The Economic Benefit of Transitioning Healthcare Systems: A Study of Private and Singe Payer Systems

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Abstract

American healthcare consumers pay the highest cost for healthcare out of any other country in the industrialized world. Consumers pay on average $9255 per capita a year for healthcare and related expenses (Center for Medicare and Medicaid Services, 2014, P. 5). Such high prices are a result of a combination of rapidly increasing billing, bureaucratic expenses, and profit maximization by for-profit healthcare providers and related producers. Consumers see very little positive gain for the increase in price, ranking highest in metrics such as infant mortality rate and obesity related issues (Masters, et al. 2009, P. 2). Consumers are also hampered long term by increasingly expensive medical bills, which constitutes the largest portion of citizen-based bankruptcies in America. By transitioning to a single payer-based insurance system consumer will see a significant drop in administrative expenses, lower costs for operations, medications, and wellness exams, and an increased availability in access to physician care.

Introduction

Healthcare in America has been on the forefront of political reform for the better part of the last 20 years. The Covid-19 pandemic has highlighted some of the most glaring inequalities in our nation's health insurance system. One of the biggest problems with this debate, is the misunderstanding and contortion of the information at hand. The idea of "socialized medicine" has become a catch-all in American politics, shown as something we as citizens should be petrified of. Whether unknowingly or intentional, this debate is mired with misinformation and propaganda. This paper is designed to explore the data, not the thoughts, behind the cost of the United States healthcare system and other comparable countries' healthcare systems. This process is undertaken to see if there is a better healthcare alternative for the citizens of the richest country on earth. However, the question inevitably arises: What is "better" health insurance? There are a multitude of different meanings of "better" for a system this large so throughout this paper "better" will qualify as increased cost efficiency, easier access to care, and a decrease in preventable deaths. The economic trade off transitioning from a private health insurance system to a single-payer health insurance system will have American consumers see lower costs, easier access to care, and an elimination of medical debt.

The American Healthcare System

Healthcare and its related costs are currently one of the largest expenses in the United States, and continues to grow year over year. Health care continues to grow as an exceedingly larger amount of the national GDP. Over the past two years the spending on healthcare has amounted to 17.6% of the national GDP, or $3.8 trillion (Center for Medicare and Medicaid Services, 2020). This equates to average spending of over $11,000 per person for 2019 (Center

for Medicare and Medicaid Services, 2020). The per capita expense growth will be explored later in the paper.

Health insurance, as any other type of insurance, is a way to help protect yourself from paying the full balance of a medical bill. Rockefeller et al. (2009) finds that the average medical expense of the time was just over $45,000 (p. 1). For reference, the average yearly salary of an American citizen is under $70,000. These costs are a substantial amount of money for individuals, so to mitigate these costs, health insurance covers most of the costs for individuals. The largest form of insurance in the United States is in the form of private insurance companies, most of the time provided through an individual's place of employment (employer sponsored insurance or ESI). The private health insurance market makes up the largest market share of insured individuals, at 31% of individuals, according to the Center for Medicare and Medicaid Services (2020). Individuals pay monthly into their insurance programs; these payments are called premiums; each individual pays a different monthly premium. The exact price is determined by multiple factors, including current physical health and habits, such as smoking, for example. In turn, the insurance companies use these premiums paid by individuals to pay the majority of an individual's medical bill should they need any sort of medical evaluation or treatment. However, to prevent any type of overuse or abuse of the system at the margin, consumers pay a portion of this balance, which is called a copay. This is a form of financial burden which consumers must bear, as the companies prefer for consumers to use the insurance only when absolutely necessary. These copays are dependent on the type of insurance coverage an individual purchases and vary on the type of medical coverage that is needed at the time. Year over year, there continues to be an increase in the amount spent by private insurance companies.

In 2019, there was an increase of spending to $1.2 trillion dollars, an increase of 3.7% from 2018 (Center for Medicare and Medicaid Services, 2020).

