Conclusion: How did we get here and why is this so hard to fix?

My goal for this website was to try to untangle and explain a system that has an enormous financial impact on everyone, but makes almost no sense to anyone. It's a system with hidden costs, enormous mark ups to discourage direct payment and a labyrinth of billing and reimbursement schedules that almost guarantees that no person directly involved would likely understand it. So, why is our health care system such a mess?

Five years ago, when I began my attempt to answer that question, the information I had was very limited. I had my own office finances and the bills and receipts my patients brought me, but not much more. Five years later I've broaden the scope of my research considerably to include overviews of the finances of nearly all of the various industries in health care. This research has provided answers to many of the questions I was asking then, but has also uncovered answers to questions I never would have imagined to ask when I began my research.

My website contains an enormous amount of information now. It would take several days for most people to sift through it. So what conclusions can be drawn from all of this information? Perhaps the best way to sum it all up is to answer three basic questions about our health care system:

1) How did we in the US end up with the most expensive and inefficient health care system in the developed world?

2) Where is all of the money going?

3) And, why is it so difficult to reform our health care system?

First, How did we get here?

The evolution of our health care system is a somewhat complicated story that involves several unrelated factors and, probably, a few accidents.

The push for universal health care in the US began more than a century ago. In 1912 Theodore Roosevelt was trying to retake the Presidency as an independent candidate. He was running as a progressive so he had a number of progressive reforms in his campaign platform including a national health insurance program. Roosevelt lost that election and it was decades before the idea of national health insurance again became a political issue.

A major problem with Roosevelt's national health insurance plan was that he was way ahead of his time with the idea. Prior to the 1920's health care was rather inexpensive because most of what it had to offer didn't really work. So the idea of everyone having insurance to cover products that were largely inexpensive and ineffective seemed a bit silly.

By the 1920s, though, scientific advancements really started to have an impact on health care. For the first time, doctors could offer remedies that really were better than snake oil and hospitals became more than just places where poor people went to die. The problem was that most of these effective remedies, as well as hospitalizations, were quite costly so very few people were willing to pay for them unless they were critically ill.

This was a problem for both doctors and patients. Patients often wouldn't seek out legitimate medical treatment until they were so sick it was too late to help them, and doctors and hospitals were getting less business because only the rich and the deathly ill were seeking them out.

In 1929 Baylor University in Dallas, Texas came up with a solution to this problem. For just 50¢ a month, people could buy insurance that would cover their hospitalizations should they get sick. They called this insurance "Blue Cross." This was the birth of modern health insurance in the US.

It took a while for private health insurance to catch on in the United States because the Great Depression hit very shortly after Baylor started their program. During the Depression most people could barely afford food, so things like health insurance weren't a priority for them.

World War II changed all of that for a very unanticipated reason: employers started buying health insurance for their employees. There were two reasons employer sponsored health insurance became popular during World War II. First, there was a wage freeze during the war so employers couldn't compete for good employees by offering them more money. In place of offering increased wages, employers started offering free health insurance as a benefit to attract good employees.

Then, in 1943 the Internal Revenue Service cemented the concept of employer sponsored health insurance in the US by ruling that it should be tax free. With that ruling health insurance benefits became an expectation of all employers because it was less expensive for employers to purchase health insurance for employees than for the employees to buy it themselves.

Business for the health insurance companies exploded after that.

By the end of World War II, health insurance companies had grown large enough to have powerful lobbies. Harry Truman discovered this the hard way in 1945 way when he proposed a nationalized health insurance program similar to the one that was being implemented in the UK.

Private health insurance companies saw this proposal as a threat to their blossoming business, so they joined with the American Medical Association (AMA) in a campaign to defeat Truman's plan in Congress. They attacked the bill by running a national campaign accusing Truman of trying to make the US a communist nation by giving us a communist health care plan.

The campaign worked so well that the bill was killed and the Democrats suffered a huge defeat in the 1946 mid-term elections. Truman recovered somewhat in the 1948 election, but he had learned his lesson: don't mess with the health insurance companies. Health care costs were only about five percent of our GDP at the time and only about half of the US population had private health insurance but, even then, the insurance companies were big enough to take on the President and win.

By the 1960's, 70 percent of working Americans had some form of private health insurance that was mostly provided by their employers. In 1962, John F. Kennedy attempted to broaden health insurance coverage to cover those who couldn't get private coverage. This time, rather than go after the business of the private insurance companies, Kennedy decided to only address the people private insurance companies didn't want to cover: the elderly, the disabled and the poor.

