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Healthcare Market, Government Intervention, And The Need For A Single-Payer System

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Abstract: *Even though the United States has the highest healthcare spending per capita, over 41 million individuals do not have health insurance and 37 million do not have access to adequate care. A worsening of health inequities and potential changes to the availability and efficacy of health care on a national level are consequences of repealing the Affordable Care Act. Private health insurance is more common than government-funded coverage, and more than 78 million Americans lack adequate coverage. Between 2021 and 2022, drug costs rose 8.4 percent to $405.9 billion. Laws prohibiting price negotiation of drugs, products, or equipment, and the political influence of the pharmaceutical industry preventing U.S. exports. The Medicare system model is one possible solution to the rising cost of health care: a single-payer system. Government subsidies were cut and enrollment in the Affordable Care Act plummeted, driving up insurance premiums. All hospitals and hospital services can be charged according to current Medicare rate schedules and cost reductions can begin. Unfortunately, private insurers often demand exorbitant rates for services that do not match their offer. Insurers can be encouraged to compete with new market rules and transparency requirements that make it easier for consumers to see the benefits of the health plan. Provider reimbursement methods for regulation are necessary to prevent demand compliance by suppliers and avoid abuse of services. Aggressive regulation of healthcare costs or expenditure targets by government policy would have devastating effects on all parties involved, including consumers, payers, and state and federal governments.*

Keywords— healthcare market, intervention, single-payer system, government, costs

1. INTRODUCTION

The United States has the highest healthcare expenditure per capita, but more than 41 million people lack proper access to care, and 37 million people do not have health insurance at all. A universal system, like the one put out in the Medicare for All Act (MAA), might revolutionize the accessibility and effectiveness of healthcare in the United States, in contrast to the continuation of attempts to dismantle the Affordable Care Act, which would only bring healthcare disparities worse [1]. Millions more are in danger of losing health insurance, and over 78 million do not have sufficient coverage. Among the 24% of Americans without sufficient health coverage, there are both those who do not have health insurance at all and those whose out-of-pocket expenses and deductibles are significantly higher than their wages [2]. Health insurance was available to 92.1% of the population at year's end 2022. Simply put, 7.9% of the population did not have health insurance at some point over the year. Private health insurance was more common than governmental coverage (65.6% vs. 36.1%). Among the civilian, noninstitutionalized population, 54.5% had health insurance through their employer, 18.8% through Medicare, 9.9% through direct purchase, 2.4% through TRICARE, and 1.0% through Department of Veterans Affairs (VA) and CHAMPVA health care [3].

Disparities in healthcare access and insurance coverage are major causes of racial and ethnic inequality. These discrepancies have been greatly diminished as a result of the expansion of health insurance. Individuals under the age of 65 from high-income households had 90.8% private insurance in 2019, compared to 18.4%, 35.8%, and 18.4% of poor, low-income, and middle-income households, respectively. Private health insurance coverage was lower among non-Hispanic Blacks and Hispanics than among non-Hispanic Whites [4]. Health outcomes, patient satisfaction, and the impression of need and experience with the healthcare system can all be improved when patients have timely access to treatment, which in turn reduces the financial burden of seeking out-of-network care and a potentially more distant healthcare. There is a substantial correlation between having health insurance and getting continuous and timely care, and a lack of insurance is a major factor in health service access inequities [4]. Compared to non-Hispanic White people (11.1%), Hispanic adults (18.3%) were more likely to sometimes or never get care right immediately when they required it for a sickness, accident, or condition. Among adults, 18.2% were Black, compared to 12.1% White. Adults without private insurance (12.0%) and those with just public insurance (33.3%) were more likely to be uninsured. Compared to individuals residing in big fringe metro areas (11.7%), those residing in micropolitan areas (16.4%) were more likely to sometimes or never receive prompt medical attention for a serious health issue in 2017. There was a significant difference in the likelihood of getting an appointment for routine treatment as soon as needed between adults of Hispanic (19.0%) and non-Hispanic White (14.4%) backgrounds. White adults were less likely to obtain a timely appointment for routine care (15.0% vs. 26.3% and 20.7%, respectively) than Asian and Black adults. Compared to people with private insurance (18.3%),

those without insurance were more likely to have trouble getting an appointment for routine treatment when they were sick or injured in 2017. People residing in big outlying metro areas (13.5%) were less likely to obtain an appointment for regular treatment as quickly as needed than those residing in large central metro areas (19.2%), medium metro (16.7%), or small metro areas (17.0%) [4].

