The Healthcare System and Manufacturing in America: An Economic Analysis

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March 3, 2023

Keywords: Manufacturing, Healthcare, Kickbacks in the Healthcare Industry
JEL Codes: H51, L60, I10, L65

"The most fundamental driving force of man is to live and not suffer, but the Healthcare Industry that is responsible for our care has taken this innate desire to live pain free and used it to destroy personal financial lives and the United States economy."**Roy Meidinger**

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1 Abstract

In this article, we have examined the issue of healthcare costs in America, which are uncompetitive in comparison to the quality of service and other G20 countries. These costs are often directly burdened on employers, resulting in a direct impact on manufacturing costs and competitiveness.

Our analysis has focused on identifying means to reduce healthcare costs without compromising on quality and availability, as well as exploring alternatives that do not burden costs directly on employers, with a particular emphasis on the manufacturing industry. This is crucial in order to address the persistent trade deficits that have plagued the American manufacturing sector.

It is important to note that healthcare costs are a complex and multifaceted issue, and any solutions proposed will require a comprehensive and nuanced approach. However, our analysis has highlighted several potential solutions, such as increasing competition in the healthcare market, implementing cost-containment measures, and shifting the financing of healthcare away from employers.

Furthermore, we have also considered the potential benefits of regulatory reform, as well as the potential for innovation and the use of new technologies to drive down costs and improve efficiency.

We hope that our analysis will contribute to ongoing discourse and efforts to address the issue of healthcare costs and their impact on American manufacturing competitiveness.

2 Introduction

The healthcare industry plays a significant role in the American economy, but its current structure is causing negative impacts on the manufacturing sector. The United States mandates healthcare for employees, unlike other countries, and the lack of competition in the industry has led to higher costs. This results in limited consumer dollars available for other industries, such as manufacturing.

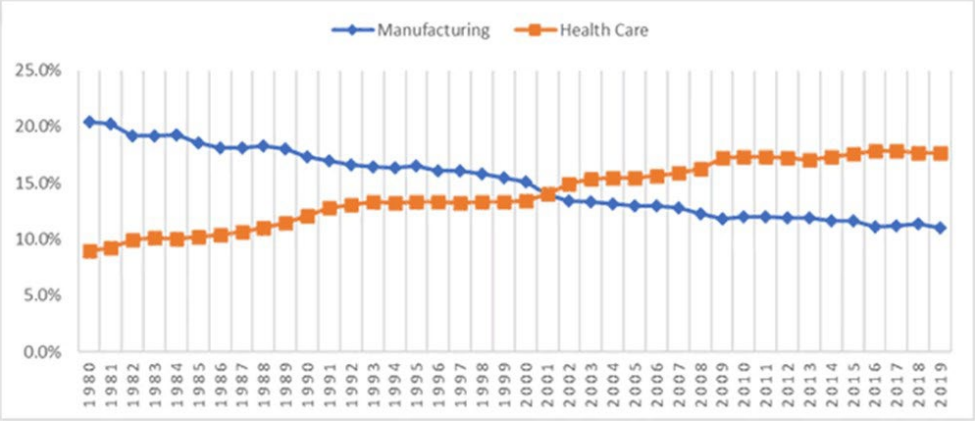


Figure 1: Manufacturing vs Healthcare as a percentage of U.S. GDP; Source: Roy Meidinger

The decline of the U.S. manufacturing industry, now at a mere 11% of GDP, can perhaps be attributed to the growth of the healthcare industry and the way it is financed in the U.S. Unlike other industrialized nations, where healthcare costs are primarily financed by citizens through income taxes, in the U.S. employers bear a substantial portion of employees' healthcare benefits. This results in manufacturers incurring spiralling healthcare benefit costs that impede their competitiveness in the global market.

A comparison of the percentage change in the healthcare industry's GDP versus the manufacturing industry illustrates a direct correlation between the growth

of one and the shrinkage of the other. No other sector besides manufacturing has experienced such a decline in recent years.

The persistent trade deficit with other countries, who have citizen-paid universal healthcare coverage, further emphasizes this correlation.

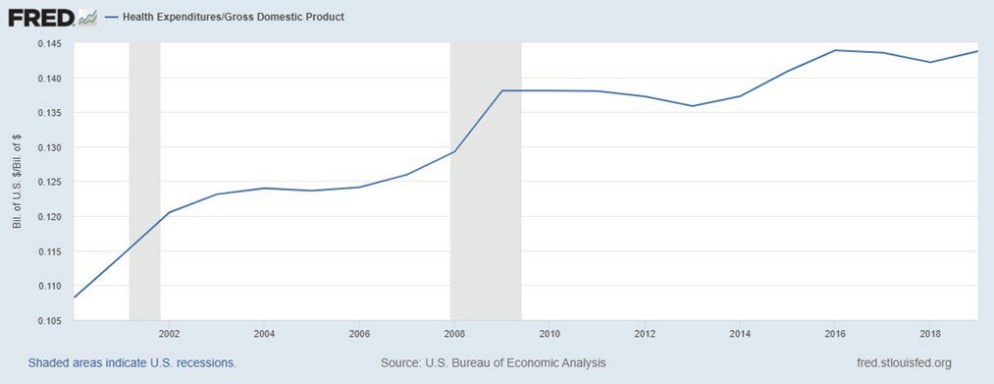


Figure 2: Healthcare Expenditure/Gross Domestic Product; Source: fred.stlouisfed.org

To address this issue, the U.S. must transition from an employer-paid system for healthcare benefits to a citizen-paid policy. This will lower manufacturing costs and restore competitiveness in the global market. Additionally, the elimination of indirect healthcare costs, such as those incurred during the various stages of the manufacturing process, will also lower the final cost of the finished product, and improve competitiveness. It is important to note that this transition would require a comprehensive reworking of the healthcare system, and a thorough evaluation of the potential impact on both the healthcare and manufacturing sectors.

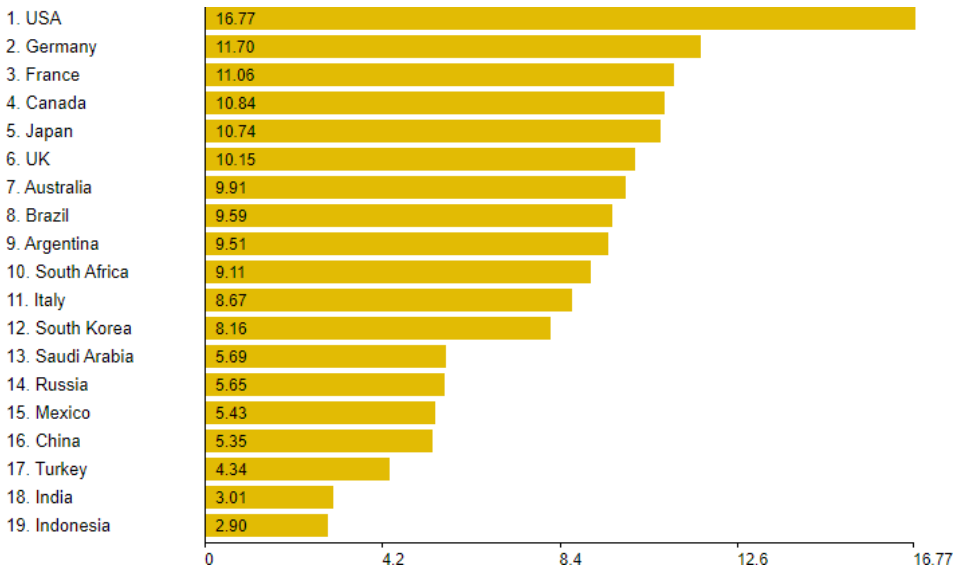


Figure 3: Health spending as percent of GDP 2019 - Country Rankings; Measure: Percent; Source: The World Bank

However, the long-term benefits of such a transition would be significant for the manufacturing industry, and for the overall economy. It would allow for the reallocation of resources to more productive sectors and would ultimately lead to an increase in jobs and economic growth. Additionally, it would also improve the overall quality and availability of healthcare in the U.S.

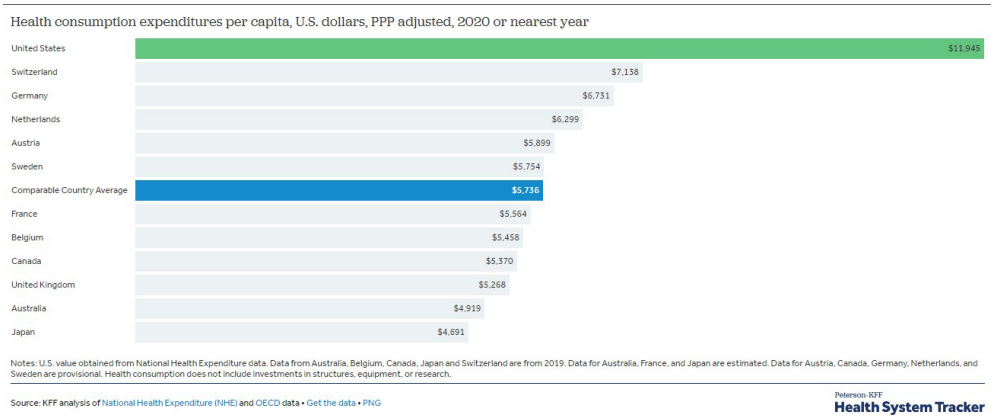


Figure 4: Health spending per Capita - Country rankings; Source: KFF analysis of National Health Expenditure (NHE) and OECD data

It is crucial that the government and industry leaders work together to find a solution that addresses the current imbalances between the healthcare and manufacturing sectors. This may involve a combination of free market solutions and government intervention, but what is important is that steps are taken to address the issue at hand. This article aims to contribute to the ongoing discourse and provide insights into potential solutions that can be implemented to improve the competitiveness of the U.S. manufacturing industry and the overall health of the economy.

3 Background & Literature Review

3.1 Per Capita Expenditure

The National Health Expenditure Accounts (NHEA) provide a comprehensive measure of the total healthcare spending in the United States. These official estimates date back to 1960 and include data on annual expenditures for health-care goods and services, public health activities, government administration, the net cost of health insurance, and investments related to healthcare. The data is presented in a detailed manner, including the types of services, sources of funding, and types of sponsors,CMS [2021b].

As per the NHEA data, U.S. healthcare spending grew by 2.7% in 2021, reaching a total of $4.3 trillion, or $12,914 per person. The share of healthcare spending in relation to the Gross Domestic Product (GDP) accounted for 18.3%.

The usual critique of the U.S. healthcare system focuses on the allocation of healthcare spending and suggests that the funds could be better utilized in other ways. The NHEA data provides a detailed understanding of the healthcare spending in the U.S and can be used to evaluate the efficacy of the current healthcare system and to identify areas for improvement.

It is well established that the United States healthcare system is facing financial challenges. The high cost of healthcare in the country, as evidenced by the $12,914 per individual expenditure as reported by the National Health Expenditure Accounts (NHEA), highlights the unsustainable nature of the current system.

When considering the cost of healthcare for a family of four, the annual expense is substantial, approaching $52,000 for a fully comprehensive national health insurance policy. Such a policy would cover all medical expenses, include coverage for all individuals, and eliminate pre-existing conditions as a factor in determining eligibility.

This cost is comparable to what an individual would pay for high-quality commercial insurance, if they are not part of a large insurance pool. It is unlikely that the average American family would be willing to bear this cost for healthcare.

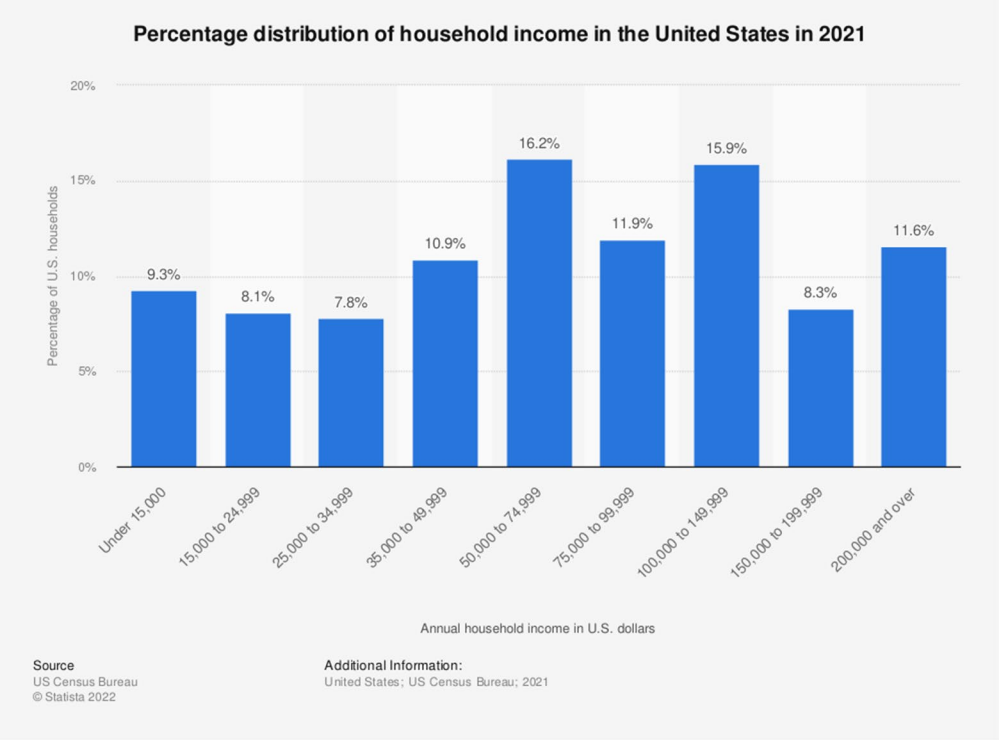


Figure 5: Distribution of Household Income (2021); Measure: Percent; Source: Statista

The data from the Census Bureau shows that the average household size in the United States was 2.60 between 2017 and 2021. This means that the average household's share of national health expenditure was $33,576.40. Furthermore,

the census data estimates that 17.4% of households had an income less than $25,000 in 2021, and 25.2% of households had an income less than $35,000. This indicates that over one-fifth of U.S. households earn less income than their share of national health expenditure.

The Bureau of Labor Statistics (BLS) also provides insight on the median household pre-tax cash income in 2021, which was $69,021. However, when considering the average household, in 2021, a typical U.S. consumer unit of 2.4 persons made $87,432 pretax income. This income was allocated towards various expenses such as food, housing, clothing, and transportation, which amounted to $8,289, $22,624, $1,754, and $10,961 respectively.

When considering the average federal tax rate of 21% for the entire 1979–2019 period (2020 - 2022 unrepresentative/data unavailable), which equates to $14,494.41, the typical U.S. household is left with $10,898.59 after these expenses. However, their "share" of national health expenditure was $30,993.60. This highlights the fact that the typical U.S. household cannot afford a healthcare product targeted to the entire U.S. population. It's important to note that the shortfall is financed by budget deficit spending enabled by foreign credit, low interest rates, and quantitative easing.

3.2 Medicare

Medicare is a national health insurance program for individuals aged 65 and older, as well as for certain disabled individuals. Under Medicare, the government pays for a portion of the healthcare costs for eligible individuals and sets the reimbursement rates for services provided by healthcare providers. The reimbursement rates set by the government are often lower than the costs incurred by healthcare providers, resulting in a gap between what the government pays and the actual costs of providing care. This gap, known as the ”Medicare reimbursement gap”, has led to several challenges for healthcare providers, including the need to make operational and financial decisions based on what the government will pay for, rather than on consumer preferences.

One of the consequences of this reimbursement gap is that healthcare providers may be incentivized to provide services that are reimbursed at a higher rate, rather than those that are more beneficial for patients. This can result in overuse of certain services, and under use of others. For example, a provider may choose to provide more diagnostic imaging services, which are reimbursed at a higher rate, rather than preventive care services, which are reimbursed at a lower rate.

Additionally, the reimbursement gap can also result in a lack of access to certain services for Medicare beneficiaries, particularly those that are not reimbursed at a high enough rate to cover the costs of providing them. This can lead to disparities in access to care for Medicare beneficiaries, particularly those who live in rural or under served areas.

Providers of healthcare thus make decisions based not on consumer preferences but rather based on what the government will pay for.

The government involvement in Medicare is obvious, but the so-called private sector of healthcare is increasingly made up of government employees and employees of private companies whose income largely comes from government. The U.S. healthcare system is a classic credit-induced bubble of malinvestment where notions of profit and loss have been hopelessly distorted by government decisions.

The Medicare program plays a significant role in the overall expenditures on healthcare in the United States. According to the Medicare trustees, in 2021, Medicare paid out $900.8 billion in expenditures to 63.9 million beneficiaries, resulting in an average benefit of $14,097 per individual. While this is higher than the per capita national health expenditure of $12,914, it is not a significant difference. However, it is important to note that government expenditures on healthcare also include coverage for government employees and employees of private companies whose incomes come from the government.

It is important to note that Medicare is not a healthcare provider, but rather a program that guarantees payment for certain services under certain restrictions. As such, if payment rates become too low or restrictions become too onerous, access to healthcare for the elderly population may be compromised. It is important to acknowledge that while Medicare is not solely responsible for the financial difficulties facing the healthcare system, it has contributed to a distorted perception of health insurance held by many individuals.

TABLE OF KEY MEASURES[3]

Dollars in billions

	2021	2020	2019
Net Position (end of fiscal year)			
Assets	$690.8	$590.1	$502.0
Less Total Liabilities	$186.4	$133.4	$134.2
Net Position (assets net of liabilities)	$504.4	$456.7	$367.8
Costs (end of fiscal year)			
Net Costs	$1,272.4	$1,157.0	$1,087.3
Total Financing Sources	$1,285.0	$1,189.5	$1,079.0
Net Change in Cumulative Results of Operations	$12.7	$32.5	$(8.3)
Statement of Social Insurance (calendar year basis)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	$(5,057)	($4,800)	$(5,484)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	$(4,800)	$(5,484)	$(4,708)
Change in present value	**$(257)**	**$683**	**$(776)**

Figure 6: Medicare Financial Statement; Source: Centers for Medicare & Medicaid Services

The short-term financing status of the Hospital Insurance (HI) trust fund is determined by comparing the projected assets at the beginning of each calendar year to the program's obligations for that year. According to the 2021 Trustees Report, the HI trust fund is not projected to be adequately financed over the next 10 years. Specifically, the report estimates that the ratio of assets to obligations will decline steadily, ultimately leading to the depletion of the trust fund in 2026. The report also states that as of the end of 2020, the trust fund's assets were $134.1 billion, and are expected to decrease over the next few years until the depletion of the fund.

The long-term outlook for the Hospital Insurance trust fund, as reported by the Trustees Report, indicates that it is not sustainable with current tax rates and expenditure levels. The trust fund is projected to be depleted in 2026, and program costs are expected to exceed total income in all years thereafter. This is primarily due to a decrease in the ratio of workers paying taxes to individuals eligible for benefits, as well as the faster growth of healthcare costs compared to taxable wages. In present value terms, the 75-year shortfall is estimated

to be $4.9 trillion, which constitutes a small percentage of taxable payroll and GDP over the same period. However, it should be noted that there is significant uncertainty surrounding these estimates, as actual future values of demographic, economic, and programmatic factors may differ from the assumptions used in the projections. For more detailed information, it is recommended to consult the Required Supplementary Information disclosures on Social Insurance, as required by the Federal Accounting Standards Advisory Board.

