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RESEARCH ARTICLE

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Healthcare Reforms Within and Without

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ABSTRACT

Healthcare reform has been a significant and ongoing issue in the United States, with various initiatives and policies implemented over the years to improve access, quality, and affordability of healthcare. We review recent literature as to attempts to reform a healthcare system in the US that is driven by profit greed and fraud. Examples of such attempts are critiqued for their working within a system that is structurally broken.

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Healthcare reform has been a significant and ongoing issue in the United States, with various initiatives and policies implemented over the years to improve access, quality, and affordability of healthcare. Here's an overview of key aspects of healthcare reform:

The Affordable Care Act (ACA)

The ACA, also known as Obamacare, was a major healthcare reform law enacted in 2010. Its key provisions include:

- Expanding health insurance coverage through Medicaid expansion and the establishment of Health Insurance Marketplaces
- Introducing new consumer protections and coverage standards
- Eliminating annual dollar limits on coverage for essential health benefits
- Allowing young adults to stay on their parents' health insurance until age 26
- Implementing medical loss ratio requirements for insurers

The ACA has led to significant reductions in uninsured rates across various demographic groups [1].

Ongoing Reform Efforts [2]

Recent legislative and administrative initiatives have built upon the ACA's foundation:

- The Inflation Reduction Act (IRA) of 2022 introduced measures to improve Medicare drug pricing and affordability
- Continued efforts to expand access to affordable coverage through Medicaid and the Health Insurance Marketplaces
- Implementation of value-based payment models to improve care quality and reduce costs

Challenges and Areas for Improvement

Despite progress, several challenges remain in healthcare reform:

- Addressing remaining uninsured populations and disparities in coverage
- Controlling rising healthcare costs
- Improving care coordination and integration
- Enhancing primary care and addressing provider shortages in underserved areas
- Leveraging health information technology to improve care delivery and outcomes

Key Principles for Future Reform

To create a more equitable and patient-responsive healthcare system, future reform efforts should consider:

- Focusing on outcomes that matter to patients and consumers
- Improving transparency in healthcare quality and costs
- Strengthening primary care and community health centers
- Addressing social determinants of health
- Involving the public more directly in the reform process

Healthcare reform remains a complex and evolving issue. While significant progress has been made, particularly through the ACA and subsequent initiatives, there is still work to be done to achieve a healthcare system that provides universal access, high-quality care, and affordable costs for all Americans.

In our continuing series revisioning models of healthcare delivery we now come to others who have attempted to classify reforms in US system over the last decade. Willard C. Harrill, and David E. Melon write in their *field guide to U.S. healthcare reform* of a number of healthcare reform paradigms [3]. They reviewed the literature with a view towards the evolution of value-based healthcare

Consistent stakeholders identified within these paradigms were the patient, the physician and the payer (the “Big 3”). A `patient-centred' approach is increasingly regarded as crucial

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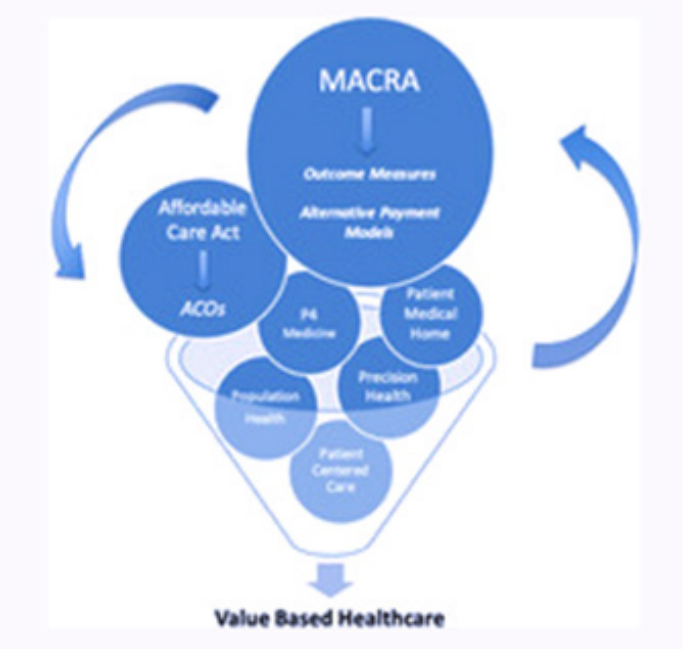
for the delivery of high quality care by doctors. However, there is considerable ambiguity concerning the exact meaning of the term and the optimum method of measuring the process and outcomes of patient-centred care.

