

Editorial Opinion

A proposal to reroute and reform the healthcare money trail

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Healthcare reform;
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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.

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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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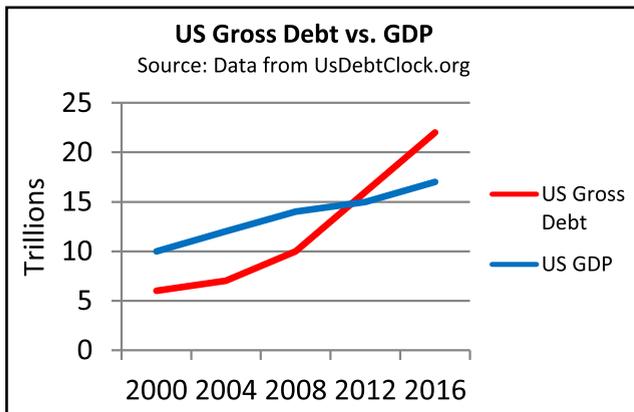


Figure 1 US gross debt versus GDP.

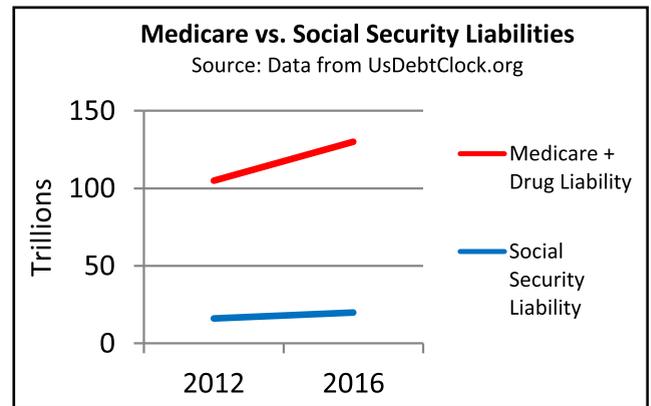


Figure 3 Medicare versus social security liabilities.

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

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

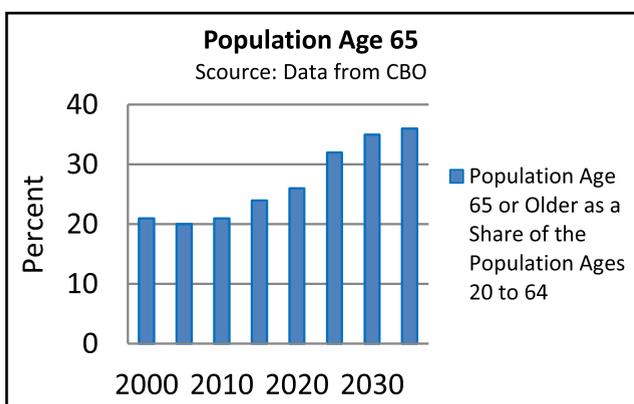


Figure 2 Population age 65.

Defense, Veterans Health Administration, and the Indian Health Service. Each is administratively priced and the administrative expenses are additive.

On the hospital side, in the 1980s the attempt to control costs was through the bundling of services and controlled pricing to modify provider practice patterns which is the same argument used today for AC. Both the Diagnostic Related Groups for hospitals and the RVUs for physicians had an initial effect because of the otherwise non-competitive pricing system. These government programs in turn inspired the Health Maintenance Organization in the private sector. However, the full non-competitive fee structure still exists today as a penalty for those who do have insurance and was a large justification for the ACA and its ostensible insurance expansion. It is "ostensible" because the ACA changes the concept of insurance. An insurance premium and payment is determined by risks and limits. By eliminating risks and limits, the ACA, while maintaining the unnecessary expense and complexity, eliminates the principle of insurance, with the exception of having someone else paying the bill.

The failure of these programs to control costs has led to the ACA with the development of AC by the federal government and the Organized System of Care in private industry. The essence of these is the management of health care to maximize quality and minimize cost through the collaboration among providers, treatment of populations, and the more intensive outpatient treatment of individuals to reduce hospital admissions. There is very little novel thinking in these programs, although they have shown limited promise through increased productivity. However, like the early success of Diagnostic Related Groups and RVUs, they fail to address patient responsibility and will not be sufficient to reverse the acceleration of cost. Of course, if costs were the only issue, reimbursements could simply be cut but that would limit access to quality care.

The necessity of personal responsibility

Incentives modify personal behavior, yet this aspect of health care is not only neglected but rejected by the "no risk" and "no limit" clauses in the ACA and represents its Achilles' heel. If there is ownership, health care becomes a responsibility which has its roots in action and accountability. If there is no ownership, as in the ACA, health care becomes an entitlement which has its roots in privilege and consumption. It is the vast unaccountability within the "affordable" ACA which guarantees its ultimate demise.

Although we would not place a risk or limit on any individual instance of care, we propose a feedback tax rising and falling with expenditures along with a personal health-care budget. This dynamically allocated budget includes the projected and actual costs, both acute and chronic, as they apply to each individual. Given a physician's order, the patient authorizes the transfer of funds to the providers, similar to a credit card transfer. If the patient beats the

projected costs, they receive a bonus. If many individuals have a budget surplus, taxes would fall, but if too many individual budgets are exceeded, taxes would rise.