The Medicare program is composed of three main components:

- Part A covers inpatient hospital and related services.
- Part B covers physicians' services and other outpatient services.
- Part D covers prescription drug coverage.

Financing for Part A is primarily derived from the Medicare payroll tax, while financing for Part B and Part D is primarily sourced from general revenue.

It is important to note that there is a common misconception that the Medicare payroll tax fully finances the program. In reality, only a portion of Part B costs are covered by premiums paid by beneficiaries, with the remainder financed through general revenue.

The long-term sustainability of the Medicare program has been a subject of concern, particularly due to the impending retirement of the baby boom generation and the resultant increase in beneficiaries. An estimate of the unfunded liability of the program, which represents the additional funds required to ensure the program's ability to fulfill future obligations, ranges from $40 trillion to over $100 trillion, depending on the economic assumptions used. Regardless of the

specific estimate, it is clear that the current financing structure of the program will not be sufficient to sustain it in the long-term.

While the SMI trust fund does not have an unfunded liability in the short or long-range from a program perspective since it is financed on a yearly basis,from a government-wide perspective, general fund transfers, as well as interest payments to the Medicare trust funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public, resulting in a $43.2 trillion unfunded liability over 75 years. Additionally, there is concern over the rapid increase in cost of the SMI program as a percent of GDP, which is projected to grow from 2.3% in 2020 to 4.5% by 2095, as stated in the CMS Financial Report, for Fiscal Year 2021, CMS [2021a]. [1]

[1]"The SMI trust fund consists of two accounts – Part B and Part D. In order to evaluate the financial status of the SMI trust fund, each account needs to be assessed individually, since financing rates for each part are established separately, and their program benefits are quite different in nature.

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues, and transfers from state governments. Unlike the Part B account, the appropriation for Part D has generally been set such that amounts can be transferred to the Part D account on an as-needed basis; under this process, there is no need to maintain a contingency reserve. In September 2015, a new policy was implemented to transfer amounts from the Treasury into the account 5 business days before the benefit payments to the plans. As a result, the Trustees expect the Part D account to include a more substantial balance at the end of most months to reflect this policy.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement, the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government-wide perspective, general fund transfers, as well as interest payments to the Medicare trust funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government wide perspective, the corresponding estimate of future income less expenditures for the 75- year projection period is $(43.2) trillion.

Even though from a program perspective the unfunded liability is $0, there is concern over the rapid increase in cost of the SMI program as a percent of GDP. In 2020, SMI incurred expenditures were 2.3 percent of GDP. By 2095, SMI expenditures are projected to grow to 4.5 percent of the GDP."

3.3 Healthcare Insurance

Despite various attempts by U.S. presidents to implement government-funded universal healthcare, private health insurance continues to play a prominent role in the American healthcare system. While President Lyndon B. Johnson's signing of Medicare in the 1960s provided a safety net for those over the age of 65, the majority of individuals under 65 still rely on private insurers for their healthcare needs. Employer-sponsored coverage remains the most prevalent form of insurance, with 60% of non-elderly Americans obtaining insurance through their job, while a smaller percentage opt to purchase coverage on the individual market.

In addition to employer-sponsored group health insurance plans, which are widely utilized by Americans, there are also options for obtaining coverage on the individual market. The Affordable Care Act, also known as Obamacare, has brought significant changes to this market, making coverage more accessible and comprehensive for those who do not have access to employer-sponsored plans. Prior to the ACA, many states employed medical underwriting, which resulted in coverage only being available to those who were relatively healthy. Additionally, coverage in the individual market was often less comprehensive than employer-sponsored options, with key areas such as maternity care, prescription drugs and mental health care often not covered. Furthermore, individuals were solely responsible for paying the entire premium for their coverage.

According to a survey conducted by the Kaiser Family Foundation, employer-sponsored health insurance premiums for family coverage in 2020 averaged $21,342 per year. However, employees only paid around $5,588 of this amount, with employers covering the remaining 74% of total family health insurance premiums.

Additionally, premiums for group health insurance plans, including the portion paid by both the employer and employee, are paid with pre-tax funds, resulting in them not being counted as taxable compensation. This is a significant benefit of group health insurance, as it contrasts with the tax deductibility of individual health insurance, which can vary based on factors such as self-employment status and total medical expenses.

The implementation of the Affordable Care Act (ACA) brought significant changes to the individual health insurance market. Prior to its implementation, the process of obtaining coverage often involved medical underwriting, where insurance companies would closely examine an applicant's medical history before providing coverage. This made it difficult for individuals with pre-existing conditions to obtain coverage. However, with the ACA, medical underwriting is no longer used and all new individual major medical plans are required to cover essential health benefits in every state. Additionally, the ACA provides premium subsidies for plans purchased through state health insurance exchanges and limits the amount of premiums that can be used for administrative costs and profits. As a result, insurers have been required to refund billions of dollars to consumers.

3.3.1 Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) of 2010, also known as Obamacare, was a comprehensive national healthcare reform legislation aimed at expanding health insurance coverage and improving access to care in the United States. The ACA implemented several key provisions to achieve this goal, including the expansion of the publicly funded Medicaid program to cover adults with annual incomes up to 138% of the federal poverty level, the establishment of the Health Insurance Marketplace for individuals and small businesses, and

the enforcement of an individual mandate that required eligible individuals to obtain federally approved health insurance coverage.

However, the implementation of the ACA varied across states, with some choosing not to expand the Medicaid program. As of 2020, 39 states, including the District of Columbia, had opted to expand Medicaid, while 12 states had decided against implementing the expansion. Despite this inconsistent implementation, the ACA has enabled millions of uninsured individuals to gain coverage, with an estimated 10.8 million low-income uninsured individuals enrolling in Medicaid in 2014 and this number increasing to 12.2 million by 2015. The Health and Human Services Department estimates that 11.7 million individuals enrolled in private health insurance (PHI) plans in 2014, leading to a significant reduction in the rate of uninsured individuals, which dropped to 9% by 2015, as per the National Health Interview Survey. Studies have also highlighted the differential impact of the ACA on uninsurance rates between states that expanded Medicaid and those that did not, with the former experiencing a larger decline in uninsurance rates.

The Affordable Care Act (ACA) of 2010 aimed to expand health insurance coverage and improve access to care in the United States. However, the effectiveness of this expansion in improving access to care remains inconclusive, with studies yielding inconsistent results. Furthermore, there is a lack of understanding regarding the ACA's impact on access to care for low-income patients served by Federally Qualified Health Centers (FQHCs). These centers are a vital component of the U.S. safety net system, providing primary care services to vulnerable and underserved populations. Despite the ACA's potential to improve access to care for these patients, studies have suggested that limitations in access to care may persist, particularly in terms of provider availability and capacity at

FQHCs. [2]

The ACA implemented measures to provide coverage for those who may have lost access to health insurance. The ACA aimed to address the shortcomings in the healthcare system by expanding Medicaid coverage to low-income individuals earning less than 138% of the federal poverty level, providing subsidies cost sharing measures for those below 250% of the federal poverty level, and providing subsidies for Marketplace coverage for those below 400% of the federal poverty level. These expansions helped to ensure that people had access to coverage and protected them against losses, improving affordability and making it easier for low-income individuals to gain and retain coverage. This has led to a decrease in the number of uninsured individuals, with the number dropping by nearly 1.5 million from 28.9 million in 2019 to 27.5 million in 2021 and the uninsured rate decreasing from 10.9% in 2019 to 10.2% in 2021.

[2]Shartzer et al. [2016] found that access to care improved between 2013 and 2015 among nonelderly adults, while key informants (such as Medicaid and marketplace officials, assisters and advocates) interviewed in four Medicaid-expanded states (Colorado, Connecticut, Kentucky, and Washington) in 2016 believed Medicaid patients generally had good access to care, but acknowledged that limitations remained Artiga et al. [2016]. Wherry and Miller [2016] findings suggest that the evidence supporting improvements in access to care in Medicaid-expanded states is inconsistent. Studies on the effect of ACA's coverage expansion on newly insured low-income patients' access to care served by Federally Qualified Health Centers (FQHCs) have yielded mixed results. Some studies found that FQHCs in Medicaid-expanded states experienced an increase in their visit rates compared to non-expanded states Hoopes et al. [2016], Rosenbaum et al. [2017] and Angier et al. [2015] found that FQHCs in five expanded states (California, Minnesota, Ohio, Oregon and Washington) experienced a 32% increase or 71 more visits per month among Medicaid patients. However, these findings suggest the immediate rise in demand may have challenged FQHCs to meet higher demand for care, particularly in sites that had limited capacity prior to the ACA taking effect. Additionally, some studies have found that improvements in accessing care depend on primary and secondary care providers' willingness to accept certain coverage types, with newly insured patients, particularly with Medicaid, unable to always get care from their chosen provider, as it was not widely accepted Sommers et al. [2015], Hsiang et al. [2019].

3.4 Diagnostics Related Groups

Diagnosis-related grouping (DRG) systems are a method used by Medicare and some health insurance companies to categorize hospitalization costs and determine payment amounts for hospital stays. This system was established to ensure patients receive the necessary care and their bills are not inflated by unnecessary charges. DRGs encompass several metrics designed to classify the resources required for patient care based on diagnosis, prognosis, and other factors.

The DRG system has two components: the all-payer component for non-Medicare patients and the Medicare-Severity Diagnostic-Related Group (MS-DRG) system for Medicare patients, which is more widely used and the focus of this subsection. Under Medicare's DRG approach, Medicare pays hospitals a predetermined amount through the inpatient prospective payment system (IPPS) based on the patient's DRG or diagnosis.

Long-term care is handled through a different system, the Long-Term Care Hospital Prospective Payment System (LTCH-PPS), based on DRGs under the Medicare Severity Long-Term Care Diagnosis-Related Groups system (MS-LTC-DRGs).

When a patient is discharged from the hospital, Medicare assigns a DRG based on the main diagnosis causing hospitalization and up to 24 secondary diagnoses. The DRG can be affected by the necessary treatment procedures, patient age, and gender. If the hospital spends less than the DRG payment on treatment, it makes a profit, but if it spends more, it loses money.

Before the DRG system was introduced in the 1980s, hospitals would send bills to Medicare or insurance companies including charges for each item used, such

as X-rays, bedpans, and aspirin, plus a daily room charge. This incentivized hospitals to keep patients as long as possible and perform as many procedures as necessary, driving up health care costs. The DRG system was established as a cost-control measure that standardizes hospital reimbursement.

The DRG system's implementation has faced challenges, with private hospitals sometimes diverting resources to higher-profit services. The Affordable Care Act (ACA) introduced reforms, including bundled payments and Accountable Care Organizations (ACOs), to counteract this. DRGs remain the framework of the Medicare hospital payment system.

DRG payment amounts are calculated based on the average cost of resources required for treatment for patients in a particular DRG, taking into account primary and secondary diagnoses, medical procedures, and patient factors such as age and gender. The base rate is then adjusted for regional factors such as the wage index, cost of living, and other hospital-specific factors. These baseline DRG costs are recalculated annually and released through the Centers for Medicare and Medicaid Services (CMS).

The DRG payment system reduces incentives for hospitals to overtreat patients, but also encourages discharge as soon as possible, leading to some concerns over early discharge and potential readmission. Despite its challenges, DRGs continue to be an integral part of the Medicare hospital payment system.

The Centers for Medicare Medicaid Services (CMS) is the entity in charge of determining the yearly updates to the DRG reimbursement rates, which determine how much hospitals receive for the care they provide. To reach these updates, CMS takes into account various factors that reflect the current cost of

healthcare services, including the hospital market basket index, the productivity adjustment, and the inflation adjustment.

The hospital market basket index is a comprehensive tool used to determine the change in the cost of goods and services required to operate a hospital. This index is updated every year using data from both the Bureau of Labor Statistics (BLS) and the American Hospital Association (AHA). It takes into account the cost of inputs such as labor, supplies, and services that are vital for hospitals to provide quality care to their patients. By including the market basket index in its calculations, CMS aims to accurately reflect the changes in the cost of operating a hospital in its DRG reimbursement rates.

The CMS determines the annual updates to the DRG reimbursement rates using hospital market basket indexes including; the Medicare Market Basket Index (MMB), Hospital Market Basket Index (HMB), and All Urban Consumer Price Index (AUC-CPI).

- **Medicare Market Basket Index** - The MMB is a weighted average of the hospital market basket, reflecting the costs of inputs specific to the Medicare program. It is used to determine updates to the DRG reimbursement rates for hospitals participating in Medicare. On the other hand,

- **Hospital Market Basket Index** - On the other hand, the HMB is a weighted average of the costs of inputs specific to all hospitals, regardless of their Medicare participation.

- **All Urban Consumer Price Index** - The AUC-CPI, which is updated annually by the Bureau of Labor Statistics (BLS), measures the change in the cost of living for urban consumers and reflects changes in the cost of living. The productivity adjustment, which is also updated annually by the BLS, accounts for changes in the efficiency of the economy and the output of goods and services produced by hospitals. The inflation

adjustment, also based on data from the BLS, reflects changes in the overall level of prices in the economy and accounts for changes in the cost of living.

CMS incorporates the changes in these three indexes, along with the productivity adjustment and inflation adjustment, to determine the annual updates to the DRG reimbursement rates. In addition to these annual updates, CMS may also make changes to the DRG payment system, such as adjusting the weights for each DRG category or adding new categories, to reflect changes in medical practice or to improve the accuracy of the payment system.

It is noteworthy that the charges listed on the beneficiaries' bills are distinct from the reimbursement rates paid by Medicare to hospitals. The charges are often established by the hospital, lacking government regulation, and as a result, are frequently much higher than the actual reimbursement rates.

To determine the reimbursement rates, CMS utilizes a cost-to-charge ratio (CCR) that is specific to each hospital. The CCR is calculated by dividing the total cost of providing care by the total charges for that care, and serves as an estimation of the cost of caring for Medicare beneficiaries and a basis for determining the DRG reimbursement rates.

3.5 US Manufacturing Industry

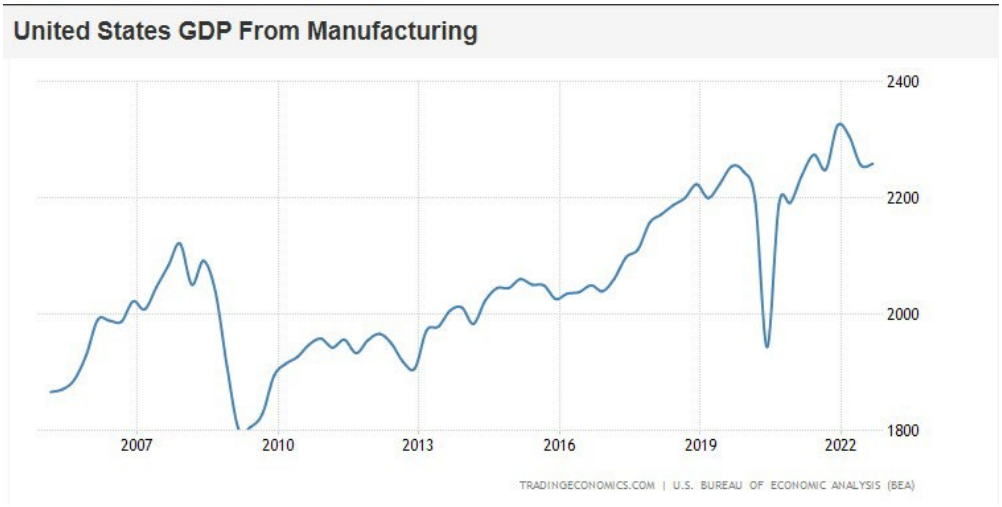


Figure 7: United States GDP From Manufacturing;
Source: U.S. Bureau of Economic Analysis (BEA); tradingeconomics.com

The Manufacturing Industry in America has been an integral part of the country's social and economic landscape for over a century. It has been the driving force behind America's development, playing a crucial role in transforming the nation from an agrarian society to an industrial powerhouse. The industry has contributed to the creation of numerous jobs, spurred technological advancements and played a critical role in the country's economic growth.

The concept of "Made in America" has been a symbol of quality, reliability, and innovation for decades. American-made products have become synonymous with a superior level of craftsmanship and attention to detail. As the manufacturing industry has grown and evolved, so too have its products. From the early days of assembly lines to the advanced technologies of today, American manufacturing has maintained its reputation for producing high-quality products that are both durable and innovative. The industry continues to play an important role in the country's economic stability and is an important part of the American

identity. ”Made in America” has gained some momentum in recent years, with consumers becoming increasingly interested in products that are domestically manufactured. This trend has led to an increase in demand for American-made products, and has led to some companies relocating their production facilities back to the United States. This shift has had a positive impact on the manufacturing industry and has led to the creation of new jobs in the sector.

In recent years, the manufacturing industry in America has faced several challenges, but has also seen growth in some areas. From 2010 to 2020, the manufacturing sector experienced a slow but steady recovery from the 2008 financial crisis. During this period, the sector added more than 900,000 jobs, which is a significant increase from the 2 million jobs lost during the recession. Despite this growth, the industry still has not returned to its pre-recession employment levels.

The past decade has also seen a shift in the types of products manufactured in America, with a focus on high-tech goods and products in the aerospace and defense industries. Additionally, the use of automation and robotics has increased in the manufacturing process, leading to increased productivity and efficiency. The focus on innovation and technology in the sector has also resulted in the development of new products and processes, positioning the industry for future growth.

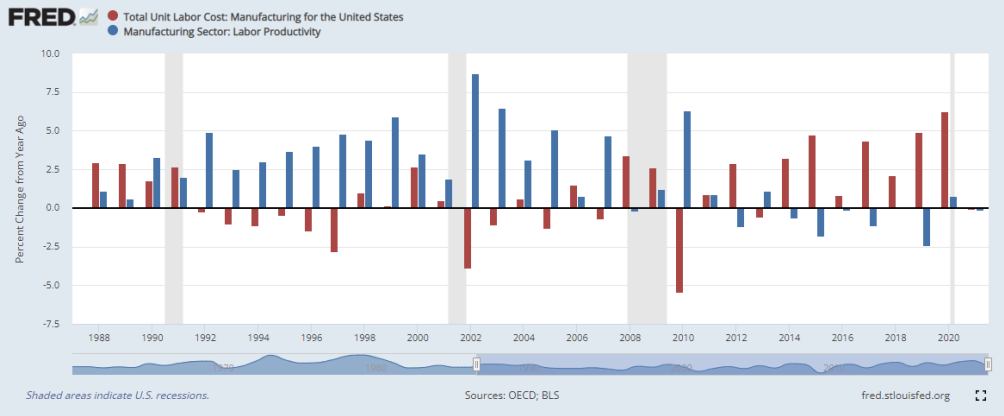


Figure 8: Annual Change in Labour Productivity & Unit Labor Cost, Manufacturing Sector
Source: Organisation for Economic Co-operation and Development (OECD)
& U.S. Bureau of Labour Statistics (BLS)

The United States GDP from Manufacturing has shown a consistent upward trend over the years, with some notable dips during the 2008 and 2020 recessions. Despite these setbacks, the manufacturing sector has demonstrated its resilience and has been able to bounce back, reaching an all-time high in 2022. This highlights the significance of the manufacturing industry as a key contributor to the overall economy and thus the importance to protect this industry and maintain its growth.

