Health Care

Why? Your insurance will cover it.

...dentist upon hearing that your author would seek a second opinion regarding the need for recommended oral surgery

Health care accounts for a large and growing proportion of all spending and production in the United States. We currently spend close to 18 cents of every dollar on health-related items, up from only five cents in 1960. Why such an increase?

First, we keep getting older. Life expectancy is up and the percent of Americans who are 75 years or older is increasing rapidly. That’s good news for those who need more birthday candles than a typical cake can accommodate, but it comes at a cost. The older we get, the poorer our health becomes. That means more aches and pains, more disease, more trips to the doctor, more medications, and more days in the hospital. As the population ages, medical expenses rise.

But the primary cause of higher medical costs is technological change. In fact, it's why we keep getting older. In the not too distant past we spent almost nothing on cancer or heart disease or kidney disease or even infections. We spent nothing because we had no treatments to offer. Physicians could do little more than verify illness and wait for patients to die. CAT scans, MRIs, kidney transplants, chemotherapy, hip replacements, heart bypasses – common procedures in modern hospitals – were unknown in the past. In a world in which we could neither diagnose nor treat most medical ailments, health care was cheap.

Mounting medical costs now have forced countries to confront a critical question: who should pay?
Should we treat medical care like potato chips and allow individual consumers and producers make free choices about what and how much to buy and sell? Should we allow market supply and demand to allocate medical resources?

Health care systems differ significantly across countries, but all can loosely be categorized as either government-run or privately-run. In every developed country except the United States citizens view basic health care as a “right” of all citizens and provide universal access to everyone either through a taxpayer-financed government-run system or mandated private insurance with government subsidies. For example, Canadians visit government clinics or government hospitals that are staffed by government-paid physicians, nurses, technicians and pharmacists. The services provided are “free” to the patient. All costs are covered by government (taxpayer) funds.

The U.S. has chosen a very different route. We rely more on free-market supply and demand. Private health-care professionals and organizations offer services and compete for patient business. Individual consumers visit the health-care providers of their choice and pay for whatever services are provided. Some consumers pay out of their own pockets, but most have medical insurance that covers major expenses. Medical insurance often is part of the package paid by our employers.

Even though government does not provide medical care directly in the U.S. (with the exceptions of medical care to military personnel and some veterans), it impacts the system nonetheless. All health care professionals, hospitals and medical schools must meet government licensing standards. All drugs must pass Federal Food and Drug Administration (FDA) testing for safety and efficacy. Also, the federal government gives tax breaks for employer-provided insurance, provides heavily subsidized health insurance for elderly citizens through Medicare and covers many medical costs for eligible low-income families through Medicaid.

Although countries vary widely in the way medical care is provided, they share one important characteristic: discontent. Citizens throughout the world express frustration with their respective health care systems. Unfortunately, U.S. citizens are more frustrated than others. Surveys repeatedly show that Americans are less satisfied with their health care system than are those in other countries. We do lead the world in medical spending; no other country spends nearly as large a percent of income on health. Regrettably, despite this disproportionate spending, we lag behind in life expectancy and other measures of health outcomes. While some still proclaim that our free enterprise health care system is the best in the world, the data clearly show that it is not, and loud protestations will not make it so. The U.S. system falls far short of attaining the economic goals of efficiency and fairness and is plagued by problems on the both the demand and supply sides of the market.

**Demand-side inefficiencies**

First, many Americans demand inefficiently high levels of health care. Remember, most of us have medical insurance that covers a large chunk of the costs. The net cost to consumers is well below the true marginal cost of providing the care.

Check the graph below. For allocative efficiency, we should produce care as long as the marginal benefit covers the marginal cost ($Q_0$). However, suppose that our health insurance covers 80 percent of the expense. Because this lowers the net MC to the patient, the rational consumer will want to purchase $Q_1$ units of care – considerably more than the efficient level.
Stop and listen. Is your memory calling out *moral hazard, moral hazard*? It should be. It’s exactly the issue we discussed with *saving lives*. The more we insure against the effects of something, the more likely it is to occur.