You would think that health insurance companies wouldn't be bothered if the government provided a service they had no interest in providing, but that's not the way it worked out. The health insurance companies perceived any competition by the government as a direct threat to their business, so they again partnered with the AMA to defeat Kennedy's bill. This time they hired a famous B movie actor to help in

their campaign. Ronald Reagan gave speeches throughout the US in 1962 warning Americans that this "Medicare" bill would be the first step toward socialism and would eventually rob us of all of our freedom.

Again, the campaign worked and Medicare was killed in 1962 only to be revived by Lyndon Johnson in 1965. Johnson had the largest supermajority of Democrats any President has had since 1937. In 1965 Johnson had 68 Democrats in the Senate and 295 Democrats in the House. Johnson was also rather famous in his ability to "convince" unwilling Democrats to go along with his plans, so he managed to get Medicare through Congress.

Since then, private insurance companies in the US have coexisted along side of Medicare in sort of a hostile truce. Private insurance companies have never stopped wanting to either eliminate or control Medicare. Jimmy Carter attempted to expand Medicare in 1980 and failed and, more recently, a Medicare expansion was attempted in 2009 that also failed.

Both Richard Nixon and Bill Clinton tried to provide universal health care in the US by making private health insurance more affordable and available, but failed to get any legislation passed. Barack Obama has been moderately successful in expanding private insurance coverage in the US, but that expansion has met fierce opposition from the health insurance industry.

The vast majority of people in the US who have health insurance that's neither Medicare nor Medicaid still get their insurance through their employer. The fact that most health insurance is bought by employers, and not consumers, is a major reason our health care system has become so confusing and byzantine.

Since most people in the US get their health insurance as a benefit, rather than purchasing it directly, we've grown to expect the insurance companies to manage all or most of our health care costs. So, our employers buy our health insurance for us and our insurance companies manage nearly all of our health care. This arrangement ensures that the average consumer has almost no direct input on the cost of their own medical care.

Any time you allow another party to to have complete and unchecked control of your finances, they will always find ways to manage your finances to their own benefit. Employers purchase our health insurance but, since they're the ones paying for it, they'll look for insurance plans that are in their best interests, not the best plans for their employees.

Insurance companies control almost all of the money that goes into health care. That means that the more our health care costs us, the more power they have. Clearly, there is no reason for insurance companies to want to cut health care costs and the insane levels of over billing in health care give the insurance companies an excuse to keep increasing their payments (and your premiums). The many layers of confusion and byzantine systems of networks and obscure rules also work to the advantage of the insurance companies because they make it very difficult for anyone even inside of health care to trace where all of this money is really going

So, where is all of this money going?

The simplest answer is that the money is going into the pockets of the many providers of health care. After all, for any great deception to work, all or most of the players in the deception have to be paid well

enough to not ask too many questions or cause trouble. You can't run a major con game unless everyone necessary to make the con work is happy enough with their role to not want to cause trouble.

The best way to account for where all the money is going, then, is to list all the various players in our health care system and describe their role in driving up these costs. So, in no particular order, here they are:

1) The pharmaceutical companies: These companies have the highest profit margins in health care and some of the highest profit margins for any industry. Given the ridiculously high prices of brand name medications, not to mention the rates at which these prices are increasing, the pharmaceutical companies would appear to be an obvious target for why health care prices, overall, are climbing so rapidly in the US.

The truth is, though, that the total revenue for the pharmaceutical companies has been rather flat since 2008. This is because the pharmaceutical companies have had very few good ideas in the past 20 years. So, even though the prices of most brand name medication are insanely high, and going up, we're buying far fewer of them. Big pharma's contribution to health care prices in the US isn't what it used to be. The pharmaceutical companies are still quite bad, but their overall contribution to the rising cost of health care in the US is waning.

2) Pharmacies: If you pay too much money for your prescription drugs, chances are it's your pharmacy, not the pharmaceutical company, that is overcharging you. Over 80% of prescriptions written in the US are for generic medications. Most of these generic medications are bought using insurance and the insurance copays for these medications are typically more, sometimes far more, than what the medication really should cost. This means that retail pharmacies gouge consumers on prescription medications far more often than pharmaceutical companies gouge us.

