdown, returned on November 12, and lapsed briefly again after January 30, 2026. The appropriations law of February 3, 2026 extended it through December 31, 2027. Among the commercially insured, telehealth made up 5.51% of medical claim lines in the first quarter of 2026, up from 5.01% in the fourth quarter of 2025, and 18.4% of patients had at least one telehealth claim, with mental health the most common diagnosis (FAIR Health, a nonprofit that holds a large database of claims, June 15, 2026).

2f. Specialists, Procedures, and Surgery Centers

Most American physicians are specialists (2b), a higher share than in most rich countries, and much of the system's money flows through what specialists do: scans, scopes, injections, and operations. More of that work has moved out of hospitals into ambulatory surgery centers, free-standing clinics for same-day surgery, often owned in part by the surgeons who use them. MedPAC counted 6,436 such centers in 2024, and Medicare and its beneficiaries paid them $7.5 billion. For 2027 Medicare has proposed adding 618 procedures to the list it will pay surgery centers to perform.

Where a procedure is done changes its price. In 2026 Medicare pays a gastroenterologist about $165 for a diagnostic colonoscopy, wherever it is done, but pays the facility about $510 if it is a surgery center and about $950 if it is a hospital's outpatient department (Olympus, a maker of endoscopes, from Medicare's rates, January 2026). The difference is the hospital's higher facility fee, which Module 9 follows.

How much care Americans get also depends on where they live. Researchers at Dartmouth, starting in the 1970s and publishing as the Dartmouth Atlas, found that Medicare spent more than twice as much per patient in some regions as in others, with no better results in the high-spending ones. Later work refined the finding. The Institute of Medicine reported in 2013 that most of Medicare's regional variation came from care after hospital stays, in nursing homes and at home. For the privately insured, a 2019 study by Zack Cooper and colleagues found that spending varies mainly with prices, so the regions costly to Medicare are often not the ones costly to private insurers.

2g. Can Nurse Practitioners, Retail Clinics, and Telehealth Stand In for the Family Doctor? The Cases as Their Advocates Make Them

The case that they can: the nurse practitioners' association, many state legislators, and economists who favor competition argue that the shortage of primary-care doctors will not end and that other clinicians can safely fill much of the gap. A Cochrane review of trials, published in 2018, found that care led by nurses in primary-care settings probably produces similar or better outcomes for many conditions, with higher patient satisfaction. Nurse practitioners go where doctors do not, into rural counties and clinics for the poor, and cost less. Retail clinics and telehealth are open evenings and weekends, when doctors' offices are closed.

The case that they cannot: the American Medical Association and most physicians' groups argue that training matters. They note that a physician completes about 10,000 to 16,000 hours of clinical training, against 500 to 720 for a nurse practitioner, by the association's count. They cite a study by the economists David Chan and Yiqun Chen of emergency departments in the Veterans Health Administration between 2017 and 2020. It found that nurse practitioners practicing alone produced 11% longer stays, 20% more preventable hospitalizations within 30 days, and 7% higher costs than physicians, with the gaps widest for the most complex patients. Retail clinics and telehealth, they add, scatter care among strangers. RAND studies in 2016 and 2017 found that most of their visits were new use of care rather than replacements for office visits, so spending rose.

What the evidence says: it sorts by task. For routine and chronic care in a primary-care practice, the trials summarized by Cochrane show little difference in outcomes, though their quality is moderate at best and many are old. For complex and acute patients, the best study, the one from the Veterans Health Administration, finds worse outcomes when nurse practitioners work alone. For convenience care, the RAND findings suggest that easier access adds visits and spending as well as saving trips to the emergency room.

The course's reading: nurse practitioners, clinics, and telehealth can widen the front door for routine and follow-up care, and they are often the only door in places without doctors. They substitute for the family doctor's continuity only when they work inside a practice that knows the patient. The case for unsupervised practice is strongest for routine care and weakest for complex patients.

Worked example — A Family Doctor's Morning Against a Gastroenterologist's

The volumes are illustrative; the prices are Medicare's for 2026, before adjustment for local costs. A family doctor sees 12 patients in four hours, six for an ordinary visit (billing code 99213, a standard office visit, $95.19) and six for a longer, more complex one (code 99214, $135.61). That brings in $1,385 at Medicare's rates (6 × $95.19 + 6 × $135.61). From it the practice must pay its nurses, receptionists, rent, records system, and billing. Across the hall, a gastroenterologist performs 12 diagnostic colonoscopies in a surgery center in the same four hours and earns $1,980 in professional fees (12 × $165). The surgery center's staff, rooms, and equipment are paid by its separate facility fee, $510 a case, or $6,120 for the morning, and if the gastroenterologist owns part of the center, part of that is income too. Private insurers pay more than these rates (Module 9). The fee schedule rewards the scope over the conversation, and Module 8 shows who sets it.

Module 2 Key Points

Primary and Specialist Care

• Primary care got 4.5% of American health spending in 2023 counting physicians only, or 12% counting other clinicians.

• America has 67 primary-care physicians per 100,000 people, against about 80 in peer countries; 29.7% of adults have no usual source of care.

• Walmart, Walgreens, and CVS closed hundreds of clinics in 2024-26: visit-by-visit primary care does not pay its way.

• Medicare pays the facility about $510 for a colonoscopy in a surgery center and $950 in a hospital outpatient department.

• Trials find little difference between nurse practitioners and doctors in routine care; a large veterans' study found worse results when they worked alone.

Module 2 Quiz

Check Your Understanding

1. What share of American health spending went to primary care in 2023 on the Milbank scorecard's narrow measure?

A) About 25%, the share most rich countries spend on it
B) About 4.5%, counting only physicians; 12% counting other primary-care clinicians
C) About 12%, the narrow and broad measures being the same
D) About 9%, the same share as prescription drugs

2. What does the module say most corporate primary-care ventures of 2018-23 showed?

A) Regulators blocked them in most of the states where they opened
B) Patients refused to use clinics placed inside stores and pharmacies
C) Visit-by-visit pay does not cover costs
D) They proved so profitable that their owners sold them

3. What did Chan and Chen find in Veterans Health Administration emergency departments?

A) Longer stays and more preventable hospitalizations when NPs worked alone
B) Identical costs and outcomes for every kind of patient, simple or complex
C) Physicians ordered more scans
D) Nurse practitioners cut emergency costs by 7% while keeping outcomes the same

4. Why does the same colonoscopy cost Medicare more in a hospital outpatient department?

A) The doctor's fee is higher there
B) Patients stay overnight
C) A higher facility fee
D) Hospitals use more anesthesia

5. What is the course's reading on whether nurse practitioners, clinics, and telehealth can stand in for the family doctor?

A) They can replace family doctors for every kind of patient, so the shortage of doctors no longer matters at all
B) They can widen the front door for routine care, but substitute for continuity only inside a practice
C) They should be banned from prescribing
D) They add visits and nothing else

Module 3 — Hospitals and Emergency Care

Owners, Margins, and the Safety Net

Recommended Reading / Reference

Book: Paul Starr, *The Social Transformation of American Medicine* (1982), the Pulitzer Prize-winning history of how the hospital and the doctor came to dominate American health care

Reference: American Hospital Association, *Fast Facts on U.S. Hospitals, 2026* (February 5, 2026), and Kaufman Hall's monthly *National Hospital Flash Report* on margins and costs

3a. The Hospital Landscape

The United States had about 6,100 hospitals in fiscal 2024, with 907,216 staffed beds and 35.7 million admissions, according to the American Hospital Association (AHA). Of these, 5,121 were community hospitals, the general hospitals open to the public, as opposed to federal, psychiatric, and long-term hospitals. Most community hospitals are nonprofit: 2,984, or 58%, against 1,224 for-profit hospitals (24%) and 913 owned by states, counties, and cities (18%). Seven in ten belong to a system that owns several.

The systems have grown large. Kaiser Permanente, which combines an insurer, its own hospitals, and its own doctors in eight states and the District of Columbia, had revenue of about $127.7 billion in 2025. HCA Healthcare, the largest for-profit chain, had $75.6 billion, and the largest nonprofit chains, CommonSpirit Health and Advocate Health, had about $40 billion each (Becker's Hospital Review, a trade publication, July 28, 2026). Hospitals are the core of health care's workforce (Module 6).

3b. What Hospitals Cost and Earn

Hospitals take the largest share of American health spending (Module 1), and most of a hospital's costs are people. Labor made up 56% of hospitals' expenses in 2024, about $890 billion, by the AHA's count. Drugs and supplies are rising faster: at hospitals with 500 or more beds, spending per day on supplies rose 13.1% and on drugs 13.5% in the year to April 2026, against 4.0% for labor (Kaufman Hall, a consulting firm that tracks more than 1,300 hospitals).

The typical hospital earns a thin margin. The national median operating margin, the share of revenue left after operating costs, was 2.5% for the first half of 2026 by Kaufman Hall's count, and bad debt and charity care, care for which hospitals are never paid, rose 17%. The averages hide wide differences. In 2025 the for-profit chains Tenet and HCA reported operating margins of 16.5% and 13%, while the large nonprofit systems Ascension and Providence each lost 1.6% and CommonSpirit lost 0.6%. Hospitals in wealthy suburbs with many privately insured patients do well; rural hospitals and city hospitals that serve many Medicaid and uninsured patients do not.

The reason is the payer mix. Each patient's insurer pays a different price for the same care. Medicare sets its prices by regulation, Medicaid's are lower still in most states, and private insurers negotiate theirs, paying on average far more than Medicare's rates for the same hospital services (Module 9). A hospital's finances therefore depend less on how efficiently it treats patients than on whose patients they are. The worked example at the end of this module shows the arithmetic.

3c. The Emergency Room

The emergency department is the one part of American medicine that must see everyone. The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 requires every hospital that takes Medicare and has an emergency department to examine anyone who arrives and to stabilize an emergency condition, including active labor, whatever the patient’s ability to pay. It does not make the care free: the hospital bills the patient afterward, and bills a patient cannot pay become medical debt (Module 9). The law was passed after reports of hospitals turning away or transferring uninsured patients in danger.

Americans made about 155 million emergency visits in 2022, or 473 visits per 1,000 people. Many of the patients are very sick, and many have nowhere else to go at night or without insurance. The departments are crowded mostly because the hospitals behind them are full. Patients who have been admitted wait in the emergency department, sometimes for days, until a bed opens upstairs, a practice called boarding. In the emergency departments that report to the Emergency Department Benchmarking Alliance, which see about a third of all visits, admitted patients boarded for an average of 190 minutes in 2022, against about 120 minutes in each year from 2013 to 2019. In a letter of February 2025, the American College of Emergency Physicians told the health secretary that boarding had become a public health emergency.

3d. Rural Hospitals

Rural hospitals have the hardest arithmetic: few patients, many of them old or on Medicaid, and high fixed costs. The Cecil G. Sheps Center at the University of North Carolina counted 197 rural hospitals that had closed or stopped inpatient care between 2005 and June 2026, 154 of them since 2010. Since January 1, 2023, a rural hospital can instead become a Rural Emergency Hospital, which closes its inpatient beds but keeps an emergency department and outpatient services, with an extra monthly payment from Medicare. Forty-two had converted by January 2026. Chartis, a consulting firm, counted 417 rural hospitals vulnerable to closure in 2026 and found 41.2% losing money. The share was 52.2% in the ten states that have not expanded Medicaid, against 34.9% in those that have.

The 2025 budget law, which cuts federal Medicaid spending (Module 7), also created a Rural Health Transformation Program of $50 billion over the fiscal years 2026 to 2030. The first $10 billion was awarded to every state on December 29, 2025, an average of $200 million each, from $281 million for Texas to $147 million for New Jersey (KFF). The money pays for projects that states proposed, such as telehealth networks and new kinds of clinics, rather than for the operating losses that close hospitals.

3e. Two Programs That Shape Hospital Finance

The first is 340B, named for a section of a 1992 law, which lets hospitals and clinics that serve many low-income patients buy outpatient drugs at deep discounts and bill insurers at full price. It has grown fast: purchases passed $100 billion in 2025, against $53.7 billion in 2022, across 15,249 covered hospitals and clinics with 49,214 sites by April 2026. Drugmakers say hospitals use the margin for profit rather than for the poor and have sought to pay the discounts as rebates after the fact, which they say would curb abuse. A rebate pilot with ten manufacturers is due to begin on January 1, 2027, after a federal appeals court ruled in July 2026 that rebates are lawful only with the government’s approval.

The second is the hospital at home. Since 2020 Medicare has paid hospitals to treat some acute patients, such as those with pneumonia or heart failure, in their own homes, with daily visits and remote monitoring, under a waiver that the appropriations law of February 3, 2026 extended to September 30, 2030. A few

hundred hospitals use it. It is small, but it is one of the few ideas that could reduce the number of beds the system needs.

3f. The Night It Begins

The course's patient wakes at 2 a.m. with pressure in her chest and pain down her left arm. She is 58, works for a mid-sized company, and is covered by its insurance plan. Her husband calls 911. A crew with advanced life support arrives, records an electrocardiogram, and sends it to the nearest hospital with a cardiac catheterization laboratory, which recognizes the pattern of a heart attack caused by a blocked artery and calls in its team. American and European guidelines call for the artery to be opened within 90 minutes of first medical contact.

In the emergency department a physician confirms the diagnosis. Within the hour an interventional cardiologist threads a catheter from her wrist to her heart, finds the blocked artery, opens it with a balloon, and props it open with one drug-eluting stent, a mesh tube coated with a drug that keeps the artery from narrowing again. She spends two nights in the hospital, the first in the cardiac unit, and goes home with four prescriptions: two drugs to prevent clots, a statin to lower cholesterol, and a beta blocker to slow her heart. She is referred to cardiac rehabilitation, a supervised program of exercise and education that lowers the risk of another heart attack and of returning to the hospital.

By the end of the second day at least six organizations have treated her, and each will bill separately. They are the ambulance service, often run by a town or a private company; the emergency physicians, usually employed by a staffing firm rather than the hospital; and the cardiologists, a group the hospital may own. Then come the hospital itself, for the room, the nurses, the laboratory, and the catheterization suite; the radiologists and the laboratory physicians who read her tests; and the pharmacy. Module 8 shows how each is paid, and Module 9 follows the bills.

3g. Do Nonprofit Hospitals Earn Their Tax Exemption? The Cases as Their Advocates Make Them

The case that they do: the AHA argues that nonprofit hospitals return far more to their communities than their tax exemption is worth. An analysis it commissioned from the accounting firm EY, published on November 17, 2025, estimated that the federal exemption was worth $13.2 billion in 2022 while the hospitals reported $149 billion of community benefits on their tax forms, more than $11 for every dollar of exemption. The benefits include free and discounted care, losses on Medicaid patients, training of doctors and nurses, research, and services such as trauma and psychiatric care that lose money. The AHA adds that hospitals absorbed $130 billion of underpayments from Medicare and Medicaid in 2023.

The case that they do not: the Lown Institute, a health-policy research group, and other critics argue that most of those benefits are not charity. Losses on Medicaid patients and the cost of training are borne by for-profit hospitals too, which pay taxes. Lown studied hospitals in 20 states and found, in April 2025, that their charity care and community spending fell $11.5 billion a year short of the value of their federal, state, and local tax breaks. More than half of the hospitals it studied, 54%, gave back less than they received. Critics add that many nonprofit systems earn healthy margins, pay their executives millions, and sue patients for unpaid bills.

What the evidence says: the two sides measure different things. The AHA counts the federal exemption alone and a broad definition of benefit; Lown counts all tax breaks and a narrower definition. Federal law

sets no minimum: since 1969 the Internal Revenue Service has required nonprofit hospitals to provide a community benefit without saying how much. A few states set their own floors, and Indiana's 2025 law limits the prices its largest nonprofit systems may charge (Module 9). Charity care, the clearest measure, is a small share of most hospitals' spending, and it varies widely between hospitals of similar size and wealth. One study found that nonprofit hospitals spent $2.30 of every $100 of expenses on charity care in 2018, less than for-profit hospitals' $3.80 (Ge Bai and colleagues, *Health Affairs*, 2021).

The course's reading: the measure that fits the exemption is what nonprofit hospitals give beyond what taxpaying hospitals also give, and on that measure many give back less than their exemption is worth, since their charity care is no larger than for-profit hospitals'. The broad measure flatters them, because it counts the shortfalls of public programs that every hospital bears. A minimum of charity care, set as a share of revenue, would be a clearer test than either side's totals.

Worked example — A 250-Bed Hospital's Year, by Payer

The hospital is illustrative, with costs of $500 million a year spread across its patients in roughly the national pattern: 45% for Medicare patients, 20% for Medicaid, 30% for the privately insured, and 5% for the uninsured. The AHA reports that Medicare paid 83 cents for each dollar of hospital cost in 2023, and Medicaid 58 to 65 cents before the supplemental payments many states add. At 83 cents, the hospital's Medicare patients bring in $186.75 million against $225 million of cost; at 65 cents, its Medicaid patients bring $65 million against $100 million; and if the uninsured pay a tenth of their costs, they bring $2.5 million against $25 million. To earn the median margin of 2.5%, the hospital needs about $512.8 million of revenue ($500 million ÷ 0.975), so its privately insured patients must pay about $258.6 million for $150 million of care, about 172% of what that care costs.

Hospitals call this a cost shift: private patients pay more because public programs pay less. The evidence is weaker than the arithmetic. Austin Frakt's review of the research found that cost shifting happens, but usually at a low rate (*Milbank Quarterly*, 2011), and in a 2013 summary he put it at no more than about a fifth of lost Medicare revenue. Chapin White found that when Medicare cut its rates, private rates tended to fall too (*Health Affairs*, 2013). And MedPAC's staff found that hospitals with market power charge private insurers high prices, run up higher costs, and then lose money on Medicare, while efficient hospitals in competitive markets earn a profit on Medicare (*Health Affairs*, 2010). On that reading, high private prices come first and Medicare's losses follow (Module 9).

Module 3 Key Points

Hospitals and Emergency Care

• America had about 6,100 hospitals in 2024; 58% of community hospitals are nonprofit, and seven in ten belong to systems.

• The median hospital margin was 2.5% in the first half of 2026, but for-profit chains earned 13-17% in 2025.

• Federal law since 1986 requires emergency rooms to screen and stabilize everyone, but not to treat them free.

• Some 197 rural hospitals closed or stopped inpatient care between 2005 and June 2026; 42 became Rural Emergency Hospitals.

• Nonprofit hospitals report $149 billion of community benefit; a study of 20 states found their charity $11.5 billion short of their tax breaks.

Module 3 Quiz

Check Your Understanding

1. What share of American community hospitals is nonprofit?

A) About 24%, roughly the for-profit share in the same count
B) Under 10%
C) Nearly all of them, since federal law requires nonprofit status for any hospital that takes Medicare
D) About 58%, by the AHA's count

2. What does the 1986 emergency law require of hospitals?

A) That they screen and stabilize anyone who comes to the emergency department, whatever the ability to pay
B) That they treat every patient free of charge
C) That they keep a bed open for every patient admitted
D) That they join a system

3. Why are emergency departments crowded, according to the module?

A) Most visits are for minor problems a clinic could treat
B) Full hospitals leave admitted patients boarding there
C) They are understaffed
D) EMTALA bans hospitals from transferring any patient elsewhere

4. What is a Rural Emergency Hospital?

A) A former rural hospital that closes its inpatient beds but keeps emergency and outpatient care
B) A clinic run by a county health department
C) A federal hospital for rural veterans
D) A hospital that opens a second emergency department in a nearby town, paid for by a federal grant

5. What is the course's reading on nonprofit hospitals' tax exemption?

A) They return $11 for every dollar, so the exemption is well earned
B) All of them should lose it, whatever charity care they provide
C) Many give back less than it is worth
D) The exemption is worth nothing once state taxes are counted

Module 4 — Mental Health and Addiction Care

Need, Supply, and Who Pays

Recommended Reading / Reference

Book: Thomas Insel, *Healing: Our Path from Mental Illness to Mental Health* (2022), by a former director of the National Institute of Mental Health, on why better science has not produced better care

Reference: The Substance Abuse and Mental Health Services Administration (SAMHSA), *2025 National Survey on Drug Use and Health* (July 27, 2026), and the quarterly statistics of the Health Resources and Services Administration (HRSA) on health professional shortage areas

4a. How Many Need Care, and How Many Get It

The federal government measures mental illness through an annual household survey run by the Substance Abuse and Mental Health Services Administration (SAMHSA). Its survey for 2025, released on July 27, 2026, counted 54.6 million adults with a mental illness in the past year, 20.6% of all adults. Of these, 18.2 million (6.9% of adults) had a serious mental illness, one that substantially interfered with daily life. The survey changed its definitions in 2025, so these figures cannot be compared with those published before.

About half of those with a mental illness, 50.9%, received treatment, and 67.7% of those with a serious one did. Addiction is treated far less often. The survey counted 44.6 million people aged 12 and over with a substance use disorder, 15.3% of that population, and only 16.0% of those who needed treatment received it. Of the 18.5 million adults with both a mental illness and a substance use disorder, 42.6% got no treatment for either.

