



Policy Note

2001/3

FINANCING HEALTH CARE: THERE IS A BETTER WAY

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The problem is that the payers of health care-government and employers alike-are in open revolt against costs they never anticipated would become so high. Payers succeeded for a time in limiting increases to rises in the general price level. But it is one thing to remedy the most glaring inefficiencies in the system-to pick, as it were, the low-hanging fruit-and quite another to maintain quality when all of that has been harvested.

LAST FEBRUARY, THE WALL STREET JOURNAL published a health and medicine section headlined "Can the System Be Fixed?" An editor's note introducing the articles observed, "Eight years ago, health care was at the top of the nation's agenda. Costs were soaring, as were the ranks of the uninsured. Now, costs are rising again-and the gap between the haves and the have-nots is worse than ever. What exactly is the problem? And what can be done to solve it?"

These questions are not so difficult, but even the best answers don't offer much help. The real task is to translate answers into public policy-and, in turn, into universal, affordable, high-quality health care. The challenge is not so much for the economist to devise a feasible institutional structure, but for the political leadership to implement it.

What, exactly, is the problem? Ask a doctor arguing with the clerk of a health plan to authorize a procedure that the doctor regards as medically necessary but the plan does not. Ask an uninsured patient with appendicitis, whose ambulance was redirected to an impoverished public hospital. Ask the CFO of a private hospital who has to balance the books with payments for Medicare patients that fail to cover the hospital's costs.

Their answers will be different on the surface, but underneath, much the same. They will also be essentially unchanged from answers given eight years ago. Then, as now, the problem is that the payers of health care-government and employers alike-are in open revolt against costs they never anticipated would become so high. The payers succeeded for a time in limiting increases to rises in the general price level. But it is one thing to remedy the most glaring inefficiencies in the system-to pick, as it were, the low-hanging fruit-and quite another to maintain quality when all of that has been harvested.

What can be done? To this question, in contrast, answers will vary. This is unsurprising, considering how difficult it is to get the political leadership to agree on much of anything, let alone on reshaping a sector of the economy that is approaching 15 percent of GDP. From an economist's perspective, the answer lies in rethinking, from the bottom up, how the nation finances health care. This is even more important to do on the eve of a significant increase in demand as the population ages. The aging of baby boomers alone will add several percentage points to health care's claim on GDP.

How We Got Here

The key feature of health care financing in this country is its link to employment. The link exists for one reason: Health care benefits, whether paid through insurance premiums or directly by the employer, are tax-free income to employees, which makes it possible for employers to leverage compensation costs.

The advent of health care benefits linked to employment left out the working poor-those whose work was not valued highly enough for health care benefits, even if tax free, to be included in their compensation package. It also left out the unemployed and the retired. Medicare and Medicaid-the first a federal entitlement program for people over the age of 65, the second a joint federal-state program for welfare recipients-were designed in the 1960s to fill those two gaps. People who were still left out-notably, the working poor and their children-were cared for mainly through the charity budgets of hospitals, many of them religiously affiliated. Those budgets were funded, to put it plainly, by padding the bills of paying customers.

For years the system worked, however imperfectly. The care of the uninsured was often too little, too late. Every incentive was designed to provide for their care in high-cost settings like hospitals, rather than for preventative care and early intervention. Because Medicaid payments in many states were set too low to enable beneficiaries to obtain care from topflight doctors, the "Medicaid mill" flourished. There was no mechanism for financing long-term care, which came to absorb a disproportionate share of Medicaid disbursements, further crowding out the care Medicaid was supposed to deliver.

Still, the system worked well enough that by the late 1960s it had begun to resemble a system of universal health care. The associated taxes and employee benefits (a form of wages, as already noted) were not terribly onerous-only 7 percent of GDP was dedicated to health care at that time, a mere half of today's allocation. Neither employers nor government seemed especially perturbed about the cross-subsidies to the uninsured that were built into the bills they paid.

The system was considered "affordable." Compared with medical practice today, there wasn't all that much that could be done to diagnose and treat illnesses. The mind-set was "Do all you can, doctor." That was, after all, what doctors were trained to do; the easy financing of what was once relatively inexpensive medical care permitted them to do it, and their patients came to expect it. This combination drove research, technology, and, in turn, costs.

Being a price taker became unacceptable, however, when the payers came to realize just how expensive the system had become. Advances in technology, albeit a blessing, had made the system intolerably costly and thus ripe for change.

By the early 1980s, ballooning federal deficits touched off a search for economies by government, notably by Medicare through things such as fixed fees paid to hospitals for treating specific illnesses. Payments in effect became prospective, replacing retrospective outlays based on actual costs.