The next largest provider of health insurance is the government, through programs like Medicare and Medicaid. Medicare is a form of government insurance for those over the age of 65. This insurance was implemented for older individuals because most of the population over 65 do not work, which makes it difficult to get insurance. According to the Center for Medicare and Medicaid Services (2020), 21% of individuals in America, all of whom are over the age of 65, are insured through Medicare, and spending has increased to $799 Billion in 2019. Medicare is comprised of four parts: A, B, C, and D. Medicare Part A gives coverage for in patient and hospital stays. Part B covers outpatient procedures, such as doctor appointments. Part C is a special type of coverage called Medicare Advantage (MA). MA plans are pre-organized plans (HMOs) which limit your out-of-pocket costs but offers less complete coverage networks. This is designed to replace parts A and B for more cost-conscious individuals. Part D covers medications, to help ease the impact of rising medication costs for those on Medicare. Medicare is funded through the same tax structure as social security, the government program where people pay portions of their salaries now, to receive it back once the reach eligible age. Once accepted into the program, the consumers pick and choose what kind of coverage and plans they subscribe to. While the majority is paid for by the government through social security, each part is partly paid for by the consumer, each section is financed through different means, with each person contributing differently.

Medicaid, however, is slightly different from the other previously mentioned insurance methods. Medicaid is a combination state and federally run program designed to give insurance to those who cannot afford insurance otherwise. The Center for Medicare and Medicaid Services

(2020) reported that spending for Medicaid was $613 billion in 2019, with the average spending per enrollee being just under $8500 (p. 2). Most of the program is funded through federal tax dollars, which is distributed to the states, which in turn use it to fund their systems. Eligibility for Medicaid is determined through a "means tested method" that examines both taxable income and things such as whether you file as an individual or as a family. Medicaid benefits are designed individually by each state, with coverage differing from state to state.

Over time, there have been attempts to reform the insurance system, with the largest and most recent passed legislation being the Affordable Care Act (ACA), also known as "Obamacare". The ACA was designed to help expand health insurance accessibility to those who would otherwise not have it, whether it be through private insurance programs or public programs, such as Medicare and Medicaid. A study conducted by David Blumenthal, et al. (2015) had found that the ACA achieved one of its main goals in making insurance more available to citizens across the country. Blumenthal, et al. (2015) notes over the course of the five-year study, the number of uninsured individuals has dropped from 20 million to 16 million (p. 2). This is a decline of 20% of uninsured individuals across the country. This was able to happen due to multiple factors. One of the largest was the government subsidies that, again, according to Blumenthal, et al. (2015) 87% of all health insurance consumers across the country qualified for (p. 2). By doing this, the government attempted to make health care more affordable, resulting in a greater number of people consuming these plans.

Another way in which access was increased for the uninsured was through the extension of the age out policies for young adults. Prior to the enactment of the ACA, most children fell outside of their parent's coverage plan at the age of 19, sometimes higher based on if the student was living with parents, was going to school, or was single. By increasing the eligible age to 26,

this preserved coverage for more than 3 million young adults who otherwise might not have coverage (Blumenthal, et al. 2015, p. 2). The ACA also allowed states to expand their Medicaid programs, with a portion of the initial expenses being absorbed by the federal government. The expansion increased the amount of people who were eligible to be covered under Medicaid.

The Affordable Care Act also helped most minority communities that were previously uninsured. Some of the largest minority groups to see an increase in coverage were Hispanic individuals. In the *Social Science and Medicine* journal, Ye Wei and Javier Rodrigues notes that there is an increase of insured Hispanics in the years following the ACA and subsequent expansion of Medicaid. Specifically, in states which chose to expand their Medicaid programs, the number of insured Hispanics increased from 50% in 2010 to over 80% in 2018 (Wei, et al. 2021, p. 5). Such a large increase in insured individuals can be attributed to a more inclusive Medicaid program which accepts individuals who, prior to the ACA, would make over the amount to qualify for coverage, but not enough to purchase their own insurance. Similar increases can be seen across the board for other minority groups. African Americans saw similar increases in numbers, going from around 60% insured to just over 80% (Wei, et al. 2021, p.5). This increase cannot just be seen in states who chose to expand their Medicaid programs, but even in those who chose not to expand. The ACA had achieved its main goal of making health insurance more accessible to all individuals. The result is an increase of 30 million more enrolled individuals combined across multiple years from 2010 to 2018. (Blumenthal, et al. 2015 p. 2). Although the ACA had completed its main goal of making insurance more attainable for those who are previously uninsured, there still remains a sizeable portion of Americans who are uninsured.