Group (2025)	People	Share treated
Adults with any mental illness	54.6 million (20.6% of adults)	50.9%
Adults with a serious mental illness	18.2 million (6.9%)	67.7%
People 12 and over with a substance use disorder	44.6 million (15.3%)	16.0% of those who needed treatment
Adults with both	18.5 million	57.4% (42.6% untreated)

SAMHSA, *2025 National Survey on Drug Use and Health*, July 27, 2026. The survey asks households, so it misses people in prisons, hospitals, and shelters, and it changed its definition of mental illness in 2025.

4b. Who Provides It

Mental-health care comes from a wider range of people than most medicine. Psychiatrists are physicians and can prescribe; psychologists, licensed counselors, and clinical social workers provide most talk therapy; and primary-care doctors write most prescriptions for depression and anxiety. Many states also license marriage and family therapists and addiction counselors, and nurse practitioners specializing in psychiatry can prescribe in most states.

The supply falls short across much of the country. The Health Resources and Services Administration (HRSA), the federal agency that designates shortage areas, counted 7,109 mental-health shortage areas on June 30, 2026, home to 157.1 million people, about 46% of Americans. It estimated that only 26.5% of the need in those areas was met, and that 7,825 more clinicians would be needed just to lift the designations. Six months earlier the count had been 137.1 million people, so the shortage areas are growing as well as wide.

4c. The Networks That Do Not Answer

A mental-health clinician who exists is not necessarily one a patient can see. Many do not join insurers' networks, because insurers pay them less than they can earn from patients paying cash, and because billing insurers takes time. A 2019 analysis by Milliman of claims from 2017 found that 17.2% of behavioral-health office visits were out of network, against 3.2% for primary care and 4.3% for medical and surgical care.

The directories that insurers publish overstate even those who have joined. In a study published in October 2026, researchers at Ohio State University placed more than 5,800 calls to psychiatrists and psychologists listed by the largest commercial insurers in five states. Fewer than a quarter of the calls produced an appointment, and about 60% went unanswered. Of the calls that reached someone, 56% revealed an error in the directory. A 2024 study of Medicaid plans in four large cities found that fewer than 18% of listed clinicians would take a new Medicaid patient. Lists like these are called ghost networks.

The ghost networks have reached the courts. In December 2025 the American Psychiatric Association sued EmblemHealth, which runs a plan for about 750,000 New York City employees and retirees and their families, alleging that its directory turned roughly 154,700 search results into only 12,550 unique clinicians. The Labor Department, which oversees employer plans, lists inaccurate directories among its enforcement priorities for 2026.

4d. The Parity Law

Federal law has required equal treatment of mental and physical illness in insurance since the Mental Health Parity and Addiction Equity Act of 2008, which the 2010 Affordable Care Act extended to individual and small-group plans. A plan that covers mental health may not impose higher copayments, tighter visit limits, or stricter approval rules on it than on comparable medical care. The hard cases are the rules that are not numbers, such as how a plan builds its network, sets its rates, or decides what is medically necessary.

A rule issued on September 9, 2024 required plans to measure those practices, comparing how often mental-health claims were denied and how many clinicians joined their networks, and to fix any gaps. An employers' group sued in January 2025. On May 15, 2025 the departments of Labor, Health and Human Services, and the Treasury, which enforce the law, said they would not enforce the rule's new requirements until 18 months after a final court decision, leaving the 2008 law and an older rule of 2013 in force. On March 30, 2026 they told the court they would no longer defend the 2024 rule and would propose a replacement by December 31, 2026.

4e. Crisis Care, Beds, and Jails

A national three-digit crisis number, 988, began in July 2022, routing calls, texts, and chats to about 200 local centers. The Government Accountability Office (GAO), Congress's auditor, counted about 19.1 million contacts by September 2025, and found that the share of calls answered had risen to about 90% by September 2025. In September 2025 alone the line took 460,264 calls, 119,747 texts, and 92,936 chats. Its specialized option for young gay, lesbian, bisexual, and transgender callers ended on July 17, 2025; Congress restored its funding for fiscal 2026, but as of March 2026, the latest report, the line had not restored the option.

Behind the line sits a patchwork. Certified Community Behavioral Health Clinics, which must offer crisis care around the clock and take every patient regardless of ability to pay, number more than 500 in 46 states, the District of Columbia, and Puerto Rico. Ten more states joined their Medicaid demonstration, which pays

them a daily rate built on their costs, on May 28, 2026. The public psychiatric hospital, which once housed hundreds of thousands of patients, shrank from the 1950s onward as new drugs arrived and states closed their asylums, and the community services meant to replace it were never fully built.

Many of the people the hospitals once held are now in jails and prisons. A 2014 survey by the Treatment Advocacy Center, a group that campaigns for more treatment of serious mental illness, and the National Sheriffs' Association counted about 356,000 people with a serious mental illness in prisons and jails and about 35,000 in state psychiatric hospitals, roughly ten to one. In 44 states and the District of Columbia, a single jail or prison held more people with a serious mental illness than the state's largest psychiatric hospital. No newer national count exists.

4f. Addiction Care

Deaths from drug overdoses, which passed 100,000 a year in the pandemic, have fallen three years running. The CDC predicted 69,973 deaths for 2025, against 81,313 in 2024, and counted 67,798 in the twelve months to March 2026, down 12.3% on a year earlier. Deaths involving opioids fell from 55,296 to 44,564 between 2024 and 2025. Not every state shared the decline: New Mexico, Arizona, and Colorado rose by 10% or more in 2025.

The treatment that most reduces deaths from opioid addiction is medication: methadone, which is dispensed only in licensed clinics, and buprenorphine, which doctors may prescribe. A 2018 study of overdose survivors in Massachusetts found that opioid deaths fell 59% among those taking methadone and 38% among those taking buprenorphine, yet fewer than a third of the survivors received either. Congress removed the special federal license doctors needed to prescribe buprenorphine in December 2022, but a study published in August 2025 found that growth in the number of patients receiving it slowed rather than quickened, so the license had not been the only barrier.

Telemedicine has become part of the system. A permanent federal rule allowing buprenorphine to be started by telemedicine took effect on December 31, 2025, and the wider pandemic-era permission to prescribe controlled substances without an in-person visit runs through December 31, 2026 unless it is extended again. The money that funds much addiction treatment is less settled. SAMHSA lost about half its staff in 2025, by one count, and closed its ten regional offices. In January 2026 it canceled about $2 billion in grants and reversed itself within a day. Congress gave it $7.44 billion for fiscal 2026, and the administration has asked for $6.69 billion for fiscal 2027, 10.1% less. Medicaid, the largest payer for addiction treatment, is about to impose work requirements (Module 7).

4g. Is the Shortage One of People, or of Payment? The Cases as Their Advocates Make Them

The case that it is people: professional groups, rural health advocates, and HRSA argue that the country simply has too few clinicians. The shortage areas of 4b are growing. Psychiatry is a small specialty whose members are older than most doctors', and rural counties often have no psychiatrist at all. On this view the answer is to train more people, through more residency positions, loan repayment for those who work in shortage areas, and wider prescribing rights for psychiatric nurse practitioners and psychologists.

The case that it is payment: patients' groups, the psychiatrists' association in its lawsuit, and many economists argue that the clinicians exist but do not take insurance. Out-of-network use is five times as common for behavioral visits as for primary care. Most listed clinicians cannot be reached, and the rates

insurers pay and the paperwork they require drive therapists to cash practices. On this view enforcing parity, policing directories, and raising rates would open care that already exists.

What the evidence says: both effects are real, and they sort by place. In cities, the secret-shopper studies show clinicians who are listed but not taking insured patients, which is a problem of payment and paperwork. In rural counties, where the shortage designations concentrate, there is often no one to call, which is a problem of people. Telehealth has narrowed the gap (Module 2). Much of that, though, is cash-paid or out-of-network care that serves those who can afford it.

The course's reading: payment is the faster lever. Parity enforcement, accurate directories, and rates that match those for comparable medical care would bring more of the existing clinicians into networks within a few years. Training more clinicians takes a decade and matters most where none practice now.

Worked example — Finding a Therapist

The figures are illustrative, except the directory odds, which come from the October 2026 study in 4c. A woman with employer insurance looks up in-network therapists and finds 20 listed. If fewer than a quarter of calls produce an appointment, she can expect four or five offers at best, some of them months away. Suppose she instead sees an out-of-network therapist who charges $180 a session. Her plan pays 60% of an allowed amount of $110 a session, but only after a separate $3,000 out-of-network deductible, and she owes the therapist the rest of each charge. The allowed amounts count toward the deductible, so $110 a session reaches $3,000 during the 28th session. For the first 27 sessions she pays the full $180, or $4,860; for the 28th she pays $132: the last $30 of her deductible, 40% of the remaining $80 of the allowed amount, or $32, and the $70 by which the charge exceeds it, while the plan pays $48. From the 29th session the plan pays $66 (60% of $110) and she pays $114. Over a year of 52 weekly sessions she pays $7,728 of the $9,360 billed, and the plan pays $1,632. Weekly visits to an in-network therapist with a $30 copayment would have cost her $1,560.

Module 4 Key Points

Mental Health and Addiction Care

• About half of the 54.6 million adults with a mental illness were treated in 2025; only 16% of those needing addiction treatment got it.

• Mental-health shortage areas covered 157.1 million Americans in June 2026, and only 26.5% of their need was met.

• Behavioral visits are five times as likely as primary care to be out of network; most listed clinicians could not be reached.

• The 2024 parity rule is unenforced; the government has said it will propose a replacement by December 31, 2026.

• Overdose deaths fell to 67,798 in the year to March 2026, yet in one state study fewer than a third of survivors got medication.

Module 4 Quiz

Check Your Understanding

1. What share of adults with a mental illness received treatment in 2025, according to the federal survey?

A) About a sixth, the same share as for addiction
B) About 90%, as nearly all now see a primary-care doctor
C) About a quarter
D) About half, 50.9%, a far higher share than among people with a substance use disorder

2. What did the October 2026 secret-shopper study find when it called listed psychiatrists and psychologists?

A) Most calls were answered within a day by the clinician
B) Directories were accurate in nine cases of ten
C) Fewer than a quarter of the calls produced an appointment
D) Most listed clinicians took new patients, but only for cash

3. What happened to the 2024 parity rule?

A) The government stopped enforcing its new parts and said it would replace it
B) The Supreme Court struck it down in 2025
C) Congress wrote it into law in the 2025 budget law
D) It took full effect in January 2026 after a court upheld it

4. Where does the module say many people with serious mental illness are now held?

A) In state psychiatric hospitals, which have grown since 2014
B) In nursing homes paid for by Medicaid
C) In community clinics that admit patients overnight
D) In jails and prisons

5. What is the course’s reading on whether the shortage is one of people or of payment?

A) People: only training more clinicians can open care
B) Payment, which is the faster lever to pull
C) Neither: screening inflates demand
D) Both are equally slow to fix, so neither should be tried first

Module 5 — Long-Term Care

Caregivers, Nursing Homes, and Who Pays

Recommended Reading / Reference

Book: Atul Gawande, *Being Mortal: Medicine and What Matters in the End* (2014), a surgeon's account of how America cares for the old and the dying, and how it might do better

Reference: KFF's issue briefs on long-term services and supports (2024-26), and CareScout's *Cost of Care Survey* (March 2, 2026)

5a. Care That Is Not Medicine

Long-term care is help with the tasks of daily life, such as bathing, dressing, eating, using the toilet, and moving about, for people who cannot manage them alone because of age, dementia, disability, or chronic illness. Most of it is not medical: it is done by relatives and aides rather than doctors, at home far more often than in an institution, and it can last for years. That is why the insurance that covers medical care mostly does not cover it, and why paying for it is the largest financial risk of old age that most Americans do not insure.

Families provide most of it, unpaid. A survey by AARP, the lobby for Americans over 50, and the National Alliance for Caregiving, released on July 24, 2025, found that 63 million Americans, nearly one adult in four, had provided ongoing care to a relative or friend in the past year, 20 million more than in 2015. Nearly a quarter of them gave 40 or more hours a week. Six in ten caregivers also held jobs, and nearly half reported a major financial setback, such as taking on debt, stopping saving, or going without food.

5b. Who Provides the Paid Care

The paid workforce is large and poorly paid. Home health and personal care aides held about 4.68 million jobs in 2025, at a median wage of $17.21 an hour in May, and the Bureau of Labor Statistics (BLS) projects 847,300 more such jobs, an 18% increase, between 2025 and 2035. Many aides are immigrants, and many work for agencies paid by Medicaid at rates that leave little room for raises.

Nursing homes care for the frailest. KFF counted 14,742 nursing homes certified by Medicare or Medicaid in July 2025, with about 1.24 million residents, down from 15,648 homes and about 1.37 million residents in 2015. Most, 73%, are run for profit, 20% are nonprofit, and 7% belong to governments. The share of homes cited for serious problems, those causing actual harm to a resident or putting one in immediate jeopardy, rose from 17% in 2015 to 27% in 2025. Assisted living, for people who need help but not round-the-clock nursing, is regulated by the states and paid for mostly by residents themselves.

5c. What It Costs, and Who Pays

Setting	Median cost, 2025	Change from 2024
Nursing home, private room	$355 a day; $129,575 a year	+1%
Nursing home, shared room	$315 a day; $114,975 a year	+2%
Assisted living	$6,200 a month; $74,400 a year	+5%
Home care by an aide	$35 an hour; $80,080 a year at 44 hours a week	+3%
Adult day care	$95 a day; $24,700 a year	−5%

CareScout, *Cost of Care Survey*, March 2, 2026, from more than 25,000 providers' rates collected from July to November 2025.

Medicare, which most older Americans assume will pay, mostly does not. It covers up to 100 days in a skilled nursing facility after a hospital stay of at least three days, for rehabilitation, and short spells of skilled care at home, but not the custodial care, help with daily tasks, that most long-term care is. In a 2022 KFF poll, 45% of adults 65 and over thought Medicare would pay for a long nursing-home stay.

Medicaid pays instead, once a person is poor. Of the $415 billion spent on long-term services and supports in 2022, Medicaid paid 61%, patients paid 17% out of pocket, and other payers, chiefly private insurance and the Veterans Health Administration, paid the rest (KFF). Medicaid is the main payer for 63% of nursing-home residents. Nearly 6 million people use its long-term services, 4.2 million of them at home or in their communities and 1.6 million in institutions, and since 2013 most of its long-term care spending has gone to care outside institutions, 62% in 2020.

To qualify for long-term care, a person must spend down to the state's limit on assets, $2,000 for a single person in most states in 2026, although a car and personal belongings do not count. A spouse living at home may keep between $32,532 and $162,660 of the couple's assets, depending on the state, and an income of at least $2,705 a month from July 1, 2026. A home counts once its equity passes a limit each state sets between $752,000 and $1,130,000, unless a spouse or dependent child lives there, and gifts made in the five years before applying can delay eligibility (CMS, December 9, 2025 and April 27, 2026). After the person's death, the state must try to recover what Medicaid spent from the estate, which is often the house.

Care at home under Medicaid is rationed by waiting. States offer it through waivers, programs that let them pay for home care and cap the number of people served. KFF counted about 607,000 people on waiting lists in 41 states in 2025, 74% of them with intellectual or developmental disabilities, and found an average wait of 32 months. Most states also cap their waiver spending, and fifteen planned new limits for fiscal 2026 as the cuts of the 2025 budget law approached.

Private insurance plays a small part. About 7.1 million people paid premiums for long-term care insurance in 2021, averaging $1,860 a year (KFF). The market has shrunk since the early 2000s, because insurers underestimated how long policyholders would live and keep their policies, and how low interest rates would fall. Many left the business, and those that stayed raised premiums on existing customers, sometimes by more than half. Most new sales now are life-insurance policies with a long-term care feature attached.

5d. The Staffing Rule

Nursing homes' quality rises with their staffing, and in April 2024 the federal government set its first minimum. The rule required a registered nurse on site around the clock and 3.48 hours of nursing care per resident per day, including 0.55 hours from registered nurses and 2.45 from aides, with the rest from any nursing staff, phased in from 2026 to 2029. Only 19% of homes met all the hours standards when it was

issued, 12% of for-profit homes against 47% of nonprofit ones (KFF). The industry sued, and a federal judge in Texas vacated the rule on April 7, 2025, finding that the agency had exceeded its authority. The 2025 budget law then barred enforcing it until 2034, and the agency repealed it with effect from February 2, 2026.

5e. Social Insurance for Long-Term Care

Some countries, and now one American state, treat long-term care as a risk to insure for everyone. Washington State created the country's first public program, WA Cares, funded by a payroll premium of 0.58% of wages, paid by workers, since July 2023. Benefits became available statewide on July 1, 2026: up to $36,500 over a lifetime, rising with inflation, for people who need help with three or more daily activities for at least 90 days. The money can pay for home care, including care by a relative, as well as assisted living, nursing homes, meals, and changes to a home. Voters rejected a 2024 initiative to make the program voluntary, 55.5% to 44.5%. About 413,000 workers opted out before the deadline by buying private policies.

Germany has run compulsory long-term care insurance since 1995. Workers and employers pay 3.6% of wages, 4.2% for childless workers, into funds that pay cash or services according to a person's assessed level of need. About 6 million people receive benefits, three times as many as in 2005. Costs have outrun contributions: the system needed a €3.2 billion federal loan to balance in 2026, faces a gap of €5 billion or more in 2027, and residents in their first year in a nursing home still paid an average of €3,245 a month of their own money in early 2026. The cabinet approved a reform on September 30, 2026 that would raise the childless rate to 4.5% from January 2027, if parliament passes it.

Japan's long-term care insurance, begun in April 2000, covers everyone aged 65 and over, and people aged 40 to 64 whose need comes from one of 16 specified diseases of aging. Half its cost comes from taxes and half from premiums, 23% paid by people aged 65 and over and 27% by those aged 40 to 64, and users pay 10%, 20%, or 30% of the cost of their services, depending on income. About 7.1 million people were certified as needing care or support in 2024, 19.4% of those aged 65 and over. The government is weighing whether to make more users pay 20% from 2027.

5f. Social Insurance or Medicaid as the Backstop? The Cases as Their Advocates Make Them

The case for social insurance: advocates for older people, many economists, and the designers of Washington's program argue that long-term care is a textbook case for it. Most people will need some care, a minority will need years of it, and no one can know in advance which group they will be in. Private insurers cannot price that risk, as the collapse of their market shows, and Medicaid helps only those who have spent nearly everything. The real cost now falls on families, mostly women, who give unpaid care at the expense of their jobs, savings, and health. Germany and Japan show that universal programs can run for decades.

The case for Medicaid as the backstop: fiscal conservatives and opponents of new payroll taxes argue that a public program would be costly and would grow. Germany's and Japan's contributions have risen repeatedly, and both face deficits as their populations age. A payroll tax falls on today's workers to pay for care that many of them will not need, and it may displace care families would have given anyway. Savings, home equity, private and hybrid policies, and Medicaid for those who run out are, on this view, a better division of the risk. Washington's benefit, they add, is small against the cost of care and has started slowly.

What the evidence says: both sides' facts hold. Private long-term care insurance has failed to cover more than a small minority. Medicaid has become the main payer, but it requires families to impoverish

themselves first, and its home-care waiting lists run for years. The universal programs abroad work, but their contributions have had to rise faster than their founders planned, and Germany's residents still pay much of a nursing home's cost themselves. Washington's program is too new to judge: in June 2026, 113 applicants had met its contribution test and 44 had been found eligible, by the count of the Washington Policy Center, a free-market think tank critical of the program.

The course's reading: the risk is one private markets cannot cover and families cannot plan for, which is the classic argument for social insurance. A capped public benefit, such as Washington's, pays for the first months of need and leaves Medicaid as the backstop for longer stays; covering years would take a larger benefit and higher contributions. Every program that has tried more has had to raise its contributions, so the benefit's size is the real choice.

Worked example — Three Years of Dementia Care, Paid Three Ways

The case is illustrative and uses the 2025 median prices above, without inflation. A widow with dementia needs an aide at home 44 hours a week for a year, $80,080, and then two years in a private nursing-home room, $259,150, a total of $339,230. She has $150,000 in savings, a paid-off home, and an income of $2,000 a month; her other living costs are set aside. Paying privately, her income and savings cover the year at home and about ten months in the nursing home. By then she has spent down to $2,000, and Medicaid pays for the last fourteen months, while nearly all her income still goes to the home. Her paid-off house does not count toward Medicaid's limit unless its equity passes her state's cap, but after her death the state must try to recover what Medicaid spent from her estate, which may mean the house (5c). In Washington, WA Cares pays the first $36,500, about five and a half months of the aide, so her savings last about four months longer in the nursing home before Medicaid takes over. In Germany her care insurance pays a fixed amount each month for her assessed level of need, up to €1,859 for professional care at home at the second-highest of five grades. In a nursing home she pays the rest of the bill herself, about €3,245 a month, roughly $3,645, in her first year, or about €38,900 ($43,700) for the year, and less in later years as a supplement from her care insurance grows with her length of stay. If she cannot pay, social assistance does.

Module 5 Key Points

Long-Term Care

• 63 million Americans gave unpaid care to a relative or friend in 2024-25, nearly a quarter of them 40 hours a week or more.