Nicola Mead and Peter Bower described the conceptual and empirical approach in order to develop a model of the various aspects of the doctor±patient relationship encompassed by the concept of `patient-centredness' and to assess the advantages and disadvantages of alternative methods of measurement. Five conceptual dimensions were identified: biopsychosocial perspective; `patient-as-person'; sharing power and responsibility; therapeutic alliance; and `doctor-as-person' [4].

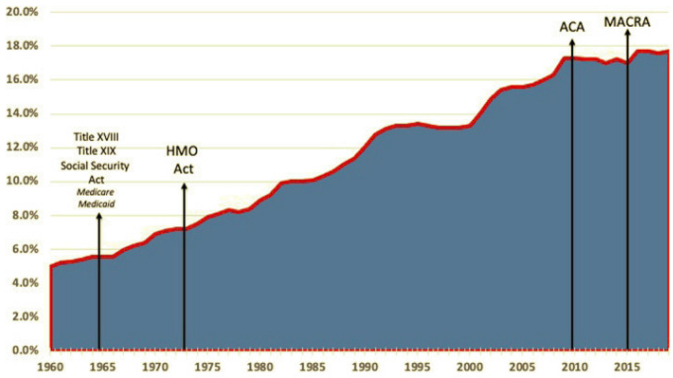
The definition of "Value" within each reform model was found to be based upon the perspective of the targeted stakeholder. Within VBH, the perspectives of the Big 3 stakeholders form a multidimensional meaning of "Value" that can be represented by the equation *Value = Patient Experience Management*.



In the United States (U.S.) between 1960 and 2019, healthcare spending as a percentage of U.S. Gross Domestic Product (GDP) grew from 5% to 17.7%, reaching $3.8 trillion dollars in 2019. Payment reform models have emerged to both control this growing expense and realign how quality, as a return on investment of the healthcare dollar spent, is measured.

U.S. Healthcare Spending as a Percentage of GDP

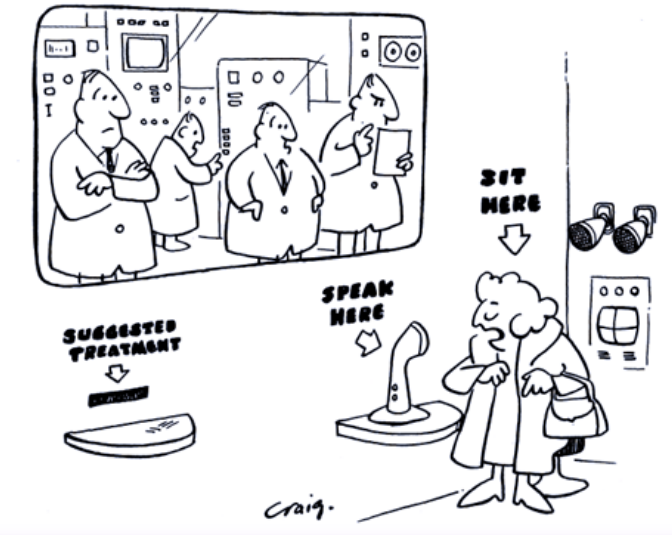
Many of these paradigms have similar names, overlapping concepts and evolving meanings creating inconsistency in working definitions and conceptual boundaries reported in peer-reviewed literature. Value-Based Healthcare (VBH) is the main driver of current healthcare reform through the use of pay-for-performance (P4P) and alternative payment models (APM). A Healthcare Reform Relative Comparability Index was developed to capture major themes and impacts within U.S. healthcare reforms:



U.S. Healthcare Reform Relative Comparability Index

The Patient-Centered Care Model (PCCM) has been defined by the Institute of Medicine as healthcare that is "responsive to the patient's preferences, needs and values. This core principle establishes the patient as an equal stakeholder in a horizontally oriented physician-patient relationship rather than the traditional subordinated participant in a vertically oriented physician-directed approach.

The eight principles within PCCM include:
(a) Respect for the patient's preferences,
(b) Coordination and integration of care,
(c) Information and education,
(d) Physical comfort,
(e) Emotional support,
(f) Involvement of family and friends,
(g) Continuity and transition, and
(h) Access to care.



These Principles Recognize the Patient's Perception of Value Shaped Through Engagement, Treatment and Outcomes of their Medical Care

Association established the core principles within this model included:

- Physician-stakeholder providing initial contact, continuous and comprehensive care within the physician-patient relationship.
- A physician-directed medical care team.