The labor productivity and cost measures are calculated using data on hours worked for all individuals engaged in the sector, including wage and salary workers, self-employed individuals, and unpaid family workers. The Bureau of Labor Statistics' (BLS) Current Employment Statistics program provides the primary source of hours worked data and employment data. This monthly survey data covers the number of jobs held and hours paid to wage and salary workers in non-farm establishments.

Figure 9: Real Sectoral Output for All Workers
Source: U.S. Bureau of Labour Statistics (BLS)

Figure 10: Productivity in the Manufacturing Sector per Labor Hour
Source: U.S. Bureau of Labour Statistics (BLS)

In the context of the Manufacturing Industry, Labor Productivity is a crucial metric that reflects the efficiency of the workforce in producing goods and services. This measure quantifies the relationship between the real output and the amount of labor time required to produce it. The changes in labor productivity over time indicate the growth in the quantity of goods and services produced per hour worked. This metric is influenced by various factors, including advancements in technology, capital investment, production capacity utilization, the efficiency of energy and material usage, the organization of production pro-

cesses, the skill and expertise of management, and the characteristics and effort of the workforce.

As human capital utilizes technology, technological improvements result in productivity boost that should outpace labor compensation for the same human capital. The real sectoral output for workers is a measure of the production output in the manufacturing sector, adjusted for inflation, including the contributions of all workers such as wage and salary employees, self-employed individuals, and unpaid family workers. This measurement provides an indication of the real value produced by the sector, taking into account changes in the cost of goods and services over time. Despite the innovation that has spurred the manufacturing industry since the industrial revolution, output has plateaued since the 2000s and the subsequent great depression.

The continued increase in labor productivity until 2010 definitively rules out the contribution of labor productivity to the prolonged plateau, and it is more likely to be a result of either stagnant technological progress (which is considered unlikely) or the rise in labor costs. Inflated labor costs significantly hinder the progress of real output for all workers by reducing the overall productivity of the sector, thus leading to lower output per worker hour. [3]

An important consideration when estimating distribution of healthcare costs across the American Economy is the labor hours required for every dollar in revenue. Industries that are more labor intensive will naturally incur a greater distribution of healthcare relative to the generated revenue.

[3]The relationship between labor costs and output is not always straightforward and may depend on various factors such as technology, capital investment, and the nature of the industry.
The shift towards part-time workers in this industry mandates the use of **labor hour** instead of **labor headcount** to ensure unbiased statistics.

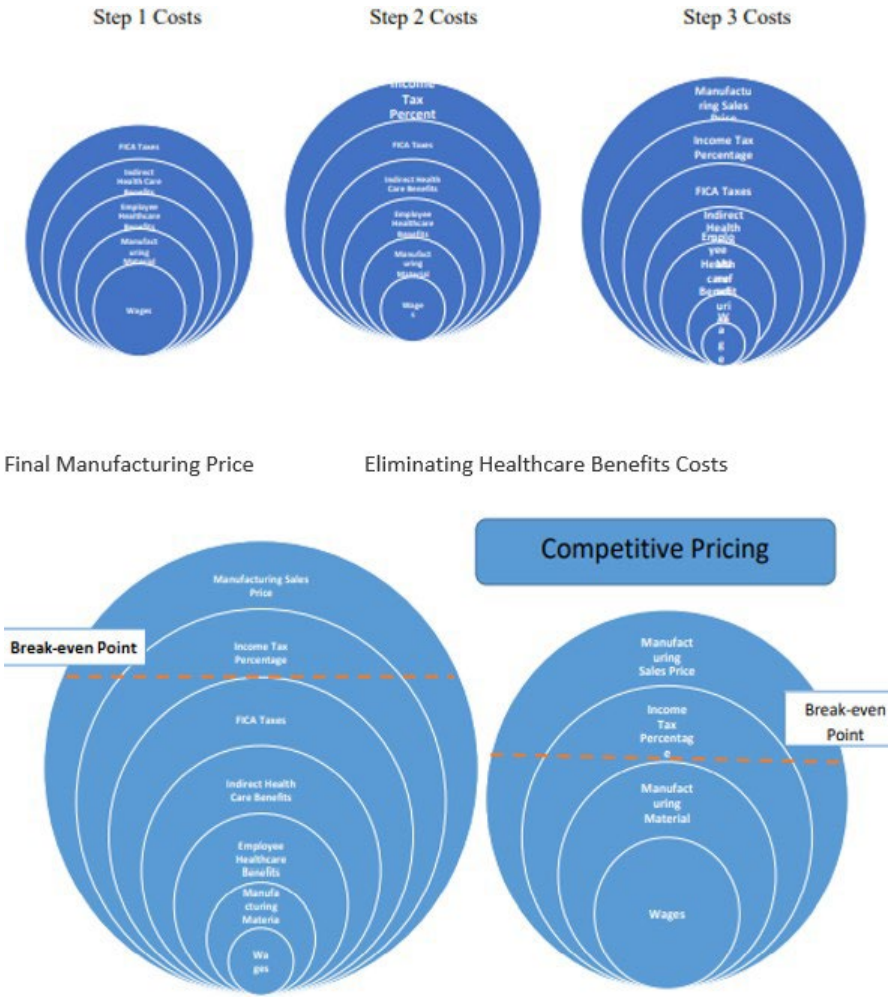


Figure 11: Compounding Healthcare Costs in a Supply Chair
Graphic supplied by Roy Meidinger

The manufacturing sector is unique in its multiple links in the supply chain and intense international competition. $3.6 trillion in health care costs are incorporated into the manufacturing process, passing through each contributor in the supply chain. While international competition has eliminated employer-paid healthcare costs, this remains existent in America. Thus, at each stage of the manufacturing process, the healthcare costs incurred directly by the company are added onto the healthcare costs incurred by the company's suppliers for their respective workers as demonstrated below.

A supply chain for a consumer electronics product could have the following stages:

- **Raw Materials Procurement** - The procurement of raw materials such as metals, plastics, and other components needed to produce the electronic device.
- **Component Manufacturing** - The manufacturing of individual components such as microchips, batteries, and screens that will be used in the final product.
- **Assembly** - The assembly of the individual components into a final product.
- **Distribution** - The distribution of the final product to retailers, wholesalers, or directly to consumers.
- **Retail** - The sale of the final product to consumers through retail stores, online platforms, or other channels.

Each stage is typically carried out by a separate company, with different levels of specialization and expertise. The supply chain is optimized for efficiency and cost, with each stage passing along the value-added to the next until the final product reaches the consumer. While many countries have structured healthcare costs to avoid double taxation, this would not happen under America's employer-paid system. In this example, healthcare costs make every stage of manufacturing increasingly less competitive, as companies must burden the healthcare costs of their suppliers.

Internationally, companies benefit from Value-Added Tax (VAT) exemptions to avoid double taxation by excluding the VAT incurred on inputs from the VAT charged on outputs. The VAT exemption for companies is implemented through the input tax credit (ITC) system. This system allows companies to claim back the VAT paid on inputs, such as raw materials, as a credit against the VAT

charged on their outputs. The VAT charged on outputs is then passed on to the final consumer.

In this way, the VAT is only charged on the value added by each stage of the supply chain, avoiding double taxation and ensuring that the tax burden is only imposed on the final consumer. By claiming back the VAT paid on inputs as a credit, companies are able to reduce the cost of their production, making them more competitive and improving their bottom line.

Overall, the VAT exemption for companies helps to avoid double taxation and supports the efficient functioning of the VAT system by reducing the cost of production for companies and promoting competition in the marketplace.

Having demonstrated the unsustainable cost of healthcare in America, the lob-sided distribution across the U.S. Economy, and thus the disadvantages placed on industries, such as the manufacturing industry, that have to carry the burden of a bloated healthcare industry, it clear that regulatory reform must be urgently considered before irreparable harm is inflicted. The international competitive-ness of American industries is impacted, particularly in comparison to countries where the healthcare system operates differently, such as China. In these coun-tries, the manufacturing industry is not weighed down by the excessive costs associated with healthcare, allowing for a more favorable business environment. It is imperative that regulatory reform is enacted in the United States to ad-dress these issues and level the playing field for American industries in the global market.

4 Medical Fraud & Kickback Schemes

Cost reduction measures are pointless if medical fraud is not addressed first, especially if centralized funding is to be considered. "Illegal kickback schemes corrupt the healthcare system. They cause billions of dollars in losses each year, generate business for dishonest service providers and erode trust in our health care system," said Dallas FBI Special Agent in Charge Matthew DeSarno.

4.1 What is Considered a Kickback?

In the context of health care, a kickback refers to a payment or compensation given to a physician or medical provider with the intention of influencing a patient's choice of care or a referral from another medical provider. This form of compensation can take various forms, including but not limited to, monetary payments (including cancellation of debt), gifts, services, or other incentives. The practice of kickbacks in health care is considered unethical and has been prohibited by law through the Federal Anti-Kickback Statute and the Physician Self-Referral Law, also known as the Stark Law.

Kickbacks can contribute to the inefficiencies and high costs in the health care system by creating a system of incentives that prioritize profits over patient care. This can lead to over utilization of medical services, increased health care costs, and potential harm to patients. The prohibition of kickbacks is aimed at preserving the integrity of the health care system and protecting patients from receiving substandard care or being subjected to increased costs. Therefore, it is important for health care providers and organizations to adhere to laws and regulations that prohibit kickbacks and ensure that the health care system operates with transparency and fairness.

4.2 The Anti-Kickback Statute — 42 U.S.C. § 1320a-7b

The Anti-Kickback Statute, outlined in 42 U.S.C. § 1320a-7b, prohibits any person from accepting or offering compensation in exchange for referring patients to services paid for by a federal healthcare program, or for purchasing items or services paid for by a federal healthcare program.

This law is frequently violated and is one of the most common grounds for government investigations into healthcare fraud, as well as disciplinary proceedings against physicians and actions taken by medical boards.

For a violation to occur, two key elements must be present: the exchange of remuneration between parties and the intention to engage in illegal activity.According to federal law, it is a criminal offense for any individual to knowingly and willingly solicit or accept any form of compensation, including kickbacks, bribes, or rebates, in exchange for referring a patient for treatment covered by a federal healthcare program.

The False Claims Act (18 U.S.C. § 287) also makes it illegal to submit false, fabricated, or deceitful claims.

Under 42 U.S.C. § 1320a-7b(b), a person may be convicted of a federal crime if they either receive or pay a bribe or kickback in exchange for referring a patient for treatment covered by a federal healthcare program or for the purchase, leasing, ordering, recommendation, or arrangement of any goods or services that are compensatable under a federal healthcare program. In essence, the Anti-Kickback Statute governs kickback accusations aimed at individuals who are obtaining financial gain by enrolling patients in federally funded healthcare programs. The most widespread situation involves a physician providing a fee to a

third party for every patient referred to their practice. This results in increased patient volume and the possibility of high reimbursement rates from the federal government. Meanwhile, the referral source benefits through a bribe or kickback from the physician's office. This provision also covers the sale of goods and facilities related to healthcare, not just services. An example of this would be if a pharmacist offers kickbacks to a referral source in exchange for supplying patients needing an expensive medical device or drug that will be reimbursed by a federal healthcare program. This would also fall under the jurisdiction of 42 U.S.C. § 1320a-7b.

While the statute governs compensation received in connection with federally reimbursed healthcare, it does not penalize legitimate practices. Properly disclosed discounts or reductions in price and employee compensation with legitimate business relationships are exempt from the statute's provisions. The aim of the statute is to address patient referral and kickback activity, not to harm legitimate healthcare providers who receive federal reimbursement for their services.

To prosecute under the Anti-Kickback Statute, federal prosecutors must demonstrate the presence of remuneration between parties and the intention behind it. Remuneration can include anything of value and courts have interpreted the law broadly to include any type of payment or financial benefit to a physician. Proving the intent behind the exchange, either to induce referrals or to purchase goods or services payable by a federal healthcare program, is also crucial. Under the Patient Protection and Affordable Care Act, knowledge of the law's violation is not a requirement for prosecution. The Anti-Kickback Statute imposes severe penalties for individuals found guilty of healthcare kickback offenses. The punishment for violating 42 U.S.C. § 1320a-7b includes a prison sentence of up to

10 years, a fine of $100,000 or both. The final sentence for a defendant may vary due to the complexities of federal sentencing and the various factors considered by the sentencing judge.

4.2.1 $300 million healthcare fraud Indictment

The following information is sourced from the official announcement by the U.S. Attorney for the Northern District of Texas, as published on the website of the U.S. Department of Justice - https://www.justice.gov/usao-ndtx/pr/11-defendants-plead-guilty-300-million-healthcare-fraud.

All 11 defendants implicated in the $300 million Spectrum/Reliable healthcare fraud have pleaded guilty just two months after being charged, according to U.S. Attorney for the Northern District of Texas Chad E. Meacham. Ten defendants, including two medical doctors, were indicted on February 9 and the eleventh defendant was charged on March 16. According to court documents, the founders of several lab companies, including Unified Laboratory Services, Spectrum Diagnostic Laboratory, and Reliable Labs LLC, paid kickbacks to induce medical professionals to order medically unnecessary lab tests, which they then billed to Medicare and other federal healthcare programs.

The labs, through marketers, paid doctors hundreds of thousands of dollars for "advisory services" which were never performed in return for lab test referrals. They also paid portions of the doctors' staff's salaries and a portion of their office leases, contingent on the number of lab tests they referred each month. The labs were able to submit more than $300 million in billing to federal government healthcare programs as a result of these kickbacks.

In plea papers, Dr. Maldonado admitted he received more than $400,000 in kickbacks for ordering more than $4 million worth of lab tests, while Dr. Canova admitted he received more than $300,000 in kickbacks for ordering more than $12 million worth of lab tests. The defendants face up to 15 years in federal prison under the applicable statutes. U.S. Attorney Chad Meacham emphasized the importance of not allowing physicians' judgement to be clouded by financial considerations, while Dallas FBI Special Agent in Charge Matthew J. DeSarno praised the hard work of the investigative agencies in unraveling the schemes perpetrated by these defendants and protecting the integrity of the healthcare system.

This healthcare fraud case is a clear example of the need for enforcement of anti-kickback laws to protect the integrity of the healthcare system and prevent financial considerations from affecting medical professionals' judgment. However, incidence of kickbacks are frequent, with many such criminal charges brought up every year.

4.3 Stark's Law - 42 U.S. Code § 1395nn

The federal physician self-referral prohibition, 42 U.S. Code § 1395nn, is commonly known as Stark's Law. This set of regulations, under the purview of Centers for Medicare Medicaid Services (CMS) fraud and abuse laws, pertains to physician self-referral in the US. Enacted in 1992 and expanded in 1995, the Stark law restricts the financial and business relationships that physicians can enter. Initially, the law applied to physician referrals for clinical laboratory services, but it has since been expanded to include "designated health services" or DHS, such as physical and occupational therapies, clinical laboratory testing, radiology services, medical equipment, inpatient hospital services, outpatient

prescription services, or home-health services. Referral is defined as a request for a specific service by a physician for Medicare Part B services and/or a care plan that includes designated health services. Financial relationships include investment interest, ownership, and compensation arrangements.

Stark's Law broadly prohibits physicians from referring their patients to a DHS if a financial relationship exists between the physician, their immediate family member, and the healthcare entity. Financial relationships include physician or family member ownership or investment interest in the entity, and compensation arrangements between the physician or family member and the entity. Although the law is broad, there are several exceptions. The law is a strict liability statute, meaning that a defendant is liable for their actions without proof of specific intent to violate the law, and violations of Stark's Law can also implicate other CMS fraud and abuse laws.

The Stark law is different from other healthcare fraud and abuse laws, such as the anti-kickback statute and false claims act. The anti-kickback statute prohibits knowledge of a willful payment to induce patient referrals or generate business involving any item or service payable by federal healthcare programs. The false claims act deals with the prohibition of fraudulent claims for payment. Violation of the Stark law or anti-kickback statute may also indicate violations of the false claims act. The enforcement of the Stark law is overseen by the Department of Justice, CMS, and the Department of Health and Human Services, and recent amendments to the Patient Protection and Affordable Care Act and False Claims Act have made it more strictly applied.

In conclusion, the Stark law is a critical statute that limits financial and business relationships between physicians and healthcare entities to prevent conflicts of

interest and unnecessary medical services. Although some medical practitioners argue against its limitations, understanding the nuances and complexities of this law is crucial for providing high-quality and comprehensive patient care without violating regulations. It is essential that all members of the healthcare team are aware of the Stark law to avoid potential violations and adverse effects on patient care and legal action.

4.4 Inner Workings of Healthcare Kickbacks

The healthcare industry plays a crucial role in modern society by providing medical services and support to individuals for maintaining their health and well-being. However, the high demand for medical services has made healthcare expensive, leading to the growth of insurance revenues, profits, and return on investment for some of the largest insurance companies in the United States. The majority of patients in the US are covered by private health insurance, paid for by their employers. Insurance companies spread the risk of high medical expenses among many individuals, and pay for these expenses from employer-paid premiums. In exchange for steady income, insurance companies also receive kickbacks, which are illegal payments made by healthcare providers, allowing them to ”wash” otherwise taxable income and increase revenue growth.

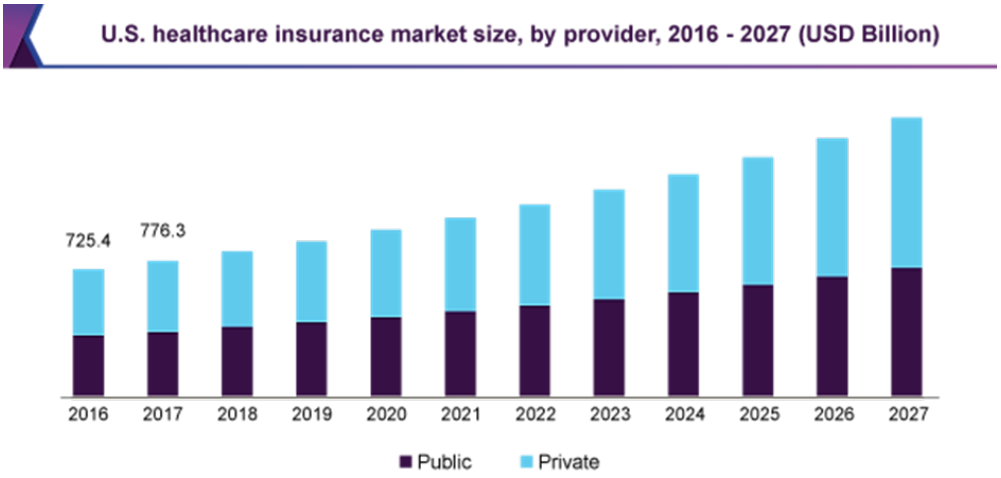


Figure 12: Private vs Public Insurance by Market Size; Source: Grand View Research, Inc.

