



Policy Note 2000/4

Health Care Finance in Need of Rethinking

[Walter M. Cadette](#)

Hospitals have been squeezed by the Balanced Budget Act; the uninsured population is still on the rise; long-term care is paid for largely by welfare grants. The nation's flawed structure of health care finance ultimately will adversely affect the quality of care for all.

Not long after the failure of the Clinton health plan in 1994, Henry J. Aaron, senior fellow at the Brookings Institution, published a book entitled *The Problem That Won't Go Away*. The conventional wisdom at the time was that health care policy would be off the nation's agenda for a long time to come. But Aaron knew better.

It took no special gift of prophesy, though, to conclude that the problems building in health care several years ago were deeply entrenched: a rising number of uninsured, inordinately high out-of-pocket costs (for prescription drugs, in particular) for many who are otherwise well insured, loss of patient and physician autonomy with the ascendancy of managed care, and the resistance of third-party payers, government and employers alike, to pay for health care with the openhandedness of old.

Aaron, unlike many others, clearly foresaw that these and other increasingly characteristic features of American health care would put it back in the headlines before long. And so it is. Patients' rights are now the subject of a House-Senate conference; adding a prescription drugs benefit to Medicare is high on the administration's agenda; and access to medical care was central to the insurgency candidacy of Senator Bradley. Even Harry and Louise are back-this time not to tell you how terrible it would be for them if government helped pay for health insurance for people who cannot afford it (their message just a few years ago), but to tell you what a fine idea that is, after all.

The proposition I would put to you today is that the problems not only will not go away, they will worsen, unless there is a major rethinking of health care finance. Five issues need to be addressed:

- The responsibility of government, as the major payer of hospital bills, to ensure that the delivery of health care is not compromised by increasingly tight-fisted Medicare reimbursement
- An appropriate role for Medicare in a background of unfavorable demographics
- A suitable model for the financing of long-term care, this, too, with sharply increased demand on the horizon
- A role for government in patient advocacy in response to the rise of managed care
- The misallocation of tax subsidies to health care

The Key problem hospitals face is a sharp cutback in Medicare reimbursement under the Balanced Budget Act of 1997-this, it should be stressed, at a time when managed care has been increasingly successful in exerting its own market power. On the in-patient side, hospitals may bill Medicare for increased costs, but they are able to recover even less of those costs than before. Stripped to its essentials, the act provides for a 1 percent increase in Medicare reimbursement over the five-year period 1998 through 2002, as against a projected cumulative rise of 16 percent in the estimated cost of hospital services.¹ The decline is even steeper for academic medical centers because Medicare has also reduced, by some 30 percent, the adjustment intended to compensate teaching hospitals for public goods like medical education and research. Concentrated in inner cities and specializing in high-risk cases, teaching hospitals account for as much as three-quarters of the nation's uncompensated care.

On the out-patient side, Medicare is moving to a prospective payment system, mimicking the fixed fees in place for in-patient care since the mid 1980s. Payment is to be fixed at a given rate for procedure X or Y, irrespective of the actual cost of treating an individual patient. Payment for home care, meanwhile, is to be capped at a set rate per beneficiary per year. Skilled nursing facilities are already being reimbursed on a per-case basis.

In short, the next shoe has begun to drop in a long-term strategy of shifting from cost-based reimbursement to fixed fees. The underlying message: "There is a limit to what Medicare will finance; live within it or suffer the financial consequences." The subtext: "We will squeeze out the remaining excess capacity in the system, even if that pulls under viable institutions in the process."

While still largely beneath the surface, the consequences are worrisome, not just for hospitals but for the people they serve. Several years ago, the projection was for a five-year savings under the Balanced Budget Act of \$116 billion (almost half of which represented forgone acute-care hospital revenue). The savings were against then-current law, which itself was for less than full indexation to the cost of providing hospital services. Significantly, the estimated savings over the five-year period are now almost \$200 billion. Clearly, the financial burden on hospitals was grossly underestimated. But the added savings also reflect the implicit threat hospitals face under fraud and abuse regulations designed to ensure that the savings are, indeed, forthcoming. The safe response to Medicare's byzantine billing code regulations is to undercharge, even if-Catch-22-that means compromising financial soundness itself.

