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EC NURSING AND HEALTHCARE
Review Article

Who Controls Healthcare Spending? Who Should??

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Received: June 15, 2022; **Published:** June 30, 2022

Abstract

The U.S. healthcare system is unsustainably expensive, extremely dollar inefficient, and fails to deliver timely, high quality medical care to most individuals. The reason for these failures is market separation: supply is disconnected from demand. Third parties control healthcare spending, yet they do not expend their own money nor do they consume the goods and services they "buy." The payer for healthcare is neither the patient (consumer) nor the provider (supplier). The solution is reconnecting supply with demand. The person who should control healthcare spending is the patient, not a third party.

Keywords: *Healthcare Spending; U.S. Healthcare System; Consumer; Supplier*

Introduction

Polls show that Americans'#1 concern is the cost of medical care, which is prohibitive for individuals and leading the nation toward bankruptcy.

Currently, the U.S. expends more than twice what most other developed countries spend on healthcare. In 2019, total national expenditures on healthcare were as follows: U.S. = $3.6 trillion (14 percent of GDP), Japan = $612 billion (12.5 percent), Germany = $554 billion (12.9 percent), and United Kingdom = $293 billion (8.6 percent).

Despite spending the same amount on healthcare as the entire GDP of Germany, American taxpayers, who fund this profligate spending, have no understanding of how their money flows or where it goes.

Americans do know one thing: they are not getting good value for massive spending on healthcare.

Patients can wait more than four months [1] to see a primary care physician. Some wait times are so long, people die waiting [2] in line. For some, the wait is forever because they don't have a doctor: nearly 1/3 of U.S. physicians refuse to accept new Medicaid patients [3].

Economists advise organizations, for profit and not for profit alike, to be dollar efficient, to expend the most dollars on activities that produce value for the customer or end-user and to eliminate any dollars spent that do not produce consumer value. The latter is wasteful or value-less spending. The "values" desired by consumers are good health and timely, quality care necessary to keep or restore good health.

The U.S. healthcare system is extremely dollar inefficient, as demonstrated by figure 1 and 2.

Figure 1 shows components of the U.S. healthcare system and how money flows. The arrows represent monies paid for administration of a system that employs millions of middlemen (and women) who create and follow rules and regulations, policies and procedures; fill out forms; review and validate information; assure compliance; and investigate fraud. These activities consume hundreds of billions of dollars, taking healthcare dollars away from care to pay for BARRCO: bureaucracy, administration, rules, regulations, compliance, and oversight.

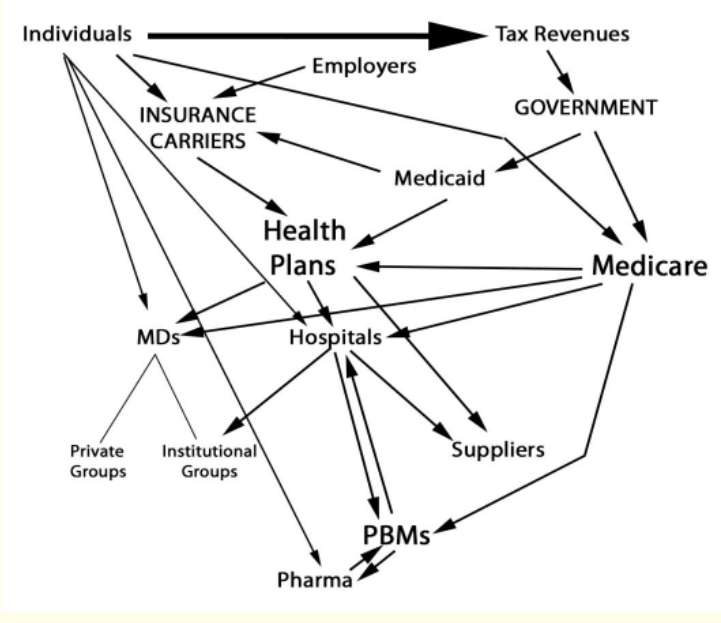

Figure 1: *Dollar flow in U.S. healthcare system.*

Money flow starts with 144.3 million individual Americans (43 percent of population) who pay taxes to Washington and to their home states. Government in turn pays Medicare and Medicaid, (and Tricare for the military, not shown on the chart) after first spending on bureaucracy, administration, rules, regulations, compliance, and oversight (BARRCO).