The rise in revenue for insurance companies has resulted in an increase in health-care costs, making it difficult for individuals and employers to afford medical care. The healthcare industry employs millions of people, including healthcare professionals, support staff, and administrative personnel. The promise of kick-backs attracts more revenue for healthcare providers, while insurance compa-

nies are willing to tolerate higher costs. This creates a complex system where healthcare providers are incentivized to increase prices unchecked, while insurance companies receive illegal kickbacks, contributing to the overall high cost of healthcare.

However, the contracts between insurance companies and providers often include a provision where the providers collect these co-payments and deductibles from insured patients. This creates a tax problem when the co-payments and insurance company payments are less than the amount billed, and the uncollected amount cannot be written off as bad debt. This leads to a cancellation of debt for the provider and forgiveness of debt income for the insurance company.

The healthcare industry uses a novation to transfer a patient's medical debt to the insurance company through contractual agreements. Similar to the real estate industry, where a novation transfers mortgage obligations from a seller to a buyer with the bank's approval. However, any partial cancellation of the debt, the difference between the patient's billed amount and the insurance company's payment, is taxable income and must be reported to the IRS. The insurance company is responsible for paying taxes on this forgiven debt income, and the patient may receive a Form 1099-C indicating the cancelled debt amount that must be reported on their tax return.

A closer examination of these contracts reveals that providers often pay insurance companies to steer insured members their way, which is legally defined as a kickback payment. In the healthcare industry, kickbacks are illegal and cannot be deducted from gross income, even for not-for-profit corporations. The Tax Code recognizes the provider's income when services are performed and a bill is issued, and when an insurance company is utilized, the full amount of

the bill is transferred to the insurance company, who has the power to steer patients to providers. To gain access to privately insured members, providers often pay kickbacks in the form of partial cancellation of debt, which is illegal and not recognized as a legitimate deduction by the Tax Code. These kickbacks are often recorded as ”contract adjustments” but are not recognized as a legitimate deduction from gross income. Not-for-profit hospitals, which normally have tax-exempt status, must pay taxes on these illegal kickbacks and have their tax-exempt status revoked.

The healthcare industry soon realized that by increasing the amount listed on the beneficiaries' bills, the government would increase the Medicare reimbursements. The healthcare insurance companies and the healthcare providers worked together to increase the billed amounts, thereby shifting the payment of healthcare costs to the government. The insurance companies would not pay the increased amounts, so the providers partially cancel the debt created on the insured patient's bill. Instead of recording it as canceled debt, which is a violation of the price discrimination statutes, it is recorded as a contract adjustment. To justify these accounting practices, the insurance companies and providers entered into contracts with an agreement to pay less than the standard charge.

The insurance companies went even further, requiring any provider who wished to access its insured members to give them a kickback in the form of a partial cancellation of debt. This practice of referring patients for cash or cash equivalents is barred by the anti-kickback statutes and Stark laws. The contracts also require all patients to be billed the standard charge, which includes Medicare and non-insured patients. Presently, non-insured patients are paying seven times more than the amount collected from insurance companies. Since the customer of the healthcare provider is the patient, the difference in the amounts collected

is price discrimination.

Insurance companies also created a list of approved providers known as ”in-network providers” and financially penalized insured patients who sought care from ”off-network providers.” This financial coercion is a restraint of trade and illegal, but it has resulted in a growing difference between the amounts billed and the amounts collected, with non-insured patients now paying seven times more than the amount collected from insurance companies. For example, consider a scenario where the standard charge for both an in-network and an off-network provider is $100. The insurance company has an agreement to pay $15 to the in-network provider, resulting in a co-payment of $1.50 (10% of the agreed amount). However, if the insured member seeks care from an off-network provider who bills $100, the co-payment increases to $20, which is a 12-fold increase from the co-payment for the in-network provider. This increase is a result of the insurance company requiring a co-payment of 20% of the billed amount, instead of the original 10%. These actions, which restrict the insured member’s choice of provider and increase their cost, are considered a restraint of trade and illegal.

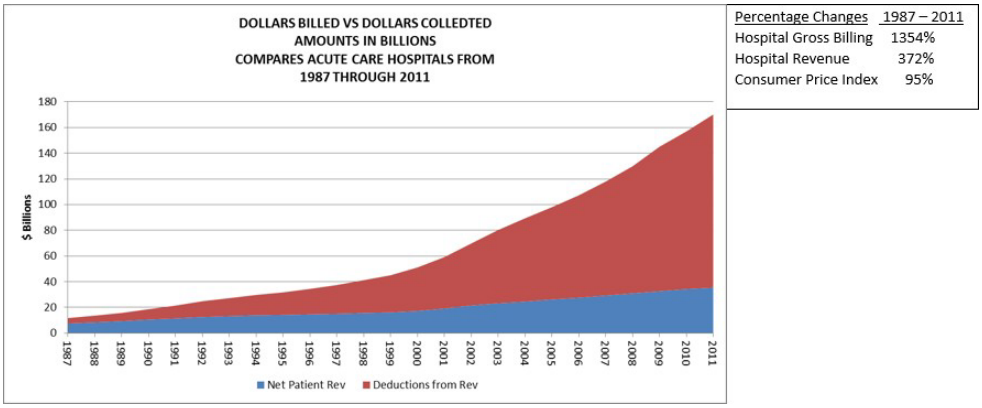
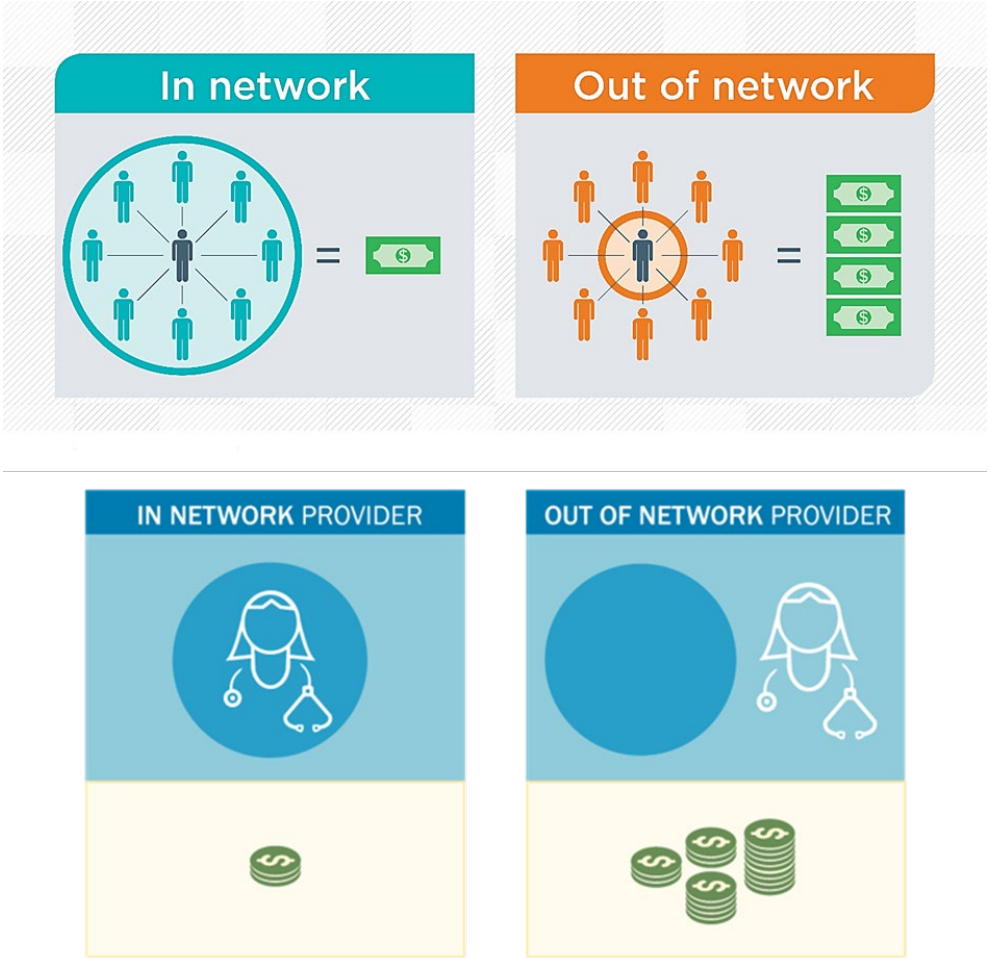


Figure 13: Amounts Billed vs Collected

Over time, the providers started to raise the billed amount for insured patients and public beneficiaries. Initially, the increase was just a few percentage points, but every year the difference between the billed amount and the collected amount grew larger. The gap between the two is now greater than 85%. The Florida Healthcare Finance Administration has created a chart that depicts the expansion of hospital revenues and the rise in hospital charges: see Figure 13. The red section of the chart shows the difference between what is billed and owed and what the insurance companies pay; it is the amount the providers pay the insurance company is paid for referring insured members to the provider; it is the providers' biggest expense.



In recent years, insurance companies have implemented a list of approved providers known as the in-network providers. This list is meant to guide insured patients towards medical facilities and doctors that have agreements with the insurance company for discounted services. However, these insurance companies have taken it one step further by penalizing patients who choose to go to off-network providers.

The financial penalty imposed on insured patients is substantial, making it difficult for them to seek medical treatment outside of the approved network. In most cases, the co-payment for seeing an off-network provider is increased from 10% of the agreed contract amount to 20% of the billed amount, a 12-fold increase. This kind of financial coercion forces patients to avoid off-network providers, even if they offer better quality care or specialized services not available in the approved network.

For example, let's say the standard charge for both an in-network and an off-network provider is $100. The insurance company has an agreement with the in-network provider to only pay $15, so the co-payment is only $1.50. However, if the off-network provider bills $100, the new co-payment is $20, or 12 times the original co-payment amount.

These actions by insurance companies are considered a restraint of trade and illegal. They restrict patients' freedom to choose the best medical care for their needs, instead forcing them to conform to the approved network. It's time for insurance companies to reconsider their practices and allow patients the freedom to seek medical treatment from the providers they choose, without fear of financial penalties.

4.4.1 Cost Shifting

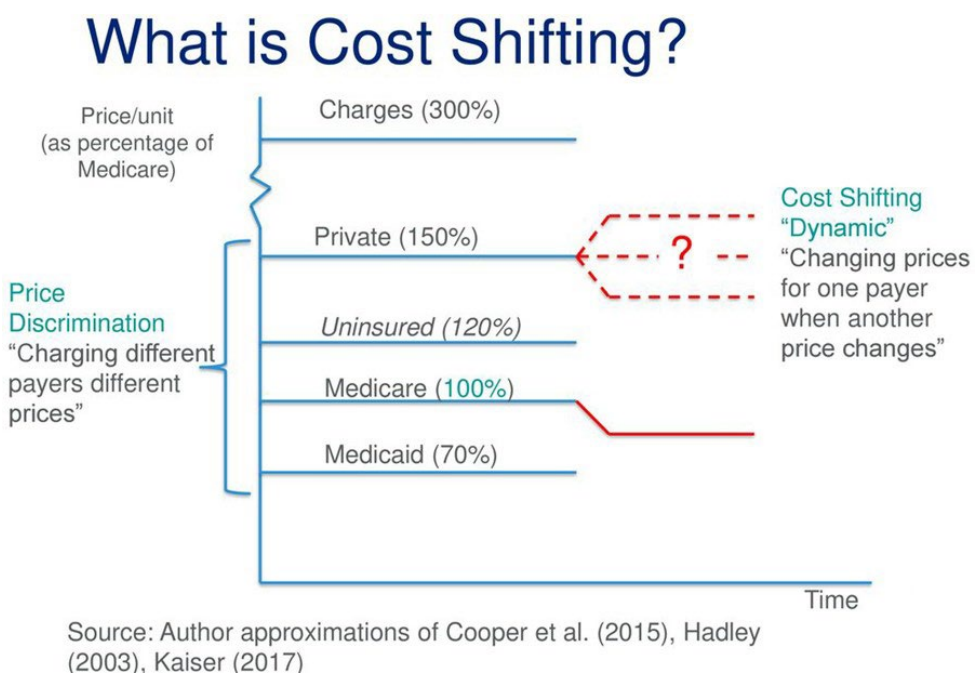


Figure 14: Cost Shifting

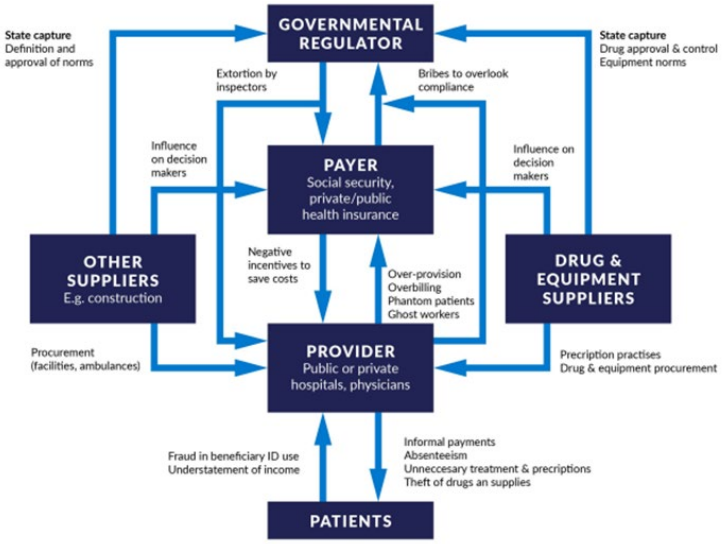
There is a prevalent concept of price discrimination in the healthcare industry, with different amounts being collected from private-pay patients, insured vs uninsured patients, and different insurance companies. The amount collected is also different for different services, which is referred to as cost shifting. The charges often reflect the demographics of the insured members and not the average cost to price ratios of each service, especially when it comes to charges for the elderly, where the government picks up the charges.

Due to these kickbacks, the amounts collected from different insurance companies are different, which helps insurance companies get their insured members and boycott competitive providers. The kickbacks are considered trade secrets and are hidden from competitors, even though the latter may be lower in price. The charges do not reflect the actual price, except for uninsured patients. The

healthcare industry and insurance companies worked together to increase the billed amounts, thereby shifting the payment of healthcare costs to the government. This was done by partially cancelling debt, which is recorded as a contract adjustment instead of cancelled debt, which would be a violation of price discrimination statutes.

In order to access insured members, insurance companies require providers to give them a kickback in the form of a partial cancellation of debt. This practice of referring patients for cash or cash equivalents is barred by anti-kickback statutes and Stark laws. The insurance companies also created a list of approved providers, known as in-network providers, and imposed financial penalties on insured patients if they sought services from an off-network provider. This led to financial coercion and restraint of trade, which is illegal.

4.4.2 Accrual Accounting



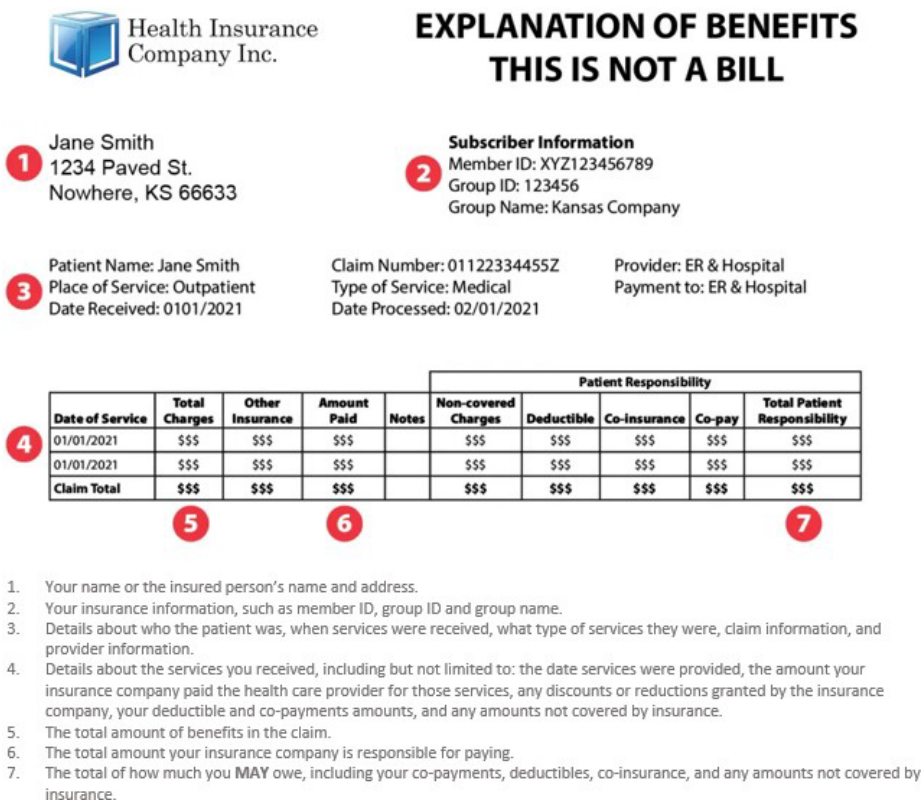
Source: Adapted from Savedoff and Hussmann (2006).

Figure 15: Flowchart of money amongst different health sector players.

Illegal transactions in the health sector can occur during the accounting phase of kickbacks that hospitals have to pay to insurance companies. The practice of kickbacks, or payments made to insurance companies in exchange for access to their insured members, is allowed by the IRS as long as the hospitals call the cancelled debt a contract adjustment to the patient's contract. However, under the Revenue Recognition Principle and accrual accounting method, which is required by law, the recognized income is determined by the right to receive payment and not the actual receipt of payment. The IRS erroneously recognizes cash payments (made by insurance companies) as income for privately insured patients, which violates the accrual method of accounting and the Tax Code. [4]

Kickbacks in the healthcare industry are illegal and not deductible as a business expense, according to 26 USC § 162 (C)(2) (c). The use of the write-off of contractual adjustment account as a means to pay kickbacks has been in practice since the start of the Medicare and Medicaid programs in 1965, but it is still illegal. Furthermore, as discussed further in 4.5, this process becomes problematic for the IRS to handle when two separate financial transactions are involved, as in the accrual method of accounting. The creation and recognition of the amount listed on the patient's bill as income for tax purposes, and the deduction or write-off of the kickback or cancelled debt not paid by a third-party payer, such as an insurance company. Under the accrual accounting method, the amount listed on a customer's bill is the amount recognized for income tax purposes.

[4]The principle of equitable estoppel cannot be used by the IRS to claim inability to collect taxes. Estoppel does not apply to the government, even if there was an officer or agency undertaking to waive a public right without the proper administrative authority. Bills and receivables are similar to promissory notes. Assumption of indebtedness occurs when someone agrees to pay a debt incurred by another.



Health Insurance Company Inc.

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

1. Jane Smith
1234 Paved St.
Nowhere, KS 66633

2. **Subscriber Information**
Member ID: XYZ123456789
Group ID: 123456
Group Name: Kansas Company

3. Patient Name: Jane Smith
Place of Service: Outpatient
Date Received: 0101/2021

Claim Number: 01122334455Z
Type of Service: Medical
Date Processed: 02/01/2021

Provider: ER & Hospital
Payment to: ER & Hospital

4.