The Cost of Health Care in the United States

The cost of healthcare in America is notorious for being the most expensive healthcare in the world, and it continues to rise. A study published by the Center for Medicare and Medicaid Services (2014), has shown just how rapidly the cost of healthcare has risen. According to their research, since the data has begun to be collected in 1960 up to 2013, healthcare spending per person has risen from $147 to $9255 per individual, resulting in a year over year increase of 8.1% (p. 5). This is almost double the rate of increase of personal income over the same period. Why do consumers continue to see and experience the brunt of these seemingly exponential increases in health care prices? One of the biggest reasons is due to the rapid technological increases that the medical field has seen recently. The rapid progression and proliferation of technology is a double-edged sword. While the increase in technology makes procedures more efficient, the increase in efficiency results in more of these same procedures being prescribed and undertaken. One of the most common examples of this can be seen in the amount of Magnetic Resonance Imaging (MRI), an advanced type of imaging device to see things an x-ray could not see. In the United States compared to the rest of the world. Compared to the average of other developed countries, the US has almost 2 1/2 times more MRI scanners when compared to the average (Blumenthal, et al. 2015, p. 3). Having so many of these machines allows people who, in other countries would not qualify for such imaging, to get one. With doctors continuing to send people to get these types of imaging, demand continues to rise, and as a result, so does the price that hospitals and independent imaging centers can charge individuals and their insurance. This goes beyond just imaging and can even be seen in procedures, as well. Thomas Bodenheimer (2005) writes, “Laparoscopic cholecystectomy provides a medical example of this phenomenon. Whereas the price of a laparoscopic procedure may be 25% less than the price of open

cholecystectomy, the rate of both types of cholecystectomy has increased by 60%," (p. 1). Underneath the surgical jargon, the writer is referring to a surgery to remove an individual's gallbladder. The evolution of the technology to perform this surgery laparoscopically (using smaller incisions) as opposed to open (one large cut) incisions, drove down costs due to an increase in efficiency, and a shorter recovery stay in the hospital. However, the ability to perform these operations at a cheaper and more efficient rate, results in more of these procedures being done. The savings from the technological innovation has been offset by the increase in the number of procedures being done.

In a study titled *Comparing Price Levels of Hospital Services Across Countries: Results of Pilot Study* (2010), the authors compare a multitude of other services performed in many different hospitals across the world. The best example can be seen with childbirths. In the study, the authors compared the price of a standard vaginal birth. The cost of this birth method in the United States is $4,451(Koechlin, et al. 2010, p. 21). Using data from the same study, the average of the 10 first world countries used comes out to just under $2300. For almost twice the price of the study average, what benefits are the American consumers seeing? Well, the answer is unfortunately, not much at all. Consumers in America are some of the few in the world who have the ability to pick and choose what doctors they wish to see, as opposed to being told who they have to go to. Outside of this perk, the reality is highlighted when Roger Masters notes in his study (2009) that the United States leads the Organization for Economic Co-operation and Development (OECD) countries in infant mortality rate at 6.9 per 1000 infants born (p. 2). The massive difference in price is not attributed to an increase in the quality of care that American citizens receive. The difference in price is due to the system in which hospitals and insurance interact with each other.

The billing system between hospitals and insurance companies introduces a lot of layers for inflated prices and increased costs. The administrative side of billing for medical procedures has produced a system that comprises a significant portion of inflated prices in the American healthcare system. A study by Aliya Jiwani and colleagues (2014) was able to quantify just how much this billing system has added onto prices of American Healthcare. The study uses a metric called billing and insurance-related activities (BIR). In 2012, it was estimated that BIR activities resulted in a total of $471 billion in added costs for medical bills (Jiwani, et al. 2014, p.4). Going deeper into how the costs are distributed, most of the expenditures come from private insurance companies. Private insurance companies added a total of $198 billion dollars in BIR activities (Jiwani, et al. 2014, p. 4). There are several reasons for this, the biggest being that most private insurance companies are public corporations. The goals of a public corporations are to make money for shareholders by increasing stock value. The easiest way to do this is to increase revenues. By doing this, the companies are making their books look better, but at the expense of consumers. Physicians, hospitals, and related suppliers combine for approximately $250 billion in BIR activities (Jiwani, et al. 2014, p.4). These costs can be attributed to an increased amount of administrative effort and for-profit hospitals and clinics. The issue with this continuing practice of rising billing costs is that consumers are faced with higher costs but see very little increase in quality of care they receive.