	Patient Centered Care Model (PCCM)	Patient Centered Medical Home (PCMH)	Population Health (PMH)	Personalized Medicine/Precision Medicine/P4	Healthcare management Organizations (HMOs)	Accountable Care Organizations (ACOs)	Value Based Healthcare (VBH)
Healthcare Cost Reduction							
Alternative Payment Model							
Big Data Integration							
Meaningful Quality Measures							
"Big 3" Alignment Patient/Physician/Payer							
Coordination of Care							
Patient Focused							
Expand Healthcare Access							
Social Health Determinants							
Contemporary Origins	1990s	1960s	1990's	1970s	1970s	Mid 2000s	Mid/Late 2010s
Peak Interest	1995-2005	1995-2010	Current	2000-2010	1980s-2000s	Current	Current
Defining Feature(s)	Purely philosophical construct based on equality of the physician/provider and patient stakeholder relationship	Patients are engaged in a direct relationship with a chosen provider who coordinates a team of healthcare professionals, takes collective responsibility, advocates and arranges appropriate care with other qualified providers and community resources as needed.	An interdisciplinary, customizable approach that allows health departments to connect practice to policy for change to happen locally. This approach utilizes non-traditional partnerships among different sectors of the community – public health, industry, academia, health care, local government entities, etc. – to achieve positive health outcomes.	The patient stakeholder is empowered through knowledge of their personal genetic data to take more responsibility and control over their lifestyle and healthcare decisions. The era of genetic identification and predetermination of patient-specific disease risk.	A medical insurance group that provides health services for a fixed annual fee. It is an organization that provides or arranges managed care for health insurance, self-funded health care benefit plans, individuals, and other entities, acting as a liaison with health care providers (hospitals, doctors, etc.) on a prepaid basis.	ACOs expand on the concept of a PCCM and PHM through the broader goal of coordinating care beyond that of just individual physicians/providers and their patients to include hospitals, specialists and other healthcare providers caring for a panel of patients within a defined geographic region. Payers engage and partner directly with physician/provider stakeholders and/or hospitals to create shared financial risk-reward pools based on predefined quality measures and continuity of care metrics.	A healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way. It is achieved by active management of the cost, patient experience and patient outcomes.
Relative Comparability Index	High Goal Achievement			Medium Goal Achievement		Low Achievement or Not a Goal	

- A whole person orientation of care through all stages of the patient's health cycle from preventative care to acute and chronic care and finally, end of life care.
- Coordination across all elements of the patient's care plans.
- Incorporation of quality and safety metrics within patient reported outcomes, evidence-based medicine, continuous quality improvement, healthcare information technology data and communication, and professional recognition standards.
- Enhanced patient access strategies for care availability, and (g) payment reform that recognizes the added value to the patient rather than the volume of services consumed.

Population Health Definition

Developed in the Canadian and United Kingdom health systems, the term "population health" highlights the fluid and evolving use of healthcare terminology.

In this model, "population" is defined as groups of individuals within economically, socially, or politically distinct boundaries known as a health service area (HSA). Population Health Management (PHM) merges healthcare reform with social reform. Dominant themes of PHM are the dependent (health outcomes) and independent variables (the multiple health determinants) impacting healthcare outcomes and integrating the influence of public health policy on these variables. Examples of dependent variables include mortality rates, disease prevalence and recidivism, and patient-reported outcome measures (PROMs).

Independent variables include social determinants such as lifestyle, socio-economic variables (income, employment, education and living standards) as well as the availability and accessibility of community resources within an HSA.

Art of Medicine

Too often today we have placed our medical trust in the science of medicine, ignoring the art. Too often, we physicians see sitting across the desk from us, not a fellow-being in need of human as well as medical understanding, but a "condition" to be treated. In this world of technology I'm convinced that the "condition" is being better diagnosed and treated that it ever has been, but that is not enough. The art of medicine conveys to me the thought of an Osler or a Hunter, curious, watchful, observant yet scientific, with the ever present knowledge that the patient is a fellow human being in trouble and that the physician's whole training, clinical and moral, is pointed towards help and cure.

The primary goal of PMH, or "Triple Aim," is to coordinate modification of dependent and independent risk variables with preventative care strategies within an HSA to improve overall public health and lower costs.