					Patient Responsibility				
Date of Service	Total Charges	Other Insurance	Amount Paid	Notes	Non-covered Charges	Deductible	Co-insurance	Co-pay	Total Patient Responsibility
01/01/2021	$$$	$$$	$$$		$$$	$$$	$$$	$$$	$$$
01/01/2021	$$$	$$$	$$$		$$$	$$$	$$$	$$$	$$$
Claim Total	**$$$**	**$$$**	**$$$**		**$$$**	**$$$**	**$$$**	**$$$**	**$$$**

5. 6. 7.

1. Your name or the insured person's name and address.
2. Your insurance information, such as member ID, group ID and group name.
3. Details about who the patient was, when services were received, what type of services they were, claim information, and provider information.
4. Details about the services you received, including but not limited to: the date services were provided, the amount your insurance company paid the health care provider for those services, any discounts or reductions granted by the insurance company, your deductible and co-payments amounts, and any amounts not covered by insurance.
5. The total amount of benefits in the claim.
6. The total amount your insurance company is responsible for paying.
7. The total of how much you **MAY** owe, including your co-payments, deductibles, co-insurance, and any amounts not covered by insurance.

Figure 16: Health Insurance Claim Costs Example

Hospitals do not give discounts and the only medical bills issued list the patient's name, not the insurance company's. Insurance companies act as independent third-party payers and send Explanation of Benefits Forms (EOB) to their insured members that show the patient's debt, how much the insurance company pays, and the co-payment and deductible owed by the insured member.

An example of a kickback transaction is as follows: see Figure 16. A hospital bills a privately insured patient $100, but only collects $25 in cash. The $75 difference is owed to the hospital by the insurance company, but it is erroneously written off as a contractual adjustment instead of a liability for the insurance company. The hospital treats the $75 write-off as a business expense, but it is actually a kickback for steering the insured member to the hospital.

4.5 The IRS's Responsibility in Recognising Kickbacks

The Internal Revenue Service (IRS) has responsibilities under the Anti-Kickback Statute (4.2) and the Physician Self-Referral Law (4.3) to recognize kickbacks between insurers and providers. The IRS is responsible for enforcing tax laws and regulations and ensuring that healthcare providers and insurance companies are in compliance with the AKS and Stark Law. The IRS can assume these responsibilities by conducting audits of healthcare providers and insurance companies to detect illegal kickback arrangements. The IRS can also work with the Department of Health and Human Services (HHS) and the Office of Inspector General (OIG) to investigate suspected kickback arrangements and enforce penalties for non-compliance.

The IRS can penalize non-compliance with AKS and Stark Law, disallow tax deductions for illegal kickbacks, and collaborate with other agencies to educate healthcare providers and insurance companies. While taxation is the IRS's primary focus, it can recognize kickbacks if they are structured as taxable income and not reported properly. Payments made to a third party or an individual in exchange for services, and documentation such as invoices, contracts, and bank records can indicate kickbacks. Evasion of taxation can occur if hospitals or insurance companies fail to report payments or mischaracterize them.

The evasion of reporting kickbacks as taxable income by hospitals and insurance companies reduces their tax liability and may result in paying less than the appropriate amount of taxes owed. To prevent this, the IRS examines tax returns for unreported income and imposes penalties for non-compliance. Examples include not reporting the payment amounts, mischaracterizing payments as business expenses, and omitting payments on tax returns. For instance, if a

hospital pays $10,000 to an insurance company as a kickback to receive more patients, not reporting this payment as taxable income would be considered tax evasion.

The IRS prevents unreported income from kickback arrangements between insurance companies and healthcare providers by:

- **Reviewing tax returns** - Checking for discrepancies in reported income and expenses and patterns of behavior.
- **Auditing companies** - Conducting audits to ensure accurate reporting of all forms of income and uncover unreported kickback arrangements.
- **Imposing penalties and fines** - Holding companies accountable by imposing fines, interest charges, and potential criminal charges for tax evasion.
- **Working with Whistle-blowers** - Encouraging whistle-blowers to come forward by offering financial rewards for information leading to the detection and prosecution of illegal practices.

The Internal Revenue Service (IRS) is responsible for monitoring and collecting taxes on kickbacks between healthcare providers and insurance companies. However, the IRS has not effectively fulfilled this responsibility due to a lack of understanding of Generally Accepted Accounting Principles (GAAP) for the accrual method of accounting. [5]

[5]GAAP stands for Generally Accepted Accounting Principles, and it is a set of accounting standards and procedures used in the United States to ensure that financial statements are accurate and complete. GAAP provides a framework for recording, classifying, and reporting financial transactions in a consistent manner, so that investors and other stakeholders can rely on the information presented. The principles and guidelines that make up GAAP are established by the Financial Accounting Standards Board (FASB) and other authoritative organizations, and they cover a wide range of topics such as revenue recognition, inventory valuation, and depreciation methods. Compliance with GAAP is required for companies that are publicly traded in the US, and it is also used by many private companies as a best practice.

Under GAAP, private-pay patient bills determine gross income, and the insurance company is not acting as an agent for their insured members but rather is requesting a partial cancellation of debt from the patient's obligation transferred to the insurance company. Additionally, the IRS does not recognize the impact of the Universal Commercial Code for contracts, which states that any prior agreements cannot change the amounts on a new bill or new contract terms. As a result, the patient's medical bill supersedes any prior agreement between the provider and the insurance company.

In the healthcare industry, providers add the amounts billed to their gross income and deduct the difference not collected from insurance companies as a contract adjustment. However, the IRS does not allow contract adjustments as a deduction, as it is not listed in the tax code. Only operating expenses, bad debts, and cancelled debts can be deducted from gross income. The IRS director's lack of familiarity with GAAP for accrual accounting exacerbates the issue.

The IRS wrongly considers all insured private-pay patient bills to be false, despite state and federal claims courts treating these bills as prima facie evidence with a sum certain. These courts have found that the amounts listed on the bills are accurate, and the patient's contract states that they are liable for the full amount charged.For out-of-network providers, insurance companies charge patients a higher variable co-payment, which is considered economic duress and a restraint of trade. This practice is part of the contract between in-network providers and insurance companies to encourage insured members to boycott out-of-network providers. It is imperative for auditors to possess a thorough understanding of the legal and financial implications involved in the billing and payment process when auditing healthcare providers and insurance companies.

4.6 Conscience Parallelism

Conscious parallelism, also known as the interdependence theory of oligopoly pricing, refers to a situation in markets where there are few sellers. In this situation, although there may not be a written agreement, the sellers appear to establish their prices in a way that is "consciously parallel." The concept of conscious parallelism has been recognized in legal cases, such as *Shapiro v. General Motors Corp.*, 472 F.Supp. 636, 647 in the District Court of Maryland. [6]

Antitrust laws and free-market principles are violated by anti-competitive behavior that involves coordinated actions and decision-making by competitors to achieve a common objective, such as fixing prices or allocating market share. This behavior harms consumers by leading to higher prices and reduced choice. Industries where parallel consciousness and anti-competitive behavior have been found include automotive parts, air cargo, LCD panels, and chocolate. For example, in 2010, several auto parts makers, including Yazaki, Denso, and Mitsubishi Electric, were fined for participating in a cartel to fix the prices of alternators and starters sold to car manufacturers. Similarly, in 2010, several major airlines, including Air France-KLM, British Airways, and Cathay Pacific, were fined for colluding to fix the prices of air cargo services.

The McCarran-Ferguson Law, enacted in 1945, transferred the enforcement of antitrust laws from the Federal Government's FBI agency Antitrust section to

[6]Parallel consciousness refers to a theoretical concept in philosophy, psychology, and neuroscience that suggests the existence of multiple parallel streams of consciousness in an individual's mind, operating in parallel, independently, and yet influencing each other. This idea proposes that our subjective experience of the world is not a singular, unified experience, but instead is composed of multiple, partially independent processes. It is still a topic of ongoing research and debate, and there is not yet a widely accepted definition or explanation of parallel consciousness.

state law enforcement agencies, creating a patchwork of regulations and enforcement across the country. This has led to inconsistencies in the application of antitrust laws, particularly in the insurance industry, where some practices that would be considered anti-competitive in other industries are exempt from antitrust scrutiny.

The healthcare industry has seen instances of parallel consciousness and anti-competitive behavior. For example, in 2018, several large health insurance companies, including Aetna and Humana, were accused of coordinating their actions to avoid competing on price in certain markets. The companies reportedly used tools like rate setting software to monitor each other's prices and ensure that they were not undercutting each other's prices.

Another example from the healthcare industry is the case of pharmaceutical companies conspiring to keep generic drugs off the market, which has resulted in artificially high drug prices for consumers. In some cases, brand-name drug companies have paid generic drug companies to delay launching their cheaper alternatives, a practice known as "pay-for-delay". The antitrust laws define price as the actual amount collected or paid, therefore it is Price discrimination when the providers collect different amounts from uninsured and insured private-pay patients and different amounts from insurance companies for the same services.

These instances illustrate how parallel consciousness and anti-competitive behavior can occur in the healthcare industry, leading to higher prices and reduced access to care for patients. Anti-trust regulators and policymakers must be vigilant in monitoring and addressing such practices to protect consumers and ensure that the healthcare system is functioning in a fair and competitive manner.

Oligopoly markets often exhibit the lack of competition, high prices and low output of monopoly markets Harkins Amusement Enterprises Inc. General Cinema Corp. [1988]. Oligopoly industries, such as tobacco American Tobacco Co. and United States [1946], cereal Kellogg Co. [1972], motion picture advertising FTC and Motion Picture Advertising Serv. Co. [1953], cement, shoe, fashion, chemical, refining, and others have been prosecuted for anti-competitive practices that lead to supra-competitive prices and poor quality of services.

5 Single-Payer Healthcare Reform

In order to revive the manufacturing industry, increase production of goods for export and establish new companies, it is necessary to decrease the national healthcare costs to the level of other countries. This will enable the costs associated with employees, including the Federal Insurance Contributions Act (FICA), to be moved above the manufacturer's cost break-even point. It is imperative that we adopt a system of paying for healthcare out of profits, as has been done by our international competitors. Elimination of the employer-pay healthcare system and a transition to a personal and business income tax system is recommended. [7]

FICA taxes are a top priority on the list of taxes on income that everyone must pay, and employers must withhold them from employee paychecks and remit to the Internal Revenue Service (IRS). While reducing corporate taxes may benefit existing businesses by generating short-term profit, it does not reduce the cost of manufacturing. The positive outcomes of this proposed system include universal health care coverage, coverage for people with pre-existing conditions, and the freedom to choose healthcare providers. Workers with existing illnesses or disabilities can be productively employed and retain their jobs. A reduction of 25% in administrative health care expenses incurred for billing and collecting will also be achieved. The elimination of sales jobs due to lack of demand for salespeople is a downside; however, these jobs can be relocated to the manufacturing industry.

[7] FICA taxes are payroll taxes that are deducted from employees' paychecks to fund Social Security and Medicare programs in the United States. FICA stands for Federal Insurance Contributions Act, which is the law that mandates these payroll taxes.

The General Accounting Office will determine the new amount of flat tax to be imposed on all earned income tax levels. This will ensure that everyone pays their fair share of taxes. The medical portion of the new tax will increase by 3% to 4%, raising each contribution to 10.65% to 11.65%, including the government's obligation to military veterans. The increase in the amount collected for the new taxes will be lower than the increase in income of each individual.

Failure to implement the proposed changes may lead to dire financial consequences. The manufacturing sector is a source of wealth creation, and without a robust manufacturing industry, the country risks becoming a third world country with agriculture as the main industry. The implementation of a single-payer health system has the potential to significantly enhance capitalism and the manufacturing industry in the United States. Although this proposal has received mixed reactions and criticisms, it could enhance economic efficiency and boost the income of Americans.

The present American healthcare system heavily relies on private insurance firms, which can lead to elevated costs for customers and businesses. A single-payer system would be funded via a universal tax system, resulting in lower healthcare costs for both businesses and consumers. This reduction in healthcare expenses would boost the competitiveness of American firms by decreasing the cost of healthcare as a factor when calculating their operational expenses.

The production industry would also benefit significantly from a shift to a single-payer health system. With lower healthcare costs, businesses would have more resources to invest in their operations, including expanding their production capability. This enhanced production capacity would result in more economic growth, as businesses would produce more goods and services.

The implementation of a single-payer health system would also raise the income of Americans. Reduced healthcare expenses would release more funds for businesses and consumers, enabling them to spend on other aspects of their lives, such as education and home improvements. This increased expenditure would lead to more employment opportunities and higher salaries, contributing to economic expansion.

5.1 Single-Payer Healthcare System

Single-payer healthcare refers to a form of universal healthcare that covers the costs of essential healthcare for all residents through a single public system. This system may either contract private healthcare services (as done in Canada) or own healthcare resources and personnel (as seen in the United Kingdom). The term ”single-payer” refers specifically to the payment mechanism used, where a single public authority, typically the government, is responsible for financing healthcare services for all citizens, rather than a private authority or a combination of both. Under a single-payer system, all medical expenses are paid for with taxes collected by the government. In this way, healthcare is considered a public good, similar to other services provided by the government such as education and public safety.

The idea behind single-payer healthcare is to provide universal access to healthcare while containing costs. Proponents of single-payer healthcare argue that by pooling healthcare resources, the government can negotiate lower prices for medical services, devices, and drugs on behalf of the entire population. Additionally, a single-payer system reduces administrative costs, as providers would only need to bill a single entity, rather than dealing with multiple private insurers.

Under a single-payer system, patients would have the freedom to choose their healthcare provider and receive necessary medical services without worrying about out-of-pocket expenses. While the quality of care would be maintained or even improved, SPH promises to make healthcare more affordable and accessible to all, regardless of their socioeconomic status. Moreover, the absence of cost-sharing measures, such as co-payments, deductibles, and coinsurance, is an attractive feature of single-payer healthcare, as it eliminates the financial barriers to accessing care. This also allows individuals to seek preventative care, which can prevent more serious medical issues in the future, potentially reducing healthcare costs in the long run.

This approach would achieve a variety of goals, such as ensuring universal healthcare access, reducing the economic burden of healthcare, and improving health outcomes. In 2010, the World Health Organization made universal healthcare a priority for its member nations, and the United Nations General Assembly adopted it as part of the 2030 Agenda for Sustainable Development in 2015.

Single-payer healthcare systems use a single risk pool that encompasses an entire geographic or political region, along with uniform rules for services, reimbursement rates, drug prices, and minimum standards for required services. In affluent nations, single-payer health insurance is usually available to all citizens and legal residents. Some examples of single-payer healthcare systems include the United Kingdom's National Health Service, Australia's Medicare, Canada's Medicare, and Taiwan's National Health Insurance.

The term "single-payer healthcare" was first used in the 1990s to highlight differences between the Canadian healthcare system and other systems like the United Kingdom's NHS. In Canada, private agencies are paid by the govern-

ment to offer healthcare to qualifying individuals, whereas in other systems, the government both funds and delivers healthcare. The term usually refers to health insurance provided as a public service and offered to citizens and legal residents. The government can manage the fund directly or through a publicly owned and regulated agency. This type of healthcare funding is in contrast to other funding mechanisms such as ”multi-payer”, ”two-tiered”, and ”insurance mandate”, which can combine elements of each other. Some writers have used the term ”single-payer plans” to describe all publicly administered systems or systems that intend to cover the entire population, but these usages generally do not meet strict definitions of the term.

5.2 Single-payer Healthcare vs Socialised Healthcare

Single-payer healthcare and socialised healthcare are both alternatives to a completely free market healthcare system, but they differ in their approach to providing universal healthcare. Socialised healthcare, also known as a national health service, is a system where the government owns and operates healthcare facilities and employs healthcare providers. In this system, the government provides healthcare services to everyone, regardless of their ability to pay. While socialised healthcare can provide access to care to everyone, it often comes with long wait times, rationing of care, and limited options for patients. While a single-payer healthcare system is often seen as being at odds with free market principles, it is possible to incorporate certain elements of the free market into the system to improve its efficiency and quality of care; providing healthcare services for everyone without the government owning or operating healthcare facilities, retaining free market principles.

The free market is a complex system that functions based on the interactions of buyers and sellers, who are driven by supply and demand. In a free market, prices for goods and services are determined by the intersection of supply and demand curves. When supply exceeds demand, prices fall, and when demand exceeds supply, prices rise. However, the free market is not immune to constraints put upon it by nature or acts of God. Likewise, free market principles are not violated by regulation so as long as it acts as any other form of constraint.

Natural disasters, such as hurricanes, earthquakes, and wildfires, can disrupt supply chains and cause shortages of goods and services. This can cause prices to rise due to increased demand and decreased supply. In response, entrepreneurs and businesses may look to adapt their products or services, adjust their pricing, or find alternative supply chains to meet the needs of consumers. Regulations can also impact the functioning of the free market. Regulations can be designed to correct market failures, such as externalities, monopolies, or information asymmetry, but they can also limit competition and innovation. In response, entrepreneurs and businesses may seek to find new ways to meet the needs of consumers, such as developing new products or services or finding ways to operate more efficiently within the constraints of the regulations.

Furthermore, the free market also has the ability to respond to changes in consumer preferences, technological advancements, and shifts in societal values. For example, as consumers become more health-conscious, demand for organic and healthy foods has increased. This has led to the development of new markets for these products and services, as well as an expansion of the organic farming industry. Technological advancements have also created new markets, such as ride-sharing and online marketplaces.

A single-payer system can be seen as a form of constraint on the free market. In a free market, businesses compete with each other to provide goods and services, and consumers choose which products to purchase based on price and quality. In a single-payer system, the government is the sole purchaser of healthcare services, which means that healthcare providers must negotiate prices with the government rather than competing with each other. This can be seen as a constraint because it limits the ability of healthcare providers to set prices based on market forces. However, it can also be seen as a way to control costs and ensure that everyone has access to healthcare, even those who cannot afford it. By negotiating prices with healthcare providers, the government can potentially achieve lower costs than would be possible in a fully free market system. Furthermore, even in a single-payer system, there can still be competition among healthcare providers to offer high-quality care and attract patients. This competition can be driven by factors such as reputation, patient satisfaction, and the ability to offer specialized services. In this sense, a single-payer system can still incorporate certain elements of the free market, even if it does not operate on the same principles as a fully free market system. A single-payer system can be seen as a constraint on the free market, but but one which retains free-market principles to provide affordable healthcare to all by allowing for competition and innovation within the healthcare industry.

Allocation of resources is an essential component of the free market system, where resources are allocated to the areas of highest demand or need. In the case of constraints due to acts of nature or regulation, the free market tends to adjust resource allocation to meet changing needs. If a natural disaster strikes an area, causing a shortage of food, the price of food in that area may go up, which will incentivize suppliers to increase the supply of food in that area. As the

supply increases, the price of food will go down, eventually returning to its pre-disaster level. This mechanism ensures that resources are allocated efficiently, with no shortages or waste. Similarly, under a single-payer healthcare system, healthcare infrastructure and workers would relocate to meet the demands of different areas.

In a single-payer healthcare system, the government pays for healthcare services on behalf of the patient, but the allocation of healthcare infrastructure and workers still relies on the healthcare needs of the population. As healthcare needs change, healthcare providers must adjust the allocation of resources to meet those needs. For example, if a particular area experiences a sudden outbreak of a disease, healthcare providers may need to shift resources from other areas to address the outbreak.