One hundred and eighty million American workers pay premiums to insurance carriers, both out-of-pocket and in foregone compensation as "employer supported" insurance. Current workers are also paying into the Medicare Trust. Retired workers did so until retirement.

Insured individuals pay copayments to doctors, hospitals, pharmacies and suppliers of durable goods. Uninsured people receive bills in full: what they do varies with the person and his/her financial status.

Both federal and state governments pay into state Medicaid programs. The amount each state from Washington receives is based on a formula driven by the median income in that state: low income states receive much more support than the richer states [4]. The cost of each state program is determined by federal benefit packages.

Medicare is funded by mandatory contributions into the Trust Fund collected from all U.S. workers. Washington has gradually increased benefits without corresponding increases in funding so that Part A of the Medicare Trust is predicted run out of money by 2026 [5]. At that time, Medicare will be unable to pay for hospital care for seniors.

Bernie Sanders repeats [6] the false common wisdom that Medicare spends only two percent on administrative costs, implying 98 percent of Medicare expenditures go for care. That is not true. Roughly 22 - 31 percent of Medicare revenue is paid to care givers [7]. Three quarters of Medicare spending - 69 - 78 percent - goes to rules, regulations, billing codes, forms, compliance, updating, investigations, assessments, accounting, and of course, bureaucrat salaries. These funds are taken from payments to nurses, doctors or therapists.

Though Medicare and Medicaid are often thought of together as the two big entitlement programs, they are, in fact, very different. Medicare enrollees pay for their coverage over decades of work; Medicaid enrollees pay nothing for insurance (excluding MERP [8] the Medicaid Estate Recovery Program). Medicare directly pays care providers; Medicaid contracts with insurance carriers and health plans. Medicaid will never go broke as it has unlimited funds via state and federal tax revenue; Medicare will be insolvent in less than four years [5].

Insurance carriers function as financial risk managers. First, their actuaries predict how much care will be required for a large number of people and what it might cost. Then, they price their premiums accordingly, and sell their policies to millions of Americans, promising all the care they need. Insurers negotiate contracts with health plans to provide care for a total cost less than what their actuaries calculated. The difference is insurance profit. The less they spend on care, the more they can keep as profit. This leads insurance to the "3D strategy:" delay, defer, and deny care [9].

Health plans are dollars' final stop on their circuitous journey before they reach the care providers: clinicians (doctors, nurses, therapists), institutions (hospitals, clinics, out- patient facilities), and suppliers of everything from uniforms and bed linens to needles, IV tubing, and wheelchairs. Pharmaceutical medications are handled separately.

Insurance carriers contract with health plans for the clinicians to provide care for those enrolled by the insurance carriers. Health plans in turn negotiate contracts with care provider groups, institutions, and PBMs (to be explained). The health plans determine care that patients receive according to the limits of different insurance policies. Plan managers tell the physicians what procedures can be done on their patients, where and when, and what drugs can be prescribed, or not.

When purchasing a car, sweater, dry cleaning, or legal services, the price is determined by the seller competing with other sellers and paid by the consumer directly to the chosen seller for the goods or services. No middlemen are involved. That is not the way price is determined in healthcare.

In healthcare, price is determined by negotiations between middlemen without buyers or sellers involved. Supply and demand play no role. There are no market forces to keep prices low or to keep quality high and access rapid. Each middleman tries to wring as much profit as possible from its contracts, taking healthcare dollars away from care.