It is a usual practice for patients to pay out of a pocket for medical treatments in the United States. Several factors determine the amount, including the patient's insurance status (insured or uninsured), the type of insurance (public or private), the benefit design (deductible, coinsurance, annual out-of-pocket maximum), the amount of out-of-pocket spending in the same fiscal year, the provider's network membership (in-network or out-of-network), and the price negotiated between the insurance and the provider. Most of the time, patients are aware of their insurance coverage. However, they are less informed regarding the specifics of their insurance, including the structure of their coverage, the providers that are part of their network, and the amount they were able to save through negotiations. Patients can't get a good idea of how much they'll have to pay out of a pocket without this data. In addition, even within the same region, there can be a wide range of charges and negotiated pricing for similarly sized medical services [5,6].

When it comes to in-network imaging services, about half of all US private health insurance policies impose coinsurance and over 90% require coinsurance for out-of-network imaging services; this means that patients often face substantial financial burdens when utilizing radiology services [7]. Even within the same hospital, there can be significant variations in the costs that commercial insurance companies negotiate for shoppable radiological treatments among different health plans offered by the same insurance company [6]. Hospitals in the United States have not done a great job of following price transparency regulations. Despite being mandated to disclose the prices of some medical services, including radiology services, the hospital price transparency rule was not fully implemented for nearly half of the institutions surveyed [8]. Large providers (e.g., hospitals having more than 30 beds) are subject to a penalty for non-compliance that can reach $5,500 per day, caused by the poor compliance [9]. If a hospital was big, located outside of a major city, for-profit (rather than non-profit), affiliated with other hospitals in the referral area, and had a better customer rating, it would be more likely to comply with the pricing transparency requirement. This shows that hospitals may be unable to comply with the requirement due to a lack of funding, and that compliance is heavily impacted by the hospital's focus on the patient and the actions of similar institutions in the same market [10].

At present, medications consume billions of dollars, driven by prices that surpass all others and persist in outpacing inflation. Compared to 2021, when spending climbed 6.8 percent, 2022 saw an even faster 8.4 percent increase, reaching $405.9 billion. Medicaid and commercial health insurance spending grew more slowly, although Medicare and out-of-pocket spending for retail prescription medications surged. Retail prescription medicine costs increased by 1.2% in 2022 following four years of reductions, and the number of prescriptions dispensed increased at a quicker rate, both of which contributed to faster growth in 2022 [11]. As an example, whereas insulin costs around $30 in Canada, it costs about $300 in the US. Legislation prohibiting price talks for drugs, supplies, or equipment is a hindrance to the existing Medicare system. Price control faces strong opposition from the pharmaceutical sector, which wields tremendous political influence thanks to the Supreme Court's "Citizens United" decision, which lifted restrictions on corporate political expenditure [1].

Private insurance plans usually only enroll patients for a set period, and their primary goal is to maximize profit by minimizing immediate expenses. Health insurance companies have a fiduciary duty to their shareholders, but this approach undermines their ability to put their customers' long-term health first. Cutting corners in the short term can have devastating effects on a patient's health and finances in the long run. When compared to other countries' healthcare systems, Canada's single-payer system devotes greater resources to prevention, both in terms of total national health expenditure and per capita spending [12]. Cutting costs in the US will have consequences that go beyond just long-term health problems. Take the ongoing problem of insurance companies refusing to cover alternatives to physical therapy and less addictive but more costly drugs. While the United States is experiencing an unprecedented epidemic of opioid dependence, this is still occurring. Alternative treatments for chronic pain may be more expensive up front, but the benefits to health and quality of life from avoiding addiction and the expenses of substance abuse treatment will surely surpass them in the end [1, 13].

In the US, health insurers buy a lot of medical treatment through the individual market and employer-sponsored insurance programs, such as the ACA Marketplaces. There are two possible outcomes from a concentration of health insurers: first, savings from economies of scale; and second, reduced premiums for employers and consumers because of price negotiations with healthcare providers and hospitals that are trying to charge more than the market rate. Lower hospital and physician pricing relates to increasing health insurer concentration, suggesting that this is happening to some extent, according to the study. The data, however, reveals that customers do not benefit from these price cuts. Several studies have shown that premiums, for both companies and people buying Marketplace plans, increase as the number of health insurers increases [14]. The American people are increasingly demanding healthcare reform, which puts lawmakers in a prime position to overhaul the system and annually save tens of thousands of lives. Medical treatment could be more accessible, affordable, and of higher quality under a single-payer system. Fearing a violation of capitalist ideals or excessive federal control over such a sizable portion of the economy, some Americans have voiced their disapproval. But

there are already a lot of regulations in place in the healthcare industry, and it doesn't follow capitalist principles because of monopolistic pricing and all. Health insurance and pharmaceutical industries, among others, have strong vested interests and will likely oppose this. On the other hand, there is an ethical need to ensure that everyone has access to health care, regardless of their financial situation or job status [1].