Similarly, in areas with a high demand for healthcare services, healthcare providers may need to allocate more resources to meet that demand. For instance, if a particular region has an aging population with an increased need for specialized care, healthcare providers may need to invest in more infrastructure and skilled workers to meet the population's needs.

Hospitals would still need to operate efficiently to provide quality care while being fiscally responsible. With the government paying for healthcare services, empty hospitals that are not needed would not receive money without serving patients, which would not be profitable for the hospital. Therefore, hospitals that are not serving patients in a specific area would downsize or relocate, ensuring that healthcare resources are allocated efficiently and not wasted. This resource allocation would be done regardless of whether healthcare workers are paid directly by the patient or by the government on behalf of the patient, just

as in the current system.

This allocation of resources is critical to ensuring that the healthcare system operates efficiently and effectively. By directing resources to areas of highest need, the system can ensure that patients receive the care they require, and that there is no shortage or waste of healthcare resources. Although the government may be paying for the services, the allocation of resources is still influenced by the healthcare needs of the population, ensuring that the healthcare system is responsive to changing healthcare demands. This is in-contrast to a socialised healthcare system where it may be hard for a centralised authority to allocate resources effectively, while also reducing the scope for corruption.

Innovation is another critical aspect of the free market system, as it drives improvements in productivity, which can help to alleviate constraints. For example, in the case of an oil shortage caused by geopolitical tensions, high prices will incentivize companies to develop new sources of energy, such as renewable energy. This innovation will eventually lead to more significant supply and lower prices, making it easier to meet the energy demands of consumers. This process is also helped by the fact that the incentive structure of supply and demand in the free market encourages companies to invest in research and development to create new and better products and services.

In a single-payer healthcare system, healthcare providers still have an incentive to innovate, just as they would in a free market system. This is because a better product or service will help them to attract more patients, which will increase their revenue and profitability. Additionally, healthcare providers can improve their efficiency and reduce their cost basis by implementing new technologies or processes, which also maximizes their scope for profitability. The providers who

are most successful in attracting patients and improving their efficiency will be the most profitable, just as in a free market system. As a result, healthcare providers are incentivized to continue to innovate and improve the quality of care they provide, leading to better outcomes for patients.

While it is not possible for a single-payer healthcare system to fully adhere to free market principles, it is possible to incorporate certain elements of the free market into the system to improve efficiency and quality of care.

5.3 Competition amongst Healthcare Providers

A single-payer healthcare system retains competition amongst providers. By allowing multiple providers to compete for patients, the government can encourage innovation, lower costs, and improve quality. This can be done by setting up a framework that encourages competition, such as creating a marketplace or allowing providers to compete on the basis of quality and cost.

Another way to incorporate free market principles into a single-payer system is through price transparency. By making prices transparent, patients can compare the costs of different treatments and providers and make informed decisions. This can encourage providers to offer lower prices and higher quality, as they know they are competing with others.

[7]Another approach is to allow private insurance to coexist alongside the single-payer system. This allows patients to choose between the two, and it can encourage competition and innovation among providers. However, this approach has the potential to create a two-tiered system in which those with private insurance receive better care than those relying solely on the single-payer system. This is not dissimilar to the current healthcare system in the United States, where a patchwork of public and private insurance options are available. The vast majority of Americans have private insurance through their employer or purchased on the individual market, while others rely on government-funded programs like Medicaid and Medicare. This has led to a system in which healthcare quality and access can vary significantly based on a person's insurance status, income level, and geographic location. While private insurance may incentivize providers

Additionally, a single-payer system can use market-based incentives to encourage efficiency and quality. For example, by tying provider reimbursement to performance metrics, such as patient satisfaction, health outcomes, and cost-effectiveness, providers are incentivized to deliver high-quality care in a cost-effective manner.

Finally, a single-payer system can incorporate elements of consumer-driven healthcare, in which patients have more control over their healthcare decisions and are given more information about the costs and benefits of different treatments. By empowering patients with more information and more control, they can make better decisions and encourage providers to offer higher quality, more cost-effective care.

In conclusion, while a single-payer healthcare system may not fully adhere to free market principles, there are ways to incorporate elements of the free market to improve its efficiency and quality of care. By encouraging competition, price transparency, market-based incentives, private insurance, and consumer-driven healthcare, a single-payer system can offer high-quality, cost-effective care to all patients.

5.4 Global Perspectives on Single Payer Healthcare

Single-payer healthcare has been a topic of debate in the United States for decades, with opinions ranging from enthusiastic support to outright rejection. While there are a variety of different single-payer systems around the world, three countries in particular have received significant attention for their success-

to offer more innovative and higher-quality care, it can also exacerbate inequalities and leave many people with inadequate or no insurance coverage.

ful implementation of universal healthcare: Canada, Taiwan, and South Korea. By analyzing the experiences of these countries, we can gain a greater understanding of the possibilities and limitations of single-payer healthcare, and how it can be adapted to meet the specific needs and challenges of different societies.

5.4.1 Canada

Canada's publicly funded healthcare system, established by the Canada Health Act of 1984, provides most services through private entities and is mostly free at the point of use. Healthcare is cost-effective due to administrative simplicity and is funded through income taxes. All essential basic care is covered, while dental and vision care may not be covered, but are often insured by employers through private companies. Canadians receive the same level of care, and health coverage is not affected by loss or change of jobs, and there are no lifetime limits or exclusions for pre-existing conditions. Medications can be covered by public funds, privately out-of-pocket, or through employment-based private insurance, and drug prices are negotiated by the federal government to control costs. Physicians are chosen by individuals, and patients may wait for some treatments and diagnostic services. While physician income initially decreased, by the beginning of the 21st century, medical professionals were again among Canada's top earners.

5.4.2 Taiwan

Taiwan's National Health Insurance (NHI) is a compulsory single-payer social insurance plan that was instituted in 1995. It promises equal access to healthcare for all citizens and has reached a 99% population coverage. The system is mainly financed through premiums based on payroll tax and supplemented with out-of-pocket payments and direct government funding. NHI initially used a fee-for-

service model for public and private providers, but it was changed to a global budget to contain costs. Despite the initial economic shock from increased costs, the single-payer system has made healthcare more financially accessible for the population, resulting in a 70% public satisfaction rating.

5.4.3 South Korea

Prior to the 1977 reform, South Korea had a voluntary private health insurance system. However, the country transitioned to a multipayer social health insurance universal healthcare system, like those found in Japan and Germany, which was fully implemented by 1989. In 2000, a significant financing reform merged all medical societies into the National Health Insurance Service, which became a single-payer healthcare system by 2004.

5.4.4 International Profiles of Health Care Systems, 2013

The International Profiles of Health Care Systems, 2013 is a comprehensive report that provides a detailed overview of the health care systems of 14 different countries, including Australia, Canada, Denmark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States. The report examines the structure of each country's health care system, as well as key health care indicators, such as life expectancy and disease prevalence. It also analyzes issues related to health care access and affordability, including the role of insurance and the availability of health care services. The report serves as a valuable resource for policymakers, health care providers, and researchers seeking to better understand the complex landscape of global health care systems. The specific funding mechanisms used by each country's healthcare system are detailed in the report, and it is important to consult the report for accurate information. Mossialos et al. [2017]

5.5 Manufacturing Industries using Single Payer Healthcare

The manufacturing industry is a significant contributor to the Canadian economy. According to Statistics Canada, the manufacturing sector's output totaled CAD 182.6 billion in June 2021, accounting for 10.2% of the country's GDP. While the sector's share of GDP has declined over the years due to the growth of the services sector, it is still an essential part of Canada's economy.

Canada is a significant exporter of manufactured goods, including transportation equipment, machinery, and electronics. In 2020, manufacturing exports accounted for $372 billion, with the United States being the largest destination for Canadian-made goods. The Canadian manufacturing industry is also reliant on imports of raw materials, including energy and other commodities such as timber. According to the Government of Canada, the manufacturing industry is the second-largest exporter of goods and services, accounting for approximately 64% of all merchandise exports in 2020. The industry employed over 1.7 million people in 2020, making it a crucial source of employment in Canada. In recent years, the manufacturing industry in Canada has been impacted by the COVID-19 pandemic, with supply chain disruptions and reduced demand affecting production. However, the sector is showing signs of recovery, with manufacturing sales rising by 20.7% in June 2021, the largest monthly increase since July 2020. Statistics Canada [2021]

Although Canada's manufacturing % of GDP has declined over the years, the country is still a significant net exporter of manufactured goods, unlike the United States. According to Global Affairs Canada, in 2020, Canada exported $372 billion worth of manufactured goods, while importing only $313 billion in manufactured goods, resulting in a positive trade balance of $59 billion in

manufactured goods. This positive trade balance is a beneficial thing because it means that Canada is earning more revenue from manufacturing exports than it is spending on importing manufactured goods. It indicates that Canada's manufacturing industry is competitive and has a strong presence in the global market. Additionally, the revenue generated from manufacturing exports can support economic growth, job creation, and investments in research and development. Furthermore, being a net exporter of manufactured goods can help improve Canada's balance of trade and reduce its reliance on resource-based industries such as oil and gas. By diversifying its economy and increasing its presence in the manufacturing industry, Canada can reduce its exposure to commodity price fluctuations and create a more stable economic environment. Global Affairs Canada [2021]

Taiwan is also a major exporter of manufactured goods, particularly electronics and high-tech products. According to data from the World Bank (2021), manufacturing accounted for 30.3% of Taiwan's GDP in 2020. The country has a highly developed and sophisticated manufacturing sector, with a strong focus on research and development, innovation, and automation. Taiwan's exports are dominated by electronics and information technology products, which accounted for 54.7% of total exports in 2020 (Central News Agency, 2021). Other significant exports include machinery and equipment, chemicals, and precision instruments. Taiwan's major trading partners for manufactured goods are China, the United States, and Japan. Taiwan's imports of manufactured goods are also significant, with machinery and equipment, electronic products, and precision instruments being the top import categories (Global Affairs Canada, 2021). The country is largely self-sufficient in agriculture, and therefore imports of agricultural goods are relatively minor compared to manufactured goods.

In recent years, Taiwan's manufacturing sector has faced increasing competition from lower-cost producers in countries like China and Vietnam. However, the country has responded by focusing on higher-value, high-tech manufacturing and by investing in research and development to remain competitive in the global market (Central News Agency, 2021). Overall, Taiwan's manufacturing sector has been a significant driver of economic growth and has contributed to the country's development into a high-income economy. The sector's contribution to GDP has remained relatively stable in recent years, but the country faces on-going challenges in maintaining its competitiveness in the face of global economic pressures.

South Korea is well-known for its robust manufacturing industry, which has played a significant role in the country's economic growth over the years. In terms of trade, South Korea is a major exporter of manufactured goods, including electronics, automobiles, and shipbuilding. In 2020, the country's exports of manufactured goods accounted for around 84% of its total exports, while agricultural products and commodities accounted for around 2.7% and 1.1%, respectively. According to the World Bank, the manufacturing sector has been a significant contributor to South Korea's gross domestic product (GDP), accounting for over 29% of the country's GDP in 2020. The country's manufacturing sector has been relatively stable in recent years, with a slight increase in its contribution to GDP from 2019 to 2020.

The South Korean government has been investing in the manufacturing industry to maintain its competitiveness in the global market. In April 2021, the government announced plans to focus on fostering high-tech manufacturing industries, including artificial intelligence, semiconductors, and batteries. This initiative aims to maintain South Korea's global competitiveness in the manu-

facturing industry, particularly as the world shifts towards a more digital and technology-oriented landscape.

Similarly to Canada and Taiwan previously, South Korea's manufacturing industry has been a vital driver of economic growth, and the country has established a strong reputation as a leading exporter of high-quality manufactured goods. The government's commitment to investing in high-tech manufacturing bodes well for the future of the industry and the South Korean economy as a whole.

These economies benefit from having more efficient healthcare industries that employ a relatively small percentage of capital, compared to their respective GDPs. In 2020, the healthcare industry's contribution to Canada's GDP was 10.4%, while in 2019, the healthcare and social assistance industry accounted for 6.4% of Taiwan's GDP, and the healthcare industry's share of South Korea's GDP was 6.1% in 2019. By comparison, in the United States, the healthcare industry assumes 17.7% of the country's GDP (as at 2019).

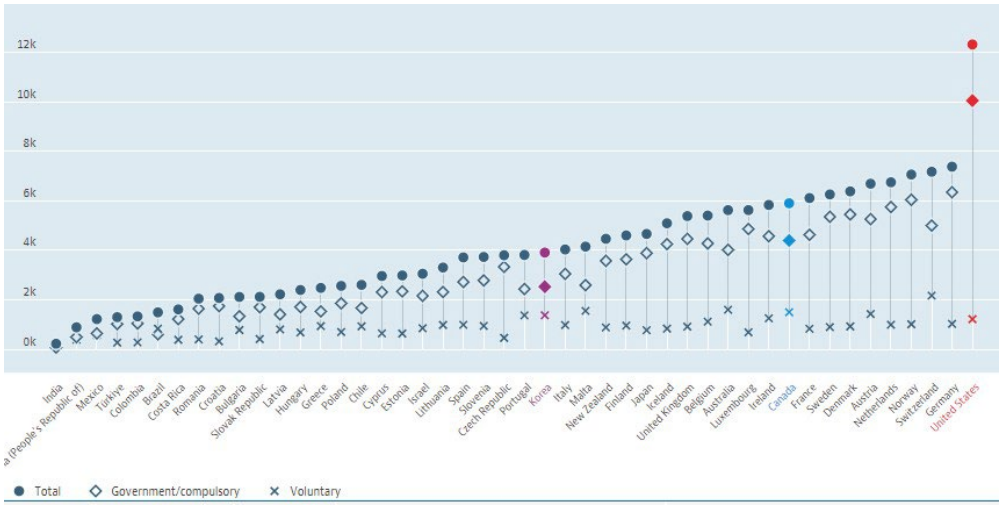


Figure 17: Total / Government/compulsory / Voluntary, US dollars/capita, 2021 or latest available,
Source: Health expenditure and financing: Health expenditure indicators

Rank	1	2	17	23	30
Country	***South Korea***	***Taiwan***	***Germany***	***Canada***	***United States***
Health Care Index (Overall)	78.72	77.7	52.3	48.64	45.62
Infrastructure	87.16	79.05	78.93	62.39	84.18
Professionals	14.23	13.06	13.6	16.89	13.1
Cost	83.59	78.39	66.04	55.73	65.52
Medicine Availability	82.3	78.99	60.94	52.91	76.28
Government Readiness	87.89	65.09	85.68	89.75	76.21

Figure 18: Health care index for selected countries.

Table ?? shows the health care index for selected countries, whereby it is evident, that despite America's disproportionate healthcare expenses, healthcare is of inferior quality. CEOWORLD Magazine [2021]

5.6 Foundational Documents and Human Rights

5.6.1 Decleration of Independence

The United States is one of the few developed countries without a universal healthcare system. However, the founding documents of the United States suggest that there is a right to health care. The Declaration of Independence declares that all men have "unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness."[42] These rights inherently include the right to health care since access to adequate medical care is necessary to preserve life and pursue happiness. Therefore, it can be argued that a single-payer healthcare system is consistent with the values enshrined in the Declaration of Independence.

A single-payer healthcare system would provide universal access to healthcare, ensuring that every American has the opportunity to lead a healthy and productive life. This would promote the general welfare, a stated goal of the US Constitution. The Preamble of the Constitution reads, "We the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defense, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America."[43] By establishing a single-payer healthcare system, the government would be promoting the general welfare of its citizens, a duty that it is explicitly charged with by the Constitution.

Opponents of a single-payer healthcare system argue that it violates individual rights, claiming that it would force individuals to pay for healthcare services they do not want or need. However, this argument is flawed. In a single-payer healthcare system, the government would be responsible for funding healthcare services, which would be provided to all citizens regardless of their ability to pay. This would ensure that everyone has access to healthcare when they need it, regardless of their financial situation. This is consistent with the principles of the Declaration of Independence, which recognizes that access to healthcare is essential to preserve life and pursue happiness.

In conclusion, a single-payer healthcare system is consistent with the principles outlined in the Declaration of Independence and the US Constitution. By providing universal access to healthcare, it promotes the general welfare of the people, which is a duty that the government is explicitly charged with. In this sense, the implementation of a single-payer healthcare system would be consistent with the founding values of the United States.

5.6.2 United Nations Universal Declaration of Human Rights

Access to health care is recognized as a fundamental human right under the United Nations Universal Declaration of Human Rights, which was signed by the United States in 1948. This declaration includes the provision that "everyone has the right to a standard of living adequate for the health and well-being of oneself and one's family, including. . . medical care." Despite this recognition, the United States remains the only country in the Organization for Economic Cooperation and Development (OECD) that does not have universal health care. This lack of access to health care is a violation of human rights and should be addressed through the implementation of a single-payer health care system.

A single-payer health care system would ensure that all Americans have access to the medical care they need without financial hardship. This is in line with the World Health Assembly resolution 58.33, signed by the United States and other member states of the World Health Organization in 2005, which states that everyone should have access to health care services and should not suffer financial hardship when obtaining these services. By implementing a single-payer system, the United States would be fulfilling its obligations under international human rights law.

Furthermore, according to a study in the Lancet, the right to health care is not only a matter of good management and humanitarianism, but also a legal obligation under human rights law. This underscores the importance of ensuring that all individuals have access to medical care, regardless of their ability to pay.

In light of the recognition of health care as a fundamental human right under the United Nations Universal Declaration of Human Rights, and the obligations of member states to provide access to health care services under international human rights law, it is imperative that the United States implement a single-payer health care system. Doing so would not only address the issue of access to medical care, but also ensure that the country is fulfilling its legal and moral obligations to its citizens.

5.7 Implementation and Impact of Single-Payer Healthcare in the United States

Overall, implementing a single-payer healthcare system in the United States would require significant legislative and administrative action, as well as coordination between the federal government and the states. While there are potential

challenges, proponents argue that the benefits of increased access to healthcare and reduced administrative costs outweigh these concerns.

5.7.1 Necessary Legislative and Administrative Steps for Implementation

Implementing a single-payer healthcare system in the United States would require significant legislative and administrative action. The first step would be to pass legislation at the federal level that establishes a national single-payer healthcare program. This legislation would need to outline the details of the program, such as the benefits provided, eligibility requirements, and funding mechanisms.

In order to finance the program, the federal government would likely need to increase taxes. This could be accomplished through a variety of methods, such as implementing a payroll tax or increasing income taxes on high earners. The specifics of how the program would be funded would need to be determined through the legislative process.

An alternative to a federally funded single-payer healthcare system would be for each state to independently establish and manage its own system. This would allow for greater flexibility in the design and implementation of the system to meet the unique needs of each state's population. Additionally, a state-run system would enable voters to have a higher individual electoral representation, as decisions about the system would be made closer to home by state lawmakers.

State-run single-payer healthcare systems could be financed through a variety of methods, including state taxes and fees, as well as federal funding through Medicaid and Medicare. However, states would need to carefully consider the costs and benefits of implementing such a system. While a single-payer healthcare

system has the potential to reduce overall healthcare costs and provide universal coverage, it would also require significant upfront investment and ongoing funding to sustain.