The Integration of Big Data in Healthcare

The original use of the term "Personalized Medicine" can be traced to an article by W.M. Gibson in 1971, which addressed the growing concern at the time that scientific advances were having a depersonalizing effect on healthcare. He wrote: [5]

In this period of explosive therapeutic advancement, the patient stakeholder was increasingly seen as the secondary host of a treatable disease rather than as an individual afflicted by disease. The concern was that disease itself was replacing the patient as the targeted stakeholder. This philosophical reform model acknowledged the risk of advances in science lending a detrimental impact on the physician's traditional role of treating the patient's total personal wellbeing. Personalized Medicine aimed to realign the physician-patient relationship to both treat the disease, to heal the patient as well as the secondary impact of the disease on the total well-being of the patient. Heal the disease/treatment burden on the patient as well as treat the disease itself. Ironically, with the completion of the Human Genome Project (HGP) in 2003, the era of Big Data, the aggregation of massive amounts of deidentified patient data for the purpose of medical/healthcare analytics, reduced the patient stakeholder to the level of their genetic code, allowing for potentially infinite "personalized" medicine options based on a patient's specific DNA [6]. Genomic data of the patient was incorporated into the medical decision-making guided by the four P's (Predictive, Personalized, Preventative and Participatory) of healthcare delivery. Designed to be a proactive systems-based approach rather than a reactive evidenced-based approach, Personalized Medicine moved towards a holistic model of integrating genetic data within a shared physician and patient decision-making relationship. In this model, the patient stakeholder is empowered through knowledge of their personal genetic data to take more responsibility and control over their lifestyle and healthcare decisions. Overtime, the terms Personalized Medicine have become interchangeable, referring to the era of genetic identification and predetermination of patient-specific disease risk. However, the implication that genetically determined customized treatments could be created for each individual patient to choose based on their genetic data was not realistic. This underscored the need to emphasize community-based treatments, not bespoke treatments for the individual based on their genetic factors, social determinants, and personal choice [7].

In 2011, the National Research Council crafted the term Precision Medicine (PM) to clarify the point that genomic data does not specifically allow for the personalized creation of treatments for patients within a community [8]. Rather, Precision Medicine integrates professional interpretation and shared decision-making, utilizing the patient's genomic data, clinical data, and social data with the available treatments in an HSA. Thus, with Precision Medicine, the data is interpreted and processed by the physician stakeholder who discloses the genetic risks to the patient and prescribes the recommended treatment and social modifications. The patient stakeholder becomes accountable to adhere to the professional recommendations after understanding the treatments and risks.

Health Maintenance Organizations

An era of managed care was born following the passage of the Health Maintenance Organization (HMO) Act of 1973 [9]. This act expanded private healthcare coverage through federal legislation pre-empting state laws which restricted pre-paid health plans and broadened private insurance coverage options. Prior to this law, HMOs were only in 14 states with 43% of all HMO's operating in California, the largest of which was Kaiser Permanente. Comparatively, Blue Cross and Blue Shield (BCBS) and commercial indemnity plans were in existence nationwide, but neither had HMO models. The "Blues" model consisted of a physician owned network (Blue Cross) and a hospital owned network (Blue Shield).

Blue Cross utilized a pre-paid, negotiated fee-for-service insurance network comprised of private practice physicians utilizing a pricing system that became the precursor to the Current Procedural Terminology (CPT) fee-based system in use today. Blue Shield operated under a negotiated itemized price list for services that today represents the hospital "chargemaster" currently used in hospital fee-for-service billing.

The Blue plans were under the control of physicians and hospitals until the 1970s when most transitioned to a mutual insurance model whose governance was elected by the policyholders, ultimately converting to a network of non-profit corporations known as the BCBS Association today. As a result of the HMO Act, Managed Care Organizations (MCO) offered a variety of HMO health plans. MCOs evolved to include not just traditional HMO health plans, but also BCBS companies, private insurance companies, as well as Medicaid and Medicare offering hybrid fee-for-service products. These MCOs developed four basic models of managed care plans: (a) the HMO (either a group model or independent practice association [IPA] model), (b) the preferred provider organization (PPO), (c) point-of-service plans (POS), and (d) high deductible health plans (HDHP) with or without health savings accounts [10].

In the HMO group model, physicians are exclusively employed, or groups of physicians exclusively contracted with an MCO. A physician, typically the primary care provider, is the decision-making stakeholder (gatekeeper) who coordinates care within a network and assumes bidirectional financial risk through a fixed payment or capitated payment model [11]. Originally in the HMO model, the capitation cost containment strategy paid the gatekeeper and contracted specialists a monthly upfront fixed payment to manage patients covered within the plan rather than through a volume based fee-for-service model. The capitation payments had no direct links to quality measures or outcomes. This fixed payment model significantly restructured relationship risk between the physician and patient stakeholders. The physician had risk of not being paid for services nor compensated for expenses after the capitation

limits had been reached and the patient carried perceived risk for being denied access to care based solely on utilization driven costs without consideration to quality or outcomes.