The biggest question brought up by this fact is who does the insurance company see as more important: the customer or the stakeholder? The long-term impacts of rising health costs will be explored later on, but what have the insurance companies done to limit these costs? One could argue that they have not done enough, and instead are choosing to put their shareholders over the customers they cover.

Economic Impact of US Healthcare on Individuals

Much of this paper has examined the reasoning for US consumers paying such high costs, but little of it up to this point has examined how consumers are individually impacted. The high prices have impacted consumers of all economic backgrounds in life-altering ways. Medical debt has become an increasingly prevalent cause of consumer bankruptcy, with a conservative estimate of 26% of all bankruptcies coming from unpayable medical debt (Austin, 2014, p.1). The concept of bankruptcy is not a part of this paper but the general idea is as follows: When an individual cannot repay their debts, they receive debt forgiveness from the courts, which absolves them from their debt obligations completely, or allows them to restructure their debt in a way that makes it easier to pay back. Most medical bankruptcies are a result of unforeseen medical emergencies, which the average individual did not account for in their budget. Even with insurance that can absorb the majority of these costs, the out-of-pocket costs for serious and chronic illnesses can amount to unpayable levels of debt.

The inflated prices of health care have predictably increased the economic burden on the individual consumer. For insured individuals this burden is seen in increased out of pocket costs, and for uninsured individuals, it means an even larger bill which they are expected to pay in full. As of 2015, the average cost for a vaginal birth totaled $23,148 (Acharya, et al., 2021, p.1). This is a cost for a routine birth, barring any specialty care needed between the mother or child. The out-of-pocket costs for insured individuals are just over $4,300. The cost for a cesarian birth is almost double that at just over $43,000 with the out-of-pocket costs being over $5,000 (Acharya, et al., 2021, p.1). The average individual in America does not have $5,000 in savings to be able to pay off these bills, so for many uninsured $43,000 is out of the question. The cost of this procedure is over half the amount that the average American makes in a year of work. This cost

is amplified for patients who face more intensive medical care, such as cancer treatment. In a study conducted on the long-term financial burden on cancer patients, the average total cost over the course of the treatment ranged between $100,000 to $280,000 (Pak, et al., 2020, p.2). While insurance absorbed the majority of these costs, Pak, et al. (2020) reports the following out of pocket costs for various insured individuals:

> $2116 among those on Medicaid, $2367 among those with coverage from the Veterans Health Administration, $5976 for those insured by a Medicare health maintenance organization, $5492 among those with employer-provided coverage, $5670 among those with Medigap, and $8115 among those with a traditional fee for-service Medicare coverage but without supplemental coverage. (p. 3)

The economic impact of a cancer diagnosis is massive, from both direct and indirect costs. Between out-of-pocket costs for the insured, the full amount for the uninsured, these costs are exacerbated by the patient often being unable to work, or if they are able to, they work a far reduced capacity, reducing income. Costs after the initial diagnosis are significant as well, between follow up exams and medications. In the 15 years after a diagnosis, rectal cancer patients pay $75,000 in associated costs (Pak, et al., 2020, p. 2). This amount of debt is impacting individuals in the worst ways possible. In a report published by Dr. Michele Doty, et al. (2008), 21 million Americans had medical debts so large they could not afford basic necessitates or utilities bills, and 8 million needed a second loan on their house to pay back debts. This is an alarming number of individuals who are being faced with massive medical debt (p. 5). When faced with the possibility of this debt, many individuals choose not to seek help immediately, and when consumers choose to seek help for serious problems, the severity of their condition often amplifies these issues even more. The result are conditions where individuals are

faced with a significant unplanned expenditure and decreased income. This combination is one of the biggest reasons for medical bankruptcies, as consumers cannot pay back these constantly rising costs.

A Possible Solution to Benefit Consumers

It is now known that American consumers do not receive a level of healthcare commensurate with what they pay for. The prices are a result of increasing levels bureaucracy and profit raising for corporate shareholders. While the term "socialized medicine" has become increasingly misunderstood in America, a single-payer health insurance system has the ability to offer many benefits to consumers. A single payer health insurance system is a system in which all citizens have the same insurance plan from the same provider, which would be a public company, ran and overseen by the government. In this system, all individuals are afforded access to care from doctors' visits and emergency visits, to dental and vison care. This system would be very similar to the current government run Medicare and Medicaid systems. The implementing of a system such as can have many hurdles, especially for a country as large as America, but the long-term benefits would outweigh the initial startup hurdles.