Tax policy aggravates the problem. Most Americans receive health insurance as a "fringe benefit" of their job. Providing this insurance is quite expensive and costs more than $18,000 to cover an employee and his/her family. Of course, employers providing health insurance cannot afford to pay as much in wages. In effect, employees are opting for "free" insurance rather than higher paychecks. But why? It's because the value of this health insurance benefit is not taxed. If an employer pays a worker $100 in straight wages or salary, the $100 is subject to both Social Security and income taxes. Only part of that $100 will end up in the worker's pocket after tax. But if the employer "pays" the worker by buying her $100 of medical insurance, the entire value goes to the worker. The $100 escapes taxation. Without that tax break, a worker in a 30% tax bracket who wants to buy medical insurance on her own would need $142 of pre-tax earnings to get the needed after-tax $100. In effect, the tax laws make health insurance less expensive for the workers. And, like everything else, when the effective price goes down, the quantity demanded goes up. We buy more and better insurance than we normally would.

While insured Americans probably seek inefficiently large amounts of care, those without insurance demand too little. Unable to afford visits to the doctor, uninsured patients face two possible options. Some forego routine check-ups for preventative care and ignore medical difficulties hoping that they will disappear in time. This strategy sometimes proves effective, but too often the uninsured end up with major medical problems that could have been cured far less expensively or prevented altogether had they seen a physician earlier. Other uninsured patients do seek medical care for minor ailments but, because they cannot pay private physicians, they flock to hospital emergency rooms that face various legal obligations to treat patients regardless of ability to pay. Unfortunately, the earache that could have been treated for a few dollars in a doctor's office sucks up thousands of dollars of expensive ER resources and creates bottlenecks for those truly needing emergency assistance. In both cases the costs can be excessive -- so excessive that providing them with insurance could sometimes be less expensive in the long run.

**Supply-side inefficiencies**

More problems arise on the supply side of the market. Just as insured consumers tend to demand inefficiently large quantities of care, health-care providers traditionally have eagerly supplied inefficiently large quantities.
Imagine walking into a boutique and explaining to the sales clerk (working on commission) that you have been a bit blue and are thinking about some new clothes. If you ask the clerk whether or not new clothes will boost your spirits, what response should you expect? Is the sales person likely to say “no” and send you on your way? Of course not. Next, imagine explaining that you will buy whatever clothes the clerk recommends. Should you expect the clerk to point you toward the clearance rack? Of course not. The clerk has a financial incentive to sell you as large and as expensive a wardrobe as possible. The more you spend, the more commission the clerk earns.

Historically, the patient-doctor relationship was quite similar. Patients seldom decided what and how much care to buy; their doctors made those decisions. Patients would ask their doctors what they needed and then purchase whatever the doctor recommended. With this traditional fee-for-service provided arrangement, just as with the sales clerk on commission, the more tests and visits and procedures the doctor would recommend, the more income the doctor would earn. The incentive was to recommend or supply as much as possible without scant attention to relative costs and benefits. Could health care providers be so crass? Would they actually prescribe medical care that cost more than it was worth just to pad their own wallets? Some would not, but many would.

Such oversupply provided another benefit to physicians as well – protection against malpractice suits. As long as they were provided with everything possible, unhappy patients had few legal grounds on which to sue for malpractice. Besides, as many doctors might reason, the extra expenses will be paid by insurance companies, not by the patients themselves. So, why worry?

The predictable result is an unusually expensive system with huge amounts of unnecessary care. But, in addition to inefficient quantities of care, Americans are beset by inefficiently high prices. Indeed, Americans pay almost twice as much for medical care than do residents in other developed countries and, what's worse, with no evidence that it has resulted in better overall care. A 2012 report by the International Federation of Health Plans found that U.S. prices for medical procedures and drugs were higher, often much higher, than those in other countries for every category and country studied. For example, a one day hospital stay in the U.S. cost an average of $4,287 compared to the $782 in Australia, $408 in Canada and $231 in Spain. The total hospital and physician cost of heart bypass surgery averaged $73,420 in the U.S. compared to $17,729 in Switzerland and $14,061 in the Netherlands. The average cost of Lipitor, commonly prescribed for high cholesterol, was $124 in the U.S. compared to $43 in the United Kingdom and $6 in New Zealand. We also find huge variations in prices across U.S. hospitals for identical services. For example, 25% of U.S. facilities charged $525 or less for a diagnostic MRI while 5% charged more than $2,800 for the same test.  

Why do Americans pay so much more? Limited competition is one reason. The big bucks go to hospitals and, in most markets, consumers have very few hospitals to choose among. In fact, often their doctors are affiliated with only a single hospital. Would Walmart prices be so low if it did not have to lure shoppers away from Target and K-Mart? Of course not. Would McDonald's offer a Dollar Menu if it was not competing with Burger King and Wendy's? Of course not. Firms facing little or no competitive pressure are free to raise prices well above the true cost of service. Monopoly power drives up prices in medical care, just as it would it in retailing and restaurants.