The so-called cost-plus system (shades of the Pentagon's relationship with defense contractors) had been extraordinarily favorable for hospitals. It had made it possible, without financial penalty, for hospitals to add capacity (overadd, in fact), incorporate the latest technology, and provide for the care of the poor (another cost that could be passed along). The regime was also a boon for doctors, whose fees were readily passed along to government and to employers, who in a tax-free financing environment added generously to employee benefits. To be sure, those benefits were dispensed in lieu of wages, but they were spent very differently from wages. No matter how tenuous the prospect of benefit accruing from any new technology-and no matter how high, even over-the-top, the charge-there was little market resistance from the vast majority of the population. The demand for a service and the payment for it had become disconnected. As health benefits became more extensive, moreover, so did the possibility of moral hazard.

The single most important force in the rise in health care expenditures over the years has been the march of technology. This advance did not occur in an institutional vacuum, however. In large part it has been the product of subsidized financing, with its associated incentives for the overuse of medical care. Medical research flourished in that background. But openhanded reimbursement of technological advances also left the nation with a high-cost health care system that now has its payers in open revolt.

The Rise of Managed Care

At first, Medicare's new, fixed-fee method way of reimbursing hospitals affected only inpatient services, thus creating incentives for outpatient services, which mushroomed throughout the late 1980s and the 1990s. Recently, however, outpatient services, along with home-based and nursing home care, have also been put on a fixed-fee schedule. The shift from cost-based to fixed-fee reimbursement is now complete. It carries a powerful message: "There is a limit to what government will finance; act within it or suffer the financial consequences."

With Medicare putting a financial squeeze on inpatient care, the overcapacity hospitals had let develop during the regime of cost-based reimbursement became glaring. Advances in technology, meanwhile, had made it possible to economize on inpatient care. Consider cataract surgery as it is performed today, without so much as an overnight stay, in contrast to the weeks of hospitalization that were routine in the 1960s. Such changes posed a vexing problem for hospitals that had added capacity at a time when procedures like cataract surgery were much more complicated than they are today and when cost-based reimbursement encouraged overcapacity.

Employers, meanwhile, faced double-digit annual increases in the cost of health benefits, even in the troubled economic times of the early 1980s. The strategy they adopted was to negotiate fees with hospitals and doctors, through either a network health maintenance organization (HMO) or a preferred provider organization (PPO), which is now the more common vehicle. These two major variants of managed care, which were virtually unknown in the early 1980s, now account for as much as 85 percent of employment-based health benefits. They have pushed aside the fee-for-service model, with its freedom of choice and openhanded reimbursement.

If the glass is viewed as half-full, the HMO is a way to optimize cost-effectiveness in an industry in need of such improvement. To the question of why the rates of cesarean sections or hysterectomies in one part of the country are double those in another, the HMO's answer is clear: the disparity is due to unnecessary surgery or geographical imbalances in the number of obstetricians and gynecologists. The HMO philosophy thus boils down to "less is more."

If the glass is viewed as half-empty, however, prepayment of an annual premium for care by an HMO carries with it powerful incentives to skimp on that care, if not to deny it outright. Resources that are not utilized in providing care go directly to the bottom line and thus to the stock price of the health plan and, in turn, the pockets of its management when that group exercises its employee stock options.

The PPO also has inherent incentives to skimp on care. What is basically discounted fee-for-service medicine means that hospitals and doctors must find other ways to maintain their income. Should they treat more patients, but at the risk of fatigue and error? Spend less time with each patient, but at the risk of missing something important that a thorough search would have unearthed? Provide, in a word, assembly-line patient care? The answer seems to have been all of the above.

Today's health care, in short, is painfully cost conscious, although some observers would say not nearly enough. The prevailing mind-set, as communicated to the health care marketplace by state and federal regulators and employers, is that resources are limited and the nation cannot afford to provide all the medical care that technological advances have made possible, except by pushing aside other expenditures that the nation is apparently unwilling to forgo.

Financial Crunch

In revolt, the payers are no longer price-takers. It is the providers-nursing homes, home-care agencies, and social welfare institutions, as well as doctors and hospitals-that now play that role. Through fixed fees, government has fashioned a politically negotiated payment model. And it has done so in a country that has always been suspicious, and seems especially so now, of public sector spending.

Managed care, meanwhile, has forced hospitals and doctors to compete with each other in unheard-of ways. Health plans have used their market power not just to negotiate fees, but to actually bring about change in medical practice. The test for caregivers has become not what might help, but what has been proven to help.