The concern that patients will avoid needed care to save dollars is addressed by simply inverting the incentives. For instance, preventive care is necessary to receive any bonus. A deeper concern is the complexity of health care, but the bundling of services and prices already being done in retail medicine demonstrates the simplicities, guarantees, and transparencies which can be achieved.

These personal healthcare budgets would originally be composed and modified from available data but represent an area for research and development. Modest budgets would exist initially and then become more complex. In many ways it represents a patient's problem list from which cost projections can be made. Even without this proposal, institutional cost analysis by diagnosis and provider is a necessary field of study and will improve with time.

Each provider would have their risk-adjusted quality and price data published in a uniform format. Quality and systems of care would be similar to the present developments, but pricing would be distinctly different. At present, price is determined primarily by Medicare through a political process which cannot hope to approach the optimum price for a given product. Our proposal makes healthcare system pricing competitive. This would represent a significant change and be implemented over time.

Approximately 10 regions could be selected as test sites. The fees would begin at Medicare prices and float from there with patients authorizing the transfer of funds under the care of a physician. The middleman structure as it now exists would be eliminated except for modifications desired by the patients. Perhaps primary care, physician/hospital organizations or reinvented insurance companies might function as brokers. We foresee the governmental structure as referee instead of the present referee, general manager, and owner. From the provider's perspective, they receive at most the median price as a patient authorization. If they charge more than the median, they may balance bill if the patient agrees before the service. If they charge less than the median, the provider receives their charge while the patient receives a bonus.

It is likely that many of the patients need not pay attention to the price because the providers, in competition with other providers, are going to do that. Furthermore, only a percent of the patients need to be price conscious, for they would set the best value for everyone else. By the same token, not everyone need contribute to the tax or be eligible for the bonus to obtain the effects of this proposal, although the higher the percentage, the greater the effect. Moreover, getting business out of the business of health care and back to business where it belongs would have the additional economic benefits of increased job growth.

Healthcare funding would be through taxes and we propose a personal flat tax on income, sales, and services. This could be on a regional, state, or federal (the downside would be mission creep) level and we believe would significantly reduce the total healthcare tax/premium/co-pay/low-pay structure as it now

exists. Although resolving the tax fairness debate is beyond the scope of this article, we have chosen these flat taxes because of their relative simplicity and their inclusiveness. We feel that responsibility means a significant majority must “own” the “healthcare business” and thus pay for it. If you have personally earned and owned something, it has more value and meaning. A flat tax is more difficult for someone to pay if they do not have much disposable income; but under this proposal, there is a greater return on the investment for those who pay less, and classes of care are eliminated. Moreover, the bonuses are based on performance, not the amount of tax the individual paid. Whatever the final “feed-back” tax structure, the idea is to define an individual’s economic footprint and propose that as their relative proportion of the healthcare “premium” for their “insurance”.

In an emergency, the price and quality comparisons will be only of note to the patient after the fact, but the providers will be well aware of where they stand. Physicians are very competitive and this in itself will have an effect. In addition, the public’s perception of the value of a provider will be influenced by all of its prices and quality. Furthermore, in any given year, a small percentage of the people spend most of the healthcare dollars, particularly at the end of life. We believe that competitive pricing, as opposed to central committee pricing, will have significant advantages, while any bonus could be transferrable.

However, most telling is the deeper and sinister effect of price fixing, price controls, and the present top-down administrative structure. They inhibit the imagination. For example, systems of care is an old idea long overdue and would have been instituted years ago, emergency room visits would be dramatically fewer, and the electronic medical record would be the personal property of the patient accessible to the providers if given permission by the patient, not the other way around.

Conclusions

The United States has a debt problem extending to the state and local level, and the largest portion of that problem is from health care. The objective of this proposal is to provide maximal healthcare access (not merely coverage) and quality at minimal cost. It begins with the present quality, systems of care, and provider structures. It then makes several major changes in the delivery of health care. First, it removes the determination of the price of a service from special interest

groups, central committees, and politicians and puts it into a competitive environment. Second, it funds health care with personal taxes eliminating all other premiums, taxes, copays, and so on and removes health access from its link to employment while eliminating classes of care except where the patient agrees to balance billing. Third, it puts the money in control of the patients who, with a physician’s order, authorize the service such that both the patient and physician are paid for their performance. Fourth, it maintains an officiating system to guarantee a level playing field. Finally, it eliminates the need for insurance companies to collect and distribute money along with a substantial reduction in administrative costs incurred by both the insurance companies and the providers.

In essence, this takes the money and gives its control back to the people. We do not have hard data to prove our position and this needs more analysis but it is based on a philosophy of individual responsibility. Moreover, there is evidence in retail medicine of the potential savings while it takes the opaqueness of price controls and price fixing and places it into the light of day. We have personal experience in retail medicine, office administration, employment, illnesses, and surgery, and find the potential benefits numerous. Nonetheless, significant details are in need of elaboration but are beyond the scope of this introductory editorial and much could only be obtained through testing, for as in any endeavor, its initial description is usually only an approximation of the final event.

Finally, a study of healthcare finances, literature, and history reveals a lack of transparency, an abundance of paternalism and the marginalization of the patient when in fact it is the patient who should be the boss. The current system is about control and is telling the patients how it should spend their money. We propose giving the patients responsibility and having them tell us how to spend their money. After all, it is their money.

The Patient Protection and Affordable Care Act: <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>

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