Insurers demand low prices from the health plans, and these plans pass on even lower payments for the services their contract physicians must provide. Money saved from low prices goes to insurance profits and health plan bottom lines, not to patients' pockets.

Both Medicare and Medicaid establish price lists in advance of what they will pay for goods and services. There is no real negotiation. Hospitals and physicians can take it or leave it.

Every transaction in the money flow chart (Figure 1) up to the MDs and Hospitals represents BARRCO spending that has consumed nearly 2 trillion "healthcare" dollars without a single dollar paid for patient care. All this money was paid to middlemen – accountants, actuaries, agents, billers and coders, compliance officers, consultants, executives, fraud investigators, lawyers, lobbyists, managers, regulators, rule writers, etc., millions of them, along with their benefits packages, computers, and office buildings [9,10].

Pharmacy benefits managers are middleman organizations that control both the money flow for medications and the prescribing of drugs in healthcare [11]. Patients expect their doctors make medication decisions, but in fact, PBMs do. Figure 2 shows an example of

patient "Scott" who paid $408 dollars for a drug priced at $400. Only the $110.25 paid to manufacturer and to the pharmacist for advice provided value to the consumer/patient. The rest - $297.75 or 73 percent of what Scott paid - went to unnecessary middlemen.

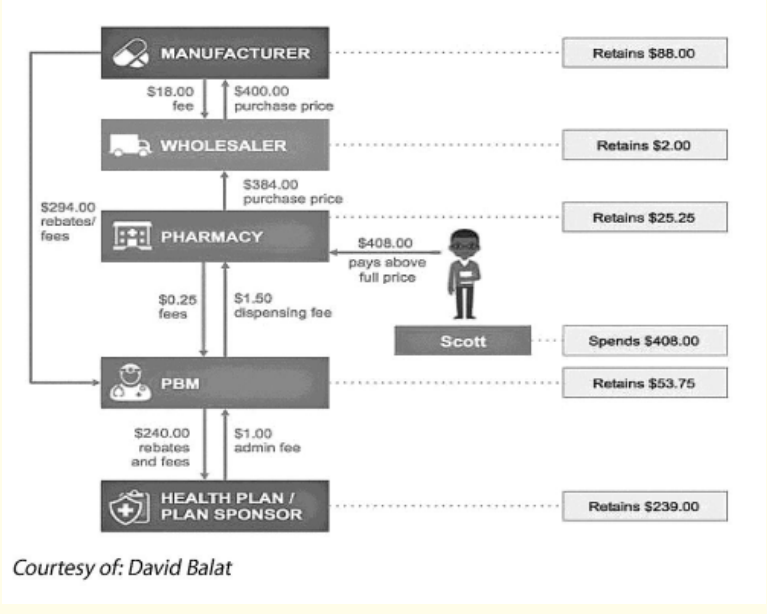

Figure 2: *Example of pharmaceutical money flow.*

PBMs are a paradigm of wasteful, bureaucratic, no-value-to-consumer healthcare spending [12]. PBMs claim they "save money" and "negotiate rebates," but the money they save and the rebates they negotiate are paid to the health plans or the PBMs themselves, not to the consumer. Furthermore, despite a legal excuse carved out for PBMs, their rebate function is against the spirit and even the letter of the federal anti-kick law [13].

What would happen if all healthcare dollars were spent to pay for care? How would that work? Could the $2 trillion of wasteful administrative spending be recouped, either to spend on care or to return to taxpayer pockets? Yes!

Healthcare spending produces low value for patients because patients do not control their own spending. Middlemen control both pricing and spending, consumers don't. To produce great quality for patients and reduce unnecessary spending, simply return control of spending to patients (Figure 3). However, the massive government bureaucratic system will fiercely resist losing control of one sixth of the U.S. economy.

In figure 3, most of the middleman entities (arrows) in figure 1 and 2 have been deleted or crossed out in a patient-controlled system, where individuals, not bureaucrats, decide spending. The money goes directly from consumers (patients) to health care, the service, rather than healthcare, the system. The absence of unnecessary, wasteful administrative activity could save up to $2 trillion [9,10].