Health plans have brought about this change through their power to contract selectively and to set fees. The typical physician has become a guardian of the health plan's resources (and, ultimately, those of society at large) as well as a caregiver to individual patients. Should a patient remain another day in the hospital if it is the physician's best judgment that the patient do so? The health benefit may be uncertain. For the physician, the cost will surely be high. The extra day will mean wrangling with insurance company bureaucrats over payment, manipulating the system by exaggerating the severity of the patient's condition, and risking yet more financial trouble, not just for the hospital, but also for the physician. It might mean all three of the above. One is dealing, after all, with a health plan whose practice guidelines and market power are two sides of the same coin.

Not surprisingly, hospitals have sought to merge in order to build countervailing market power of their own in local areas. Doctors, for their part, have begun to develop networks of their own, replicating the old staff-model HMO, with its roots in medicine rather than insurance. Both parties seem to be losing out financially, however, judging by the decline in physician income in recent years and the deterioration in the financial condition of hospitals. A politically negotiated payment model and the shift to managed care by employers have been a powerful combination.

At work recently is the cutback in funds flowing to hospitals as a result of the Balanced Budget Act (BBA) of 1997. The legislation was designed to extend the life of the hospital insurance trust fund until 2008 by putting Medicare reimbursements on an even slower track. At the time, the Congressional Budget Office (CBO) projected a savings in the first five years of \$103 billion compared to the projection under current law, which itself called for less-than-full indexation of payments to the cost of providing hospital services. The object was to hold the growth in payments to hospitals through the year 2002 to nearly zero.

The savings to the government turned out to be grossly underestimated. In addition, tightened enforcement of fraud and abuse regulations has intimidated hospital administrators. Byzantinely complex, the regulations are almost impossible to follow to the letter, and the penalties are draconian. All told, the savings have been roughly double what CBO had estimated, even with some sweetening of reimbursement rules in the past two years when it became clear how damaging BBA had been.

The trust fund is now projected to be in the black long after 2008. The federal government enjoys a huge revenue surplus, so much so that a large tax cut has been made possible. A politically negotiated payment model-the essence of the BBA-has been a major contributor to the surplus. Draconian regulation of hospitals may seem anomalous in a country suspicious of the public sector, but it is integral to the model.

Washington is flush with cash, but hospitals are not. The 2000 figures from Moody's show that the average operating margin of hospitals had fallen to 0.5 percent in 1999, continuing a steady decline from the average 3.5 percent that had prevailed in the first half of the 1990s. Net income margins had a commensurate decline, but remained significantly positive as endowmentlike assets kept hospitals on average in the black. Median return on assets had fallen below 3 percent by 1999, according to HCIA data-not even close to the return on a cash asset like a Treasury bill.

There is a limit to the contribution any hospital's financial assets can make to its financial soundness. The decline in operating margins to nearly zero puts an end to any further set-asides for a rainy day. And, to say the least, the stock market looks a lot less promising than it did a few years ago. In any case, investors in hospital bonds are scrutinizing the ability of hospitals to succeed financially as hospitals, not as financiers; that message has been made clear by repeated downgrades of hospital bonds by credit agencies like Moody's in recent years. Significantly, Moody's statistics also show that the average age of hospital plants and equipment increased to just over 8.5 years in 1999, up from just under 8.0 years in the mid-1990s.

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All these events, moreover, have occurred in a setting of full employment. The cyclical economic weakness looming on the horizon will do added harm. Charity budgets will be harder to contain. Facing financial troubles of their own, the health plans will become even more tightfisted. Even against a background of cyclical weakness, hospitals will face continued labor problems. The nationwide shortage of nurses was a long time coming; it will not be remedied quickly. The wages of many other hospital workers are already close to poverty levels. The cost of new drugs continues to escalate and will continue to rise steeply even in a recession. However beneficial, advances in drug therapy have been at the heart of the renewed rise in health care costs after years of relative calm.

With payers now dictating prices, doctors and hospitals have become mediators in a noisy clash between the spare-no-expense care that many Americans had come to expect and the kind of care that payers are now willing to underwrite. As mediators, doctors and hospitals search for some measure of accommodation, doing whatever they can to tweak practice styles and still remain true to their own ethic. That ethic, it must be stressed, was never grounded in the values of the marketplace. As a practical matter, however, marketplace values are increasingly intruding on decisions about care. Providers have been pushed to make changes in practice style that go far beyond tweaking.

No one should be surprised if in time the financial squeeze that many hospitals and doctors now face leads to significant deterioration in the quality of care. Some economies are easy to put in place, but others require reduction in real output. The march of technology, advances in drug therapy, and staffing needs cannot be financed on the cheap.