3) Pharmacy Benefit Managers: A major source of income for pharmacy benefit managers is from collecting a portion of your copay when you over-pay for your generic prescription drugs. In other words, if you use your insurance to buy 30 cheap generic pills from your local pharmacy, you might pay $10 for 60¢ worth of medication.

Your Pharmacy Benefit Manager (which is either contracted by your health insurance or a branch of your insurance company) gets to collect some of your copay from the pharmacy. How does it benefit you to have a third party take some of your overpriced copay? It doesn't, of course. Pharmacy Benefit Managers couldn't exist at all if the pharmacies were more transparent about the prices of prescription drugs and they know this.

4) Doctors: In October 2014 a segment on 60 Minutes profiled the fact that cancer doctors have a severe conflict of interest when choosing chemotherapy agents for their patients. In fact, all doctors who administer drugs in their offices get a commission based on the price of that drug. This means doctors have a strong financial incentive to give the most expensive drug they can justify if that drug is administered in the doctor's office.

This conflict of interest has even encouraged some doctors to commit massive fraud. Even in the absence of fraud or conflicts of interest, though, doctors over-bill for office visits in the same way that all other health care providers over-bill for medical services. Over-billing is a huge problem in health care because it allows patients to be overcharged for medical services whenever they're uninsured, their insurance denies coverage for a service, or their insurance company isn't responsible for covering the cost of the

service. Clearly, any time people are forced to pay too much for services, the cost of those services goes up.

5) Hospitals: There has been a lot of recent media attention to the excessive mark ups in most hospital bills. Hospitals certainly aren't the only institutions in health care that over-bill for medical services, but they're easily the worst offenders. Over-billing drives up health care costs for the reasons listed above, but it also serves to strengthen the power insurance companies have on health care.

Since insurance companies never have to pay the insanely high billing charges that hospitals and other health care providers use, these billing charges allow the health insurance companies to act as protection rackets. You need your health insurance to "protect" you from an $80,000 hospital bill, even though the insurance company might only pay $15,000 for that bill.

6) Health Insurance Companies: There is no single "bad guy" responsible for pocketing all of the money in our health care system. The money in health care is spread around rather evenly throughout the industry. But the health insurance companies bear most of the blame for *why* health care is so overpriced in the US. They control most of the money that goes into health care and directly benefit from all of the obscurity and waste that exists in our system.

The health insurance companies aren't hiding any money— they know that would be stupid. Instead, they're distributing the money to all providers so they can drive up their revenue by driving up their costs. This strategy helps to ensure that most providers will side with insurance companies in opposing health care reforms. They also know that the more everything costs in health care, the more everyone will rely on them to manage these costs. They've effectively rigged the game in a way that allows them to win every time they make things worse for everyone.

Why is health care in the US so difficult to reform?

The simple answer is that few people in our health care system really want reform. Florida governor Rick Scott put it best when he said:

> "*How many businesses do you know that want to cut their revenue in half? That's why the healthcare system won't change the healthcare system.*"

Everyone in health care likes the idea of making our health care system more efficient and less costly, right up until it starts to impact their paychecks. So health care reform, of any kind, will always be met with a lot of resistance from inside the system. All of that money isn't just wasted— it's going into the pockets of a lot of people who will fight very hard to keep things as they are.

There is no shortage of good ideas for how we can reform our healthcare system. Nearly every other country in the developed world has a healthcare system that's less expensive, more efficient and has better outcomes than ours. We could easily take all the best ideas from all the existing systems in other countries to create more efficient and effective ways to deliver healthcare in the US, were it not for the resistance each new idea would face. At least $1 trillion is wasted each year in our healthcare system, but the people getting that $1 trillion can use that money to fight reform at every turn.

So, what can we do?

Clearly we need more legislation that will both mandate transparency in our healthcare system and protect consumers from over-billing. Insurance companies need to be more transparent in their financial

statements. Pharmacies need to be more transparent with prescription drug prices and the bills from all healthcare providers should reflect the cost of the services provided.

Without increased transparency and protection from over-billing, no reform will effectively reduce our healthcare costs or even slow the rate in which they're increasing. Increased transparency in health care costs would make it very difficult for health care providers and insurance companies to continue operating the way in which they do now.

Most of all, remember: All healthcare reform in this Country will be met with strong opposition from inside the healthcare industry. They'll say anything to prevent it simply because they're protecting their own bottom line. If you've learned anything from this website, you should know, you can't always believe what the health industry "experts" are saying.