In the IPA model, independent physicians or groups are non-exclusively contracted within HMO networks. A gatekeeper model is used within the IPA, and physician compensation is either through a discounted fee-for-service agreement or capitation model for those patients within the network. The patient stakeholder usually has no out-of-network benefits.

The PPO model eliminated the gatekeeper role, allowing the patient to become the decision-making stakeholder for coordination of their care through a network of preferred physicians and hospitals without a referral requirement. Out-of-Network physicians and hospitals are usually covered, but with greater costs to the patient. PPO's can have discounted fee-for-service or capitated payment models. The POS model is a hybrid of the HMO and PPO models and contains no capitation. Physician compensation is based on a discounted fee-for-service payment structure. Similar to an HMO, a gatekeeper is required in the POS model, but out-of-network benefits for the patient are similar to the PPO model. The HMO model grew rapidly in the 1980s and most not-for-profit systems converted to for-profit corporations to access capital markets and fund growth [12].

This led to intense competition and underpricing of HMO contracts and premiums. Subsequent financial losses resulting from market price wars led to significant premium hikes and a rise in employer and patient costs. Cost containment strategies initiated by MCOs to stem financial losses included reduction in plan benefits, an increased use of medical necessity denials, prior authorization requirements for requested care, and narrower networks through the involuntary removal of physicians/providers from HSA provider panels.

These growing restrictions began to alienate the patient and physician stakeholders which led to political opposition resulting in over 900 legislative actions and tort reforms to curb HMO plan restrictions as well as physician led class action lawsuits in the late 1990s. Entering into the 2000s, the physician-patient stakeholders were firmly aligned in opposition to the HMOs utilization of cost control strategies containing minimal focus on stakeholder value or quality-of-care delivered. Not surprisingly, the popularity of HMO plans achieved an all-time low by 2010 as insurance and out-of-pocket costs continued to rise despite the unpopular stakeholder restrictions.

The HMO healthcare reform model was ultimately unsuccessful because it failed to unite the key stakeholders politically and had most certainly failed to control the rise in healthcare costs. This occurred for two major reasons: (a) most HMO networks developed tended to be too narrow and challenging to accurately price and (b) the providers in the network did not have the ability to effectively control costs and keep care within the network. Kaiser Permanente, in contradistinction, has enjoyed success as it is structured as “staff” HMO model and therefore has more structure to control the providers, cost and quality.

Accountable Care Organizations

ACOs emerged in the post-HMO era in an effort to repair the relationship between the payer and physician stakeholders by allowing physicians/providers to partner in financial risk and cost savings with payers. The origins of ACOs came from the Centers for Medicare and Medicaid (CMS) engagement of physician groups during 2005-2010 through the Medicare Physician Group Practice Demonstration [13].

The 2010 Patient Protection and Affordable Care Act (ACA) established P4P incentives for alternative payment model (APM) design within the Medicare Shared Savings Program (MSSP) [14].

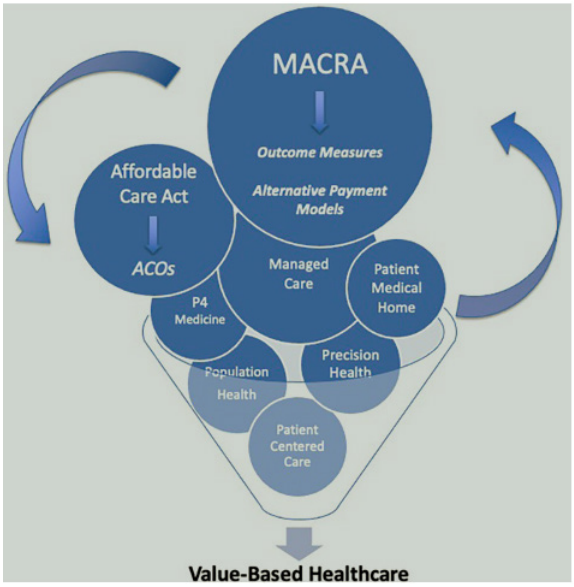
ACOs expand on the concept of a PCCM and PHM through the broader goal of coordinating care for a panel of patients within a defined geographic HSA based on physician stakeholder ACO participation. ACOs incentivize the Triple Aim of PHM within an HSA through shared financial risk-reward APMs combining fee-for-service payments with a P4P MCBR payment linked to quality metrics within a Population-Based Payment (PBP) model. Use of APMs to create risk sharing between the payer and the physician stakeholders realigned the traditional relationship in a fee-for-service structure which relied on a more hierarchical volume driven transactional payment relationship which, at times, could be adversarial. Clinically, the ACO P4P model would not have been achievable without the federally funded expansion of Electronic Health Records (EHR) mandated through the 2009 American Recovery and Reinvestment Act. [15].