• A private nursing-home room cost a median $129,575 in 2025; Medicare does not pay for long-term custodial care.

• Medicaid paid 61% of long-term care spending in 2022, but only after people spend down their savings.

• The 2024 federal staffing rule for nursing homes was vacated, barred until 2034, and repealed in February 2026.

• Washington’s WA Cares began paying up to $36,500 in July 2026, the first public long-term care insurance in America.

Module 5 Quiz

Check Your Understanding

1. Who provides most long-term care in America?

A) Medicare-funded home health agencies
B) Nursing homes, which care for more people than every other setting combined
C) Unpaid family members and friends, 63 million of them in a year
D) Hospitals

2. Which program pays most of America's long-term care spending?

A) Medicaid, 61% in 2022
B) Medicare
C) Private long-term care insurance
D) Patients themselves, out of pocket

3. What happened to the 2024 federal staffing rule for nursing homes?

A) It took effect in 2026 for urban homes only
B) Congress wrote it into the 2025 budget law
C) The Supreme Court upheld it
D) A judge vacated it, the 2025 law barred it until 2034, and it was repealed

4. What does Washington's WA Cares pay?

A) All nursing-home costs for life
B) Up to $36,500 over a lifetime
C) A tax credit for family caregivers
D) A monthly cash benefit of $3,245

5. What is the course's reading on social insurance for long-term care?

A) A capped public benefit with Medicaid as the backstop; the benefit's size is the real choice
B) Private insurance should replace Medicaid entirely, because families can plan for the risk themselves
C) Medicaid alone, after savings and private policies
D) A German-style program paying for care for life

Module 6 — The Workforce

Doctors, Nurses, and the Training Bottleneck

Recommended Reading / Reference

Book: Sandeep Jauhar, *Doctored: The Disillusionment of an American Physician* (2014), a cardiologist's account of how pay, paperwork, and the business of medicine changed the doctor's work

Reference: Bureau of Labor Statistics, *Occupational Outlook Handbook* (pay data for May 2025), and the National Resident Matching Program's *Results and Data: 2026 Main Residency Match*

6a. Who Works in Health Care

Health care and social assistance employed 24.0 million Americans in September 2026, more than any other private industry and far more than retail's 15.5 million (BLS, October 2, 2026). Its largest occupations are the home health and personal care aides of Module 5 and registered nurses, who held about 3.47 million jobs in 2025, at a median pay of $97,550 a year in May. Physicians and surgeons held about 862,800 jobs, at a median of $275,930. Nurse practitioners earned a median $132,300 and physician assistants $135,880, and the BLS projects their numbers to grow by 41% and 21% between 2025 and 2035. Technicians, therapists, pharmacists, and clerks make up much of the rest.

The country has fewer doctors per person than most rich countries (Module 1). Across the OECD the average was 3.9 practicing doctors per 1,000 people in 2023, up from 3.3 in 2013, and the OECD names the United States, Canada, and Japan among the countries with relatively few. American physicians are also unevenly spread. Primary-care shortage areas, which HRSA designates where there are too few primary-care clinicians for the population, were home to 108.6 million people on June 30, 2026, and HRSA estimated that 18,541 more practitioners were needed to lift them.

6b. Making a Doctor

An American doctor trains for longer than most professionals: four years of college, four of medical school, and three to seven years of residency, the paid hospital training in a specialty, sometimes followed by a fellowship. According to the Association of American Medical Colleges (AAMC), 71% of the class of 2024 graduated with education debt, at a median of $205,000 among those who owed anything. First-year residents earned an average stipend of about $68,000 in the AAMC's latest survey, for weeks that may run to 80 hours.

Residency is the bottleneck. A medical graduate cannot be licensed without it, and the number of positions depends largely on Medicare, which pays teaching hospitals for residents' salaries and for the higher costs of teaching. Medicare spent about $21.2 billion on graduate medical education in fiscal 2023, $6.1 billion in direct payments and $15.0 billion for indirect costs, supporting about 116,000 to 124,000 full-time resident positions (Congressional Research Service, August 2025). The Balanced Budget Act of 1997 capped each hospital's Medicare-funded positions at its 1996 count. Congress has added only 1,200 since, in 2021 and 2023, and a bill to add 14,000 over seven years has not passed.

Hospitals fund positions beyond the cap themselves, so the match keeps growing. The National Resident Matching Program offered a record 44,344 positions in March 2026, counting first-year and advanced positions together, and 38,354 applicants matched to first-year positions. Specialties fill unevenly: psychiatry filled 97.4% of its positions in the main match, while family medicine filled only 83.6%, leaving 899 open.

6c. Doctors Trained Abroad

About one practicing American physician in four graduated from a medical school abroad, by the American Medical Association's count, and such doctors are especially common in primary care and in rural and poor areas. In the 2026 match, 70% of American citizens who had studied abroad matched, a record, but only 56.4% of foreign citizens did, a five-year low, and 54.4% of those who needed a visa.

A proclamation of September 19, 2025 imposed a fee of $100,000 on new petitions for H-1B visas, the temporary work visas many hospitals use to hire foreign-trained doctors after residency, from September 21. Twenty states sued in December 2025, and a federal judge in Massachusetts vacated the fee on June 8, 2026; the administration said it would appeal. No exemption for physicians was granted, and a bill to create one, introduced in March 2026, has not passed.

6d. Pay, at Home and Abroad

Specialists earn far more than generalists. In a survey by Doximity, a networking site for physicians, of nearly 23,000 full-time physicians, published on August 25, 2026, family doctors averaged $325,040 in 2025 and pediatricians $273,665, against $604,635 for cardiologists, $696,852 for orthopedic surgeons, and $829,161 for neurosurgeons. The BLS, which surveys employers rather than doctors, reports lower figures: a median of $244,180 for family physicians. Recruiters' offers to new physicians averaged $419,000 in the year to March 2026, and 87% included a signing bonus (AMN Healthcare, a staffing firm, September 16, 2026).

American clinicians also earn far more than their peers abroad. In the comparison of the United States with ten rich countries by Irene Papanicolas and colleagues (Module 1), using data from the mid-2010s, American general practitioners earned $218,173 a year, against $86,607 to $154,126 in the other countries, and specialists $316,000, against $98,452 in Sweden to $202,291 in Australia. American nurses earned $74,160, against $42,492 in France to $65,082 in the Netherlands. Clinicians' pay is one of the prices that make American care expensive.

6e. Burnout, Unions, and Strikes

By the American Medical Association's survey, 45.2% of physicians reported at least one symptom of burnout in 2023, down from a peak of 62.8% in 2021 and close to the level of 2017. The work itself has changed. Most physicians are now employees rather than owners of their practices (Module 9), and employed doctors have begun to unionize, led by residents, whose unions have spread across teaching hospitals since 2020.

Nurses are the most organized. About 15,000 members of the New York State Nurses Association struck at three New York hospital systems, Mount Sinai, Montefiore, and NewYork-Presbyterian, from January 12, 2026, the largest nurses' strike in the city's history. The strike ended after about six weeks with raises of more than 12% over three years. The central issue in most nurses' disputes is staffing: how many patients each nurse must care for. California has set minimum ratios by law since 2004, and Oregon passed its own in 2023; most states leave staffing to hospitals.

6f. The Software That Writes the Notes

A physician spends a large share of the day on the electronic health record, and one technology is aimed squarely at that burden: the ambient scribe, an artificial intelligence (AI) program that listens to a visit and drafts the note. Large health systems adopted it quickly in 2025-26. The early evidence is modest. A study published in 2026 compared more than 1,800 doctors who used a scribe with 6,770 who did not and found that users saved about 16 minutes a day on documentation, with no change in their work after hours; only 32% used it in most visits. A smaller study published in October 2025 reported that the share of users with burnout fell from 51.9% to 38.8% after 30 days.

6g. Is America Short of Doctors? The Cases as Their Advocates Make Them

The case that it is: the AAMC, hospital groups, and many members of Congress argue that the supply has not kept up with an older, sicker population. The AAMC projects a shortage of up to 86,000 physicians by 2036. Americans have fewer doctors per person than most rich countries (6a), family medicine leaves hundreds of residency positions unfilled each year (6b), and a large share of physicians are near retirement. On this view the answer is more residency positions, which requires lifting Medicare's 1997 cap, and easier entry for doctors trained abroad.

The case that it is a problem of pay and place: many health economists and advocates for nurse practitioners argue that the total is less the problem than its distribution. Specialists concentrate in cities and in lucrative fields, while primary care, psychiatry, and rural areas go short, because the fee schedule pays procedures better than time (Module 8). On this view more residents would mostly become more specialists. The faster answers are to pay more for primary care and rural practice, to let nurse practitioners and physician assistants do more, and to free doctors from paperwork.

What the evidence says: both are partly right. The national count is low by international standards, which supports the first case. But the shortages that patients feel are concentrated in primary care, psychiatry, and rural counties, where the shortage areas of 6a and Module 4 lie. In primary care the link to pay is plain: family medicine, among the lowest-paid specialties (6d), leaves hundreds of residency positions unfilled (6b). Psychiatry is different, since it fills nearly all its residency positions; its shortage is partly one of access, because many mental-health clinicians do not join insurers' networks (Module 4).

The course's reading: America has somewhat too few doctors, and far too few in primary care, psychiatry, and rural areas. More residency positions would help slowly; paying primary care and rural practice better, and widening what other clinicians may do, would help faster.

Worked example — The Making of a Family Doctor and an Orthopedic Surgeon

The figures are illustrative, built from the averages in 6b and 6d and ignoring taxes, raises, and investment returns. A family doctor trains for 11 years after high school: four of college, four of medical school, and three of residency. An orthopedic surgeon trains for 13 or 14: five years of residency and often a year of fellowship. Both leave medical school owing the median $205,000, and both earn a resident's stipend of about $68,000 a year while they train, so the surgeon spends two or three more years on a resident's pay. Over 30 years of practice at Doximity's 2025 averages, the family doctor earns about $9.75 million (30 × $325,040). The surgeon, practicing for about 28 years after the longer training, earns about $19.5 million (28 × $696,852). Even after the extra years on a resident's pay, the surgeon earns about twice as much over a career, a gap of nearly $10 million, which is one reason family medicine leaves hundreds of residency positions unfilled each year.

Module 6 Key Points

The Workforce

• Health care and social assistance employed 24.0 million Americans in September 2026, more than any other private industry.

• Medicare spends about $21 billion a year on residency training, and has capped the positions it funds since 1997.

• One American physician in four trained abroad; a $100,000 visa fee imposed in 2025 was vacated by a court in June 2026.

• Orthopedic surgeons averaged $696,852 in 2025 and family doctors $325,040; family medicine left 899 residency positions unfilled.

• The shortage patients feel is concentrated in primary care, psychiatry, and rural areas; low pay keeps family-medicine places empty.

Module 6 Quiz

Check Your Understanding

1. About how many jobs did registered nurses hold in 2025?

A) About 862,800
B) About 3.47 million
C) About 24 million, the whole industry
D) About 10 million, counting aides

2. What limits the number of residency positions Medicare pays for?

A) The number of medical schools
B) State licensing boards
C) A cap on each hospital's count, set by the 1997 Balanced Budget Act
D) Medical students' debt

3. What happened to the $100,000 H-1B fee of September 2025?

A) Congress exempted all physicians from it in 2026
B) It was raised to $250,000 for hospitals
C) It applied only to nurses, not to doctors
D) A court vacated it

4. How did family medicine fare in the 2026 match?

A) It filled 83.6% of its positions, leaving 899 open
B) It filled all its positions for the first time
C) It filled 97.4%, the highest of any specialty
D) It had the most applicants of any field

5. What is the course's reading on whether America is short of doctors?

A) Not short at all: the problem is only that doctors cluster in cities
B) Short only of surgeons, because training takes so long
C) Short only because doctors now retire earlier than they used to
D) Somewhat short, worst in primary care and rural areas

Module 7 — Who Pays: Insurance and Public Programs

The Coverage Map and How It Is Changing

Recommended Reading / Reference

Book: Jonathan Cohn, *The Ten Year War: Obamacare and the Unfinished Crusade for Universal Coverage* (2021), the history of the Affordable Care Act from its passage through the fights over repeal

Reference: Census Bureau, *Health Insurance Coverage in the United States: 2025* (September 15, 2026), and KFF, *Employer Health Benefits Survey 2026* (October 22, 2026)

7a. Why Health Insurance Is Hard to Sell

Health insurance is harder to run than insurance against fire or theft, for reasons the economist Kenneth Arrow set out in 1963. People know more about their own health than any insurer, so those who expect to need care buy coverage and those who do not skip it, a problem called adverse selection. If premiums rise to cover the sick, more of the healthy leave, and the pool can spiral. Once insured, people use more care because it costs them less at the time, which economists call moral hazard. And the patient rarely chooses the treatment: the doctor does, often without knowing its price.

Every system answers these problems in one of three ways. It can make insurance compulsory, so that the healthy stay in the pool, as most rich countries do; it can subsidize the pool to keep them there, as America does through tax breaks and premium credits; or it can let insurers screen out the sick, as American insurers could until 2014. The Affordable Care Act (ACA) of 2010 ended that screening, required insurers to sell to everyone at prices that vary only by age, place, and smoking, and requires them to spend at least 80% of premiums on care in individual and small-group plans and 85% in large-group plans. From 2014 it also fined most people who went without insurance, until Congress cut the penalty to zero from 2019.

7b. The Coverage Map

The Census Bureau counted 26.7 million Americans, 7.9% of the population, without health insurance for the whole of 2025, a figure not statistically different from 2024's. The household survey of the NCHS, part of the CDC, found 8.3%, or 28.0 million, for the same year. The uninsured are mostly working-age adults in low-wage jobs, and their share varies widely by state: in 2024 it ranged from 2.8% in Massachusetts to 16.7% in Texas. Among adults under 65, 18.1% were uninsured in the states that have not expanded Medicaid, against 9.0% in those that have.

Coverage in 2025	Share of Americans covered at some time in the year
Employer-sponsored insurance	53.5%
Medicare	20.1%, up 0.6 points
Medicaid	17.1%, down 0.5 points, the second straight fall
Bought directly, including the marketplaces	10.5% (the marketplaces 4.2%)
Military coverage (TRICARE) and Veterans Affairs	2.8% and 1.2%
Uninsured for the whole year	7.9% (26.7 million people); children 5.8%

Census Bureau, September 15, 2026. People can hold more than one kind of coverage in a year, so the shares add to more than 100%.

The number is set to rise. CBO's projections of February 2026 put the uninsured at 30.0 million in 2026, 34.1 million in 2027, 35.3 million in 2028, and 37.3 million in 2034, 10.5% of the population. CMS's actuaries project fewer, 33.5 million in 2034, because they assume different behavior. Both expect the increase to come from the expiry of the marketplace subsidies (7f) and from the Medicaid changes of the 2025 budget law (7e).

7c. Insurance Through the Job

Most Americans under 65 are insured through an employer, about 157 million people, a system that grew by accident. During the Second World War, when wages were frozen, employers competed for workers with benefits, and in 1954 Congress confirmed that employer premiums are not taxable income. That tax break is now the government's largest for health: CBO estimated in July 2026 that excluding employer premiums from income and payroll taxes would cost $471 billion in fiscal 2026.

The premiums are large and rising faster than pay. KFF's survey, published October 22, 2026, found an average family premium of $28,303 in 2026, up 5% in a year, of which the worker paid $7,471, and an average single premium of $9,804, of which the worker paid $1,672. Over five years family premiums rose 28%, against 26.9% for wages and 24.4% for prices. The average deductible for single coverage was $1,955, and 38% of covered workers had one of $2,000 or more. Economists find that pay grows more slowly when premiums grow faster (Katherine Baicker and Amitabh Chandra, *Journal of Labor Economics*, 2006), so the employer's share of the premium comes largely out of wages, and most of the $28,303 is the worker's money.

Most large employers do not buy insurance at all. They pay their workers' claims themselves and hire an insurer only to run the plan and lend it its network, an arrangement called self-funding. Under the Employee Retirement Income Security Act (ERISA) of 1974, such plans are regulated by the federal government rather than the states, so many state insurance rules, including mandates to cover particular treatments, do not apply to them.

7d. Medicare

Medicare, created in 1965, covers about 70 million people, 64.2 million of them with both its hospital and medical coverage (KFF, 2026). Part A, hospital insurance, is financed mainly by a payroll tax of 2.9% of wages, split between worker and employer, through a trust fund that the program's trustees, in their report of June 9, 2026, project to run out in 2033. After that, incoming revenue would pay 89% of hospital claims. Parts B and D, for doctors and drugs, are financed about three-quarters from general federal revenue and a quarter from beneficiaries' premiums, so they cannot run out. Traditional Medicare has no limit on what a patient can pay in a year, which is why most beneficiaries buy supplemental coverage or choose a private plan.

The private plans, Medicare Advantage, are now the majority. KFF counted 35.2 million enrollees in 2026, 55% of those eligible, up 1.1 million in a year, with UnitedHealth enrolling 26% and Humana 20%. The government pays each plan a monthly amount per enrollee, adjusted for the enrollee's recorded diagnoses, and the plan bears the cost of care. CMS raised those payments by an average of 2.48% for 2027 on April 6, 2026, and stopped counting diagnoses found only in reviews of medical charts not tied to a visit. Plans offer extras, such as dental and vision benefits and a cap on out-of-pocket costs, and manage care through networks and prior authorization (Module 10).

7e. Medicaid and the 2025 Budget Law

Medicaid, also created in 1965, covers people with low incomes, pregnant women, children, disabled people, and the elderly poor in nursing homes. The states run it and the federal government pays 50% to about 77% of each state's costs, depending on its income, and 90% for the adults the ACA made eligible. Forty states and the District of Columbia have adopted that expansion. Most enrollees are in private managed-care plans, which the states pay a fixed amount per person to arrange their care. Medicaid and the Children's Health Insurance Program (CHIP) covered 73.2 million people in June 2026, 66.0 million in Medicaid and 7.2 million in CHIP, down 4.6 million in a year as states rechecked eligibility.

The budget law of July 4, 2025, Public Law 119-21, which its sponsors called the One Big Beautiful Bill Act, makes Medicaid's largest changes since its creation. CBO estimated that it cuts federal Medicaid spending by about $990 billion over 2025-34 (KFF, netting out the law's interactions with its other provisions, puts the cut at $911 billion) and leaves 10 million more people uninsured in 2034, 7.5 million of them because of the Medicaid changes. Its main provisions take effect over four years.

Provision	What it does	When
Work requirements	Adults 19-64 in the expansion group must show 80 hours a month of work, study, or community service, with exemptions for parents of young children, the medically frail, and others. CBO: the largest saving, $325.6 billion, and 5.3 million more uninsured	States must start by January 1, 2027; Nebraska began in May 2026
Six-month checks	Expansion adults' eligibility rechecked twice a year instead of once	Renewals from January 1, 2027
Immigrants	Medicaid and CHIP limited to citizens, green-card holders, and a few other groups	October 1, 2026
Provider taxes	The ceiling on states' taxes on hospitals and other providers, which draw federal matching money, falls from 6% of revenue to 3.5% in expansion states	Fiscal 2028-2032, from October 1, 2027
Cost-sharing	Charges of up to $35 a service for expansion adults above the poverty line	October 1, 2028

CBO estimates via the Congressional Research Service, August 18, 2025; CMS interim final rule of June 1, 2026. Under that rule, states may let enrollees attest to their work until December 31, 2027, and CMS projects about 2.3 million fewer enrollees in fiscal 2027.

Twenty-five states and the District of Columbia sued over the rule in June 2026, and a federal judge in Massachusetts declined to block it in August. The record of earlier requirements is short: when Arkansas imposed one in 2018, about 18,000 people lost coverage within months, with no measurable rise in employment, before a court stopped it.

7f. The Marketplaces

People without coverage through a job or a public program can buy it on the ACA's marketplaces, where premium tax credits cap what a household pays for a benchmark plan, the second-cheapest silver plan in its area, as a share of its income. Plans come in metal tiers by the share of an average enrollee's costs they pay, bronze about 60%, silver 70%, gold 80%, and platinum 90%, and households with incomes up to 250% of the poverty line get cost-sharing reductions, lower deductibles and copayments, if they choose silver. A 2021 law enhanced the credits, capping the benchmark at 8.5% of income and extending help above 400% of the poverty line, and enrollment nearly doubled. Those enhanced credits expired on December 31, 2025, after a Senate vote to extend them failed. The House passed a three-year extension on January 8, 2026, by 230 to 196, with 17 Republicans in favor, but the Senate has not voted on it.

The effects arrived at once. Sign-ups for 2026 fell about 5%, to 23.1 million, and enrollees moved into cheaper bronze plans, which rose to 40% of sign-ups. Paying enrollment, which excludes those who signed up but never paid, fell 12% to 19.2 million in February 2026, and what enrollees paid in premiums rose about 58% on average (KFF). For 2027 the original credits require households to pay between 2.15% and 10.22% of income, with no help above 400% of the poverty line, and insurers asked for a median increase of 15%. Open enrollment on HealthCare.gov runs from November 1, 2026 to January 15, 2027, with December 15 the deadline for coverage from January 1. A 2025 rule would have ended it in mid-December, but a federal court in Maryland vacated that provision in June 2026, and the government has appealed.