2. DISCUSSION

Health care in the US can be improved by nearly every level of government, including the federal, state, and local levels. When compared to the ideal free market, the American healthcare system falls short. Consumers do not have access to comprehensive information regarding the performance and quality of products and services, and licensing regulations limit their ability to enter and exit markets. Only buyers and sellers have any control over prices, and only sellers can drive demand for their services. Local and state governments are responsible for enforcing regulations that pertain to the quality of care, including those about licensure and the reporting of medical errors. Federal authorities like the Food and Drug Administration (FDA) establish and enforce commercial transaction regulations for the healthcare industry. The improvement of proprietary medicine names, packaging requirements, and label standards that emphasize drug-drug interactions are all part of the attempt to decrease medical errors. sixteen [15].

The United States has the highest prescription medicine prices globally. Consequently, Americans are bringing narcotics into the country illegally. On average, other high-income nations charge 56% less for drugs supplied in the US. Research and development expenses, market rivalry, lack of transparency, the country's free pricing system, and a prohibition on federal negotiation of prescription prices are some of the factors that can affect medication pricing. The goals of the pharmaceutical industry and pharmaceutical manufacturing companies, as well as differences in political and health policy concerns, cause pharmaceutical price regulation to vary widely. Take the US healthcare system as an example. It's based on capitalism, which means that pharmaceutical prices are deregulated, and the market regulates itself under invisible control. The health of some socioeconomic groups is negatively affected by health inequality because of privatization, which emphasizes private management of healthcare quality and reform rather than public financing [16]. The Department of Health and Human Services possesses substantial bargaining power due to its role in representing the whole US market. If the United States Department of Veterans Affairs (VA) were to serve as an example of a national single-payer system, it could be able to negotiate prescription prices that are in line with their therapeutic value. The VA system can negotiate pharmaceutical prices that are 40% lower than Medicare because of its bargaining strength [17]. More than $180 billion in savings might be achieved if negotiations for pharmaceutical pricing were allowed using a formulary comparable to the one used by the VA [18]. One of the most important goals of health care policy should be to slow or stop the increase in costs while keeping or expanding access. Healthcare spending tends to outpace inflation. The amount of care and its cost determine this. At least half of the increase in healthcare expenditure in the US is thought to be attributable to skyrocketing pricing. From one country to another, and even within the same nation, prices might vary greatly depending on the facility or region. The adoption of new technology, improvements in income, changes in insurance design, and demographic shifts are the main causes of price and volume rises. An aging population is predicted to lead to a rise in the demand for healthcare services [19]. Here, price regulation and setting is a tool for managing service and expenditure quantities while keeping quality high and fostering efficiency and sustainability [20].

Insurance rates have gone up for everyone, even those with employer-sponsored plans, due to the recent removal of government subsidies and the subsequent drop in ACA enrollment. A single-payer healthcare system could reduce costs and alleviate this financial burden. The substitution of payroll taxes for employer and family insurance payments, respectively, is one possible financing solution. In both scenarios, rates would be set such that savings would accumulate. Redirecting premiums to taxes would have redistributive effects on the economy because it would amount to transferring wealth from private to public hands. Applying the present Medicare fee schedule to all hospitals and clinical services might accomplish the first set of savings [1]. More than one-third of all healthcare spending in the US goes toward hospital and clinical services [21]. The quality of services provided by private insurers is frequently not commensurate with the fees charged [22].

There is an inverse relationship between clinical outcomes and appendectomy costs in the United States, which range from $9,332 to $33,250. For example, compared to other states, California's appendectomies cost the most, but there are also more cases of related complications and perforation [23].

Medicare, on the other hand, pays hospitals and other healthcare providers at predetermined rates. There would be yearly savings of $100 billion if Medicare's negotiated fees were applied to all individuals' treatment. Hospital fees would be decreased by 5.54% and clinical services by 7.38% [1]. As a result of healthcare costs surpassing economic output, the uninsured rate is on the rise, families' disposable income is decreasing, and businesses are unwilling to invest. Federal and state budgets are under pressure due to the rising costs of Medicare and Medicaid. The most compassionate way to achieve budget balance, in addition to small increases in revenue, is to slow the overall increase in healthcare costs. Because it prioritizes ensuring the health of the sick, risk selection is an unsustainable business model for universal private insurance coverage. Insurers are compelled to accept all applicants and offer flat rates regardless of health status (within certain limits based on age), according to the Patient

Protection and Affordable Care Act (PPACA), which utilizes the federal government's regulatory authority. Currently, this only applies to the 5-10% of Americans who are part of the nongroup market, but it does force more risk pooling than what's currently in place. With the support of subsidies, everyone can afford to buy health insurance. Meanwhile, new market rules and transparency mandates encourage insurers to stop using risk selection and start competing by assisting subscribers in identifying the value of the healthcare system [24].