Government's Expanding Role

With the aging of the baby boom generation, this clash of old and new values can only get louder. Thirty years from now, the population over 65 years of age will be roughly double what it is now. In proportion to the population as a whole, it will be one and one-half times as large. Health care expenditures will continue to rise sharply long after the tail end of the baby boom has reached 65. The real challenge will come when ever-larger numbers in that generation reach their 80s, an age when health care expenditures typically are about three times higher than for people in their 60s. Not only will health care claim a significantly larger share of GDP as a result of these demographic forces, but the federal government—which now pays approximately 50 percent of the nation's health care bill—will pay close to 70 percent of the tab. Uncle Sam in effect will become an almost monopsonistic buyer of health care.

How affordable an enlarged health care bill will be remains to be seen. So much depends on the kind of economic growth the nation is able to muster. It is clear, however, that the nation's unwillingness to fund the public sector is deeply rooted. How, then, will nonprofit hospitals, which in time will effectively become public utilities regulated by the federal government, raise capital under those circumstances? How will they pay their employees? How will they meet their traditional responsibility for the care of the uninsured poor? Even now, these questions are more political than economic, given the enormous presence of the federal government in health care.

If Washington's response is grudging, the temptation for community hospitals to embrace a full-fledged marketplace ethic will be great indeed. In practice, that would mean private-equity, not community, ownership of the assets. It would also mean that state-of-the-art care would be available only to those who are willing and able to pay for it. Health care thus would be no different from air travel or any other industry adept at segmenting the demand curve and providing only the kind and quality of service that consumers can afford. To be sure, this hypothesis represents nothing more than the extrapolative mind at work, but it is hard not to fear that the communitarian values that have traditionally been central to health care are in danger of being irretrievably lost in the quest for cost control.

What Can Be Done

For me, as for many other economists, the link between health care and a job makes little sense. That link exists not by design, but by accident. It is the product of World War II wage and price controls that permitted employers in an extremely tight labor market to raise compensation by providing their employees with tax-free health benefits. Imagine how fancy our cars (or any other major item of expenditure) would be if we could buy them with pretax rather than after-tax income. A better way is for each of us to pay for our own insurance, and not with pretax, but with after-tax income. Such a system would create real insurance—that is, group protection against low-probability, high-consequence events like a major illness—and would eliminate the inappropriate use of insurance for predictable expenditures.

The health insurance market as a result would move to high-deductible policies, which would be a powerful cost-control force of their own. If excessive charges were paid out of pocket instead of by insurance, they would be much harder to make stick. A measure of cost control would be gained that does not exist now except through managed care, with its heavy-handed restrictions on both patients and providers.

To be sure, many people would need alternative tax subsidies in order to afford health insurance if the tax exclusion on employment-based health benefits were ended. But such subsidies would be easy to set up, using an income-scaled tax credit that could be made refundable in order to pay all or part of the insurance for people at low and even middle income levels. With one stroke, the uninsured could be covered, costs constrained, freedom for individuals to choose their own plan (not merely accept their employer's) provided, and a market for the only insurance that is truly portable created. All of this would be easily funded by the approximately \$100 billion in tax subsidies that the tax exclusion on employment-based health benefits now claims, the vast majority of which benefits high-income families.

To have tax subsidies for health care flowing disproportionately to high-income families when millions of people cannot afford health insurance is not just bad policy, but a cause for shame. As Uwe Reinhardt observed in a recent article in *Health Affairs*, many of the nation's leaders are happy to chatter on about "family values" while leaving tens of millions of children and their low-income parents exposed to "economic ruin, physical hardship, and family dissolution" when major illness strikes.

As a nation, we also need to ask whether it makes sense to finance the health care of the affluent elderly through the public sector. The costs of this approach include underfunded care for others who must rely on the public sector, decreased quality of care for everyone, and higher Medicare taxes for successor generations, which will face the added burden of financing the baby boom's Social Security retirement benefits. How can the quality of care and the access to it be maintained when the nation's health care bill, inordinately large now, gets even larger as the baby boom ages? At the very least, Medicare subsidies should be scaled to income, in order to mitigate these inevitable pressures on the system.

Both of these suggestions are heretical, I know. That makes them hard to do politically. Any real change in health care, as the Clintons found out, is hard to make because it always founders on the question, "Who pays?" That is not a question most Americans want to answer. At some point, I hope, we may all come to recognize policy changes along the lines suggested above as preferable to the risk we now run of fashioning a health care system disconnected from any values except those of the marketplace.

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