7g. How Cost-Sharing Works

Every American plan divides a bill between the insurer and the patient in the same order. The patient pays the deductible first, then coinsurance or copayments, until reaching the out-of-pocket maximum, after which the plan pays in full for covered care in its network. Preventive services, such as screenings and vaccines, are free under the ACA. The law caps the out-of-pocket maximum at $10,600 for one person and $21,200 for a family in 2026, rising to $12,000 and $24,000 in 2027.

A plan with a high deductible can be paired with a health savings account (HSA), into which the worker and employer deposit money free of tax. In 2027 the deductible must be at least $1,750 for one person, contributions may total $4,500 for one person or $9,000 for a family, and out-of-pocket costs are capped at $8,700 (Internal Revenue Service). The 2025 budget law made marketplace bronze plans eligible from January 2026, along with catastrophic plans, which pay little before a very high deductible and are sold mainly to people under 30. In KFF’s 2026 survey, 29% of covered workers were in plans that qualify.

7h. Is Medicare Advantage a Better Medicare, or an Overpaid One? The Cases as Their Advocates Make Them

The case that it is better: the insurers and the groups that represent them argue that the majority who choose the plans know what they are doing. Medicare Advantage caps out-of-pocket costs, which traditional Medicare does not, and adds dental, vision, and hearing benefits without the cost of supplemental insurance. It coordinates care through networks and primary-care clinics that traditional Medicare, paying by the service, never does. It enrolls a larger share of low-income and Black and Hispanic beneficiaries than traditional Medicare does. Its enrollees use less hospital care, which supporters attribute to better management. On payment, they argue that MedPAC’s comparison is unfair: traditional Medicare simply records fewer of its patients’ diagnoses, and the plans deliver care for less, spending 9% to 30% less than traditional Medicare on similar enrollees by one study’s estimates (Vilsa Curto and colleagues, *American Economic Journal: Applied Economics*, 2019). What Medicare pays above a plan’s costs, they add, returns to members as extra benefits.

The case that it is overpaid: MedPAC, Congress’s adviser, estimated on March 12, 2026 that the plans are paid about 14% more than the same people would cost in traditional Medicare, about $76 billion in 2026. MedPAC attributes about 11 points of that to enrolling people healthier than their payments assume and about 4 to recording more diagnoses than traditional Medicare does; it measures the two separately, so they need not sum to the total. The Committee for a Responsible Federal Budget, a fiscal watchdog, puts the overpayment at $1.3 trillion over 2027-36. Critics add that the plans deny care through prior authorization, a minority of which patients appeal and most of which are then overturned (Module 10).

What the evidence says: enrollees are satisfied and do get extra benefits, but the government pays more for them than they would cost in traditional Medicare, by MedPAC's estimate in every recent year. The lower use of hospitals is partly favorable selection, since healthier people choose the plans, and partly management: studies that compare similar enrollees, such as Curto's, find that the plans do spend less on care. The government does not share in those savings, because it pays the plans more than traditional Medicare would cost. The denials are real, and Module 10 gives their scale.

The course's reading: Medicare Advantage gives its members real benefits, but Medicare pays too much for them. The excess comes mostly from selection and coding, not from more efficient care. Paying plans what similar beneficiaries cost in traditional Medicare would show how much of their value survives.

Worked example — Her Choice of Plan, Last November

The plans are illustrative but typical in shape; the deductible is KFF's 2026 average for single coverage. Last November the course's patient chose between two plans her employer offered, for herself alone, since her husband is insured through his own job. The first, a preferred provider organization (PPO), a plan with a network that still pays part of the cost of care outside it, cost her $1,900 a year in premiums, with a $1,955 deductible, 20% coinsurance, and a $5,000 out-of-pocket maximum. The second, a high-deductible plan with an HSA, cost her $1,000 a year, with $750 deposited by her employer, a $3,400 deductible, and a $5,500 maximum. In a healthy year with $1,200 of care, the PPO costs her $3,100 ($1,900 + $1,200, all inside the deductible), and the HSA plan $1,450 ($1,000 + $1,200 − $750). In the year of her heart attack, which reaches both maximums, the PPO costs her $6,900 ($1,900 + $5,000) and the HSA plan $5,750 ($1,000 + $5,500 − $750), before the ambulance's bill (Module 9). The HSA plan is cheaper in both years. The catch is cash: it asks her to pay the first $3,400 herself, which is why many workers who could save choose the PPO, and why people in high-deductible plans skip care (Module 10). She chose the PPO.

Module 7 Key Points

Who Pays: Insurance and Public Programs

• 26.7 million Americans were uninsured all of 2025; CBO projects 37.3 million by 2034 as subsidies lapse and Medicaid shrinks.

• Employer coverage costs a family $28,303 a year in 2026; its tax break costs the government $471 billion.

• Medicare Advantage enrolls 55% of those eligible, and MedPAC finds it is paid about 14% more than traditional Medicare.

• The 2025 law cuts federal Medicaid by about $990 billion over ten years, with work requirements from January 2027.

• After the enhanced credits expired, paying marketplace enrollment fell 12% and what enrollees paid rose about 58%.

Module 7 Quiz

Check Your Understanding

1. What economic problem arises when people who expect to need care buy insurance and healthy people skip it?

A) Moral hazard, the rise in use once care is insured
B) Cost shifting
C) Adverse selection
D) Risk adjustment by insurers

2. How large was the average family premium for employer coverage in 2026?

A) About $9,804
B) About $28,303, of which the worker paid $7,471
C) About $15,474
D) About $40,000, counting the deductible and every copayment

3. What does MedPAC estimate about Medicare Advantage?

A) Plans save Medicare 14% a year
B) Plans are paid about 14% more than traditional Medicare would cost
C) Plans cost the same as traditional Medicare
D) Plans are paid 14% less than traditional Medicare, which explains why they deny more care

4. When must states begin Medicaid work requirements under the 2025 budget law?

A) They already began nationwide in 2025
B) In 2034, when the law's staffing rule also ends
C) By January 1, 2027
D) Never; the requirement was struck down

5. What is the course's reading on Medicare Advantage?

A) It gives members real benefits, but Medicare pays too much for them
B) It is a pure overpayment with no benefit to members
C) It is the cheaper option for the government
D) It should replace traditional Medicare

Module 8 — How Providers Are Paid

Fees, Diagnoses, Bundles, and Budgets

Recommended Reading / Reference

Book: Uwe E. Reinhardt, *Priced Out: The Economic and Ethical Costs of American Health Care* (2019), the Princeton economist's last book, on how American payment and prices came to be

Reference: MedPAC, *Report to the Congress: Medicare Payment Policy* (March 12, 2026), and CMS's final payment rules for 2026 and 2027

8a. The Unit of Payment

How a provider is paid shapes the care it gives, because every method rewards something and risks something else. Paid for each service, a doctor gains by doing more; paid a fixed amount per patient, by doing less. No method is neutral, and most systems mix several to balance their incentives. The table sets out the main ones.

Unit of payment	What it rewards	What it risks	Where it is used
Each service (fee-for-service)	Doing more, and doing what pays best	Unnecessary tests and procedures; no pay for coordination	Most American physicians; Canada's and Japan's doctors
Each day in hospital	Longer stays	Days that are not needed	Some Medicaid and private contracts
Each case, by diagnosis	Shorter, cheaper stays	Discharging patients too early; coding more severe diagnoses	Medicare's hospital payments since 1983; Germany, France, England
Each episode (a bundle)	Coordinating care across an episode	Avoiding complicated patients	Medicare's joint-replacement and surgical models
Each person (capitation)	Keeping people healthy and out of hospital	Stinting on care; selecting healthy patients	Medicare Advantage plans; Kaiser Permanente; British family doctors in part
A global budget	Controlling the total	Waiting lists; little reward for extra work	Maryland's hospitals; hospitals in many national systems
A salary	Neither more nor less care	Low productivity	Veterans Affairs; most British hospital doctors

8b. Medicare's Fee Schedule

Since 1992 Medicare has paid physicians from a fee schedule based on relative value units (RVUs), a scale built from a study at Harvard led by the economist William Hsiao. Each of about 10,000 service codes carries RVUs for the physician's work, the practice's expenses, and malpractice insurance. Medicare adjusts them for local costs and multiplies them by a conversion factor to get dollars. Most private insurers and Medicaid programs use the same codes and units and pay a multiple or fraction of Medicare's rates, so the schedule sets the relative prices of nearly all American medicine.

For 2026, for the first time, there are two conversion factors: $33.4009 for most physicians, 3.26% more than in 2025, and $33.5675 for those in advanced payment models, such as accountable care organizations that take on risk. Much of the rise came from a one-year increase of 2.5% in the 2025 budget law. Medicare also cut the work value of about 7,700 codes for procedures and tests by 2.5%, which it called an efficiency

adjustment, sparing office visits and other services timed by the clock. Its proposal for 2027, published on July 14, 2026, would cut the main conversion factor to $32.8409, down 1.68%, as the one-year increase lapses; the final rule is due about November 1.

The values come largely from a committee of the American Medical Association, the Relative Value Scale Update Committee (RUC). Its 32 members include 22 named by specialty societies, and Medicare accepts about 90% of its recommendations. Critics, among them many primary-care physicians and health economists, argue that the committee has overvalued procedures and undervalued the time doctors spend with patients, which is one reason a specialist earns far more than a family doctor (Module 6). Medicare can, and occasionally does, override it.

8c. Paying Hospitals by Diagnosis

Until 1983 Medicare paid hospitals their costs, and costs rose fast. A law that year replaced cost reimbursement with prospective payment: a fixed amount for each stay, set by its diagnosis-related group (DRG), whatever the hospital spends or however long the patient stays. Medicare now uses about 770 groups. Each carries a weight reflecting its average cost; the weight times a national base rate, adjusted for local wages, teaching, and the hospital's share of low-income patients, gives the payment. Lengths of stay fell sharply after 1983, and the method spread to most rich countries.

Medicare raised its hospital rates by 2.6% for fiscal 2026 and by 2.3% for fiscal 2027, the latter in a rule of July 31, 2026: an estimated rise of 3.2% in hospitals' input prices, less 0.9 points for expected gains in productivity. The same rule created a mandatory national program of bundled payments for joint replacements from January 1, 2028. Outpatient services, such as clinic visits, scans, and same-day surgery in hospital departments, are paid under a separate prospective system, which rose 2.6% for 2026; the proposal for 2027 is 2.4%.

8d. Paying for Value

Since the ACA, Medicare has tried to move payment from volume to value, chiefly through accountable care organizations (ACOs) and bundled payments, tested by an Innovation Center the law created. In 2026, 511 ACOs took part in the Medicare Shared Savings Program, the main ACO program, with 12.6 million beneficiaries assigned to them, the most ever, and 76% of the ACOs taking on the risk of losses as well as savings. For 2024, CMS reported, the ACOs earned $4.1 billion in shared savings and Medicare saved $2.5 billion net of those payments.

The broader record is thinner. GAO reported on March 27, 2026 that of the 70 models the Innovation Center had tested, only 4 had been certified as saving money or improving quality enough to be expanded. CBO found that the center raised federal spending by $5.4 billion in its first decade, 2011-2020. The final evaluation of the largest voluntary bundled-payment model, published on September 23, 2026, found more than $800 million of net savings over eight years, too little to justify expanding it. The center has since turned to mandatory models, which voluntary participants cannot avoid: a five-year program of surgical bundles at 716 hospitals began on January 1, 2026, and others start in 2027.

8e. Maryland’s All-Payer System

Maryland is the only state that sets the prices every payer pays its hospitals, so that Medicare, Medicaid, and private insurers pay the same rate for the same care, a system that dates back to the 1970s under a waiver from Medicare’s national rules. Since 2014 each of its general hospitals has also been held to a global budget, a fixed revenue for the year set in advance, so that a hospital earns nothing extra by admitting more patients and keeps the savings if it admits fewer. Since 2016, 98% of regulated hospital revenue has been under these budgets.

The state’s rate commission reports that the system met its targets. Under the Total Cost of Care model of 2019-2025, it reported Medicare savings that rose from $365 million in 2019 to $476 million in 2023, against targets of $120 million to $300 million, and $285 million in 2024. The record is not unmixed. Its first-half sample for 2025 showed $132 million of extra spending rather than savings, and its readmission rate rose above the national rate in 2021 before falling back. From January 1, 2026 the state moved into a new federal model, AHEAD (States Advancing All-Payer Health Equity Approaches and Development), which runs to the end of 2035 and requires larger savings: from 0.13% a year against the national trend at first to 0.63% later.

8f. Has Paying for Value Worked? The Cases as Their Advocates Make Them

The case that it has: CMS, the ACOs’ trade groups, and many health systems argue that the models have changed how care is organized and saved money while keeping quality steady. The Shared Savings Program saves Medicare money even after the bonuses it pays, enrolls more beneficiaries each year, and has brought most of its ACOs to accept the risk of losses (8d); the bundled-payment models cut spending on joint replacements and other episodes. Maryland held hospital spending to its targets for a decade. On this view the models are building the habits and data that a system paid by value needs, and their savings will grow as more providers take on risk.

The case that it has not: CBO, GAO, and many economists argue that the savings are small and often overstated. Against Medicare spending of more than $1 trillion a year, the program’s net savings (8d) are about a quarter of 1%. The Innovation Center as a whole raised federal spending, voluntary models attract providers who expected to save anyway, and generous benchmarks, the spending targets against which ACOs’ savings are measured, pay ACOs for savings that would have happened regardless. Most physicians are still paid by the service, and the models add paperwork to a system already heavy with it.

What the evidence says: the savings are real but small against Medicare’s spending, and voluntary participants select themselves, which is why the Innovation Center has turned to mandatory models (8d). Quality has generally held steady or improved slightly. None of the models has changed the main driver of American spending, the level of prices that private insurers pay, which Medicare’s payment reforms do not reach (Module 9). Maryland, which does regulate private prices, is the partial exception.

The course’s reading: paying for value has made care somewhat more coordinated and saved a little money, but it has not transformed American medicine. Payment by the service still dominates, and the largest lever, the prices private insurers pay, lies outside these models.

Worked example — The Stent Paid Five Ways

The figures are Medicare's national rates for 2026 before local adjustment, from MedPAC and manufacturers' guides to the CMS rules, and the private ratios of Module 9. **By the service,** as traditional Medicare would pay if she were 65, the ambulance company gets about $645 for a 10-mile emergency trip with advanced life support in a city, and the emergency physician $171 for a visit of the highest level. The cardiologist gets $287 for the diagnostic catheterization and $590 for opening the blocked artery and placing the stent. **By the case,** the hospital gets a single payment of $12,829 for the whole stay, the national amount for a coronary procedure with a stent and no major complications, whether she stays two nights or four. Together that is about $14,500. Her employer's insurer pays the same parties in the same two ways, but at its negotiated prices, about $32,600 to the hospital and $1,470 to the physicians (Module 9). **By the person,** a plan paid by capitation, such as Kaiser Permanente, receives the same monthly amount for her whatever happens, pays its cardiologists a salary, and bears the whole cost of her care. **By the episode,** a bundle gives the hospital a target price for the stay and the following 90 days, including readmissions and rehabilitation, and shares any savings or losses against it; Medicare's largest voluntary bundled model covered heart attacks and stents this way until it ended in 2025. **By the budget,** a Maryland hospital is paid the same rate by every payer, but its revenue for the year is fixed in advance, so her admission brings it nothing extra, and keeping her from coming back saves it money.

Module 8 Key Points

How Providers Are Paid

• Each method of payment rewards something: fees reward doing more, capitation doing less, and diagnosis groups shorter stays.

• Medicare’s fee schedule sets relative prices for nearly all American medicine; an AMA committee proposes most of its values.

• Medicare has paid hospitals a fixed amount per diagnosis since 1983, and raised its rates 2.3% for fiscal 2027.

• Medicare’s ACOs saved $2.5 billion net in 2024, about a quarter of 1% of Medicare spending.

• Maryland sets every payer’s hospital prices and gives each hospital a global budget; its savings met targets until 2025.

Module 8 Quiz

Check Your Understanding

1. What does fee-for-service payment reward?

A) Keeping patients healthy and out of the hospital
B) Shorter stays
C) Neither more nor less care, whatever the patient needs
D) Doing more, and doing what pays best

2. Who proposes most of the values in Medicare's physician fee schedule?

A) Congress, code by code
B) MedPAC
C) The insurers
D) The RUC, a committee of the American Medical Association

3. What changed in 1983 in how Medicare paid hospitals?

A) It began paying hospitals their full costs, plus a margin
B) It moved every hospital to a global budget
C) A fixed amount per stay, by diagnosis
D) It stopped paying for teaching

4. What did GAO find about the Innovation Center's models?

A) Only 4 of 70 were certified for expansion
B) All 70 saved money
C) Half were expanded nationwide after their first five years
D) Most cut costs and raised quality

5. What is the course's reading on paying for value?

A) It has transformed American medicine within a decade
B) Modest savings, no transformation
C) It has raised quality but cost the government a fortune
D) Its savings will grow as more providers take on the risk

Module 9 — Prices, Bills, and Market Power

Why American Care Costs What It Does

Recommended Reading / Reference

Book: Marty Makary, *The Price We Pay: What Broke American Health Care, and How to Fix It* (2019), a surgeon's account of hospital billing and pricing, by the surgeon who was commissioner of the Food and Drug Administration from 2025 to 2026

Reference: RAND, *Prices Paid to Hospitals by Private Health Plans*, Round 5.1 (December 10, 2024), and the Health Care Cost Institute's annual *Health Care Cost and Utilization Report*

9a. The Price Gap

The central fact of American health spending is that the same care costs different amounts depending on who pays, and the private price is far above the public one. RAND, studying claims from employers and insurers, found that private health plans paid hospitals 254% of what Medicare would have paid for the same services in 2022. The ratio varied widely: among the states, only Arkansas was below 170%, and eight were above 300%. Indiana averaged 297%. For physicians' services the gap is smaller: preferred-provider plans paid about 140% of Medicare's fees in 2023 (MedPAC, March 2025).

Prices, not the amount of care, drive the growth. The Health Care Cost Institute, which studies the claims of large insurers, reported on October 13, 2026 that spending per commercially insured person reached $6,743 in 2023. From 2019 to 2023 it rose 18.8%. Over those years the prices of services rose 17.7% and their use 1.8%; by the institute's reckoning, higher prices accounted for $959, or 90%, of the $1,068 increase per person. The place a service is delivered also sets its price. In 2022 an ordinary office visit cost the commercially insured $116 in a doctor's office and $217 in a hospital's outpatient department, because the hospital adds a facility fee for the same visit (Health Care Cost Institute, May 6, 2025).

9b. Market Power

Private prices are set by negotiation between insurers and providers, and the side with fewer rivals wins. Over three decades hospitals have merged into systems that dominate their regions, so that an insurer that leaves a large system out of its network may lose its customers. Studies of mergers find that prices rise afterward, especially when the merging hospitals are close to each other. Mergers slowed in 2025, to 46 deals involving $18.5 billion of the sellers' revenue, the smallest total since Kaufman Hall began tracking it, with a record 43.5% involving a distressed party. They recovered in 2026, with 56 deals in the first three quarters (Kaufman Hall).

The systems have also bought the doctors. As of January 1, 2026, 82.0% of American physicians were employed by hospitals and health systems (59.7%) or by other companies, such as insurers and investors (22.3%), and 63.9% of practices were owned by them (Physicians Advocacy Institute, a physicians' advocacy group, and Avalere, a consulting firm). When a hospital buys a practice, the practice's offices can become hospital outpatient departments that charge facility fees (9a). Optum, part of UnitedHealth Group, employs or contracts with more than 90,000 physicians, about one in ten, which makes the company at once the largest insurer and the largest employer of doctors. The Justice Department has investigated its physician groups and its billing.

Private equity has bought practices in specialties such as anesthesia, dermatology, and gastroenterology, often several in one city. A 2023 study for the American Antitrust Institute found that prices rose by 4% to 16% after such purchases in eight of ten specialties, and a 2022 study found that allowed amounts per claim rose 11% after private equity bought dermatology, gastroenterology, and ophthalmology practices. A 2024 study found that about half of such practices were resold within three years, almost all to other private-equity firms. Two investor-backed hospital chains collapsed: Steward Health Care, owned by Cerberus Capital Management from 2010 to 2020, went bankrupt in May 2024, and Prospect Medical Holdings followed in January 2025.

States and federal agencies have begun to respond. Oregon's law of June 9, 2025 bars management companies from controlling medical practices and voids most clinicians' noncompete agreements, and California barred private-equity firms and hedge funds from controlling clinical and billing decisions from January 1, 2026. Massachusetts banned new sale-and-leaseback deals of hospitals' main campuses to real-estate trusts after Steward's collapse. The Federal Trade Commission (FTC) created a health-care task force on March 20, 2026, and the Justice Department and Ohio sued OhioHealth over its contracts with insurers in February 2026.