While private vendors can help level the playing field when it comes to information, the government should ensure that the evidence used to disseminate specialized knowledge is accurate and of high quality. This is particularly important in areas where there are significant health and safety risks [24]. Regulating provider payment systems is the key to resolving supplier-induced demand issues with fee-for-service payments. Healthcare providers may encourage improper utilization of services and consumers may seek more extensive healthcare services when uncontrolled fee-for-service payments are in place. It will take a diverse set of skills, well-functioning institutions, and competent leadership to solve the regulatory challenges in private insurance markets. The policy instruments fall into four broad classes: intelligence, monitoring, auditing, and legislation and licensing. Because of competing goals including affordability, equity, viability, and avoidance of adverse selection, risk selection, and moral hazard, controlling how private enterprises can price their products is a substantial governmental intervention that might result in unforeseen effects. The moral hazard effect occurs when individuals feel entitled to their health insurance benefits, which encourages them to purchase more and "better" health care but discourages them from maintaining a healthy lifestyle. In addition to driving up the cost of coverage, this can also lead to an increase in both the proper and improper utilization of services [25]. Although fee-for-service models were sound a century ago, they now promote excessive volume, which is problematic in asymmetric information marketplaces where third parties are used for payment. To begin bending the cost curve without enlisting clinicians' self-interest in reducing cost growth, we must first change the incentive structure, which means how we pay physicians and other providers. This will bring provider self-interest into line with the societal interest in lower per capita health spending growth [24]. The greatest way to create long-term incentive systems to replace the ones we have now is for public and private payers to work together with willing clinicians [24]. Ensuring competitive market conditions and performance is a key responsibility of the government. However, several problems can hinder market performance. These include prices that are too high, barriers to entry that allow monopolistic sellers to remain in business, information asymmetry between consumers and sellers, and the fact that real quality cannot be determined without expert knowledge.

U.S. lawmakers are discussing how to improve upon existing healthcare systems like Medicare and Medicaid to make them more accessible, affordable, and efficient for all citizens. The United States may not establish a national single-payer system anytime soon, though, because veto points abound in American institutions and new democratic administrations seldom usher in overhauls that start from scratch. In order to build a system that works for everyone, there needs to be a genuine promise to pay providers a fair wage and keep them from getting out of control. The combination of efforts to create universal access and reduce administrative processes is a surefire recipe for disaster, since providers would naturally resist any reforms or rationalization that come from on high [26]. Maintaining a national single-payer system requires the middle class, and that is the most important lesson. There is a difference in the political clout between middle-class valued systems and those whose primary target is the poor. Most redistributive single-payer systems actively seek to displace middle-class people by offering tax breaks or allowing private companies to choose which public services to use. Legislators should tailor their system to appeal to the middle class since they are the ones who will ultimately determine the United States' political survival, not corporate interests, or social justice advocates. Problems with political instability and stigma are typical in means-tested programs that target low-income and poor people [26].

3. CONCLUSION:

Spending on health care in the United States has increased at a faster rate than the GDP in recent decades, and the country ranks first in this regard. Those in the workforce, their families, and businesses who foot the bill for health insurance are all feeling the pinch as rates and deductibles continue to climb. From 2010 to 2018, private insurance spending per person increased at a pace of 3.8%, much outpacing Medicare spending per person, which increased at a rate of 1.7%. Spending on health care in 2019 exceeded $1 trillion, with 173 million individuals under 65 years old having private health insurance. An increasing portion of companies' overall remuneration goes toward healthcare costs, which is stifling wage growth. Increases in health care expenditure are a direct result of the Affordable Care Act's (ACA) direct subsidies of non-group plans, health benefits for public employees, and the tax exemption for employer-sponsored health insurance. Most of the expenditure difference between this country and others is attributable to rising costs, which has driven much of the spending growth on the commercially insured in the past few years. Healthcare costs are increasing at a far quicker rate than physician costs, because of pricing negotiations between commercial insurers and providers. There is an increasing amount of evidence showing that commercial insurers pay more than Medicare for similar services. Everyone from consumers and payers (employers and insurers included) to state and federal governments stands to lose a lot if policies impose global budgets or spending targets or actively regulate healthcare prices. Insurance companies might be compelled or given incentives to pass savings on to consumers in the form of reduced premiums and cost-sharing if government spending

cuts were to take effect. Nevertheless, there would be significant resistance from industry and concerns that healthcare accessibility and quality could be badly affected by lower provider income caused by reduced market prices. The high and very variable cost of healthcare in the US is a major factor in the overall trend of increasing healthcare expenditure. Price control, global budgets, and spending growth targets are some of the alternatives that governments and other stakeholders have sought out because market-based efforts to constrain prices have mostly failed. There are concerns over the proper role of government in controlling healthcare spending and prices, and these policies are divisive [27].

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