American hospitals, in fact, now earn virtually no income in the care of the sick. The CFO of a midwestern hospital system I work for on the finance committee did a canvass of the financial performance of Catholic health systems in the country, and he found that on average just about every dollar of net income in the last fiscal year came from investment accounts. Operating margins were under 1 percent. The latest data for health care systems as a whole cover 1998 and show an operating margin of just under 2 percent, based on Moody's numbers. The ratio today is probably close to, if not at, zero, to judge by up-to-the-minute data for Catholic systems.

The implications of numbers like these-especially at a time of uncommon prosperity-are sobering. As capital-intensive institutions, hospitals will be unable to adopt emerging technology unless they dip heavily into endowment-like reserves-a short-run strategy at best. Failing institutions will no longer be salvaged by larger systems, which themselves have come under financial stress. The threat of closings is greatest in already medically underserved areas, inner city and rural alike. The investment cushions in those areas are much too thin even for short-term survival. And let us be clear about this: The financial stress hospitals face will adversely affect even those well-insured Americans who can afford the best of care. All in one boat, they cannot be sheltered from the economies a hospital is forced to make.

Ironically, Washington is forcing hospitals into economies that threaten their financial soundness at the same time it is advocating extending Medicare to prescription drugs. The cynic in me is tempted to conclude that deterioration in the quality of American medical care will take years to become apparent to the public at large, whereas the prescription drugs benefit will be seen posthaste (and, more important, applauded at the voting booth).

This is not to argue against adding that benefit to Medicare. It is to ask whether the federal government is thinking clearly about health care finance. Yes, there is a limit to what is to be spent under the Medicare banner. What resources fall under that limit, and what fall outside it and must therefore be paid privately, is the much more difficult question.

One thing is sure, though: The shift in the population's age composition alone will add several percentage points to the share of GDP dedicated to health care in the next few decades. Most, if not all, of the increase is slated to be financed by government. Against that background, Washington has no good (in the sense of no good politically) choice.

One option is higher Medicare tax rates-never a good choice politically, but an even worse one now since Social Security retirement is similarly affected by the aging of a large generation.

Another option-the Balanced Budget Act approach-is less and less reimbursement for the same health care service, joined to a hope that the "less and less" will bring forth efficiencies rather than a deterioration in quality. Anyone who has been hospitalized of late (even more than someone who sits on a hospital finance committee) is apt to suspect that the hope is misplaced. It is whistling past the graveyard, to borrow from Mark Twain an image that is all too close to home. Official Washington's recent concern about medical errors is simply not credible (not to say disingenuous) against the background of its funding strategy.

A third option would be to key benefits and premiums paid by beneficiaries under Medicare Part B to income. That, I know, is heretical for a program structured as an entitlement. But it is perfectly reasonable to move Medicare in that direction, especially for new ventures like prescription drugs.

Many elderly, notably single women in their eighties, live in poverty. And many of them are deprived of modern medicine in the form of drugs for life-threatening illnesses or they are forced to choose between those drugs and food on the table. For others, though, drugs are a small expense, either absolutely or relative to income. Subsidizing the one group, but not the other, would be the sensible application of the principle that the function of insurance is to protect against low-probability, high-consequence events. The Clinton administration's proposal to subsidize prescription drugs for all beneficiaries is not sensible by that standard.

Inevitably, much of the rise in the share of GDP dedicated to health care in the next several decades will reflect increased need for long-term care. Not only will an unusually large generation approach old age, life expectancy will continue to rise with medical advances. Many more Americans, the prospect is, will fall victim to the chronic diseases of old age and will require years of home care and, in all too many cases, years of institutionalized care.

The nation is not equipped to deal with this eventuality. Nor is there public discussion about the problem, in contrast to the attention paid to the long-run actuarial deficits Medicare and Social Security face. And, yet, the problem arises out of the very same demographics.