9c. Transparency

Since January 1, 2021 federal rules have required hospitals to publish their prices, including the rates negotiated with each insurer, and since 2022 insurers have had to publish theirs. An executive order of February 25, 2025 told the agencies to enforce the rules and to require actual prices rather than estimates. Since January 2026 hospitals must also post the median and the range of amounts they are actually paid, with enforcement from April 1. Compliance is improving but incomplete. A review by PatientRightsAdvocate.org, an advocacy group, published on September 10, 2026, found 49% of 2,000 hospitals compliant, up from 21% in November 2024, but only 18% posted dollar prices for at least half of their items and services. CMS had fined 28 hospitals, and sent warning letters to more than 500 in June 2026.

Transparency helps researchers and employers more than patients. Most care is not shoppable, because the patient is sick, the choice is the doctor's, or the network decides, and the published files are vast and hard to read. Their main use so far has been to show employers and legislators how much prices vary, which has fed the price caps of 9h.

9d. The Anatomy of a Bill

An American medical bill is assembled in steps. The provider records each service in standard codes: diagnosis codes for what is wrong, procedure codes for what was done, and for a hospital stay, a diagnosis-related group (Module 8). It bills the insurer its gross charge, the list price from its chargemaster, which almost no one pays. The insurer pays its allowed amount, the price it negotiated, and sends the patient an explanation of benefits showing the charge, the allowed amount, the plan's payment, and what the patient owes under the deductible, coinsurance, and copayments.

A single episode produces several bills, because each organization that treated the patient bills on its own (Module 3), and claims can be denied for being out of network, lacking prior authorization, or being judged unnecessary. KFF found that marketplace insurers denied 19% of claims for care inside their networks in 2024, with rates ranging from 3% to 36% by insurer. Fewer than 1% of denials were appealed (March 24, 2026).

9e. Surprise Bills

Until 2022 a patient treated at an in-network hospital could still receive a large bill from an out-of-network doctor there, an anesthesiologist, an emergency physician, or a radiologist the patient never chose, who billed the patient for whatever the insurer did not pay. The No Surprises Act, passed in 2020 and in force from January 1, 2022, banned such balance bills for emergency care, for out-of-network clinicians at in-network facilities, and for air ambulances. Patients now owe only their in-network cost-sharing.

The law left the payment itself to be settled between insurer and provider, with an independent arbiter choosing between their offers if they disagree. The volume of disputes overwhelmed every projection. About 2.56 million were filed in 2025, against a federal estimate of 22,232 a year, and another 1.75 million in the first half of 2026. Providers won about 85% of the decisions in late 2025. The Georgetown University Center on Health Insurance Reforms estimated the median winning award in 2025 at 445% of the insurer's benchmark, its median in-network rate for the service, and the total cost of the arbitration from 2022 to 2025 at $22.4 billion, costs that return to everyone as premiums.

Ground ambulances were left out of the law. More than one privately insured ambulance trip in four may bring a surprise bill, and the average commercial ground-ambulance bill was $1,093 in 2021 (Commonwealth Fund, February 18, 2026). A federal advisory committee recommended in 2024 that balance billing for ground ambulances be banned and patients' costs capped at $100 or 10%, but Congress has not acted. Twenty-two states protect patients; four added protections in 2025, and Illinois strengthened its law.

9f. Medical Debt

Americans owed at least $220 billion of medical debt in 2021, by KFF's analysis of Census data; about 14 million adults owed more than $1,000 and 3 million more than $10,000. In January 2025 the Consumer Financial Protection Bureau (CFPB) issued a rule removing medical debts from credit reports, which it estimated would erase about $49 billion of debt from the reports of about 15 million people. A federal judge in Texas vacated the rule on July 11, 2025, at the request of the bureau and the industry plaintiffs together. The three credit bureaus still leave paid medical debts and those under $500 off their reports, and about 15 states, among them California, New York, and Maryland, restrict reporting further.

9g. Drug Prices, in Brief

Prescription drugs bought at pharmacies are the third-largest category of spending (Module 1), more if drugs given in hospitals and clinics are counted. The list price of a brand-name drug is not what most payers pay. Drugmakers pay rebates to pharmacy benefit managers (PBMs), the companies that run drug coverage for insurers and employers, in return for favorable placement. The three largest, CVS Caremark, Express Scripts (owned by Cigna), and Optum Rx (UnitedHealth), handle about 80% of American prescriptions. For employer plans, drug spending in 2023 was about $1,613 a person before rebates and about $1,162 after (Health Care Cost Institute).

The appropriations law of February 3, 2026 separates PBMs' pay from drugs' list prices in Medicare's drug program from 2028 and requires them to pass all rebates to employer plans from 2028-29. Medicare's negotiated prices for its first ten drugs took effect on January 1, 2026, fifteen more follow on January 1, 2027, and the prices for a third round, the first to include drugs given in doctors' offices, are due by

November 30, 2026, for 2028. The cap on what a Medicare beneficiary pays for drugs in a year is $2,100 in 2026 and $2,400 in 2027.

9h. Cap Prices, or Restore Competition? The Cases as Their Advocates Make Them

The case for caps: employers' coalitions, many health economists, and legislators of both parties argue that most hospital markets are already concentrated, so competition cannot discipline prices that market power has set. A ceiling tied to Medicare's rates attacks the gap directly. Oregon has capped what its state-employee plan pays hospitals at 200% of Medicare since 2019, and a Brown University analysis found it saved about $50 million a year with no significant harm to hospitals' revenue, margins, staffing, or services. Washington will cap its public-employee plans at 200% from January 1, 2027, Indiana requires its five largest nonprofit systems to offer employers prices no higher than 260% of Medicare, and Michigan, Maine, and Delaware are debating caps.

The case for competition: hospital associations and economists wary of price controls argue that caps would cut the revenue that keeps rural and safety-net hospitals open and pays for their investment, and that controlled prices lead to shortages and waits. MaineHealth estimates that Maine's proposed cap would cut its revenue by $650 million a year. They would rather enforce antitrust law against mergers, ban contract terms that stop insurers from steering patients to cheaper hospitals, pay the same for a service in any setting, which is called site-neutral payment, and repeal state laws that limit new hospitals and equipment.

What the evidence says: the one cap with a record, Oregon's, saved money without measurable harm, though it covers only about 15% of the state's commercially insured patients. Antitrust enforcement has blocked a few mergers but cannot undo the consolidation of the past thirty years. Site-neutral payment, the mildest step, saves real money: Medicare has applied it to drug administration in off-campus hospital departments since 2026 and proposes to extend it to some imaging in 2027, each step worth hundreds of millions of dollars a year. Transparency has so far changed few prices.

The course's reading: competition policy can keep markets from concentrating further, but most are concentrated already. Where they are, a ceiling tied to Medicare's rates, set high enough to keep hospitals solvent, as Oregon's is, is the tool with evidence behind it. Site-neutral payment is the least disruptive place to start.

Worked example — The Episode's Bills, From Charge to What She Owes

The charges are illustrative; the allowed amounts apply the ratios of 9a to the Medicare rates of Module 8, for the plan she chose in Module 7. The hospital charges $70,000 for her stay, and her insurer allows $32,586, 254% of Medicare's payment. The emergency physician and the cardiologists charge $4,400 between them and are allowed $1,468, 140% of Medicare's fees. Her explanations of benefits apply her $1,955 deductible and then 20% of the remaining $32,099, which would make her share $8,375, but her plan's $5,000 limit on out-of-pocket costs stops it there, and the plan pays the other $29,054. The ambulance company is outside her network and bills $1,500. Her plan pays the $1,000 it considers reasonable, and because federal law does not cover ground ambulances and her state does not protect her, the company bills her for the other $500, which does not count toward her limit. She owes $5,500 in all, on top of her $1,900 of premiums for the year, and the bills arrive separately over several months.

Module 9 Key Points

Prices, Bills, and Market Power

• Private plans paid hospitals 254% of Medicare’s prices in 2022; prices, not use, drove commercial spending up in 2019-23.

• Eight American physicians in ten work for hospitals or companies; the same visit costs far more in a hospital department.

• The 2022 surprise-billing law protects patients, but its arbitration took 2.56 million disputes in 2025 against 22,232 expected.

• Americans owed at least $220 billion of medical debt; the rule removing it from credit reports was vacated in 2025.

• Oregon’s cap of 200% of Medicare saved about $50 million a year without measurable harm to hospitals.

Module 9 Quiz

Check Your Understanding

1. What did RAND find private plans paid hospitals in 2022, relative to Medicare?

A) About the same as Medicare, once rebates are counted
B) About 120%
C) About half of Medicare, since insurers negotiate discounts
D) About 254% of Medicare

2. What drove spending growth for the commercially insured in 2019-23, according to the Health Care Cost Institute?

A) Higher prices, more than use
B) Use of services
C) An older population
D) More hospital beds and longer stays

3. What does the No Surprises Act protect patients from?

A) All ambulance bills
B) Balance bills from out-of-network clinicians at in-network facilities and in emergencies
C) Every denied claim
D) High deductibles

4. What happened to the federal rule removing medical debt from credit reports?

A) It took effect nationwide in January 2026
B) Congress wrote it into the 2025 budget law
C) A judge vacated it
D) It now applies only to Medicare patients

5. What is the course's reading on capping prices or restoring competition?

A) Competition alone will lower prices
B) Caps should be set at Medicare's own rates, since any private price above Medicare reflects market power alone
C) Prices should be left to insurers
D) Where markets are concentrated, a Medicare-based ceiling, as in Oregon, has the evidence behind it

Module 10 — Rationing: Queues, Prices, and Rules

How Every System Limits Care

Recommended Reading / Reference

Book: Henry J. Aaron and William B. Schwartz, *The Painful Prescription: Rationing Hospital Care* (1984), the classic study of how Britain limited hospital care, and of what American rationing would look like

Reference: NHS England's monthly statistics on waiting times, and the Commonwealth Fund's international surveys of patients in ten rich countries

10a. Every System Rations

No country can give every patient every service that might help, because the possible uses of medicine are limitless and the money is not. Every system therefore rations: it decides, openly or not, who gets what. The word is unpopular, and Americans often say their system does not ration at all. It does, by different means. There are five: price, which leaves the decision to what patients can pay; the queue, which makes them wait; rules, which say what will be paid for; paperwork, which makes approval slow or uncertain; and capacity, which limits the beds, machines, and staff that exist.

10b. By Price

The best evidence on what prices do to care comes from the RAND Health Insurance Experiment, run in the 1970s and early 1980s, the only large trial to assign families at random to different levels of cost-sharing. Families who paid 95% of their bills, up to a yearly cap tied to income, spent about 30% less than families who paid nothing. The cuts fell about equally on effective and less effective care. For the average participant, paying more did no measurable harm to health, but for the poorest and sickest it did, chiefly through worse control of high blood pressure and poorer eyesight.

A later natural experiment showed how patients cut back. When a large self-funded employer moved all its workers from free care to a plan with a high deductible in 2013, spending fell by about 12% to 14%, according to Zarek Brot-Goldberg, Amitabh Chandra, Benjamin Handel, and Jonathan Kolstad (2017). None of the saving came from shopping for cheaper providers; all of it came from using less care. Workers cut likely valuable care, such as preventive visits, along with likely wasteful care, and even the sickest, who were sure to pass the deductible, cut back.

Price is America's main rationing device. In KFF's survey of May 2026, 28% of adults said they had skipped or postponed needed care in the past year because of the cost, as had 62% of uninsured adults under 65. In a KFF poll in late February and early March 2026, 27% said they had not filled a prescription because of the cost.

10c. By Queue

Systems that make care free at the point of use ration largely by waiting. England's NHS promises that 92% of patients referred for planned hospital treatment will start it within 18 weeks, a standard it has not met since 2016. At the end of August 2026 its waiting list held 7.37 million cases, belonging to about 6.24 million people, and about 65% had waited less than 18 weeks. The NHS met an interim target of 65% in March 2026, but progress has since stalled; its next targets are 70% by March 2027 and 92% by March 2029. In September 2026, 74.4% of patients in its emergency departments were admitted, transferred, or discharged within four hours, against a target of 82% for March 2027; the target for March 2026 had been 78%. In August, 71.9% of patients urgently referred for suspected cancer began treatment within 62 days, against a standard of 85%.

In Canada the Fraser Institute, a free-market think tank that surveys specialists each year, found a median wait of 28.6 weeks in 2025 from a family doctor's referral to treatment: 15.3 weeks to see the specialist and 13.3 more to be treated. That was down from a record 30.0 weeks in 2024 but three times the 9.3 weeks of 1993. Provinces ranged from 19.2 weeks in Ontario to 60.9 in New Brunswick.

Universal coverage does not have to mean long waits. In the Commonwealth Fund's 2023 survey of ten rich countries, the Netherlands, Germany, and Switzerland, which cover everyone, gave the quickest access to specialists and to surgery, while Canada and Britain were among the slowest. The United States, which has no national waiting list, fell in the middle.

Country	Specialist within a week	Elective surgery within a month	Doctor or nurse the same or next day
Netherlands	23%	58%	27%
Germany	22%	50%	30%
Switzerland	21%	46%	21%
United States	17%	40%	21%
Sweden	17%	29%	17%
Australia	14%	45%	19%
Canada	12%	26%	14%
New Zealand	12%	39%	17%
United Kingdom	12%	31%	30%
France	11%	35%	21%

Share of adults needing each kind of care who got it this quickly. Commonwealth Fund, 2023 International Health Policy Survey, published in *Mirror, Mirror 2024* (September 19, 2024).

10d. By Rule

Many countries judge formally whether a treatment is worth its price. England's National Institute for Health and Care Excellence (NICE), founded in 1999, recommends a treatment for the NHS if it costs less than a threshold for each quality-adjusted life year (QALY) it adds. Under a medicines agreement that Britain and the United States announced on December 1, 2025, the threshold rose from £20,000-30,000 to £25,000-35,000 per QALY for appraisals from April 2026, the first rise in more than two decades. A treatment above it is usually not offered unless its maker lowers the price.

Germany assesses rather than refuses. Since 2011 a new drug has been covered from launch, but a federal committee rates its added benefit over existing treatment, and from the seventh month the sickness funds

pay a price negotiated from that rating. In the United States an independent group, the Institute for Clinical and Economic Review (ICER), publishes cost-effectiveness reports that payers may use, generally treating $100,000 to $150,000 per QALY as reasonable. Medicare itself is barred by the ACA from using cost per QALY to set coverage or payment, and the Inflation Reduction Act of 2022, which lets Medicare negotiate some drug prices, bars such measures from those negotiations too. Supporters of the bans argue that the measure undervalues the lives of older and disabled people.

10e. By Paperwork

American insurers ration most visibly through prior authorization. KFF found that Medicare Advantage plans made 52.8 million prior-authorization decisions in 2024, 1.7 per enrollee, and denied 7.7% of the requests in full or in part, 4.1 million in all (January 28, 2026). Only 11.5% of the denials were appealed, but 80.7% of the appeals succeeded, which suggests that many denials would not survive a challenge. Denial rates ranged from 4.2% at Elevance to 12.8% at UnitedHealth. Some services are denied far more often: in June 2024 the plans denied 65% of requests to admit patients to long-term care hospitals and 54% to inpatient rehabilitation.

The first public reports that federal rules now require of insurers, covering 2025, show standard requests denied at 12% in Medicare Advantage, 14% in Medicaid managed-care plans, and 18% in marketplace plans, on a measure that cannot be compared directly with KFF's count (KFF, August 13, 2026). Under pressure, insurers covering 257 million people pledged through their trade group, AHIP, on June 23, 2025 to cut the number of services needing approval by January 1, 2026, to honor a patient's existing approvals for 90 days after a change of plan, and to answer 80% of electronic requests in real time in 2027.

Meanwhile the government brought prior authorization into traditional Medicare, which had used it little. Its Wasteful and Inappropriate Service Reduction (WISeR) model, running from January 2026 to the end of 2031 in Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington, has technology companies review requests for 17 services, such as nerve stimulators and some knee operations, and pays them a share of the spending they avert. In Texas about 62% of initial requests were approved, rising to 84% after review by a physician (reported in June 2026). The House Appropriations Committee voted on June 9, 2026 to deny the model funds for 2027, but in the Senate a motion to take up a resolution overturning the model failed, 46 to 50, on July 16.

10f. By Capacity

A system also rations by what it builds. However generous its rules, a country can treat only as many patients as its beds, scanners, operating rooms, and staff allow, and the countries with the quickest access (10c) all spend more per person than the OECD average (Module 1). In the United States, 35 states and the District of Columbia require a certificate of need, a state's approval, before a hospital may add beds or buy expensive equipment. The rule is meant to prevent wasteful duplication, and critics say it protects incumbents from competition. Tennessee voted in April 2026 to end its requirement for most hospitals in 2030, North Carolina dropped it for inpatient rehabilitation from October 1, 2026, and 17 states pledged to loosen theirs in applications to the rural fund (Module 3).

10g. Are Waiting Lists the Price of Universal Coverage? The Cases as Their Advocates Make Them

The case that they are: free-market analysts, among them the Fraser Institute, argue that when care is free at the point of use and paid from fixed public budgets, demand outruns supply and patients wait. Canada's median wait has risen steeply since the 1990s (10c), England's list reached a record 7.77 million in September 2023, and delays to diagnosis and surgery cost health and livelihoods. Americans get elective surgery faster than Canadians or Britons, and on this view it is prices that keep the American queue short.

The case that they are not: defenders of universal systems argue that waits come from budgets and capacity, not from universality. The countries with the quickest access in 10c cover everyone; they are quick because they spend more and pay providers for the work they do. England's list grew after a decade of slow budget growth from 2010, and then the pandemic, and Canada has long limited its numbers of doctors and private clinics. The United States, meanwhile, rations by price instead (10b).

What the evidence says: the surveys support the second case on the main point. Universal systems range from the quickest access to the slowest, so universality alone does not decide waits. The first case is right that a system with fixed budgets and free care must ration by queue unless it pays for enough capacity, and that Americans wait less for elective surgery than Canadians or Britons. Neither side's figures count the Americans who never join a queue because they cannot pay.

The course's reading: waiting lists are the price of tight budgets and scarce capacity, not of universal coverage itself. Every system chooses among queues, prices, and spending, and the universal systems with short waits are those that spend more and pay for the work done.

Worked example — One New Drug, Judged Four Ways

The drug is hypothetical. A new medicine for a lung disease adds an average of half a year of healthy life, 0.5 QALY, and costs $75,000 more per patient than current treatment, or $150,000 per QALY ($75,000 ÷ 0.5). NICE's threshold of £25,000-35,000 per QALY is about $33,300-46,700 at $1.3330 to the pound, so England would refuse the drug unless its maker cut the extra cost by about 70%, to roughly $23,300 a patient. Germany would cover it at launch, and from the seventh month would pay a price negotiated from the added benefit the federal committee found. ICER would place it at the top of its $100,000-150,000 range, a finding private insurers could use to press for a discount, often by requiring prior authorization until they got one. Medicare would generally cover it once the Food and Drug Administration approved it, whatever its cost per QALY. A negotiated price could take effect only nine years after approval for a pill, or thirteen for a biologic, and the patient's own share would stop at Medicare's annual cap on drug costs (Module 9).

Module 10 Key Points

Rationing: Queues, Prices, and Rules

• Every system rations, by price, queue, rule, paperwork, or capacity; America relies most on price and paperwork.

• In the RAND experiment, families paying 95% of their bills spent about 30% less than those with free care, with little average harm.

• England’s waiting list held 7.37 million cases in August 2026; Canada’s median wait from referral to treatment was 28.6 weeks in 2025.

• The Netherlands, Germany, and Switzerland cover everyone and gave the quickest access to specialists and surgery of ten countries surveyed.

• Medicare Advantage plans denied 7.7% of 52.8 million prior-authorization requests in 2024; 80.7% of appealed denials were overturned.

• NICE’s threshold rose to £25,000-35,000 per QALY in 2026; Medicare may not use cost per QALY to set coverage or payment.

Module 10 Quiz

Check Your Understanding

1. What did the RAND Health Insurance Experiment find?

A) Cost-sharing improved health in every group, the poorest included.
B) Families facing cost-sharing switched to cheaper doctors and hospitals rather than using less care.
C) Paying most of the bill cut spending about 30%, with little average harm to health.
D) Cost-sharing had no effect on how much care families used, only on which doctors they chose.

2. How did workers at a large company cut spending after being moved to a high-deductible plan in 2013?

A) They shopped for cheaper providers and kept using as much care.
B) They used less care, including likely valuable care, instead of shopping for lower prices.
C) They moved most of their visits to telehealth.
D) They cut only unnecessary scans and tests, sparing valuable care.