A state-managed healthcare system would also have to confront the challenge of cross-border healthcare, as patients might seek treatment in neighboring states with varying healthcare systems. This could result in disparities in care access and potentially compromise the efficacy of the state-run single-payer healthcare system. The expenses of healthcare would be covered by the jurisdiction where the patient is a tax resident, and states could have arrangements allowing patients to obtain treatment in other states. These arrangements may or may not be mandated at the federal level and could be limited to emergency care or include elective care as well.

Effective implementation of a single-payer healthcare system, whether operated at the federal or state level, would necessitate significant coordination between the respective governing entities. This would entail inter-state collaboration, as well as close communication and cooperation with the federal government. Once the legislation is passed, the administrative process of implementing the program would begin. This would involve setting up the infrastructure necessary to administer the program, such as creating a national healthcare database and hiring staff to manage the program.

Another potential challenge is the impact on healthcare providers. Under a single-payer system, healthcare providers would be reimbursed by the government for their services. This could result in lower reimbursement rates than they currently receive from private insurers, which could impact their bottom line. However, proponents of single-payer healthcare argue that the elimination of

administrative costs associated with dealing with multiple insurers could offset any potential losses.

5.7.2 The Effects of a Single-Payer Proposal in New York State

The following subsection is based on the study conducted by Liu et al. [2018], which estimated the effects of a single-payer proposal in New York State.

Estimating the Effects of a Single-Payer Proposal in New York State

The implementation of a single-payer healthcare system has been a topic of ongoing debate in the United States. One proposal currently under consideration is in the state of New York. The RAND Corporation conducted an analysis of this proposal, examining the potential impact on healthcare utilization, spending, and overall outcomes. Their findings suggest that while New Yorkers may use more healthcare services under a single-payer plan, overall spending could remain stable if certain efficiencies are realized. This research provides valuable insight into the potential impact of a single-payer healthcare system in the United States.

The New York Health Act proposes the creation of a state-sponsored single-payer health plan called New York Health (NYH) that would cover all residents of New York State, including undocumented immigrants and seniors over age 65 (if federal waivers are approved). It would be financed through a new trust with money from the federal government, current state health care funding, and two new progressively graduated state taxes. The RAND Corporation was commissioned to assess the plan's effects on healthcare use and spending in the state using a microsimulation modeling approach. The analysis includes main results reflecting a set of base case assumptions and results under alternative assumptions. Patients would have no deductibles, co-pays, or other out-of-pocket

costs for services covered by the plan, and long-term care benefits may be added later.

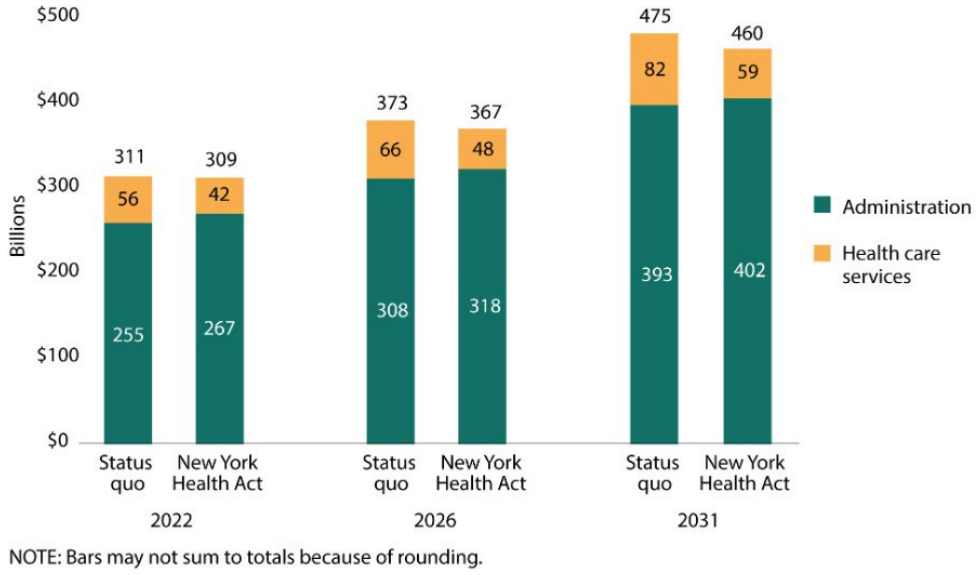
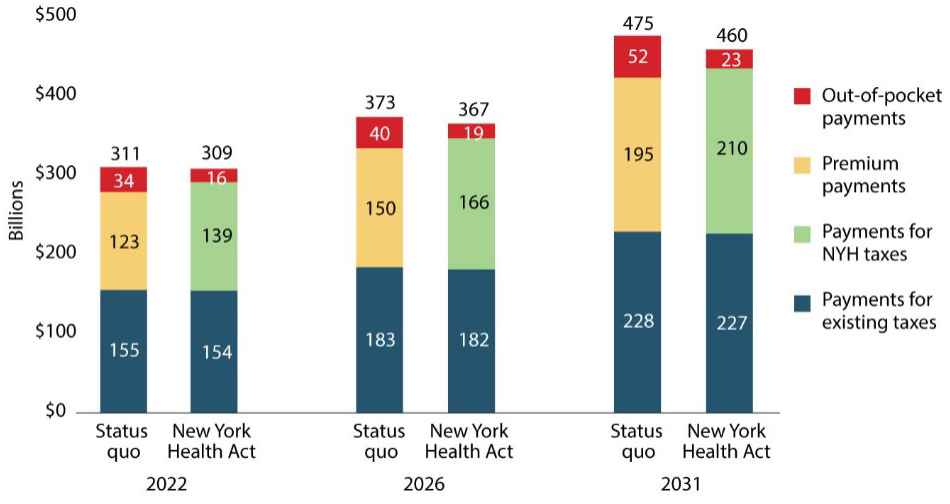


Figure 19: Total Health Spending - Status Quo vs NYHA

The study found that overall health spending under the NYHA would be slightly lower than under the current system due to slower payment growth and lower administrative costs. However, healthcare use would increase due to the elimination of cost-sharing and previously uninsured people accessing services. The study also noted that increased patient demand may not be fully met due to supply constraints.

The New York Health Act (NYHA) would replace premiums and out-of-pocket payments for covered services with taxes under a state-sponsored single-payer health plan called New York Health (NYH). The plan would cover all residents of New York State, including undocumented immigrants and seniors over age 65. The plan would be financed through a new trust with money from the federal government, current state health care funding, and two new progressively

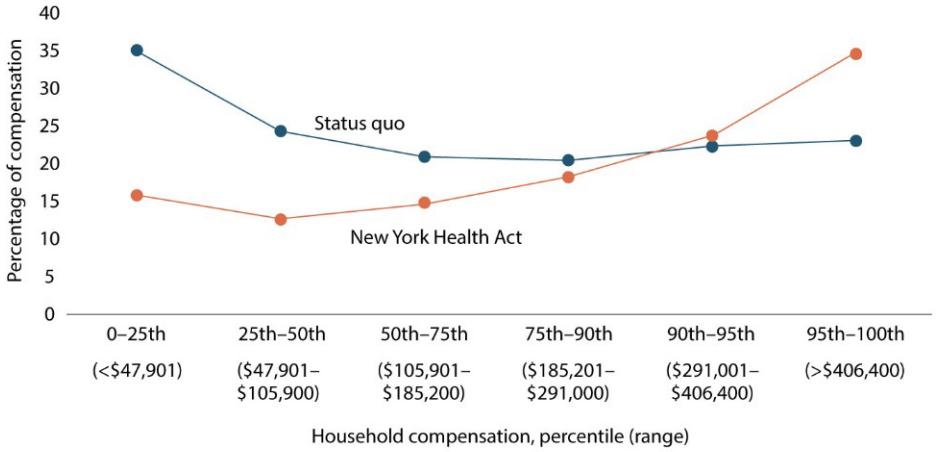


NOTE: Bars may not sum to totals because of rounding.

Figure 20: Status Quo Financing vs NYHA Taxes

graduated state taxes: a payroll tax paid jointly by employers and employees and a tax on nonpayroll income. The additional state tax revenue needed to finance the program would be $139 billion in 2022, a 156-percent increase over the projected total state tax revenue of $89 billion under the status quo. One set of possible progressive tax rates that could fully finance the program ranges from about 6 to 18 percent for the NYH payroll tax and 6 to 19 percent for the NYH nonpayroll tax in 2022.

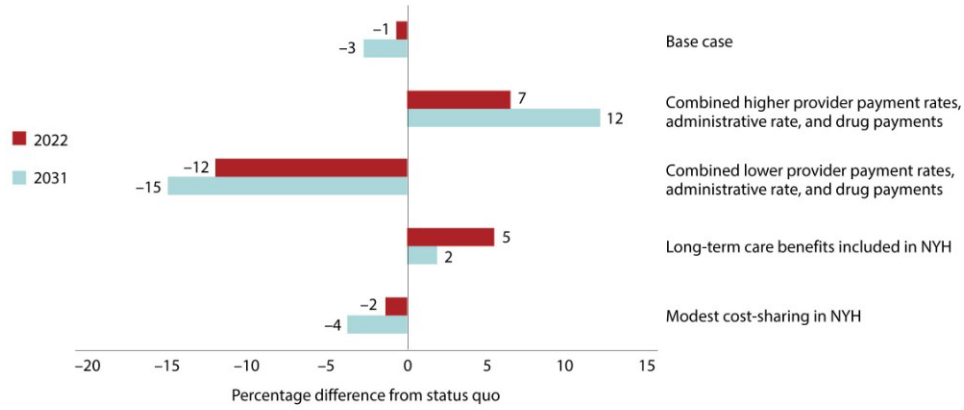
The New York Health Act (NYHA) proposes a state-sponsored single-payer health plan called New York Health (NYH) which would cover all residents of New York State, and include medical benefits currently included in Medicare, Medicaid, and Child Health Plus and essential health benefits under the Affordable Care Act (ACA). The plan would be financed through a new trust with money from the federal government, current state health care funding, and two new progressively graduated state taxes. The total health care spending under the NYHA would be slightly lower than spending under the status quo in 2022 and the difference would grow over time. The shift from premiums and



NOTE: Household compensation includes household income and employer contributions to health care.

Figure 21: Average Healthcare Payments as a Share Compensation vs Household Income

out-of-pocket payments to taxes would affect households differently based on household compensation, and the majority of New Yorkers would pay less under the NYHA, while the highest-income residents would pay more.



NOTE: In the alternative scenarios combining provider payment rates, administrative rate, and drug payments, the higher-cost alternative assumes that the average annual growth in NYH provider payment rates equals that of private payment rates under the status quo (rather than public payment rates in the base case), the administrative rate is 12 percent (rather than 6 percent in the base case), and drug payments in NYH are 2.5 percent higher than under the status quo (rather than drug prices 10 percent lower than Medicare prices in the status quo). The lower-cost combined scenario assumes that provider payment rates are 5 percent lower than under the status quo, the administrative rate is
3 percent, and drug prices in NYH equal Medicaid prices under the status quo. The modest cost-sharing scenario assumes a 95-percent actuarial value plan for households with incomes above 250 percent of FPL (rather than a 98-percent actuarial value plan for everyone in the base case).

Figure 22: Assumption Adjustments

The impact of the NYHA on employers' healthcare contributions varies based on the size of the firm and the coverage status. Employers who currently provide

coverage would pay less per worker on average ($200 to $800) for employee health benefits under the NYHA in 2022. However, those who do not currently offer coverage would pay more per worker on average ($1,200 to $1,800) due to mandatory payroll taxes under the NYHA in 2022.

The NYHA could potentially lead to tax avoidance, out-migration, and provider relocation. High-income residents may change investment decisions or move out of state to avoid taxes, which could reduce the funding base. Businesses and providers may also move out of the state to reduce payroll tax obligations or in response to lower provider payment rates. However, the analysis did not model these potential effects.

The analysis considered a range of alternative scenarios to test whether the results of the base case analysis would change. Different assumptions could have significant effects on estimated spending under the NYHA, with savings ranging from up to 15% to increases of 12% in 2031. Adding long-term care benefits could increase spending by 5% in 2022 and 2% in 2031. The inclusion of modest cost-sharing could lead to a reduction in spending by 2% in 2022 and 4% in 2031.

This study suggests that implementing a single-payer system in New York could increase coverage while reducing health spending, as long as provider payments are kept in check and administrative expenses are trimmed. However, these assumptions are uncertain and depend on factors such as provider bargaining power, the state's ability to administer the plan efficiently, and federal waivers. The proposed progressive tax schedule would lower payments for most residents, but if high-income residents avoid taxes, it may need to be revised. Overall, the single-payer option has potential, but it depends on various uncertain factors.

5.7.3 Projected Impact on Patient Outcomes and Healthcare Access

A Single-Payer Healthcare system has the potential to improve patient outcomes and healthcare access. As shown previously, countries with universal healthcare systems have better health outcomes than those without, and a single-payer system could provide similar benefits. Patients would no longer face financial barriers to accessing care, such as high deductibles or copays.

A single-payer system can incentivize more testing, diagnosis, and earlier treatment for patients. With easier access to healthcare, individuals are more likely to seek out medical attention for symptoms, which can lead to earlier detection and treatment of diseases. Early detection and treatment can not only improve patient outcomes but can also result in lower healthcare costs in the long run. This is because treating diseases at an earlier stage is often less expensive than treating them at a more advanced stage. Moreover, the cost of treating advanced diseases can be much higher due to the need for more complex and intensive medical interventions. By providing easier access to healthcare, a single-payer system can encourage individuals to seek medical attention earlier, which can ultimately result in cost savings for the healthcare system as a whole. Additionally, a single-payer system would streamline administrative processes, reducing the burden on healthcare providers and allowing them to spend more time with patients. This could improve patient satisfaction and lead to better health outcomes as a result of increased access to care.

To this effect, Woolhandler and Himmelstein argue that a single-payer healthcare system in the United States would result in better access to care for patients and improved health outcomes. They cite several studies that have found that uninsured and underinsured patients have worse health outcomes and receive

less preventative care and fewer diagnostic tests and treatments than those with comprehensive insurance coverage. A single-payer system would provide universal coverage and eliminate financial barriers to accessing care, which would incentivize patients to seek care earlier and more often, leading to earlier detection and treatment of health conditions, better health outcomes, and lower healthcare costs overall. The authors also argue that a single-payer system would reduce administrative waste and redirect resources towards patient care, which would further improve health outcomes and access to care.Woolhandler and Himmelstein [2017]

Low-income individuals often face economic constraints that limit their access to healthy foods, driving them to consume lower quality and less nutritious options. This can lead to negative health outcomes, including chronic diseases such as diabetes, heart disease, and obesity. However, by providing more equitable access to healthcare, these individuals could receive preventative care and treatment for their health conditions. Improved health outcomes could then lead to increased productivity and income, allowing individuals to better afford healthier food options and lead healthier lifestyles. Additionally, a healthier workforce could benefit the economy as a whole, as individuals would be able to contribute more to the workforce and require fewer sick days. A single-payer healthcare system could play a crucial role in improving health outcomes for low-income individuals and promoting economic growth and productivity.

Furthermore, a single-payer healthcare system can also address the issue of healthcare disparities among different socioeconomic groups. Studies have shown that low-income individuals and people of color are more likely to be uninsured or underinsured, resulting in higher rates of preventable diseases and worse health outcomes. By providing universal coverage, a single-payer system can ensure

that all individuals, regardless of their income or race, have access to the same level of healthcare. This could help reduce healthcare disparities and improve overall health outcomes for all populations. Additionally, a single-payer system could promote preventative care and education, which could help individuals better manage their health and prevent the development of chronic diseases. By addressing healthcare disparities and promoting preventative care, a single-payer system has the potential to significantly improve health outcomes and access to care for all Americans.

5.7.4 Projected Impact on Healthcare Providers and Medical Industry

A single-payer healthcare system would have a significant impact on health-care providers and the medical industry. The current healthcare system in the United States is complex and fragmented, with multiple private insurers and government programs, each with their own reimbursement policies and adminis-trative requirements. This administrative complexity places a significant burden on healthcare providers, who must navigate a complicated system to ensure that they are reimbursed for the care they provide. A single-payer system would streamline administrative processes, allowing providers to focus on delivering care and reducing the administrative burden.

One potential consequence of a single-payer system is that healthcare providers may see a reduction in reimbursement rates. This is because a single-payer system would have greater bargaining power with providers and would be able to negotiate lower prices for medical services and supplies. However, proponents of a single-payer system argue that the overall impact on healthcare providers would be positive. For example, a single-payer system would reduce the cost of providing care by eliminating the administrative complexity of the current

system. Providers would no longer have to navigate multiple reimbursement policies, reducing administrative costs and freeing up time to focus on patient care. Additionally, providers would no longer have to devote resources to billing and collections, which can be a significant source of overhead in the current system.

Another potential impact of a single-payer system is that it could change the incentives for healthcare providers. In the current system, providers are incentivized to provide more medical services and tests, as they are reimbursed for each procedure they perform. A single-payer system would change these incentives, as providers would be reimbursed based on the value of the care they provide rather than the volume. This could lead to a greater emphasis on preventative care and better management of chronic conditions, as these approaches can reduce the need for expensive medical interventions later on. Providers may also be incentivized to focus on improving patient outcomes and reducing healthcare costs, rather than maximizing profits.

The medical industry would also see significant changes under a single-payer system. Pharmaceutical companies, medical device manufacturers, and other suppliers to the healthcare industry would face greater pressure to lower prices, as the single-payer system would have greater bargaining power. This could lead to lower prices for medical supplies and drugs, reducing healthcare costs overall. However, the medical industry may also face lower profit margins, as the single-payer system would negotiate prices based on the cost of production rather than market demand. The incentives for providers would thus shift towards preventative care and improving patient outcomes, rather than maximizing profits.

5.7.5 Public Opinion and Acceptance of Single-Payer Healthcare

Public opinion and acceptance of a single-payer healthcare system are crucial factors that could influence the success of its implementation. While the idea of a single-payer system may sound attractive to some, others may be hesitant or even opposed to the concept. Therefore, it is important to consider the potential challenges that could arise when introducing a single-payer system and the ways in which they can be addressed.

One of the main challenges in gaining public acceptance of a single-payer system is the perception that it would lead to longer wait times for medical procedures and reduced access to medical care. However, proponents of a single-payer system argue that it could actually reduce wait times by eliminating administrative waste and streamlining processes. Additionally, wait times are not solely determined by the healthcare system but are also influenced by factors such as the availability of healthcare professionals and resources.

Another challenge is the potential opposition from healthcare providers, who may be concerned about reduced compensation and control over their practices. However, proponents argue that a single-payer system could actually reduce administrative burdens on healthcare providers, allowing them to focus on patient care and reducing burnout. Moreover, the shift towards value-based care in a single-payer system could incentivize providers to focus on preventative care and outcomes rather than the volume of procedures performed.

Public opinion and acceptance of a single-payer system may also be influenced by political ideologies and interests. The United States has a complex political landscape, with varying levels of support for different healthcare models across different regions and political parties. Therefore, it is important to consider

the ways in which a single-payer system could be framed and communicated to different audiences to gain their support. Additionally, stakeholders from different sectors, such as healthcare professionals, insurers, and pharmaceutical companies, may have conflicting interests and may lobby against a single-payer system.