But, wait. Aren't the numbers of available hospitals limited in other countries also? Why don't those
hospitals charge higher prices as well? Simple. Governments do not allow it. In other countries governments regulate health-care prices and/or pressure the providers to hold prices down. We do that in some markets in the United States. For example, the local electric company and the local water company and the local natural gas company typically cannot raise prices without approval from some government agency. Recognizing that there often will be only a single electric or water or gas company in an area, governments routinely regulate their prices to avoid monopoly exploitation. Although other countries regulate medical prices as well, in the United States, we do not.

The lack of price transparency aggravates the problem. Even where competition might be possible, consumers cannot easily shop for a better deal. Kroger's blasts it food prices through multiple ads every week and the Exxon station down the street posts it prices on huge signs easily visible to drivers. If those prices do not match the ones advertised by Publix and Sunoco, they quickly will lose business. Amazon.com and similar sites enable us to compare prices for socket wrenches, video games, pajamas and clarinets. Vendors offering good deals prosper; others either must match their prices or fold their tents. Not so in medical care. Prices for medical services are almost impossible to find. Clinics and offices in other countries routinely post or advertise prices for common procedures but, in the United States, such prices are treated like trade secrets. U.S. hospitals and other providers frequently cannot or will not reveal their charges until after the services are provided. Even physicians often do not know what their patients will be charged. In a world in which consumers find comparison shopping almost impossible, health-care providers have little or no incentive to keep prices low.

Controlling costs

As expenses mounted over time, pressure to control costs mounted as well. Trying to moderate cost increases in its Medicare program, the federal government acted first. It modified the traditional fee-for-services provided system and began paying hospitals set amounts for treating a specific ailment. For example, if the government decided that $18,000 should be enough to cover the costs of an appendectomy, it would agree to pay $18,000 for the procedure, regardless of what actual costs were incurred. This radically altered incentives for hospitals. If the hospital was to receive a flat $18,000, it had no incentive to hold on to patients any longer than absolutely necessary. If the $18,000 was enough to cover three days in the hospital, administrators had no incentive to let a patient stay a fourth day. Longer hospital stays now meant fewer profits rather than more profits for the institution. In fact, pushing such patients out after two days would be even better. Hospitals would still get the same $18,000 revenue, and would save the expense of caring for the patient the third day.

Private insurers followed by pushing patients into managed care programs that monitored services more closely. They directed patients to "network" providers with whom they negotiated discounted rates, forced patients to get second opinions for elective surgeries and limited access to specialist services. To some extent the reforms were successful. The rate of cost increases did slow in the 1990's and billions of dollars were saved. However, the fee-for-services provided system continues to dominate U.S. health care and the quantity of services provided to well-insured patients remains inefficiently high. However, the reforms were not without controversy.

Some of the savings were partially offset by a drop in quality. Patients often assert that necessary care and access to specialists is withheld “to save money.” Numerous patients complained that they were released from hospitals prematurely and were forced to hire private-duty nurses and other professionals to care for
them at home. Since these home-care professionals often are not covered by insurance, cost savings for the insurers often meant higher costs for the patients.

Is this drop in quality a bad thing? Not necessarily. Like other products, higher quality is efficient only when its marginal benefit exceeds its marginal cost. In daily life we willingly choose lower quality options when the dollar savings are large enough. We choose cheap generic foods over higher quality brands to save money. We choose cheap used cars over new luxury models to save money. We choose cheap coach seats over first-class seats on airlines to save money. If the cost savings are large enough, people rationally will choose lower quality medical care as well. Nonetheless, cost containment measures in health care have not been free. Some health care quality has been lost.

New concerns about fairness subsequently came to the fore. First, people with serious medical conditions found it increasingly difficult to get insurance. Insuring healthy people is far more profitable than insuring sickly ones. As cost pressures mounted, insurers reacted by denying coverage to anyone with "pre-existing conditions". For those with histories of cancer or heart problems or diabetes, medical insurance was almost impossible to find or else prohibitively expensive. Moreover, knowing that their insurance premiums will skyrocket, firms often are unwilling to hire workers with poor medical histories. As one pundit has written, "the business model of private insurance has become, in part, to collect premiums from healthy people and reject those likely to get sick -- or, if they start out healthy and then get sick, to find a way to cancel their coverage."