3. How many cases were on England's waiting list for planned hospital treatment at the end of August 2026?

A) 7.37 million
B) About 2.1 million
C) About 12.4 million
D) Under one million

4. What happens to Medicare Advantage denials of prior authorization when patients appeal?

A) Most are upheld
B) Almost all are appealed
C) Few are appealed, but about four in five of those appealed are overturned
D) Appeals are not allowed

5. What is the course's reading on whether waiting lists are the price of universal coverage?

A) Yes: wherever care is free at the point of use, demand always outruns supply and long waits follow
B) No: they reflect tight budgets and scarce capacity
C) Waits are longest in the United States, which rations by queue
D) They exist only in single-payer systems

Module 11 — Quality, Safety, and Outcomes

What the Money Buys

Recommended Reading / Reference

Book: Institute of Medicine, *To Err Is Human: Building a Safer Health System* (released in 1999), the report that made patient safety a national cause

Reference: OECD, *Health at a Glance 2025* (November 2025), and the National Center for Health Statistics' annual *Mortality in the United States*

11a. What a System Can Be Judged On

Health systems are judged on three kinds of evidence: what they have, such as doctors and beds; what they do, such as screening for cancer and treating high blood pressure; and what happens to patients. Outcomes matter most and are the hardest to pin on medicine, because diet, smoking, drugs, guns, cars, and income shape how long people live. Researchers therefore count avoidable deaths, those before age 75 that public health could have prevented or that timely, effective care could have averted, as the measure closest to what a health system controls.

11b. How Long Americans Live

Life expectancy at birth in the United States reached 79.0 years in 2024, a record, up from 78.4 in 2023 and above the previous peak of 78.9 in 2014. Women could expect 81.4 years and men 76.5 (NCHS, January 29, 2026). The improvement continued in 2025, when the age-adjusted death rate fell 4.6% to 689.2 per 100,000, the lowest ever recorded (provisional; NCHS, July 2026). The peers still live longer. Across eleven comparable rich countries, life expectancy averaged 82.7 years in 2024, so the American gap was 3.7 years, down from 4.1 in 2023 (Peterson-KFF Health System Tracker, March 31, 2026).

Much of the gap comes from deaths in youth and middle age, from drug overdoses, injuries, and chronic disease, as a National Academies panel concluded in 2013; these are causes that medicine shares with the rest of society. Infant deaths vary widely at home: 5.52 of every 1,000 babies born in 2024 died before their first birthday, from 2.97 in New Hampshire to 9.65 in Mississippi (NCHS, June 16, 2026). The gaps by race, and the deaths of mothers, are in Module 12.

11c. Avoidable Deaths, and Where America Leads

On the measure closest to medicine, the United States does badly. In the OECD's *Health at a Glance 2025* it had 217 preventable deaths per 100,000 people, against an OECD average of 145, and 95 treatable deaths, against 77. It also had 733 hospital admissions per 100,000 for conditions such as asthma, diabetes, and heart failure that good primary care usually keeps out of the hospital, against 473.

Yet it leads at rescue. Patients admitted with a heart attack were less likely to die within 30 days in American hospitals, 5.2% against 6.5%, as were patients admitted with a stroke, 4.5% against 7.7%. Screening is a strength too: 80% of women in the target ages had a recent mammogram, against 55%. The Commonwealth Fund's comparison of ten rich countries, *Mirror, Mirror 2024*, captures both sides: the United States comes last overall and on outcomes, but second on the process of care, which covers prevention, safety, and coordination.

Country	Overall	Access	Care process	Administrative efficiency	Equity	Outcomes
Australia	1	9	5	2	1	1
Netherlands	2	1	3	6	3	7
United Kingdom	3	2	8	1	5	8
New Zealand	4	5	1	3	8	3
France	5	6	7	4	6	5
Sweden	6	4	10	7	Not ranked	6
Canada	7	7	4	5	7	4
Switzerland	8	8	6	10	4	2
Germany	9	3	9	8	2	9
United States	10	10	2	9	9	10

Rank among ten countries on 70 measures, 1 best; the access domain counts affordability as well as timeliness. Commonwealth Fund, *Mirror, Mirror 2024*, September 19, 2024. Sweden was not ranked on equity because of a change in its privacy law.

11d. Safety

In 1999 the Institute of Medicine estimated that medical errors killed 44,000 to 98,000 Americans in hospitals each year, and its report started the movement for patient safety. Harm remains common. The HHS inspector general found that 25% of Medicare patients in the hospital in October 2018 were harmed by their care, and that 43% of the harm was preventable (May 2022); its earlier study found 27% in 2010, though it warns that the two are not directly comparable. A study of 2,809 admissions at eleven Massachusetts hospitals in 2018 found at least one adverse event in 23.6% of them, most often from drugs, and judged 22.7% of the events preventable (David Bates and colleagues, *New England Journal of Medicine*, January 12, 2023).

Diagnosis is the hardest to measure. David Newman-Toker and colleagues estimated in 2023 that about 795,000 Americans a year die or are permanently disabled because a dangerous disease is missed or misdiagnosed, about 371,000 deaths and 424,000 disabilities, with stroke the largest single cause (*BMJ Quality & Safety*, July 17, 2023). The estimate rests on error rates drawn from a limited and partly old literature, as the authors acknowledge, and their plausible range runs from 598,000 to 1,023,000.

Infections caught in the hospital, one of the few harms tracked nationally, keep falling. In 2024 bloodstream infections from central lines fell 9%, urinary infections from catheters 10%, and infections with *C. difficile*, a gut bacterium, 11%, although infections after hysterectomy rose 8% (CDC, July 15, 2026).

11e. Paying for Quality

Medicare has tried to pay for quality as well as quantity. Since October 2012 the ACA's Hospital Readmissions Reduction Program has cut payments by up to 3% to hospitals whose patients return within 30 days more often than expected, for conditions such as heart attacks, heart failure, and pneumonia. Readmissions fell, and the program became a model for others that reward or penalize hospitals on infections, patients' experience, and deaths.

Whether it also cost lives is disputed. Studies by Ankur Gupta, Gregg Fonarow, and colleagues (*JAMA Cardiology*, 2017) and by Rishi Wadhera, Robert Yeh, and colleagues (*JAMA*, December 2018) found that deaths among patients with heart failure rose after the program began, mostly among those not readmitted,

which suggested that hospitals were keeping some sick patients out. MedPAC found no evidence that the policy raised deaths (June 2018), and Harlan Krumholz and colleagues argued that heart-failure deaths had been rising before the program and did not rise for heart attacks or pneumonia.

11f. Public Health, 3% of Spending

Government public-health work, from tracking disease to running vaccination programs, took 3% of national health spending in 2024 (CMS). The CDC's core budget for fiscal 2026 was $9.227 billion, nearly unchanged (Congressional Research Service). In March 2025 HHS withdrew $11.4 billion of pandemic-era grants from state and local health departments, and by May 2026 it had terminated 444 of the CDC's grants. The administration's budget for fiscal 2027 proposed about $5.5 billion for the CDC, roughly 40% less, or about 18% less once the programs it would move to other agencies are set aside (Congressional Research Service), and the House Appropriations Committee's bill would give it $8.164 billion. For now a stopgap law keeps federal spending at 2026 levels until December 11, 2026.

The return of measles shows what is at stake. The United States declared the disease eliminated in 2000. An outbreak that began in West Texas in January 2025 spread to other states, and 2025 brought about 2,290 cases, the most in more than three decades, and three deaths. By October 15, 2026, the CDC had confirmed 4,410 cases in 2026, and Pennsylvania alone had reported 1,222 across 42 counties by October 14. Canada lost its measles-free status in November 2025 after more than a year of continuous spread, and the Pan American Health Organization, the World Health Organization's office for the Americas, will review America's status in November 2026.

In the 2025-26 school year, 92.4% of kindergartners had received the measles vaccine, below the 95% usually needed to stop the disease spreading, and 4.2% were exempt from at least one vaccine, up from 3.6% (CDC, August 17, 2026). The ACA's guarantee of free preventive care (Module 7) rests on the US Preventive Services Task Force, an independent panel whose top-rated recommendations insurers must cover. The Supreme Court upheld that arrangement in June 2025, ruling that the health secretary appoints the members and may remove them. On May 11, 2026 Secretary Robert F. Kennedy Jr. removed the panel's two vice chairs, and by then only 8 of its 16 seats were filled.

11g. Does American Medicine Buy Better Care, or Only More? The Cases as Their Advocates Make Them

The case that it buys only more: critics, among them the Commonwealth Fund and many health economists, argue that the measures built to isolate medicine find the United States behind. Treatable deaths count only conditions that timely, effective care should cure, and the American rate is a quarter above the OECD average. The high rate of avoidable admissions points to weak primary care. Americans use about as much care as their peers (Module 1) but pay higher prices for it (Module 9), so the extra money buys income for providers rather than health, and the uninsured and underinsured get less of the excellent care that exists (Module 12).

The case that it buys better care: defenders of American medicine, among them many physicians and market-oriented economists, argue that the comparisons blame the health system for the country's social problems. Americans die young from overdoses, gunshots, car crashes, and obesity at rates no hospital controls. Where medicine acts directly, they say, the United States leads, in survival after heart attacks, strokes, and cancer and in screening, and its patients reach specialists and surgery faster than Canadians

or Britons (Module 10). Its laboratories and companies also produce a large share of the world's new drugs and devices.

What the evidence says: both cases hold part of the truth. The United States does excel at acute hospital care and screening, and social causes explain much of its shorter lives. But treatable mortality, the measure designed to set those causes aside, still puts it well behind the OECD average while it spends far more per person (Module 1). The evidence supports better rescue, not better care overall.

The course's reading: American medicine is superb at rescue and uneven at everything before and after it. Its extra spending buys mainly higher prices rather than better results, and its weakest links are primary care and access, not hospital medicine.

Worked example — Treatable Deaths, If America Had the OECD's Rate

The OECD's rates are age-standardized and count deaths before age 75, so applying them to the whole population gives only a rough answer. The American treatable-death rate of 95 per 100,000 exceeds the OECD average of 77 by 18. Across a population of about 340 million, 18 per 100,000 is about 61,000 deaths a year (18 × 3,400). The preventable-death gap, 217 against 145, is 72 per 100,000, or about 245,000 more (72 × 3,400), from causes such as overdoses, injuries, and smoking-related disease that public health more than medical care must prevent. Together the gaps come to about 306,000 deaths a year, about a tenth of the 3.09 million Americans who died in 2025. The calculation does not say how much of the gap better care could close; it says where the gap lies.

Module 11 Key Points

Quality, Safety, and Outcomes

• US life expectancy reached a record 79.0 years in 2024, still 3.7 years below the average of comparable rich countries.

• America has more treatable deaths than the OECD average, 95 against 77 per 100,000, but better survival after heart attacks and strokes.

• A quarter of hospitalized Medicare patients were harmed by their care in October 2018; 43% of the harm was preventable.

• Researchers still dispute whether Medicare’s penalty for readmissions raised deaths among patients with heart failure.

• Measles returned: 4,410 cases by October 15, 2026, with America’s elimination status under review in November.

• Public health took 3% of health spending in 2024; the 2027 budget request would cut the CDC by about 40%, partly by moving programs.

Module 11 Quiz

Check Your Understanding

1. Where does the United States do better than the OECD average?

A) Its hospitals are better at keeping heart-attack and stroke patients alive.
B) It has fewer treatable deaths than other rich countries.
C) It has fewer avoidable hospital admissions for asthma and diabetes.
D) Its infants are more likely to survive their first year than infants in any other rich country.

2. What did the HHS inspector general find about Medicare patients in the hospital in October 2018?

A) Fewer than one in a hundred suffered any harm from their care.
B) Harm had more than doubled since 2010, mostly from hospital infections.
C) Almost all harm came from surgical mistakes, none from medication.
D) A quarter were harmed by their care.

3. What did a 2023 study estimate about diagnostic error?

A) About 7,950 deaths a year, almost all in emergency rooms
B) That diagnostic errors had nearly vanished since electronic records reached most hospitals in the 2010s
C) About 10 million deaths a year, more than all other causes combined
D) About 795,000 deaths or permanent disabilities a year

4. How many measles cases had the CDC confirmed in 2026 by October 15?

A) Fewer than 100
B) 4,410, more than a quarter of them in Pennsylvania
C) About 2,290
D) About 40,000 nationwide

5. What is the course's reading on whether American medicine buys better care?

A) It excels at rescue, but the extra money buys mainly higher prices, not better results.
B) It buys better care, and social problems explain Americans' shorter lives.
C) It buys little of value, since American hospitals trail their peers at every task.
D) It buys more care than other countries do, which is why Americans spend so much more than their peers.

Module 12 — Access and Inequality

Who Goes Without

Recommended Reading / Reference

Book: Linda Villarosa, *Under the Skin: The Hidden Toll of Racism on American Lives and on the Health of Our Nation* (2022), a reporter's account of the racial gaps in health, from maternity wards to the environment

Reference: The Commonwealth Fund's biennial survey of health insurance, and the March of Dimes' reports on maternity care deserts

12a. Uninsured and Underinsured

Having insurance is not the same as being able to afford care. The Commonwealth Fund counts as underinsured anyone whose out-of-pocket costs, apart from premiums, reach 10% of income (5% for those below twice the poverty line), or whose deductible reaches 5% of income. Its 2026 survey, released on October 22, found 46% of adults aged 19 to 64 inadequately insured: 11% uninsured, 12% with a gap in coverage during the year, and 23% underinsured. The uninsured rate rose from 8.9% in 2024 to 11.2% as the marketplace credits shrank and Medicaid rolls fell (Module 7), and half said they had skipped or delayed needed care because of the cost.

In 2024 the share had been 44%, and 57% of the underinsured had skipped needed care because of the cost. In KFF's polling, 44% of adults found it difficult to afford health care in May 2025, including 82% of the uninsured, and 22% had trouble paying medical bills in the past year; the debts that follow are in Module 9.

12b. Race and Ethnicity

American life expectancy differs sharply by race and ethnicity. In 2024 it was 85.8 years for Asian Americans, 81.8 for Hispanic Americans, 78.9 for white Americans, 74.8 for Black Americans, and 71.1 for American Indians and Alaska Natives (NCHS, August 25, 2026). The gap between Black and white Americans, 4.1 years, had narrowed from 4.4 in 2023.

The gaps are widest at birth. In 2024, 649 women died during pregnancy or within 42 days of its end from causes related to it, a rate of 17.9 per 100,000 live births, down from 32.9 in 2021. The rate was 44.8 for Black women, about 3.2 times the 14.2 for white women, and 12.1 for Hispanic women (NCHS, March 4, 2026). Black infants died at 10.98 per 1,000 births, about two and a half times the white rate of 4.41 (NCHS, June 16, 2026). Coverage differs too: in 2023, 19% of American Indians and Alaska Natives under 65 and 18% of Hispanic Americans were uninsured, against 10% of Black and 7% of white Americans (KFF).

Researchers attribute the gaps to differences in income, insurance, chronic disease, the hospitals where patients are treated, and discrimination in care, in proportions they dispute. Cost is part of it: in KFF's 2025 polling, 55% of Hispanic and 49% of Black adults found care difficult to afford, against 39% of white adults.

12c. Place

Where Americans live also shapes how long they live. Rural death rates have risen relative to urban ones: from 1999 to 2019 the rural-urban gap in age-adjusted death rates roughly tripled, and the death rate of rural adults aged 25 to 64 rose 12.1% (Cross, Califf, and Warraich, *JAMA*, June 2021). Rural hospitals' closures are in Module 3, and the ten states that have never expanded Medicaid, Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming, have far higher uninsured rates (Module 7).

Maternity care is the sharpest case. In its report of August 11, 2026, the March of Dimes counted 34.6% of counties as maternity care deserts, with no hospital offering obstetric care, no birth center, and no obstetric clinician. About 2.4 million women of childbearing age live in them, and about 149,000 babies a year are born to their residents. At least 96 hospital labor-and-delivery units closed from January 2024 to May 2026, across 35 states, and in nearly 60% of the affected counties the unit that closed was the only one, adding about 25 minutes of travel.

12d. Immigrants Under the 2025 Law

Immigrants without legal status were already barred from federal coverage except emergency Medicaid. The 2025 budget law also removes many lawfully present immigrants, such as refugees and asylees without green cards, people granted humanitarian parole or temporary protected status, and many visa holders, leaving eligible mainly green-card holders, Cuban and Haitian entrants, and migrants from three Pacific nations under compacts with the United States. About 1.4 million lawfully present immigrants are expected to lose coverage. Emergency Medicaid is exempt, and states may still cover lawfully residing children and pregnant women.

Program	Change	Effective	Added uninsured (CBO)
Marketplace	No premium tax credits for lawfully present immigrants below the poverty line	January 1, 2026	About 300,000
Marketplace	Credits and cost-sharing help limited to the eligible groups	January 1, 2027	About 900,000
Medicaid and CHIP	Limited to the eligible groups	Module 7	About 100,000
Medicare	New enrollment barred; current enrollees outside the eligible groups lose coverage	July 4, 2025; January 4, 2027	About 100,000

Georgetown University Center for Children and Families, October 1, 2025, citing CBO; the total from KFF, September 25, 2025.

12e. Does Health Insurance Save Lives? The Cases as Their Advocates Make Them

The case that it saves lives: many health economists argue that large studies, using different methods, find deaths falling when people gain coverage. Sarah Miller, Norman Johnson, and Laura Wherry found that Medicaid expansion cut the annual death rate of low-income adults aged 55 to 64 by about 9.4%, about 19,200 deaths averted in 2014-17 (*Quarterly Journal of Economics*, 2021). When the Internal Revenue Service randomly sent letters to people who had paid the penalty for being uninsured, urging them to get coverage, deaths among those aged 45 to 64 fell, by about one for every 1,600 letters (Jacob Goldin, Ithai Lurie, and Janet McCubbin, same journal, 2021). After Massachusetts covered nearly everyone in 2006, deaths among adults under 65 fell by about one a year for every 830 people who gained coverage

(Benjamin Sommers, Sharon Long, and Katherine Baicker, *Annals of Internal Medicine*, May 6, 2014). The Oregon trial below, they add, was too small and too short to detect deaths, and even it found that coverage cut depression and nearly eliminated catastrophic medical bills.

The case that the evidence is weak: skeptics of expanding coverage, among them market-oriented analysts at the Cato Institute and the Manhattan Institute, point to the one randomized trial of Medicaid. In 2008 Oregon held a lottery for about 10,000 places in its program, drawing about 30,000 names from about 90,000 who signed up. After two years, those who won coverage showed no significant improvement in blood pressure, cholesterol, or blood sugar (Katherine Baicker and colleagues, *New England Journal of Medicine*, May 2, 2013), and they used the emergency department about 40% more, not less (Sarah Taubman and colleagues, *Science*, 2014). The RAND experiment, too, found little effect of more care on health (Module 10). The other studies are not randomized, so on this view coverage remains an unproven and expensive way to buy health.

What the evidence says: the larger and newer studies, using different methods, agree that coverage lowers deaths among middle-aged adults, most of whom have chronic disease, while the effect for young and healthy adults is too small to measure. The skeptics are right that the gains in health per dollar are modest, and the clearest benefit of insurance in every study is financial protection.

The course's reading: health insurance saves lives, slowly, with hundreds covered for each death averted, and protects families' finances with certainty. The real argument is over its price and its design, not whether it matters.

Worked example — One Hospital Stay, Four Households

The stay is illustrative: four nights for a serious infection, for which the hospital's list price is $60,000 and the price it has negotiated with a typical employer plan is $30,000. A worker in an average employer plan, with a $1,955 deductible, 20% coinsurance, and a $5,000 limit, owes the deductible plus 20% of the remaining $28,045, or $7,564, capped at $5,000. A self-employed buyer of a bronze marketplace plan with a $7,500 deductible and 40% coinsurance owes $7,500 plus 40% of $22,500, or $16,500, capped at the legal maximum of $10,600 for 2026; on an income of $60,000 that is nearly 18%, which makes her underinsured by the Commonwealth Fund's definition. A low-income adult on Medicaid owes little or nothing, and Medicaid pays the hospital perhaps $10,000. An uninsured patient is billed the $60,000 list price unless she qualifies for the hospital's financial assistance. A nonprofit hospital may not charge a patient who qualifies more than it generally receives from insurers, but if her income is too high for its policy, she can owe the full charge.

Module 12 Key Points

Access and Inequality

• Nearly half of working-age adults, 46%, were inadequately insured in 2026: uninsured, underinsured, or with a gap in coverage.

• Black Americans lived 4.1 fewer years than white Americans in 2024; Black mothers died at about three times the white rate.

• A third of counties are maternity care deserts, and at least 96 labor wards closed from January 2024 to May 2026.

• The 2025 law limits lawfully present immigrants’ eligibility for Medicaid, the marketplaces, and Medicare; about 1.4 million may lose coverage.

• Large studies of Medicaid expansion and tax letters find coverage lowers deaths among middle-aged adults; Oregon’s lottery was too small to tell.

Module 12 Quiz

Check Your Understanding

1. What share of working-age adults did the Commonwealth Fund find inadequately insured in 2026?

A) 12%
B) About 75%, three in four working-age adults
C) About 46%
D) Nearly 30%, about the same as in 2010

2. How many times the white rate was the Black maternal death rate in 2024?

A) Ten times
B) About the same
C) About three times
D) About one and a half times

3. What did the Oregon Health Insurance Experiment find after two years?

A) Coverage sharply reduced deaths within the first year.
B) Coverage cut emergency visits by half.
C) Coverage had no effect on anything it measured.
D) Coverage cut depression and catastrophic medical bills, but showed no significant change in blood pressure or cholesterol.