EHRs allow for the aggregation of large amounts of population based healthcare data (Big Data). Big Data drives healthcare risk and performance analytics and when combined with claims data (Practice Management Software) to form population-based episodes-of-care analysis at the individual patient level. However, unlike practice management claims software, EHR software functionally lacks necessary enforced interoperability standards resulting in data blocking between proprietary Health Information Technology (HIT) application interfaces within the myriad of HIT EHR vendors [16].

Value-Based Healthcare

The term Value-Based Healthcare (VBH) was first introduced by Porter in 2007 as a response to the third-party cost shifting, and fee-for-service cost containment strategies utilized by HMOs that were undermining the ability of physicians to spend adequate time caring for their patients [17]. The evolving concept of VBH as a reform model is a coalescence of the multiple patient-centric reform efforts described above and progressive healthcare legislation.

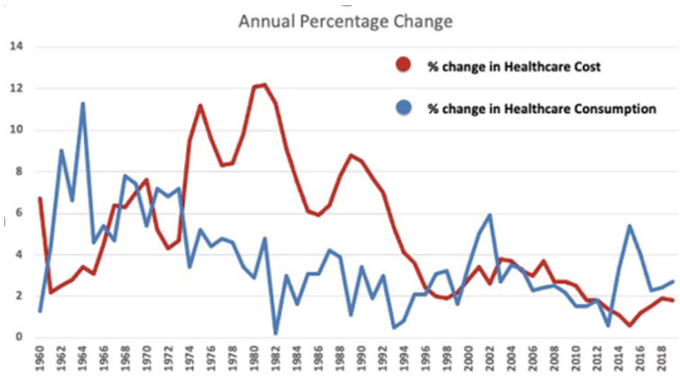
In 2015, the VBH reform concept was codified into law within CMS through the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA).



The Evolution of Value-Based Healthcare

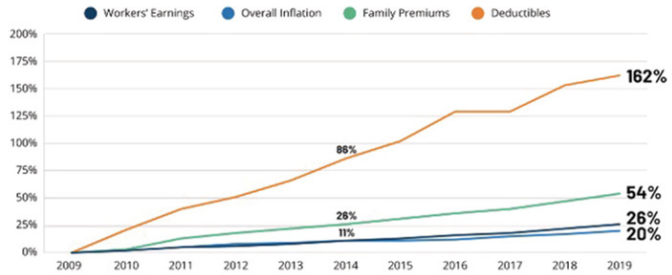
Within healthcare reform, "value" has been determined by the perspective of the individual stakeholder within the underlying components of quality, service, patient experience, access, outcomes and cost. Prior to MACRA, the payer stakeholder perspective had a dominant, fairly one-dimensional definition of "value", being actuarially defined as health quality achieved per dollar spent (ie, Value = Quality/Cost) based on claims data.

Government regulatory mandated changes under MACRA, expanded the dimensions of value by acknowledging the patient as a target stakeholder from which healthcare value is measured through the patient's clinical care journey and experience [18]. When considering the patient stakeholder, it will be increasingly important to recognize the patient as a "consumer" given the dramatic rise in out-of-pocket expenses relative to their earnings and inflation [19]. For decades, data has consistently shown that patients make economic decisions relating to their consumption of healthcare based on cost; the higher the cost, the more discerning the patient consumer becomes.



Percentage of Change in Healthcare Cost Vs Consumption (1960-2019).

Shifting healthcare expenditures have driven consumerism of the healthcare experience giving the patient stakeholder a greater voice for their perspective to be reflected in the healthcare value equation. In ACO and VBH models, the patient stakeholder will need to be a viewed as a partner in the process that defines future value in healthcare. In VBH, a more patient-centered measure of value will be required that reflects this increasing cost burden by the patient.