Second, in the past, uninsured patients who were unable to pay for care often were treated as charity cases. Hospitals covered the costs of this care by charging those with insurance a bit more and state and local governments kicked in dollars as well. In essence, patients with good insurance (and taxpayers) were indirectly subsidizing care for those who could not afford it. However, as government programs and private insurance firms clamp down, hospitals increasingly are unable to raise the extra dollars to cover the costs of charity care. It is not unusual for sick, uninsured patients to find themselves being pushed from hospital to hospital -- like the proverbial hot potato – seeking needed care.

Attempts to manage care also have added to the bureaucratic red tape health-care suppliers must endure. Providers must complete additional forms to convince government and private insurers that all care supplied is medically necessary. And, since each insurer has its own unique regulations for what is covered under what circumstances, the administrative paperwork burden is enormous.

Less government or more?

Perhaps the most contentious element of competing reform proposals involves the role of the federal government. Political liberals advocate moving more toward a system in which the government takes a more active part in financing care and ensures that that every citizen is covered. They argue that such systems are inherently fairer than our current one and also can control costs more effectively. First, government power can effectively force pharmaceutical firms and other private providers to lower prices. Indeed, patients in single-payer systems such as Canada's typically pay far less than do Americans for identical drugs and medical procedures. Second, dealing with a single government system as opposed to a complex patchwork of private insurers can slash administrative costs by hundreds of billions of dollars annually. For example, on a per-patient basis, the U.S. system employs 44% more administrative staff than does the Canadian system and, in addition, U.S. physicians spend more time on administrative issues than their Canadian counterparts. One estimate suggests that these administrative savings alone are enough to finance the cost of covering all
currently uninsured patients in the country.\(^6\)

Political conservatives recoil in horror at such a government "takeover" of the private market system. They contend that only competition among suppliers and insurers can create the quality of care Americans deserve. Just as competition compels auto companies continually to strive to produce better vehicles at better prices, competition in medical care markets creates better and more efficient health care. Where, they ask, will firms find the incentives to develop better products and processes if government controls suck potential profits out of the system? Conservatives also warn that government-run plans will ration health care -- that they will deny important services to contain costs.\(^7\)

Both sides offer valid arguments. However, it is worth noting that surveys suggest that Americans served by Medicare, a government-run single payer system for the elderly, typically express more satisfaction with their health care than those with private insurance. Amusingly, at the politically charged town hall debates about proposed health care reforms in 2009, a number of senior citizens railed heatedly against government-run "socialized" medicine while, at the same time, warning legislators to keep hands off of their (government-run, socialized) Medicare. While far from perfect, many experts in the field conclude that Medicare seems to deliver care more cost-effectively than do private insurance systems. By primarily relying on private rather than government-funded medical care U.S. residents save some dollars by having lower taxes, but often end up paying even more dollars by having to cover higher medical bills out of their own pockets.

**Affordable Care Act**

An ideal system would provide high-quality care to all in a cost-effective manner. However, those goals often conflict. Providing high-quality care to all increases costs, and attempts to control costs inevitably results in high-quality care being withheld from at least some patients. The controversial 2010 Patient Protection and Affordable Care Act, typically called the Affordable Care Act (ACA) or Obamacare, attempts to blend these disparate goals.

First, to improve access to care, it moves the United States toward universal coverage by requiring everyone (with some exceptions) to purchase medical insurance and by providing government assistance to low-income families that might otherwise be unable to afford it. It also stops private insurers from cancelling coverage for those who fall sick or denying coverage to those with pre-existing conditions, and allows dependent children to be covered under their parents' policies up to age 26. It also sets minimum standards for what insurance plans must cover.

Second, it contains a variety of measures to contain costs. For example, private individuals traditionally have been forced to pay much higher premiums for health insurance that those covered by group policies from employers with the power to negotiate better rates. Under the ACA, everyone can benefit from "group" rates by buying policies through state-run insurance exchanges. It also creates a board of independent medical experts able to push providers into using those medical strategies found to be most effective and funds a variety of innovative experiments to find still better approaches. Perhaps more importantly the ACA further shifts the U.S. away from the fee-for-services-rendered system and attempts to reward quality rather than quantity of care. It moves us closer to a system of "accountable care" in which providers are paid on the basis of health-care outcomes (or outputs) rather than what services (or inputs) they delivered. As one example, 20% of Medicare patients discharged from a hospital are readmitted within 30 days. Under the ACA hospitals whose patients must be readmitted multiple times for the same problem will face financial...
penalties. As a result, many hospitals now are implementing unorthodox policies to limit such expensive readmits. Mt.Sinai Hospital in Boston has cut its readmission rate in half by doing things such as dispatching teams of social workers to ensure that discharged patients have the needed home assistance, take medicines as prescribed, and get to follow-up visits with their physicians. The ACA has also encouraged the creation of Accountable Care Organizations (ACO's) that can participate in Medicare's shared-savings program. If an ACO can hold cost increases below prevailing rates while providing quality care, Medicare will share its savings with the organization.

