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Editorial Opinion

A proposal to reroute and reform the healthcare money trail

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Health insurance

Abstract Without fundamental changes healthcare costs will continue to accelerate faster than the gross domestic product while consuming larger portions of individual and corporate incomes. Although the problems are widely acknowledged, we believe that there is an underappreciated defect driving these undesirable events. The essence of that defect is that the major portion of the money is outside the control of the patients and competitive pricing is outside the control of the providers. We propose that the patients have virtual, dynamically allocated, evidence-based budgets grounded on their medical conditions and the patients authorize the transfer of funds to the providers while the providers compete on quality and price. Furthermore, we advocate all funding of healthcare be via taxes linked to expenditures to replace and reduce the total healthcare "premiums" and decouple health care from employment as it is archaic and hinders employment. This proposal reassigns the control of money from the government and special interest groups and returns it to the control of the patients.

Healthcare costs are typically accelerating faster than the gross domestic product (GDP) and per capita spending for other goods and services. In addition, our federal debt (The United States gross debt is roughly 100% of the GDP while the United States federal debt is about 70% of the GDP. The difference is the money in "savings" or owed to ourselves such as the Social Security Trust Fund; Fig. 1) is now second only to that at the end of World War II. Since none of the other budget items have the unique combination of an aging population (Fig. 2), advances in technology, and unacceptable levels of ineffective or inefficient care, this will be the most difficult to correct. Healthcare costs also extend into state and local budgets, reducing other needed services. Moreover, much of health care is financed through employment-based health insurance which reduces both employment and the GDP, exacerbating the problem.

It is important to include total costs of health care, not just government expenditures, and to note that the citizens ultimately fund all the healthcare costs through taxes, premiums, deductibles, copays, private pays, and the low pays absorbed by providers. The total cost of health care is well over 2 trillion dollars, of which individuals directly pay about half. In addition, there are substantial unfunded liabilities (Fig. 3).

Incredibly, the Affordable Care Act (ACA) legislates that an individual's health care is without limits (Sec. 2711) and without risk (Sec. 2712). In other words, for a discounted payment, the population is guaranteed unlimited returns without risk. Since no sensible person believes that this by itself could be economically viable, the ACA must impose some types of limits to contain an otherwise unlimited system. Although necessary and appropriate, quality and more efficient care are not sufficient. Accordingly, the ACA provides 2 other mechanisms to contain costs. Accountable Care (AC) with bundled payments can restrict the inflow of money to the providers, whereas the Independent Medicare Advisory Board has the authority to reassign all payments. Although the former imposes zero-sum distributions upon the providers, the latter, with an essentially unlimited mandate, is an unknown. In either case, we believe that the ACA, since it fails to give the patients responsibility, other than to pay taxes and buy insurance, and instead attempts to control costs through price fixing and price controls, is inherently unstable. Instead of trying to manage or control healthcare costs from above, we propose to optimize healthcare costs through a distributed process where each patient has the

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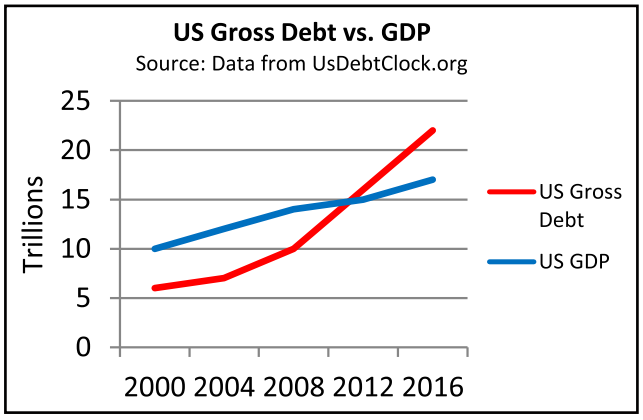

Figure 1 US gross debt versus GDP.