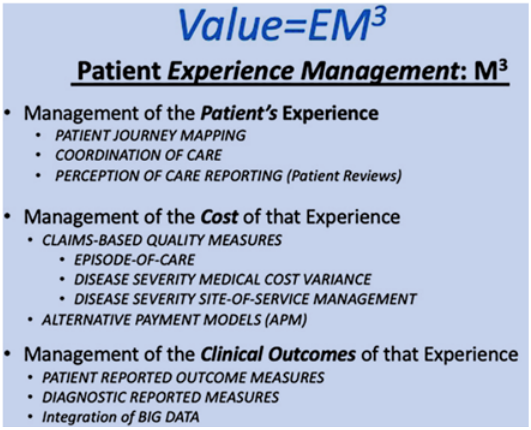


Patient Healthcare Premiums and Deductibles Vs Wages and Inflation (2009-2019).

CMS is also engaging efforts to facilitate more value-based engagements between physician stakeholders. In 2021, CMS modified regulatory barriers for physicians by allowing safe-harbor exemptions for value-based arrangements within the physician self-referral law, also known as the STARK law. The "patients over paperwork" initiative sought to improve quality-of-care and lower costs by improving disease severity site-of-service coordination-of-care within physician driven value-based competition [20].

For the physician stakeholder, the challenges and risks within value-based healthcare are best described by Porter: "*If physicians fail to lead these changes, they will inevitably face ever-increasing administrative control of medicine. Improving health and healthcare value for patients is the only real solution*." [21].

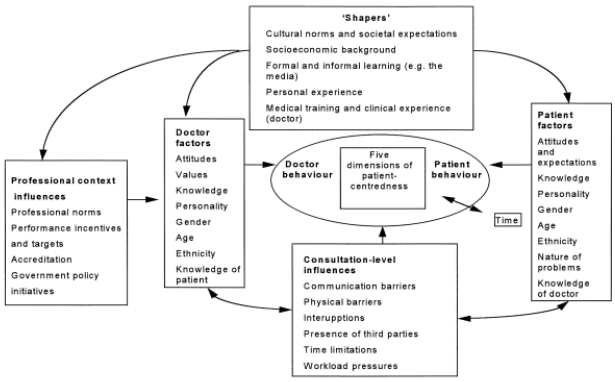
The clinician's role within the physician-patient relationship is the key point of reference from which coordination-of-care and patient engagement is measured. Within VBH, coordination-of-care between these two stakeholders integrates the concepts of the PCCM and is realized through the Integrated Practice Unit for chronic disease management. For that relationship to yield greater measurable clinical value, the physician will need to play an increased role coordinating the development of value-based models. Capturing, measuring and actively managing these evolving multidimensional perspectives of "value" from these three stakeholders (the "Big 3") within VBH can be best represented as ***Value = Patient Experience Management***



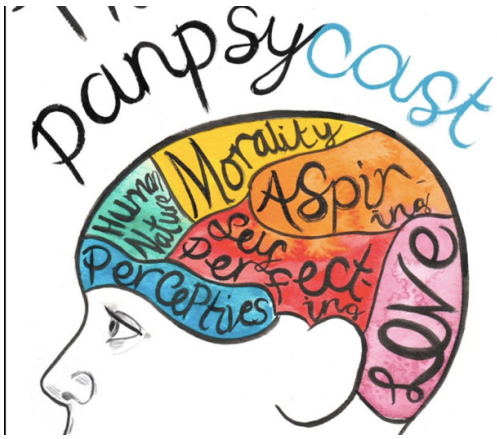
An understanding of the evolution of healthcare reform requires a historical perspective of prior reform initiatives, familiarity with the ever-changing terminology, and a recognition of primary stakeholder interests. A key theme in the journey of U.S. healthcare reform has been elevating the patient stakeholder interests and coordination-of-care relationships in healthcare delivery models. As a percentage of GDP, sustainable reductions in healthcare expenditures have been demonstrably achievable when the Big 3 stakeholder interests have been aligned within healthcare reform legislation.

To successfully shift from a volume-based reimbursement system to one based on value, these Big 3 stakeholder interests must be aligned, only then can reform goals of reducing healthcare cost, improving health quality and enhancing the patient experience be realized. Evolving "best practice" within developing practice guidelines, site-of-service utilization, and patient experience expectations will determine future measures of value. Understanding the working definitions and conceptual boundaries driving VBH reform will empower physicians to have a greater role within The Big 3 stakeholders in the transition from "volume to value" within future alternative payment model design and implementation.

Returning to Nicola Mead and Peter Bower The time dimension detailed below explicitly recognises that the propensity of a doctor to be patient-centred will vary over time, and that some dimensions require significant time to develop between the doctor and individual patient.