Currently, most long-term care is financed either out-of-pocket, which can be done only by those with substantial savings, or by Medicaid, which pays for nursing-home care for those who are too poor to begin with or who have spent down their assets to the level allowed for Medicaid eligibility. Private insurance finances only a small fraction (7 percent or so) of long-term care.

By default rather than design, the nation has fashioned a welfare strategy for long-term care, pushing Medicaid far afield of its original purpose of financing the medical care of the indigent, in particular those on Aid to Families with Dependent Children and successor welfare programs. Strikingly, more than a third of the Medicaid budget is dedicated to long-term care, most of which finances the stay of disabled elderly in nursing homes. The care of two out of three nursing-home residents is paid, in whole or in part, by Medicaid.

A welfare model has also led to two-tier nursing-home care. Private payers, irrespective of their need for care, are typically given preferential treatment in admissions; Medicaid beneficiaries are often consigned to second-rate facilities because the budgets set by state governments (albeit with heavy federal funding) do not stretch to pay comparable fees.

A welfare model, moreover, has been an open invitation to transfer assets to heirs in advance of the need for nursing-home care. To be sure, asset and income limits are an inherent part of any welfare grant; they are designed to ensure that the available resources go to those with the greatest need. In practice, however, Medicaid finances the nursing-home care of many others. Asset and income limits have given rise to a whole industry of estate planners adept at helping people meet the letter, although not the spirit, of the limits.

Insurance-public or private or some combination of the two-would be a greatly better answer to the nation's long-term care needs. Indeed, long-term care is almost perfectly suited to an insurance model.

Two out of five Americans over age 65 will spend some time in a nursing home. For most, their stay will be only for a few months, say, for rehabilitation following hip replacement or a stroke. Medicare ordinarily pays most of the costs associated with such stays. However, one in ten Americans over 65 will require care for five years or more and will incur costs that if paid directly from individual or family assets would bankrupt most families. If every family were to try to save to meet the cost of such a stay, the resulting saving would be excessive. Pooling of the needed saving through insurance premiums is the natural economic response, but one frustrated by apparent market failure.

It is not a failure of the insurance market per se. Easy access to Medicaid all but forecloses the chances of developing a broad market for long-term care insurance. And, absent adequate public funding for alternative forms of care, easy access to Medicaid for nursing home care has led to excessive institutionalization of the disabled elderly.

The challenge for government is to shift the financing of long-term care toward an insurance, and away from a welfare, model. The well-being of all the disabled elderly in need of Medicaid benefits is at stake because of two-tier care practices-a problem that promises to worsen as economies mandated by the Balanced Budget Act, for Medicaid as well as Medicare, take full effect over coming years. At stake also is "honest government"-one that not only does not fund inheritance protection but that also genuinely protects those with greatest need. Clearly, however, an insurance model cannot be developed as long as most Americans needing long-term care can turn to a safety net in the first instance.

All is not well in private health care finance either-far from it. Understandably, employers have embraced negotiated rates to control their health care costs, using their market power just as government has.

This, after all, is the essence of the main managed care model-the preferred provider organization or PPO-that has taken root in this country in the past decade. The PPO has been able to negotiate prices for physician and hospital services in ways that most employers, acting on their own, could never have done.

Employers have also embraced, although to a lesser extent, the new network-type HMO, with its strictly enforced practice guidelines as well as its power to discount fees. The HMO is thus both provider and insurer, in contrast to the old fee-for-service model in which these are separate and distinct.

The shift to managed care is a response to the extraordinary rise in health insurance premiums employers had to grapple with for years. It has been a major force behind the deceleration in the price of health care in recent years (and ultimately the much better behaved broad indexes of both price and labor cost). And it has given rise as well to recent stability in the health care share of GDP at about 15 percent.

All of this has come at a price, though-loss of the freedom people once had to choose their physician and hospital and loss of the autonomy physicians once had to pursue a particular course of treatment for a patient. The debate in

Congress over a patient's bill of rights is ultimately a debate about restoring these freedoms. And it is about making health plans accountable when decisions adopted for cost reasons do serious harm. As it is now, under ERISA, health plans escape accountability if they are seen to be acting on behalf of self-insured employers. The interpretation has been that modalities of care or denials of care that have resulted in serious harm are a benefit determination-not an occasion for a malpractice suit. Yet, no HMO can claim that all it does is implement the benefit decisions of employers. If only because HMOs can deny care, they are active in the delivery of care. That makes them fiduciaries, in the same way physicians are fiduciaries. They should be held accountable as such.