The money currently paid to insurers by employers, called employer-supported health insurance, can be paid instead to employees to be used for their medical costs. The arrow from employers to individuals in figure 3 represents this transfer. The addition to individuals' compensation should receive the same tax advantage that employers now receive.

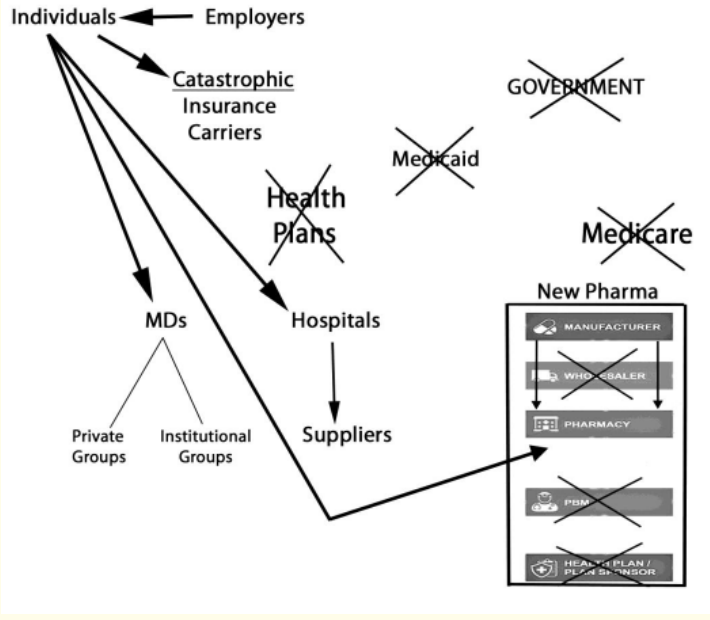

Figure 3: *Health care spending in patient-controlled system.*

Centers for Medicare and Medicaid Services, CMS, is the federal bureaucracy that oversees and controls both programs, covering more than 130 million Americans. CMS should be dissolved. It is unnecessary and incredibly wasteful.

For the medically vulnerable, Medicaid has been a failure [1,14,15]. In most states, it is the costliest item in the budget. Dissolve Medicaid and use its funds to design and support 50 state-specific, state-run medical safety nets. Washington should not be involved other than returning tax revenues currently earmarked for federal support of Medicaid.

Medicare is also a failure: wasteful and so poorly managed that it will soon be insolvent [5]. Cancel the program and pay out all those who paid into the program. Let them spend their healthcare dollars as they think best.

The average American family spent $28,256 on healthcare in 2021 [16] most of which was paid to insurance companies. If, instead, the family could spend that money as they see fit on medical care rather than on BARRCO, there would enough for all routine and elective care. Add high deductible catastrophic insurance for the rare, unexpected, expensive medical disaster - heart attack, auto accident, cancer - and the U.S. medical system becomes dollar efficient, achieving maximum value and good health at the lowest cost.

Conclusion

The individual, not a host of nameless government or insurance bureaucrats, is best suited to decide how to be dollar efficient in all commercial activities, in particular, health care. After all, it is your money.

When a patient controls his/her health care spending, $2 trillion currently diverted to healthcare BARRCO becomes available for care. The following advantages then accrue:

- You choose your physician rather than your health plan choosing for you.
- Your doctor pays attention to you, not to a computer screen.

- You decide who operates on you, where and when.
- You get the best drugs for your condition, not necessarily the cheapest.
- Prices fall as providers and hospitals compete for your spending [9].
- Providers and hospitals make more money because they are relieved of the massive, costly, time-consuming bureaucratic burden.

Who controls health care spending? Millions of faceless bureaucrats. Who should control health care spending? YOU.

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Volume 4 Issue 7 July 2022