The five behavioral dimensions included: soliciting patient views; responding to patient views; relating information to patient views; involving patient; checking understanding.



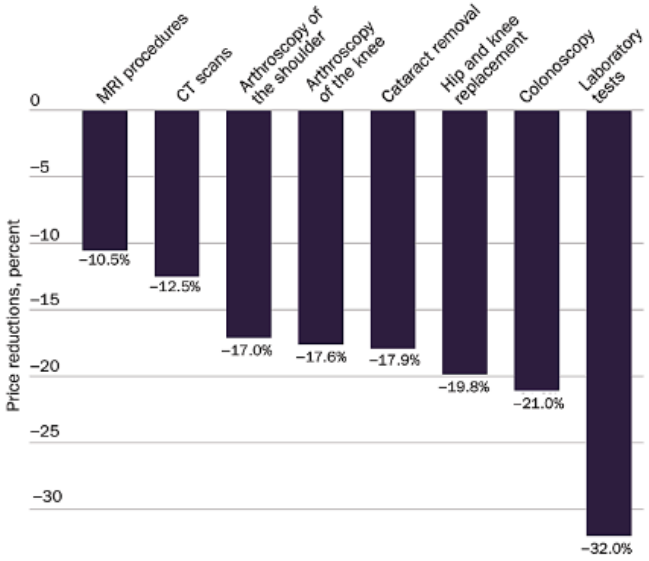
Michael F. Cannon of the Cato institute [22] outlines a series of cost cutting measures employers tested that consistently and dramatically reduced health care prices, in a very short period, across a wide range of services.

Those services included:

- MRI scans
- CT scans
- Knee and shoulder arthroscopy
- Cataract removal
- Hip and knee replacement
- Colonoscopy
- Lab tests

For every one of these medical services, the innovation these employers tested caused prices to fall immediately and significantly without denying medical care to anyone. Everyone got the care they needed. The innovation was even able to overcome the market power of monopolistic hospitals and get them to reduce their prices, too. The academics who published the results, including health economist James C. Robinson of the University of California-Berkeley, believe this innovation could bring prices down even more than it did in these experiments.

Price-conscious patients lower prices: Average price reductions within two years of patients becoming price-conscious



Source: James Robinson, Timothy Brown, and Cristopher Whaley, "Reference Pricing Changes the 'Choice Architecture' of Health Care for Consumers," *Health Affairs* 36, no. 3 (March 2017): 524–30.

Falling prices make health care more universal three times over:

- They bring health care and health insurance within the reach of those who previously could not afford them. It thereby shrinks the number of people who cannot afford the medical care they need.
- They reduce the cost of helping people who still cannot afford the care they need: that group is now smaller and health care prices are lower.
- They leave the rest of us with more resources, because we too benefit from lower medical prices, making it easier for us to help that now-smaller group of people.

If universal health care is your goal, falling prices—*this chart*—should be your obsession. It was not government programs that made food so universal that we are now keeping a record 8 billion humans alive on this planet. It was first and foremost falling food prices. As always, there's both good news and bad news here. The good news is someone discovered an innovation capable of overcoming the market power of monopolist providers to reduce prices to make health care more universal without denying care to anyone. **The bad news is that this innovation is…giving people less health insurance.**

The employers and insurers who ran these experiments noticed three things.

- Providers charged wildly varying prices for certain services. Hospitals charged anywhere from $12,000 to $60,000 for hip and knee replacements, for example.
- Those higher prices did not correlate with quality. They were pure exercises of hospitals' market power.
- For all their vaunted purchasing power, not even huge insurance companies (e.g., Aetna) and employers (e.g., the State of California) could, for the life of them, negotiate those prices down.

The innovation those insurers and employers decided to test is something health wonks call a "reference price" or a "reverse deductible." Those are needlessly dorky terms, though. All they mean is that the insurers told patients they could go to any hospital they wished for hip or knee replacements but the insurer would only pay $30,000. If their hospital charged $60,000, the patient would be on the hook for 100 percent of the difference. **In other words, this innovation gave patients *less* insurance than they had before.**

In the United States, the pursuit of universal health care has largely taken the shape of having the government encourage more and more health insurance coverage. All sorts of government policies push in that direction. However, this does not mean patients will receive equal access to care nor will it spare the rising costs of healthcare.

A radically new system will be needed that removes the profit motive and greed from big business big pharma hospital systems and medical device companies to make any dent in the problem.

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