The tax exclusion of employment-based health benefits has had enormous impact on health care finance in this country. It has linked health insurance to employment. It has given decision-making authority to employers, not to individuals as health care consumers; health insurance is thus not portable and cannot be made portable by law except for short periods. It has made health insurance more comprehensive than it ought to be, thus broadening the arena over which moral hazard holds sway, and, in turn, has raised costs. It has violated every canon of tax equity.

What is more, it is at the heart of the problem of the uninsured. The majority of the uninsured work, but at wages too low to have health insurance fit within the overall pay packet. Ironically, these are the very same people who benefit least from the roughly \$100 billion a year subsidy to health insurance flowing from tax exclusion of this form of income. The tax exclusion has drained resources from what ought to be the real object of tax preferences in health care: support of those who cannot afford it.

Getting from the existing financial structure to something sensible will not be easy politically. Herein lies the explanation for Washington's willingness over the years to do nothing more than tinker around the edges of health care policy (the ill-fated Clinton plan aside)-its unwillingness to confront basic design issues.²

The design I would favor (along with many others who have studied the issue; see, for example, Pauly, Danzon, Feldstein, and Hoff 1992) is to end the exclusion and use the proceeds to fund an income-scaled, refundable tax credit. That would attack frontally the underlying problem: large numbers of people who earn too little to have health benefits fit within the overall pay packet. Here, too, food on the table comes first. A tax credit, along with a requirement that people carry health insurance (as they must carry car insurance), would achieve universal health care, as the exclusion never did and could not have.

The tax credit approach would also remove employers from health care decision making (a role they have assumed for no reason but the opportunity to pay employees with some tax-free dollars). That, in turn, would restore a measure of freedom to health care decisions. Ultimately, it is individuals, not employers, who pay their medical bills in the form of forgone compensation of some other kind. They are the real buyers of health services, and it is they to whom health plans should be accountable.

Finally, tax credits in lieu of the exclusion would push the health insurance market in the direction of catastrophic coverage, featuring high deductibles and other co-payments, thus economizing on the claims processing and other administrative costs now associated with the use of insurance for the payment of routine and predictable expenses. It thus would reduce moral hazard and, in turn, the pressure on costs ensuing from the illusion that medical care is somehow free or, at the very least, not to be valued at its full cost. Individual, high co-payment policies would offer a good alternative to an HMO or PPO to those who now have little, if any, choice.

Design changes for Medicare are also needed. The financial stress Medicare faces as the baby boom ages is an opportunity to rethink Medicare's status as an entitlement. A heavily subsidized health care plan that is blind to income for all over the age of 64 may have made sense in the mid 1960s. Health care was less than half the share of GDP it is now, the incidence of poverty among the elderly was relatively high, and life expectancies were much lower. Conditions are now markedly different, and yet the entitlement principle has never been seriously reexamined. The Medicare debate has focused on fiscal aggregates rather than on the level of subsidy that beneficiaries ought to receive. In practice, that means top-down budgeting and continued squeezing of the incomes of hospitals at the risk of harm to not only Medicare beneficiaries but the population at large.

Whatever else is done, the administration of a President Gore or a President Bush will have to take a hard look at the problem of the uninsured. As many Americans see it, health care is a basic human right, not to be parceled out like Chevrolets or other goods and services best distributed by the laws of the marketplace. But the issue is even broader than that. Not so long ago, the consequences for health care of a nation with a large minority of poor people were muted by cross subsidies from both government and employers. No longer. The consequences now are apt to show up in hospital income statements and, in turn, in quality indicators, linked as they are to the availability of resources.

It is not just cross subsidies that are gone, but the revenue that ought to come from levying reasonably full costs on both government and employers for the care they themselves are agents for. At the very least, no one should be surprised if, in time, this confluence of forces yields a marked deterioration in the quality of American health care.

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