The biggest hurdle in implementing a single payer health care is the startup costs. In a study conducted by the Mercatus Center (2018), the author examined the potential cost of implementing Senator Bernie Sanders' (I-Vt) Medicare for All plan. From 2022, the beginning of the projections, to 2033, the latest projection date, the cost is projected to be $32.6 trillion over the course of the projections (Blahous, 2018, p. 13). The biggest caveat in this idea is this projected cost is much greater than all federal taxes being collected during the same period. This would leave not only the plan, but the country as a whole, running at an unsustainable deficit. For this issue to be resolved, there would need to be a massive overhaul in both the US tax codes

and federal spending. While both of these things are outside the scope of the paper, possible sources of funding could come from diverting part of the world's largest military budget and increase of tax on giant corporations and the wealthiest individuals in America. In doing this, America would be able to offset the majority of the costs that are expected in the implementation of this system.

Benefits of Switching to a Single-payer Insurance System.

One of the most immediate changes that citizens will experience will be a sharp decline in the amount of administrative costs they incur. As mentioned earlier in this paper, Billing and Insurance related (BIR) activities totaled $471 billion in 2012 (Jiwani, et al. 2014, p. 4). This comes out to just over $600 per capita in the same year (Yu, et al. 2017, p. 8). This amount is almost 25% greater than the next highest spender in administrative costs, which is Canada. By implementing a single-payer insurance system and getting rid of the increased bloat and layers of billings, costs go down, which ultimately mean more savings for individuals. These savings extend beyond the amount spent in BIR, however. The average worker can even begin to see an increase in their take home pay as a result of switching insurance systems. Due to the elimination of employer-based health benefits, this difference can be returned to individuals' paychecks. This is now money that can be invested, saved, or put back into the economy. This difference in paychecks has the ability to spend more and put back into the economy which can be taxed and used in turn to fund the healthcare system.

The implementation of a national health insurance will give more access to specialty care that was once not accessible to a large portion of America. The expanding of the insurance system would go on to cover dental and vision care, which is not currently covered by most insurances. Charles Blahous states that for standard health insurance, only 12% of the total cost

is paid out of pocket, but for dental services nearly 40% of the total cost is paid out of pocket (Blahous, 2018, P.8). By now covering dental and other specialty procedures, individuals are more likely to utilize these services. Increasing utilization results in more preventable diseases being caught early and treated early, limiting any long-term damage and more intensive treatments down the line.

These savings extend far beyond just administrative costs. Americans spend the most out of any country in the world in on medications. In a study on the cost savings of a US single-payer health insurance system, it was noted that, "[The US spends] $1,011 annually per capita on prescription drugs compared to the OECD average of $422," (Cai, et al. 2020, p.12). Consumers are caught in a system which prioritizes profits over affordability, which can be seen in the average mean profits for Fortune 500 pharmaceutical companies at 24%, compared to 9% of all other sectors (Cai, et al. 2020, p. 12) in the Fortune 500. Here we see again the same dilemma that the insurance companies face: Do these pharmaceutical companies care more about the patients' lives that they help with these medications, or reporting a profit to their shareholders? Based on the current climate of the pharmaceuticals industry, one could argue emphatically that they care more about reporting profits. The transitioning of health insurance systems could have massive implications for those who suffer from chronic diseases which must be treated through medication, such as diabetes, HIV, etc. A study conducted by the Mercatus Center (2018), is able to quantify the amount of savings on drugs, with the total savings from 2022-2033 being approximated at $846 billion, or about $77 billion per year (Blahous, 2018, p. 13). This would be a lifeline for many struggling to balance how to pay for both their medication and other necessary goods.

Conclusion

Healthcare in America should be something that everyone has access to, not just those fortunate enough to afford it. The current healthcare system has created a bloated system filled with private companies trying to make profits from a system that should not be profited off of. This creates an environment where individuals experience most of the price increases and see very little increase in quality of care. By overhauling the current system, consumers will be those seeing the most benefits from the change, not the corporations. Consumers will be able to go to the doctor without incurring large debts, alleviating the burden of making decisions between life and potential death. The consumer will also see increased savings on medications and other necessary items for their immediate and long-term care. Most importantly, every citizen will be covered and have the ability to be healthy and live better lives.

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