4. How many lawfully present immigrants are expected to lose coverage under the 2025 law?

A) About 1.4 million
B) About 140,000 refugees
C) About 11 million, every undocumented immigrant in the country
D) About 14 million people

5. What is the course's reading on whether health insurance saves lives?

A) No, it makes no difference
B) Yes, slowly: hundreds covered per death averted
C) Only for children and pregnant women, not for other adults
D) No: the Oregon experiment proved that insurance has no effect on health, so coverage should be judged on cost alone

Module 13 — The Rich World's Systems

How Other Countries Do It, and What They Are Changing

Recommended Reading / Reference

Book: T. R. Reid, *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care* (2009), a reporter's tour of the rich world's systems, with his own shoulder as the test case

Reference: The Commonwealth Fund's international health system profiles, and each country's health ministry

13a. Models in Practice

Module 1 set out the four basic models. No country runs a pure one: Britain's national service buys some care from private hospitals, Germany's social insurance sits beside private insurers, and Canada's single payer leaves drugs to employers. This module looks at how the main rich countries actually work in 2026, what they charge patients, and what they are changing. All face the same pressures of aging populations, costly new treatments, and tired workforces.

13b. England: A National Health Service

England's National Health Service, founded on July 5, 1948, is paid for mainly from general taxes and is free at the point of use, apart from charges for prescriptions, dentistry, and eyesight tests. A prescription item costs £9.90 in 2026/27, frozen for a second year, but about 89% of items are dispensed free, because children, people aged 60 and over, those on low incomes, and pregnant women, among others, are exempt. Family doctors are mostly independent contractors paid largely per registered patient, hospitals are public trusts, and 42 integrated care boards plan and buy care for their areas. The health department's day-to-day budget is £211.4 billion for 2026/27, about $282 billion, set to grow 2.8% a year after inflation to 2028/29 (Health Foundation, March 2026).

The service is being reorganized. The government announced in March 2025 that NHS England, the body that has run the service since 2013, would be folded into the health department. A Health Bill introduced on May 13, 2026 states that "NHS England is abolished"; the House of Lords debated it on October 13, and abolition is planned for April 2027. Resident doctors, those still in training, struck repeatedly from 2023 until they accepted a pay and jobs offer on June 29, 2026, by 52.9% to 47.1%, which adds 4,000 to 4,500 specialty training places. Britain has had three health secretaries in 2026, the third appointed when Andy Burnham succeeded Keir Starmer as prime minister in July. England's waiting lists are in Module 10.

13c. Canada: Provincial Single Payers

Canada runs thirteen single-payer plans, one for each province and territory, under the Canada Health Act of 1984, which withholds federal money from any province that lets patients be charged for medically necessary hospital and physician care. Doctors are mostly in private practice and paid fees by the province, and hospitals are nonprofit. Outpatient drugs, dental care, and eyeglasses fall largely outside the public plans, so most working Canadians rely on employer insurance for them. Canada spent an estimated 399 billion Canadian dollars (C$) on health in 2025, about $282 billion, 71% of it from public sources (Canadian Institute for Health Information).

A Pharmacare Act of October 2024 began national drug coverage with contraceptives and diabetes drugs, but only Manitoba, British Columbia, Prince Edward Island, and Yukon have signed agreements to provide it, and the federal government has continued talks with the rest while restraining its spending. Canada's waits for specialists and surgery are in Module 10.

13d. Germany: Social Insurance Through Sickness Funds

Germany created social health insurance in 1883. On January 1, 2026, 74.2 million people, about 89% of residents, belong to one of 93 sickness funds, which they choose freely; most of the rest, higher earners, the self-employed, and civil servants, have private insurance instead. Workers and employers split a contribution of 14.6% of wages plus an additional contribution that each fund sets. An official estimating committee projected on October 14, 2026 that the additional contribution would need to average 2.9% in 2027, the same as the official figure for 2026, although funds actually charged an average of 3.13% at the start of 2026. The money is pooled in a central fund and shared out according to the health risks of each fund's members.

Costs have outrun contributions. A savings law passed on July 10, 2026 aims to close a funding gap projected at about €15 billion for 2027, through bigger rebates from drugmakers, a brake on payments to hospitals and practices, and higher patient charges from January 2027. Patients will then pay €15 a day in the hospital instead of €10, for up to 28 days a year, and €7.50 to €15 per prescription instead of €5 to €10. Patients' charges remain capped at 2% of income a year, or 1% for the chronically ill. A hospital reform passed in November 2024 sorts hospitals' services into 65 groups with quality standards and pays them partly for being ready to treat.

13e. France: Insurance Plus Insurance

France's national health insurance, part of its social security system, has covered almost all residents since 2016 and is paid for by payroll contributions and a broad tax on income. Patients typically pay the doctor and are reimbursed 70% of a family doctor's €30 fee, and about 96% of the population has complementary insurance for most of the rest, so households' own payments are among the lowest in the OECD. Patients who register with a family doctor and follow its referrals are reimbursed more than those who go straight to a specialist. The health branch of social security expects a deficit of about €12.5 billion in 2026, and the 2027 social security budget, filed on October 1, 2026, aims to cut it to €7.8 billion by holding the growth of health spending to 2.0%.

13f. The Netherlands and Switzerland: Managed Competition

The Netherlands and Switzerland require every resident to buy basic insurance from competing private insurers, under strict rules: insurers must accept everyone, charge every buyer of a given policy the same premium, and cover a standard package, and a fund shifts money toward insurers with sicker members. In the Netherlands, under a 2006 law, adults paid an average premium of €159 a month in 2026, about $179, plus an income-related contribution through their employers, and children are insured free. The compulsory deductible, €385 since 2016, rises to €400 in 2027, and visits to family doctors, who act as gatekeepers, are exempt from it. Insurers must publish their 2027 premiums by November 12.

Switzerland's version, in force since 1996, leaves more to the individual. About 40 insurers sell basic cover, on which they may not make a profit, at premiums that vary by insurer, canton, and age band but not by

income, and the cantons subsidize the premiums of about a quarter of residents. Adults choose a deductible from 300 to 2,500 Swiss francs (CHF) a year and then pay 10% of costs, up to CHF 700. The average monthly premium will rise 5.0% in 2027, to CHF 412, about $500, the federal health office announced on September 29, 2026. Residents may switch insurers until the end of November.

13g. Japan: One Fee Schedule for Everyone

Japan has covered everyone since 1961 through about 3,000 insurers organized by employer, occupation, place, and age, with a separate system for people aged 75 and over. Every provider is paid from a single national fee schedule, revised every two years, and patients may use any clinic or hospital, most of them private. Patients aged 6 to 69 pay 30% of the fee, and less when younger or older, but a monthly ceiling on each household's payments protects the very sick. The government raised those ceilings on August 1, 2026, with a second step due in August 2027, and for 2026-27 it raised the fees for services by 3.09% on average, the most in thirty years, while cutting the prices of drugs.

13h. Briefly: South Korea, Taiwan, Australia, and Singapore

South Korea runs a single national insurer, with high charges to patients. Its trainee doctors walked out for about 18 months from February 2024 over a plan to add 2,000 medical-school places, and the government now plans a smaller rise, from 3,058 to 3,548 places in 2027. Taiwan has run a single payer since 1995, under a global budget since 2002. Australia's tax-funded Medicare pays for doctors and public hospitals, and about 45% of Australians also buy private hospital insurance. Singapore requires workers to save 8% to 10.5% of their wages in personal medical accounts, called MediSave, up to 79,000 Singapore dollars in 2026, about $61,700, backed by basic insurance for large bills and a fund for those who cannot pay.

13i. Single Payer or Regulated Competition? The Cases as Their Advocates Make Them

The case for single payer: its advocates, among them Physicians for a National Health Program and Senator Bernie Sanders, argue that one public insurer covers everyone simply, spends far less on administration and billing (Module 1), and has the bargaining power to hold down prices. Canada, Taiwan, and South Korea cover everyone for much smaller shares of their economies than the United States spends. A single pool also ends the churn of people moving between plans and the networks that limit their choice of doctor.

The case for regulated competition: advocates of managed competition, among them the economist Alain Enthoven, who developed the idea, argue that competing insurers under strict rules give patients choice and push insurers to manage care well, while a single payer leaves the whole budget to politics. The countries with the quickest access in Module 10 all use several insurers, while single payers such as Canada's are among the slowest. For the United States, they add, such a system could be built from the insurance most people already have.

What the evidence says: no model wins outright. The leaders of the Commonwealth Fund's ranking (Module 11) use three different models. Single-payer and tax-funded systems tend to spend less and make patients wait longer, and multipayer systems tend to spend more and wait less. What the strong performers share is universal coverage, prices set or bargained collectively rather than by each insurer alone, as in

Japan’s single fee schedule (13g), and family doctors who steer patients to specialists, as in the Netherlands and France (13e and 13f).

The course’s reading: the rules matter more than the model. Every high performer covers everyone, sets or bargains prices for all payers, and invests in primary care, whether through one payer or many; the United States does none of the three for everyone.

Worked example — The Episode in Four Countries

The comparison is illustrative, uses each country’s rules for 2026, and converts at the Fed’s rates of October 16, 2026. In every country the blocked artery is opened as an emergency, without a wait; the queues of Module 10 are for planned care. In England she pays nothing for the ambulance, the hospital, or rehabilitation. At 58 she pays £9.90 for each prescription item, so with four medicines a month she would buy a twelve-month prepayment certificate for £114.50, about $153, her total for the year. The speed of the treatment has slipped, though: in the UK’s national audit, the share of patients whose artery was opened within 150 minutes of the call for help fell from 69.7% in 2014 to 54.7% in 2024. In Germany she pays €10 a day in the hospital, and since German hospitals count both the day of admission and the day of discharge, her two nights count as three days: €30, about $34 (€45 from 2027). She also pays €5 to €10 per prescription. Her total: €30 plus her prescription charges, never more than 2% of her household income for the year. In Ontario she pays a C$45 ambulance charge, about $32, and nothing for the hospital or doctors, but her take-home drugs fall to her employer’s plan or, failing that, to a provincial program with a deductible of about 4% of household income. Her total: about $32, plus whatever her drug plan leaves her. In Japan a heart-attack admission averages 1.91 million yen in fees over about ten days, far longer than her two nights. Her 30% share would be about 573,000 yen, but the monthly ceiling for a middle income since August 1, 2026, 85,800 yen plus 1% of costs above 286,000 yen, cuts it to about 102,000 yen. Her total: roughly $646, plus meals. In the United States her share was capped at $5,000, and the ambulance billed her $500 more (Module 9).

Module 13 Key Points

The Rich World’s Systems

• England’s NHS is tax-funded and free at the point of use; NHS England is due to be abolished in April 2027.

• Canada’s thirteen provincial single payers cover hospital and physician care free, but not most outpatient drugs.

• Germany’s 93 sickness funds take 14.6% of wages plus an additional contribution; patients’ charges rise in January 2027.

• The Netherlands and Switzerland require residents to buy regulated private insurance; Swiss premiums rise 5.0% in 2027.

• Japan pays every provider from one national fee schedule and caps each household’s monthly payments.

• The best systems differ in model but share universal coverage, regulated prices, and strong primary care.

Module 13 Quiz

Check Your Understanding

1. When is NHS England due to be abolished?

A) In 2026
B) In April 2027
C) Never; Parliament rejected the bill
D) It was abolished in 2013, when the health department took over the service directly

2. What does Canada's public system largely leave out?

A) Hospital stays are covered only for children and people over 65, so working-age adults buy private hospital insurance.
B) Doctors' visits carry a charge set by each province.
C) Emergency care is billed to patients at full price.
D) Outpatient drugs are largely left out.

3. How many sickness funds did Germany have on January 1, 2026?

A) One
B) About 9
C) About 93 funds
D) More than 1,000 funds

4. How do the Netherlands and Switzerland organize basic coverage?

A) Every resident must buy basic insurance from competing private insurers under strict rules
B) A single public insurer
C) Tax-funded national service
D) Employer coverage only, as in the United States

5. What is the course's reading on single payer against regulated competition?

A) Single payer always wins
B) Multipayer systems always outperform single payers on cost and access
C) The rules matter more than the model
D) Only a national health service, as in Britain, can cover everyone at a reasonable cost

Module 14 — Systems in Transition: China, India, and the Rest

Covering Billions on Less

Recommended Reading / Reference

Book: Yanzhong Huang, *Governing Health in Contemporary China* (2013), on how China's state built, dismantled, and rebuilt its health system

Reference: WHO and World Bank, *Tracking Universal Health Coverage: 2025 Global Monitoring Report* (December 2025), and India's National Health Authority

14a. The World's Coverage Gap

Most of the world's people live in countries still building their health systems. The WHO and the World Bank reported on December 6, 2025 that 4.6 billion people lacked full coverage of essential health services. Their index of service coverage stood at 71 out of 100 in 2023, up from 54 in 2000 but projected to reach only 74 by 2030. About 2.1 billion people faced financial hardship from health costs in 2022, 1.6 billion of them living in poverty or pushed deeper into it, although the share facing hardship had fallen from 34% in 2000 to 26%.

The burden falls on the poor: in 2022 three in four of the poorest people faced hardship, against fewer than one in 25 of the richest. Medicines made up at least 55% of out-of-pocket spending in three-quarters of the countries with data, which is why coverage that pays only for hospital stays leaves much of the burden in place.

14b. China: Insurance for 1.3 Billion

China rebuilt public insurance after its market reforms of the 1980s and 1990s had left most people paying for care themselves. Two schemes, run since 2018 by the National Healthcare Security Administration, now enroll about 1.33 billion people, roughly 95% of the population: one for urban employees, funded from payroll, and one for everyone else, with about 950 million members at the end of 2024. In the second, each member pays a flat contribution, held at a minimum of 400 yuan for 2025, 2026, and 2027, and the government adds 724 yuan a person in 2026, about $108 at 6.6861 yuan to the dollar. Hospitals are mostly public, and patients crowd into the big ones rather than local clinics.

Patients still pay a large share. Out-of-pocket spending was 26.9% of the total in 2022, down from 34.3% in 2012, against a goal of about 25% by 2030, and health spending was about 7% of GDP (National Health Commission). The government has used its buying power aggressively. From 2018 to early 2023 its national drug tenders, in which manufacturers bid for a guaranteed share of the national market, covered 333 drugs in eight rounds and cut prices by more than half on average, saving about 300 billion yuan, about $45 billion, by one academic estimate. A ninth round later in 2023 brought the total to 374 drugs. A national tender in 2020 cut the median price of a coronary stent by about 93%.

14c. India: Hospital Insurance for the Poor

India’s system is mixed: the states run public hospitals and clinics paid for by taxes, while most care is bought from a large private sector, much of it paid for out of pocket. In 2021-22 patients paid 39.4% of all health spending themselves, down from 62.6% in 2014-15, and government health spending was 1.84% of GDP (National Health Accounts). Indian figures are often counted in lakh, 100,000, and crore, 10 million, and convert at 94.96 rupees to the dollar.

The national government’s answer is hospital insurance. Pradhan Mantri Jan Arogya Yojana (PM-JAY), launched on September 23, 2018 under the Ayushman Bharat program, pays approved public and private hospitals fixed package prices for secondary and tertiary care, the specialist and complex treatment that hospitals give, up to 5 lakh rupees (500,000), about $5,265, per family per year. It targets 12.37 crore poor families (123.7 million), about 55 crore people (550 million) or roughly the poorest 40%, and since October 2024 it has also covered everyone aged 70 and over, whatever their income. By the end of August 2026 it had issued more than 48 crore cards (480 million) and paid for about 13.25 crore hospital admissions (132.5 million) worth 2.03 lakh crore rupees (2.03 trillion), about $21 billion, at more than 38,000 hospitals. Its budget for 2026-27 is 9,500 crore rupees (95 billion), about $1.0 billion.

The scheme does not pay for most outpatient visits, or for medicines beyond the days just after a hospital stay, which together are much of what Indian families pay themselves. For those the government relies on public primary care, through about 1.87 lakh (187,000) health and wellness centers renamed Ayushman Arogya Mandirs, and on generic-drug stores.

14d. Thailand, Rwanda, and Mexico

Thailand shows what a middle-income country can do. Its Universal Coverage Scheme, started in 2001 and nationwide by 2002, is paid for from general taxes and covers about three-quarters of Thais, the rest being insured through government and private employment. It pays district health networks a fixed amount per person for outpatient care and pays hospitals by diagnosis group within a national budget. Insurance coverage of all kinds rose from 71% before the reform to 95% by 2003, and the share of the poorest fifth of members facing catastrophic spending fell from 6.8% in 1996 to 2.8% in 2008.

Rwanda, one of the world’s poorest countries, built community-based insurance after its 1994 genocide and covered more than 90% of its people by 2010, with premiums tiered by wealth from 2011 and the poorest fully subsidized (*Lancet*, 2012). Mexico went the other way. It abolished Seguro Popular, its insurance for people without social security, in 2020, replaced it with an institute that was itself dissolved in 2023, and moved its work to IMSS-Bienestar, a public provider. The share of Mexicans lacking access to health services rose from 16.2% in 2018 to 39.1% in 2022, or 50.4 million people, according to CONEVAL, the official social-policy evaluator.

14e. Aid After 2025

For the poorest countries, foreign aid has paid for much of the fight against tuberculosis, malaria, childhood disease, and the human immunodeficiency virus (HIV), which causes acquired immune deficiency syndrome (AIDS). The United States was the largest donor. In 2025 it dissolved its aid agency, the US Agency for International Development (USAID), cancelling 86% of its awards and moving the remaining global health programs to the State Department, and it left the WHO, effective January 22, 2026. The Global Fund to

Fight AIDS, Tuberculosis and Malaria raised $12.64 billion for 2026-28, against a target of $18 billion; the United States pledged $4.6 billion, down from $6 billion.

The administration is replacing grants with bilateral health compacts. By early October 2026 it had signed them with 35 countries, for about $14 billion of American money over five years (KFF's tracker, as reported on October 2, 2026). An analysis by Public Citizen, a consumer advocacy group, and Partners In Health, a global-health charity, found that they plan a 59% cut in American funding across 18 countries by 2030, from its level before 2025. At the end of September 2026 the United States ended its health aid to Zimbabwe, after talks on a compact broke down over a clause on sharing data.

14f. Hospital Insurance First, or Primary Care First? The Cases as Their Advocates Make Them

The case for hospital insurance first: India's government and others who favor insuring hospital care argue that the bills that ruin families are mostly hospital bills, so covering them protects the poor fastest. Insurance can buy care at once from the private hospitals that already exist, rather than waiting years for public ones, and its fixed package prices discipline what those hospitals charge. PM-JAY's admissions (14c) show how quickly it can reach people.

The case for primary care first: the WHO, many public-health experts, and the record of Thailand argue that most illness and death in poorer countries can be prevented or treated cheaply close to home. Hospital insurance draws money to cities and private hospitals, encourages admissions that primary care could have avoided, and leaves out the outpatient medicines that make up most out-of-pocket spending. Thailand covered everyone by building primary care first and paying hospitals within a budget, while India's patients still pay much of the bill (14c).

What the evidence says: the primary-care side is right that medicines dominate what families pay (14a), so hospital insurance alone leaves much of it untouched, though it does protect them against the large bills of a stay. Thailand, which cut catastrophic spending among its poorest members by more than half, paid for primary care per person and for hospital care within a national budget (14d). Neither side has shown what PM-JAY has done to Indians' health.

The course's reading: primary care and medicines first, with hospital insurance built on top. Hospital insurance alone protects against the rarer large bills but leaves families paying for the care they need most often.

Worked example — One Family's Heart Attack in India

The case is illustrative. The course's patient, 58, lives in a poor rural family whose household holds an Ayushman card, and she has the same heart attack. At an approved hospital the scheme pays for the stent procedure and her stay at a fixed package price, set at 40,000 rupees, about $421, when the scheme began in 2018 and revised since, and she pays nothing at the hospital. Without the card she would pay the hospital's own price: the government's scheme for its employees paid 71,150 to 92,000 rupees, about $749 to $969, for the same procedure in December 2023, and a private hospital charges more. Price controls help either way: since 2017 the government has capped the price of a drug-eluting stent, at 29,600 rupees, about $312, when the cap was set. After discharge the scheme covers only a short period, so her four medicines, her follow-up visits, and her travel fall on the family. Those recurring costs, more than the admission, are what the WHO and World Bank count as financial hardship when they exceed 40% of what a household has left after basic needs.

Module 14 Key Points

Systems in Transition: China, India, and the Rest

• 4.6 billion people lack full coverage of essential health services, and 2.1 billion faced hardship from health costs in 2022.

• China’s basic insurance enrolls about 1.33 billion people; its national drug tenders cut prices by more than half on average.

• India’s PM-JAY covers hospital care for about 55 crore (550 million) people, but patients still paid 39.4% of health spending in 2021-22.

• Thailand reached near-universal coverage from 2002 with tax funding and primary care paid per person.

• After American aid cuts, the Global Fund raised $12.64 billion for 2026-28, against an $18 billion target.