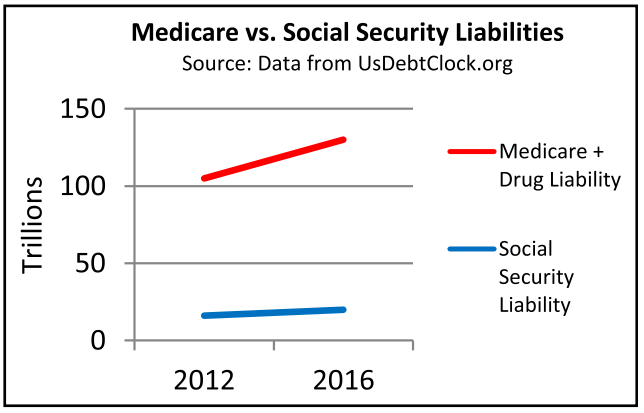

Figure 3 Medicare versus social security liabilities.

responsibility to minimize their cost yet maximize their appropriate personal service. This model pays for the performance of both the patient and the provider.

A recent history of healthcare price fixing and price controls in the United States

The wage and price controls during World War II along with the loss of workers to the military and its material requirements put manufacturing in competition for workers. Although wage controls prevented wage increases, manufactures were permitted to increase benefits. Thus, corporate health insurance became linked to employment. This incidental expedient allowed the informal development of a vast government, insurance, and provider welfare association. After the war the doctors and hospitals charged essentially whatever they wanted under the rubric of usual and customary fees which are non-competitive prices while the insurance companies collected the necessary amount of money, took their usual and customary profits, and distributed the rest to the providers. A notable benefit of these activities was an unofficial agreement among some providers to care for the indigent although others simply took advantage of the situation.

These cozy arrangements continued through the dawn of Medicare in the 1960s with Medicare paying into the same

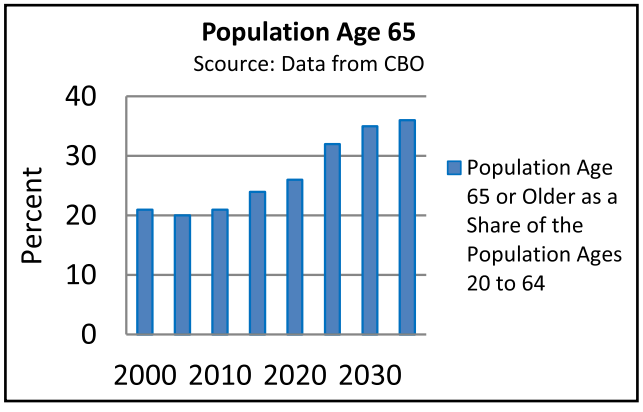

Figure 2 Population age 65.

fee structure while the population aged and technology advanced. Thus, for about 10 years after its inception, Medicare compensated physicians on the basis of their charges plus balance billing. This was actually part of the original deal but was unsustainable such that in 1975 Medicare began its price control system on top of the physician price fixing under the pseudonym of "administrative pricing" with the Medicare Economic Index (MEI) which is an estimation of physician costs, placing a cap on physician fees.

In the 1990s, physician payments were modified by relative value units (RVUs). Here the attempt was to shift physician payments based on clinical practice measures rather than to control costs, but it affects both. By the late 1990s the total physician payment rate was changed from the MEI to the sustainable growth rate (SGR) formula. This shifted reimbursement from a cost estimate to something more complicated but roughly following the GDP. However, because of the volume and intensity of services, spending for physician services exceeded the SGR target which is much less than the MEI. The delay of the implementation of the SGR has led to the looming almost 30% decrease in physician Medicare reimbursements which is unlikely to be implemented. Instead, quality and payment targets will probably be set in the form of controlled bundled payments.

Although the total physician payment is set by the government, the Specialty Society Relative Value Scale Update Committee (RUC) fixes the relative values, and thus in effect the prices for the physicians. This is a committee of the American Medical Association which makes its recommendations to Medicare. Here the competition is between the doctors for a bigger slice of the pie. There is little transparency and the incentive is for all the physicians to charge as much as possible. There is no incentive to competitively decrease prices. In this pricing system, relative values are set by the RUC, generally approved by Medicare, and then modified as a percentage for private insurance. In addition to Medicare and many private insurance companies, there are at least 6 other government healthcare programs: Workman's Compensation, Medicaid, State Children's Health Insurance Program, Department of