Some argued that bringing health insurance to more people would create more demand for medical care and drive up costs, but the initial results have been promising. Despite a shaky technological start, millions of additional Americans have signed up for health insurance through the state exchanges and ACA costs, thus far, have been below the original estimates provided by the non-partisan Congressional Budget Office. More importantly, overall health-care cost increases have slowed dramatically. While several factors are at work, many experts agree that the ACA push toward accountable care and payment reform has been a major cause.

Despite its successes, the ACA remains controversial, especially its mandate that almost everyone must buy health insurance or be fined, and President Trump and the Republican-controlled Congress have pledged to repeal the act and replace it with "something better." Unfortunately, the "something better" remains undefined and Congress will find it difficult to retain the popular provisions of the ACA without keeping the less popular ones as well. For example, large majorities of Americans favor the ACA rule that forbids insurance companies from denying coverage to people with pre-existing medical conditions, and politicians have promised to keep that rule intact. However, firms lose money insuring patients with these conditions and they cannot afford to do this unless they also insure healthy people that do not submit claims. If there is no mandate that forces everyone to buy, many healthy people will opt out of the system and the system will collapse.

What about the future?

The ACA and other reforms might help eliminate some of the waste and inefficiencies in the system and bring down the level of costs, but the upward trend in medical costs is driven primarily by technological change, not by waste. If technology continues to enable us to diagnose what we previously could not diagnose and to treat what we previously could not treat, the slowdown might be short-lived; cost increases might revert to their long run trend, albeit at a lower level. Indeed, pessimists do believe that new technologies will again cause costs to skyrocket in the future. As one medical researcher has proclaimed, the "capacity of medicine to provide ever-advanced technology is endless. No matter how much you spend, you can always spend more." But, others disagree. Optimists predict that payment reforms will alter the course of technology. Because the fee-for services provided model rewarded those using more and expensive technologies, firms had an incentive to develop more and expensive technologies. Why worry about the costs when providers could easily charge prices high enough to cover those costs? But, in an accountable care world with payments that reward efficient outcomes, providers will be more reluctant to adopt costly technologies. As a result, firms might respond by designing more cost-effective technologies. If so, optimists argue, future technologies might lower the costs of care rather than increase it.

Notes:
2. The tax break only goes to those receiving insurance from their employers. Self-employed workers and/or those working for firms that do not provide insurance are less fortunate. They must buy their own insurance (without benefit of the tax break) or do without.
6. Reinhardt, op. cit.
7. Some argue out of both sides of their mouth. When proponents of the recent health reform legislation boast of providing more care, critics blast it for running up extra costs. When proponents praise the cost-cutting measures of the legislation, critics blast it for cutting care.
8. Orszag, Peter, talk delivered at the annual meetings of the American Economic Association, Philadelphia, January 5, 2014

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**Testing Yourself**

To test your understanding of the major concepts in this reading, try answering the following:

1. Explain why Americans are spending an increasingly large percent of income on health care.
2. Describe the major ways in which the government impacts the U.S. health care system.
3. Explain why, for most Americans, the quantity of health care demanded is inefficiently high and illustrate with an appropriate graph.
4. Explain why the quantity of health care historically supplied by most U.S. health-care providers has been inefficiently high.
5. Explain why we started paying hospitals a fixed fee for treating Medicare patients with a specific diagnosis and how that changed incentives.
6. Explain the disadvantages of managed care systems.
7. Discuss why Americans typically pay more than people in other developed countries for identical medical procedures and pharmaceuticals.
8. Discuss the major provisions of the ACA and why its proponents feel it will move us closer to a system that provides high-quality care to all in a cost-effective manner.
9. Explain why we cannot expect insurance companies to offer coverage to people with pre-existing conditions unless we also mandate that everyone must buy insurance.
10. Explain why the ACA might be more successful in cutting the level of medical costs than cutting the upward trend in medical costs.

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