Module 14 Quiz

Check Your Understanding

1. What did the WHO and World Bank report in December 2025?

A) That every country had reached universal coverage

B) That 4.6 billion people lacked full coverage of essential health services, and 2.1 billion faced financial hardship from health costs

C) That coverage had fallen everywhere since 2000

D) That about 100 million lacked coverage

2. What does India's PM-JAY cover?

A) Hospital care, up to 5 lakh rupees per family a year.

B) All outpatient visits and medicines for every Indian citizen, free of charge.

C) Only childbirth and vaccinations in public clinics, in the poorest districts.

D) Private insurance premiums for middle-class families who buy their own cover.

3. What happened to Mexico's Seguro Popular?

A) It still runs unchanged

B) It became a single payer

C) It was expanded into a national single payer that now covers every Mexican, with no out-of-pocket charges

D) It was replaced in 2020, and its successor was dissolved in 2023

4. By how much did China's national drug tenders cut prices, on average, by 2023?

A) By 5%

B) Not at all, because drugmakers refused to bid

C) By more than half

D) They doubled prices, because the tenders guaranteed the winners the whole national market

5. What is the course's reading on hospital insurance first or primary care first?

A) Hospital insurance first

B) Primary care and medicines first, with hospital insurance built on top

C) Leave both to private markets

D) Hospital insurance alone, since catastrophic bills are the only cause of financial hardship in poorer countries

Module 15 — Reform: The Choices

Single Payer, a Public Option, or the Market

Recommended Reading / Reference

Book: Ezekiel J. Emanuel, *Which Country Has the World's Best Health Care?* (2020), a physician and former White House adviser's comparison of eleven systems and what America could borrow

Reference: KFF's Health Tracking Polls, and the cost estimates of the Urban Institute and the Mercatus Center

15a. What Any Reform Must Decide

Every reform has to answer four questions: who is covered, who pays and how, what providers are paid, and who decides what care is covered. The last two decide the cost. A plan that covers everyone but pays providers today's prices costs more than the system it replaces, and a plan that pays them less meets resistance from hospitals, doctors, and drugmakers, who are among the best-organized interests in American politics. Every reform also trades coverage against disruption, since most people under 65 have insurance through work (Module 7).

15b. Single Payer

The Medicare for All Act of 2025, introduced on April 29, 2025 by Senator Bernie Sanders and in the House by Pramila Jayapal and Debbie Dingell, would replace private and public insurance with one public plan. It would charge no premiums, deductibles, or copayments and would add dental, hearing, and vision care and long-term care. The Senate bill has not moved beyond its referral to committee, and like its predecessors the bill does not say how the plan would be paid for.

The estimates of its cost agree more than the politics suggest. Charles Blahous of the Mercatus Center, a market-oriented research center, estimated in 2018 that Sanders' earlier bill would add at least $32.6 trillion to federal spending over 2022-31, even if its hoped-for savings were achieved. The Urban Institute put a similar plan at about $34 trillion over 2020-29. A study in *The Lancet* by Alison Galvani and colleagues (February 2020) found that single payer would cut national health spending by about 13%, some $450 billion a year at 2017 levels, and save about more than 68,000 lives a year. The real dispute is not the federal cost, about $3 trillion a year, but whether national spending falls or rises, which depends on how much providers are paid, how much administration is saved, and how much more care people use.

15c. Public Options

A public option adds a government-designed plan to the marketplaces rather than replacing private insurance. Three states have tried it. Colorado's, sold since 2023 by private insurers under state rules, was meant to cut premiums 15% over three years; insurers missed the targets, but the plans held about half of Colorado's marketplace enrollment in 2025 and 2026, and since 2026 their premiums may not rise faster than medical inflation. When an insurer misses its targets, the state may hold a hearing and set what the plan pays hospitals; every hearing so far has been dismissed after the parties negotiated. Washington's Cascade Select, offered since 2021, grew to about 40% of its marketplace, about 115,000 people, by the end of open enrollment for 2026, at premiums about $100 a month below others, by the state exchange's

count. Since 2023 the state has required hospitals to contract with at least one public-option plan. Nevada's, launched for 2026, drew 10,762 buyers by mid-January, against about 35,000 projected, and faces a lawsuit on appeal at the state's supreme court.

15d. Prices for All Payers

A third path leaves insurance as it is and regulates what every payer pays. Maryland's all-payer hospital rates and global budgets are the American model (Module 8), and Oregon, Washington, and Indiana have capped or are capping what some private plans pay hospitals (Module 9). Site-neutral payment (Module 9) has bipartisan backers, and a bill by Senator John Kennedy of Louisiana would apply it to 66 groups of outpatient services; its sponsor cites a CBO estimate that broad site-neutral payment would save about $157 billion over ten years.

15e. Market Reforms and the White House Plan

Republicans have generally favored giving money and choices to consumers rather than to insurers or the government: health savings accounts, which the 2025 budget law widened (Module 7), more published prices, and more competition. The White House's "Great Healthcare Plan" of January 15, 2026 asked Congress to send subsidy money "directly to eligible Americans" rather than to insurers, write into law its agreements with drugmakers on most-favored-nation pricing, prices tied to the lowest paid in other rich countries, move more drugs over the counter, and fund the marketplaces' cost-sharing reductions (Module 7). It said the last would save about $36 billion: insurers now load the reductions' cost into silver premiums, which raises the premium credits pegged to those premiums. It also asked for plain-English insurance terms, published denial rates, and price posting by every provider and insurer in Medicare or Medicaid.

The Committee for a Responsible Federal Budget estimated that the plan's cost-saving parts would cut deficits by about $50 billion over ten years, while the direct payments could cost up to $350 billion, depending on design. Congress had not acted on it by October 2026. By September 2026 the White House had announced pricing agreements with 26 drugmakers.

15f. The Politics

Health costs are a leading issue in the midterm elections of November 3, 2026. In KFF's poll of September 16-21, 60% of voters worried about affording health care, and 82% said its cost was very or extremely important for candidates to discuss. Voters trusted Democrats more than Republicans on health costs, 42% to 22%. Among all adults, support for Medicare for All reached 66%, the highest KFF has recorded since 2016. It held at 52% when people were told it would eliminate private insurance plans, but fell to 24% if it meant delays in care and to 35% if it meant higher taxes. Large majorities of both parties, 89% of Democrats and 77% of Republicans, said the system needs major changes or a complete overhaul.

The pressure is rising for employers too. They expect the cost per employee to rise 8.2% in 2027 after the changes they plan, the most since 2003 and 11% without them (Marsh, a benefits consulting firm, September 2, 2026), and 59% plan cost-cutting changes such as higher deductibles.

15g. Single Payer, a Public Option, or the Market? The Cases as Their Advocates Make Them

The case for single payer: Senator Sanders, Physicians for a National Health Program, and their allies argue that only one public plan covers everyone, ends premiums and deductibles, cuts the administrative waste of many insurers (Module 1), and pays Medicare's lower prices rather than private ones (Module 9). The *Lancet* study found savings (15b), and the idea has never polled better (15f).

The case for a public option: many Democratic lawmakers and health economists who favor building on the ACA argue that a public plan competing with private ones would push premiums down without taking away the employer coverage most people like or raising taxes by trillions. Colorado and Washington show that a public option can win a large share of a market, and support for single payer falls once people hear about taxes and delays (15f).

The case for the market: Republicans and market-oriented groups such as the Paragon Health Institute argue that single-payer systems ration by waiting, as Canada's does (Module 10), and that a single payer's tax bill would be the largest in American history. Patients who pay part of their bills spend less, as the RAND experiment and the move to high deductibles showed (Module 10). They would cover people through tax credits that follow the person rather than the job, widen health savings accounts, require real prices, and pay the same for a service anywhere, so that consumers and competition, not regulators, push prices down.

What the evidence says: every estimate finds that single payer would raise federal spending by more than $30 trillion over ten years; whether it lowers national spending depends on paying providers less. Public options have won large shares in Colorado and Washington, both of which give the state some power over what hospitals are paid, though Colorado has never used it (15c); Nevada's, in its first year, has drawn few buyers. Market reforms such as published prices have changed few prices yet (Module 9), and site-neutral payment, which has bipartisan support, saves money by paying hospitals less.

The course's reading: the price rules matter more than the structure. A single payer, a public option, or a regulated market saves money only if it pays providers less, and each meets the same resistance from those who would be paid less.

Worked example — A Median Family's Bill, and What Single Payer Must Replace

The family is illustrative: a household at the 2025 median income of $87,460 (Census Bureau, September 15, 2026), with family coverage at work at KFF's 2026 averages. On KFF's premium figures and Milliman's estimate of out-of-pocket costs, it pays $7,471 a year in premiums and about $5,064 out of pocket, and its employer pays $20,832 toward the premium, money that would otherwise largely be pay (Module 7). That is $33,367 a year, about 31% of the family's total pay of about $108,300 ($87,460 + $20,832); Milliman's own total of $37,824 (Module 1) is higher because its plan costs more than KFF's average premium. Under single payer the premiums and nearly all out-of-pocket costs end, and if the employer's share came back as wages, the family would gain up to $33,367 before new taxes. It comes out ahead only if those taxes take less than about 31% of its pay. The federal government would need roughly $3 trillion a year more, and how that is shared decides whether the median family wins or loses. The 2025 bill names no taxes, which is why both sides can claim the arithmetic.

Module 15 Key Points

Reform: The Choices

• Every reform must decide who is covered, who pays, what providers are paid, and who decides what is covered.

• Single payer would add about $32-34 trillion of federal spending over ten years; whether national spending falls depends on prices.

• Public options took about half of Colorado’s and 40% of Washington’s marketplaces, but drew few buyers in Nevada.

• The White House plan of January 2026 would pay subsidies to people rather than insurers; Congress has not enacted it.

• In September 2026, 60% of voters worried about affording care, and 66% of adults favored Medicare for All.

Module 15 Quiz

Check Your Understanding

1. What do the main cost estimates of single payer agree on?

A) National health spending would certainly fall by half within the first five years.
B) The plan would pay for itself through savings, with no new taxes needed at all.
C) Federal spending would fall, because Medicare's prices are lower than private insurers' prices.
D) Federal spending would rise by over $30 trillion in ten years.

2. Which state's public option drew far fewer buyers than projected in its first year?

A) Nevada, with about 10,800 against 35,000 projected
B) Colorado
C) Washington
D) Maryland

3. What share of adults favored Medicare for All in KFF's poll of September 2026?

A) About two-thirds, 66%
B) About a third
C) One in ten
D) Under 20%, the lowest share since KFF began asking the question in 2016

4. When did the White House release its "Great Healthcare Plan"?

A) December 2025
B) January 2026
C) September 2026
D) After the midterms

5. What is the course's reading on single payer, a public option, or the market?

A) Single payer is the only path to lower costs.
B) A public option would fail everywhere it was tried.
C) Market reforms alone have already lowered prices.
D) Any of them saves money only if it pays providers less, so the price rules matter more than the structure.

Module 16 — Where Things Stand, and What to Watch

The Argument, the Contradictions, and the Calendar

Recommended Reading / Reference

Book: Elisabeth Rosenthal, *An American Sickness: How Healthcare Became Big Business and How You Can Take It Back* (2017), a physician turned reporter's account of how each part of the system learned to raise its prices

Reference: The calendars that date the watch list below: HealthCare.gov, Medicare's payment rules, NHS England's monthly statistics, and KFF's trackers

16a. The Argument on One Page

The course has made one argument from fifteen directions. Every health system answers three questions: who pays, who provides, and who decides what care is worth. Most rich countries answer each once, for everyone, through a national service, social insurance, a single payer, or regulated competition (Modules 1 and 13). The United States answers each several ways at once: employer insurance for most workers, Medicare for the old, Medicaid for the poor, the marketplaces for some of the rest, a national service for veterans, and cash for the uninsured (Modules 1 and 7).

The result is the world's most expensive system. Americans do not use much more care than people in other rich countries; they pay higher prices for it, through insurers that each bargain alone with consolidated hospitals and physician groups, and they pay more to administer so many payers (Modules 1 and 9). The way providers are paid rewards procedures over time spent with patients, so the front door of primary care is thin and specialists are plentiful (Modules 2, 6, and 8).

What the money buys is uneven. American medicine is superb at rescue but trails its peers on deaths that timely care or public health should prevent (Module 11), and it rations by price and paperwork rather than by queue (Module 10). Coverage, never complete, is shrinking: the extra marketplace subsidies have expired, the 2025 law cuts Medicaid and limits immigrants' eligibility, and mental-health and long-term care were never well covered (Modules 4, 5, 7, and 12). Abroad, the best systems differ in model but share the same rules, and the countries building coverage now must choose where to start (Modules 13 and 14). At home, every reform on offer saves money only by paying providers less, which is why each meets the same resistance (Module 15).

16b. Five Contradictions

Each module states its own findings. Read together, they produce tensions that no single module states.

The best rescue, the thinnest front door. The system that beats its peers at keeping heart-attack and stroke patients alive (Module 11) spends a small share of its money on primary care (Module 2), leaves hundreds of family-medicine residency places empty each year (Module 6), and is cutting public health as measles returns (Module 11). It pays well for the catheter laboratory that saved the course's patient and poorly for the visits that might have kept her out of it.

A country that says it does not ration, rationing everywhere. Americans reject the word, yet more than a quarter of adults put off care because of its cost, and insurers deny millions of requests that patients rarely

appeal and usually win when they do (Module 10). In 2026 the government brought prior authorization into traditional Medicare even as insurers promised to use it less. The queues abroad are visible; American rationing is spread across bills and forms.

Overpaying for the old, cutting for the poor. The government pays Medicare Advantage plans more than the same people would cost in traditional Medicare, by MedPAC's estimate, while the 2025 law cuts federal Medicaid by nearly $1 trillion over a decade (Module 7). Both programs pay private plans to manage care; only one is being cut.

Short of doctors, limiting doctors. A country that worries about a shortage of doctors still caps the residency positions Medicare pays for at roughly the level set in 1997, and in 2025 it put a $100,000 fee on the visas many foreign-trained doctors use, until a court vacated it (Module 6). England, by contrast, ended its resident doctors' strikes in 2026 partly by adding training places (Module 13).

A popular goal, an unpopular bill. Most adults now favor Medicare for All, yet support falls to about a third when it means higher taxes (Module 15), although families with employer coverage already pay for their care through wages they never see (Module 7). The money is spent either way; the argument is over whether it passes through premiums or taxes.

16c. What to Watch

The dates below are the ones that would confirm or overturn the course's readings. Each entry says what the event would show, not what the course has already reported about it.

When	What	Why it matters
November 1, 2026	Open enrollment for 2027 marketplace coverage begins on HealthCare.gov, running to January 15	The first full enrollment season without the enhanced credits shows how many people keep coverage as premiums rise (Module 7)
About November 1, 2026	Medicare's final payment rules for 2027, for physicians and hospital outpatient departments	Whether the proposed cut in physicians' conversion factor stands, and how far site-neutral payment reaches (Modules 8 and 9)
November 3, 2026	The midterm elections	Control of Congress decides the fate of the marketplace credits, the funding fight over prior authorization in Medicare, and any larger reform (Modules 7, 10, and 15)
November 2026 (date not announced)	The Pan American Health Organization reviews America's measles elimination	Whether the United States formally loses the status it declared in 2000 (Module 11)
November 30, 2026	Medicare announces negotiated prices for a third round of drugs, for 2028	How far the government's bargaining reaches into drugs given in doctors' offices (Module 9)
December 11, 2026	The stopgap law funding the federal government expires	Whether the CDC gets the deep cut the administration proposed, the House's smaller one, or neither (Module 11)
December 2026	The NCHS's final mortality report for 2025	Whether life expectancy set another record after 2025's record-low death rate (Module 11)
December 31, 2026	The government's own deadline to propose a new mental-health parity rule; remote prescribing of controlled substances lapses unless extended	Whether insurers face enforceable parity rules again, and whether patients keep remote access to addiction medicine (Module 4)
January 1, 2027	Medicaid's work requirements and six-month checks begin; marketplace help narrows for lawfully present immigrants; fifteen more negotiated drug prices take effect	The 2025 law's coverage cuts begin to bite, and the measure of how many lose coverage starts (Modules 7, 9, and 12)

When	What	Why it matters
January 1, 2027	Germany raises patients' charges, the Dutch deductible rises, and Swiss premiums go up	Whether rich countries answer rising costs by shifting more of them onto patients (Module 13)
January 4, 2027	Lawfully present immigrants outside the eligible groups lose Medicare	The first removal of current enrollees from Medicare on grounds of immigration status (Module 12)
March 31, 2027	NHS England's target of 70% of patients treated within 18 weeks	Whether England's waiting list resumes its fall after progress stalled in 2026 (Module 10)
April 2027	The planned legal abolition of NHS England	Whether moving its work into the health department improves the service or only reorganizes it (Module 13)
Spring or summer 2027	The Medicare trustees' annual report	Whether the hospital trust fund's projected exhaustion moves again (Module 7)
May 2027	The World Health Assembly chooses a new director-general of the WHO	Who leads the WHO without its largest former funder (Module 14)
October 1, 2027	The 2025 law's limits on states' provider taxes begin	The start of the Medicaid cuts that fall on states and hospitals (Module 7)
March 2029	The NHS's pledge to restore its 18-week standard	Whether a national service can clear its backlog without a lasting rise in its budget (Modules 10 and 13)

Dates are as announced by October 25, 2026. The measles review, the NCHS report, and the trustees' report are expected, not fixed.

16d. The Last Word

The course began with a heart attack at 2 a.m. and followed one patient through her bills and into five other countries. In every rich country her artery would have been opened as an emergency, though not always as fast as the guidelines ask; what differed was who paid, how much, and whether a bill followed her home. The United States pays well for the care that saved her and gets excellent results from it, and pays little for the care that might have kept her out of the hospital.

The reader who follows the system from here will learn more from prices than from plans: what insurers pay hospitals against Medicare's rates, how many people lose coverage as the 2025 law takes effect, and whether the next reform pays providers less or only moves who pays. American health care is not one system but several, and its prices, more than its patients, explain most of its costs and many of its gaps. The course's figures are current as of October 2026, and the watch list above is where they will next change.

Module 16 Key Points

Where Things Stand, and What to Watch

• Every system answers who pays, who provides, and who decides what care is worth; America answers each several ways at once.

• America pays the most mainly because of higher prices and administration, not because it uses much more care.

• It excels at rescue but trails on avoidable deaths, primary care, and access, and it rations by price and paperwork.

• Any reform saves money only by paying providers less, which is why the price rules decide its fate.

• Watch open enrollment, the midterms, Medicaid’s work rules on January 1, and NHS England’s abolition in April 2027.

Module 16 Quiz

Check Your Understanding

1. Which contradiction does the module draw from Medicare Advantage and Medicaid?

A) Medicaid now costs more than Medicare.

B) Medicare Advantage was abolished in 2026 after MedPAC found that it cost the government nothing extra.

C) The government overpays private plans for the old while cutting the program for the poor.

D) Medicaid's budget doubled under the 2025 law, while Medicare Advantage lost most of its enrollees to traditional Medicare.

2. According to the course, why does America pay the most?

A) It pays higher prices and more for administration.

B) It uses far more care.

C) Its population is much older and sicker than those of other rich countries.

D) It trains far more doctors and builds far more hospitals per person than its peers.

3. What does the module call the tension between America's rescue care and its primary care?

A) A popular goal, an unpopular bill, and rising taxes

B) The best rescue, the thinnest front door

C) Overpaying for the old while cutting for the poor

D) A country that says it does not ration, rationing everywhere

4. What does the course say any reform must do to save money?

A) It must cover fewer people.

B) It must end Medicare.

C) It must replace every private insurer with a single public plan within two years.

D) It must pay providers less than they are paid now.

5. What is the course's last word on the American system?

A) It costs the most because Americans use far more care than other peoples.

B) It spends as a rich country would, so its costs need no fixing.

C) It is not one system but several, and its prices, more than its patients, explain most of its costs and many of its gaps.

D) Its problems come mainly from too little competition among insurers.

Answer Sheet

Answers to every module's Check Your Understanding quiz.

Module	Answers
Module 1 Quiz	1. B 2. C 3. A 4. D 5. D
Module 2 Quiz	1. B 2. C 3. A 4. C 5. B
Module 3 Quiz	1. D 2. A 3. B 4. A 5. C
Module 4 Quiz	1. D 2. C 3. A 4. D 5. B
Module 5 Quiz	1. C 2. A 3. D 4. B 5. A
Module 6 Quiz	1. B 2. C 3. D 4. A 5. D
Module 7 Quiz	1. C 2. B 3. B 4. C 5. A
Module 8 Quiz	1. D 2. D 3. C 4. A 5. B
Module 9 Quiz	1. D 2. A 3. B 4. C 5. D
Module 10 Quiz	1. C 2. B 3. A 4. C 5. B
Module 11 Quiz	1. A 2. D 3. D 4. B 5. A
Module 12 Quiz	1. C 2. C 3. D 4. A 5. B
Module 13 Quiz	1. B 2. D 3. C 4. A 5. C
Module 14 Quiz	1. B 2. A 3. D 4. C 5. B
Module 15 Quiz	1. D 2. A 3. A 4. B 5. D
Module 16 Quiz	1. C 2. A 3. B 4. D 5. C