To overcome these challenges, proponents of a single-payer system must engage in effective communication and education campaigns to promote the benefits of a single-payer system and address concerns and misconceptions. Additionally, stakeholders from different sectors must be engaged in the design and implementation of a single-payer system to ensure that their concerns are addressed and their interests are taken into account. In addition, it is also important to consider the role of state-level policy and regulation in the implementation of a single-payer system. While a national single-payer system may be desirable, individual states may have unique demographic, economic, and political characteristics that require tailored solutions. As such, individual states must retain sufficient legislative power to ensure that their particular populations' needs and political ideologies are taken into account. This could include issues such as Medicaid expansion, which may vary from state to state, or other policies aimed at improving healthcare access and affordability for specific populations.

5.8 Proposal for Health Care Reform to Boost Manufacturing Industry

To revitalize the manufacturing industry, improve production, and make our goods more competitive, a comprehensive healthcare reform plan is required to reduce the costs associated with healthcare for employers. Our current healthcare system adds to the cost of manufacturing and puts domestic manufacturers

at a competitive disadvantage with their foreign counterparts who pay lower healthcare costs. We need to restructure the healthcare system so that healthcare costs are paid out of profits, as is the case with other nations. By doing so, we can increase our cost break-even points and improve our global competitiveness.

Eliminating the employer-pay healthcare system and replacing it with a personal and business income tax system will be an essential part of this healthcare reform plan. Employer-paid healthcare, along with other expenses like Federal Insurance Contributions Act (FICA) taxes, put a burden on employers and discourage the growth of the manufacturing sector. A personal and business income tax system will ensure that everyone is covered for healthcare, and pre-existing conditions will not be an issue.

With this plan, people will be free to choose their healthcare provider, and employees with pre-existing conditions will be able to get and keep jobs. Administrative health care expenditures for billing and collecting, which account for 25 percent of overall healthcare costs, will be reduced. There may be some job losses in sales, but these individuals can be retrained to work in the manufacturing sector, which will create more jobs. The government's obligation to our military veterans will also be included in the new plan.

Implementation of the proposed changes will require a new tax system that includes a flat tax on all earned income levels. The exact amount of the tax will be determined by the General Accounting Office. The medical portion of the new tax will increase by only 3% to 4%, making the contribution rise to 10.65% to 11.65%. The increase in the amount collected from new taxes will be far lower than each person's increase in income. This healthcare reform plan is

critical for the survival of our manufacturing industry. Without this plan, the manufacturing industry will continue to decline, and we will become a third-world country with agriculture as our primary industry. A massive stimulus program will be required to provide more money directly to employees and take the first steps to rebuild the United States Manufacturing Industry.

In summary, this proposal for healthcare reform will make our manufacturing industry more competitive, reduce employer healthcare costs, and create more jobs. It will also eliminate the administrative costs associated with billing and collection and ensure that everyone has access to healthcare. Although there will be some job losses, these individuals can be retrained to work in the manufacturing sector, which will create more jobs in the long run. The proposed flat tax system will provide the necessary funding for the plan and ensure that everyone pays their fair share of taxes.

6 Conclusion

As described in subsection 3.1 of the article, healthcare costs in America are unsustainable. Due to the lack of cost-containment measures, and the overwhelming regulation liming competition in the markets, this unsustainability is becoming ever greater, with healthcare cost increases superseding than the consumer price index and wage growth, and the healthcare industry becoming an ever greater drain on the overall United States labor economy. Shifting population age structures will expose this unsustainability, as less of the population is able to contribute to the workforce and the healthcare needs of an ageing population increase. This demographic shift will likely expose the unsustainability of the current healthcare system, leading to a potential collapse in the coming decades.

The healthcare system in America is already burdened by high costs and inadequate access to care, and this demographic shift will only exacerbate these challenges. Without significant changes to the healthcare system, such as the implementation of cost-containment measures and shifting financing away from employers, the system may struggle to meet the needs of an aging population, leading to significant social and economic consequences.

Employer-paid healthcare places a heavy financial burden on labor-intensive industries like manufacturing, which operate with low margins, dense workforces, via supply chains. Healthcare costs are added to each stage of the manufacturing process, making every stage increasingly less competitive as companies must burden the healthcare costs of their suppliers. These industries struggle to remain competitive in the global marketplace, in part because of the high cost of

providing healthcare benefits to employees. To address this issue, it is necessary to find solutions that reduce healthcare costs without sacrificing quality or accessibility. Doing so could help to alleviate the burden on American businesses and ultimately reduce persistent trade deficits, which have long been a source of concern for policymakers and economists alike.

This is in contrast to many other countries where structured healthcare costs avoid double taxation. As a result, American manufacturers struggle to compete with international competitors who benefit from Value-Added Tax (VAT) exemptions that allow companies to claim back the VAT paid on inputs. The burden of healthcare costs makes the manufacturing industry in America unsustainable, and this issue must be addressed to improve competitiveness. Manufacturing trade deficits occur when a country imports more manufactured goods than it exports. From an economic perspective, trade deficits can have negative consequences, such as reducing a country's GDP and increasing its debt. Additionally, trade deficits can harm a country's sovereignty by making it reliant on other countries for essential goods, including manufactured products. This can put a country in a vulnerable position, especially during times of geopolitical tension or supply chain disruptions. Therefore, it is essential to address the issue of healthcare costs in the manufacturing industry to reduce trade deficits and promote economic and national security.

One solution to address this issue is to shift the burden of healthcare costs away from employers and towards a single payer system. Single payer healthcare would not only protect jobs and labor, but it would also make healthcare more accessible and equitable for all. By removing insurance companies and other intermediaries from between patients and providers, costs can be contained, and the focus can be shifted towards improving the quality of care. This is in stark

contrast to the current system, where intermediaries have an incentive to increase costs, as seen in the prevalence of medical fraud and kickback schemes, as discussed in section 4. In section 5, we discussed the benefits of single payer healthcare reform, including lower administrative costs, increased bargaining power with pharmaceutical companies, and a more streamlined healthcare system. By implementing a single payer system, the healthcare burden would be shifted away from employers, leading to a more sustainable manufacturing industry and a more equitable healthcare system for all Americans.

The 4.3 trillion dollars spent on healthcare and other social benefits would be eliminated from the manufacturing costs. The payment of these costs would be moved to business and personal income taxes. The International Profiles of Health Care Systems, 2013 report provides valuable evidence to support the advantages of a single payer healthcare system. Other countries have demonstrated the viability of a single-payer healthcare system. Furthermore, Canada, for example, has had a publicly funded healthcare system for over fifty years, providing comprehensive coverage to all citizens without financial barriers to care. Taiwan's National Health Insurance program has been successful in providing universal healthcare coverage and controlling healthcare costs. South Korea's single-payer healthcare system, launched in 1989, has improved access to healthcare and reduced out-of-pocket expenses. These countries have demonstrated that a single-payer system can lead to more equitable access to care, better health outcomes, and lower healthcare costs. By adopting a similar system, the United States could provide better care to more people while reducing overall healthcare spending.

To complement efforts in healthcare financing, it is important to consider additional resources and recommendations for improving the healthcare system and

the structure of healthcare workers. In this regard, "The Future of Nursing: Leading Change, Advancing Health (2011)" is a valuable resource that offers insights into how nurses can play a key role in transforming the healthcare system and advancing health equity. This study is a recommended further reading for anyone interested in improving the healthcare system. The report explores how nurses' roles, responsibilities, and education should change significantly to meet the increased demand for care created by healthcare reform and to advance improvements in America's increasingly complex health system. At more than 3 million in number, nurses make up the single largest segment of the healthcare workforce. The report suggests that strong leadership will be required to realize the vision of a transformed healthcare system, and all nurses must be leaders in the design, implementation, and evaluation of healthcare. The report's recommendations cover a wide range of topics, including the need to improve nursing education, promote diversity in the nursing workforce, and enhance nurses' ability to practice to the full extent of their education and training.

The Future of Nursing: Leading Change, Advancing Health" report published by the Institute of Medicine in 2011. The report recommended several changes in the nursing profession to meet the increasing demand for healthcare reform and to advance improvements in America's healthcare system. Some of the recommendations include increasing the proportion of nurses with baccalaureate degrees to 80% by 2020, doubling the number of nurses with a doctorate by 2020, promoting nurse residency programs, and increasing the diversity of the nursing workforce to better reflect the patient population. The report emphasized the need for nurses to take leadership roles in the design, implementation, and evaluation of healthcare systems and policies. The report was also a catalyst for the creation of the Future of Nursing 2020-2030 report, which explores how

nurses can work to reduce health disparities and promote health equity in the coming decade. Institute of Medicine [2011]

In conclusion, the implementation of a single payer healthcare system is an urgent matter that requires the attention and immediate action of policy makers. The current healthcare financing structure poses significant challenges to accessibility, affordability, and equity of care for many individuals and communities in the United States. The adoption of a single payer system has the potential to mitigate these issues and promote a more efficient and effective healthcare system that prioritizes the well-being of its citizens. As such, it is imperative that policy makers take proactive steps towards the implementation of a single payer system to ensure that all individuals have access to the care they need and deserve.

Annex: The Social Impact of the Healthcare Industry

In the United States, the cost of medical care continues to rise, and as a result, many people are struggling to keep up with their medical bills. Unfortunately, a significant portion of these bills go unpaid, creating a major financial burden for healthcare providers. This burden is further exacerbated by the cost of collecting these debts, which can be substantial. One of the primary causes of unpaid medical bills is a lack of insurance coverage. While the Affordable Care Act (ACA) has made it easier for people to get insurance, many still remain uninsured. Additionally, even those with insurance may have coverage that does not fully cover the cost of their medical care.

For healthcare providers, the collection of unpaid medical bills can be a time-consuming and costly process. They must first attempt to collect the debt from the patient, and if this is unsuccessful, they may need to turn to a collections agency. This process can take months or even years, and the provider must bear the costs of hiring a collections agency, which can be substantial.

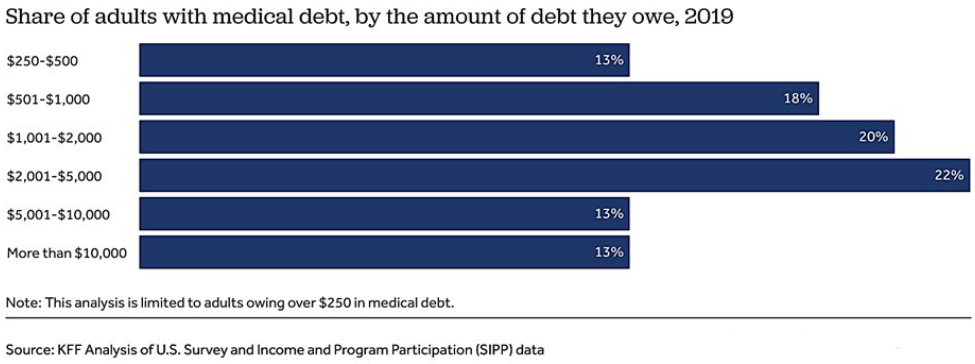


Figure 23: Share of Adults with Medical Debt,
Source: KFF Analysis of U.S. Survey Income and Program Particiation (SIPP) data

The collection of unpaid medical bills also creates an additional financial burden for healthcare providers. The costs associated with the collection process are passed on to patients in the form of higher prices for medical services. This, in turn, makes it even more difficult for patients to pay their medical bills, perpetuating the cycle of unpaid debts.

It is difficult to determine the exact portion of medical expenditures spent on collection of unpaid medical bills in the US. However, according to some estimates, healthcare providers spend billions of dollars annually on the collection of outstanding medical debt, with some estimates suggesting that as much as 25-30% of a healthcare provider's revenue may be dedicated to this purpose.

Additionally, a study by the Commonwealth Fund found that the average hospital spends over $600,000 annually on debt collection activities, representing a significant portion of their operating expenses. The burden of unpaid medical bills affects not only healthcare providers but also patients, as it can result in negative impacts on their credit scores and financial stability.

However, it has been reported that healthcare providers often hire collection agencies to collect on past due balances, and the cost of these collection efforts can be substantial. According to a report by the American Hospital Association, the cost of collecting payments from patients accounts for an average of 6-7% of a hospital's operating expenses. Additionally, it is estimated that in 2019, the total cost of bad debt and charity care for US hospitals was $57.5 billion. This shows the significant financial impact that the collection of unpaid medical bills can have on the healthcare industry.

In addition to the financial burden, the collection of unpaid medical bills can also create emotional stress for patients. They may feel guilty about not being able to pay their bills, and the constant collection calls and letters can be overwhelming. This can lead to further health problems, as patients may avoid seeking medical care due to the fear of incurring additional debt.

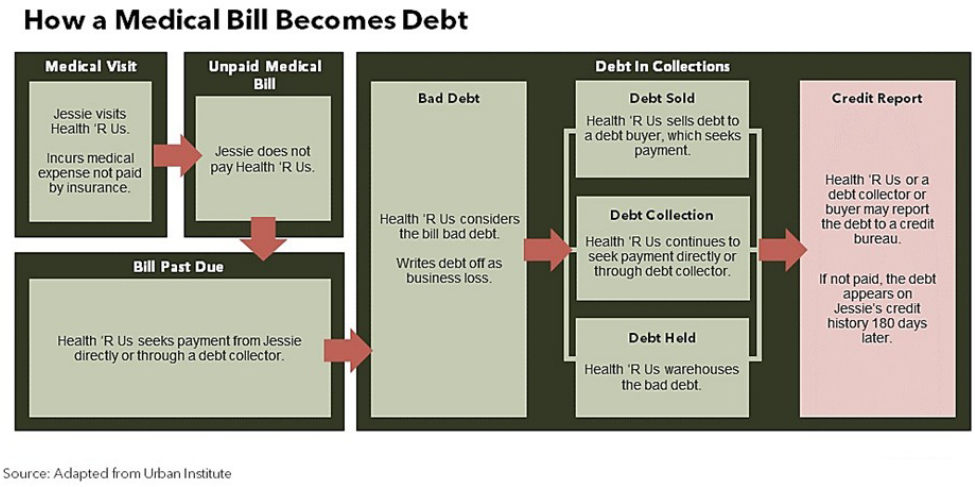


Figure 24: How a Medical Bill Becomes Debt, Adapted from Urban Institute

To alleviate the financial burden of unpaid medical bills, healthcare providers and policymakers must work together to find solutions. One option is to increase access to affordable insurance coverage for all Americans. This would reduce the number of uninsured patients and make it easier for patients to pay their medical bills.

Annex: Average Annual Incomes for Various Types of Doctors in the United States and OECD Countries

According to OECD data, the average annual income for all doctors across its member countries is $180,000. So, on average, doctors in the United States earn significantly more than the average doctor in OECD countries. However, as mentioned before, factors such as cost of living and taxes can also affect the purchasing power and overall standard of living of these salaries.

General practitioner: $211,780

Surgeon: $409,665

Psychiatrist: $220,380

Pediatrician: $187,540

Obstetrician/gynecologist: $303,540

Cardiologist: $438,850

Oncologist: $438,950

Dermatologist: $425,968

Anesthesiologist: $409,670

Orthopedic surgeon: $500,672

List of Figures

References

Cms annual financial report 2021, 2021a. URL https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2021.pdf. Accessed on January 25, 2023.

National health expenditure data - national health accounts historical, 2021b. URL https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical. Accessed on January 25, 2023.

American Tobacco Co. and United States. American tobacco co. v. united states. *328 U.S. 781*, 66(1125):90 L.Ed. 1575, 1946.

H Angier, M Hoopes, R Gold, SR Bailey, EK Cottrell, J Heintzman, et al. An early look at rates of uninsured safety net clinic visits after the affordable care act. *Ann Fam Med*, 13: 10–6, 2015.

S Artiga, R Rudowitz, J Tolbert, J Paradise, and M Majerol. Findings from the field: Medicaid delivery systems and access to care in four states in year three of the aca. https://www.kff.org/medicaid/issue-brief/findings-from-the-field-medicaid-delivery-systems-and-access-to-care-in-four-states-i 2016. Accessed 25 Jan 2023.

CEOWORLD Magazine. Health care index, 2021, 2021. URL https://ceoworld.biz/2021/04/27/revealed-countries-with-the-best-health-care-systems-2021/. [Accessed: January 21, 2023].

FTC and Motion Picture Advertising Serv. Co. Ftc v. motion picture advertising serv. co. *344 U.S. 392*, 73(361):97 L.ed. 426, 1953.

Global Affairs Canada. Trade data online, 2021. URL https://www.ic.gc.ca/tdo.

Harkins Amusement Enterprises Inc. General Cinema Corp. Harkins amusement enterprises, inc. v. general cinema corp. *C.A.Ariz.*, 850(F.2d 477):490, 1988.

MJ Hoopes, H Angier, R Gold, SR Bailey, N Huguet, M Marino, and et al. Utilization of community health centers in medicaid expansion and nonexpansion states, 2013-2014. *J Ambulatory Care Manage*, 39:290–298, 2016.

WR Hsiang, A Lukasiewicz, M Gentry, C-Y Kim, MP Leslie, R Pelker, et al. Medicaid patients have greater difficulty scheduling health care appointments compared with private insurance patients: a meta-analysis. *INQUIRY*, 56:004695801983811, 2019.

Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. The National Academies Press, Washington, DC, 2011. doi: 10.17226/12956. URL https://doi.org/10.17226/12956.

Kellogg Co. In re kellogg co. *FTC File No. 7110004*, pages 547 Attr A–3, 1972.

Jodi L. Liu, Chapin White, Sarah A. Nowak, Asa Wilks, Jamie Ryan, and Christine Eibner. Estimating the effects of a single-payer proposal in new york state. Research brief, RAND Corporation, Santa Monica, CA, 2018. URL https://www.rand.org/pubs/research_briefs/RB10027.html.

E. Mossialos, A. Djordjevic, R. Osborn, and D. Sarnak. International profiles of health care systems, May 2017. URL https://doi.org/10.26099/xp8v-kz31.

S Rosenbaum, J Paradise, A Markus, J Sharac, C Tran, and D Reynolds. Community health centers: Recent growth and the role of the aca. *The Henry J. Kaiser Family Foundation*, 2017. URL https://www.kff.org/medicaid/issue-brief/

community-health-centers-recent-growth-and-the-role-of-the-aca/.

Adele Shartzer, Sharon K Long, and Nathaniel Anderson. Access to care and affordability have improved following affordable care act implementation; problems remain. *Health Affairs*, 35(1):161–168, 2016.

B Sommers, M Gunja, K Finegold, and T Musco. Changes in self-reported insurance coverage, access to care, and health under the affordable care act. *JAMA*, 314:366–374, 2015.

Statistics Canada. Gross domestic product by industry, june 2021, 2021. URL https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=3610043401.

LR Wherry and S Miller. Early coverage, access, utilization, and health effects associated with the affordable care act medicaid expansions: a quasi-experimental study. *Ann Intern Med*, 164:795, 2016.

Steffie Woolhandler and David U Himmelstein. Single-payer reform: The only way to fulfill the president's pledge of more coverage, better benefits, and lower costs. *Annals of internal medicine*, 166(8):587–588, Apr 2017.