PRI CENTER FOR MEDICAL ECONOMICS AND INNOVATION

COVERAGE DENIED

ISSUE BRIEF PART TWO

The Fundamental Flaws of the Third-Party Payer System

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Executive Summary

- The third-party payer system is decreasing individuals' direct payments for health care services but is causing their total health care spending to increase dramatically.
- The distortions in the private (mostly employer-sponsored) plans are worsened by the expansion of government-financed health care spending.
- The significant decline in patient control creates a wedge that economically separates patients from their health care providers. This separation creates the problems of rising costs and declining quality.

Introduction

Part 1 of the Coverage Denied series documented how distortions in the U.S. healthcare system turned the important financial risk management service of health insurance into a barrier to care and an important driver of health care inflation. The insurance industry's adverse impact on costs is ironic given its current focus on implementing cost control measures.

Unfortunately, the problems of increasing obstacles to care and decreasing health care affordability are the expected outcomes from the current third-party payer system. The incentives inherent to a third-party payer system ultimately disempower patients and health care providers in favor of the payer bureaucracy. This shift in financial responsibility creates an ever-widening conflict of interest between the payer bureaucracy and the needs of patients, and this misalignment drives the unwanted outcomes that plague the current U.S. health system.

Consequently, improving affordability and access to care requires reforms that fundamentally restructure how health care is financed in the U.S. The first step toward establishing a more efficient health care sector is explicitly linking the adverse outcomes created by the current health insurance system (e.g., declining quality and rising costs) to the disincentives that are inherent to the third-party payer structure. This is the topic for parts 2 through 4 in this series.

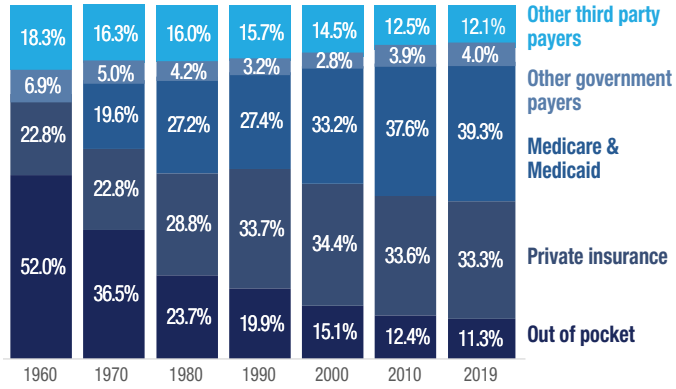
A Transformed Health Care Payment System

Although the quality of health care has revolutionized over the past 70 years, the health care payment system has digressed because patients control over how health care dollars are spent is diminishing despite ultimately paying for all the costs.

Figure 1 visualizes the changed health care financing landscape by presenting the share of health care consumption expenditures by the "source of funds," as measured by the National Health Expenditures (NHE) database maintained by the Centers for Medicare and Medicaid Services (CMS). Back in 1960 patients directly paid over half (52.0 percent) of all health care consumption expenditures in out-of-pocket expenditures. Private insurers covered a bit more than one-fifth of all expenditures (22.8 percent), with other government payers (e.g., for veterans and employees) and other third-party payers covering the remainder of the costs.

The source of funds has transformed over time. As of 2019, the latest data available, patients only directly pay about one-tenth of all health care consumption expenditures (11.3 percent). Private insurers cover one-third of all expenditures (33.3 percent) and Medicare & Medicaid covers approximately 40-cents of every dollar (39.3 percent).

FIGURE 1
SHARE OF TOTAL HEALTH CARE CONSUMPTION EXPENDITURES BY SOURCE OF FUNDS



Source: CMS, NHE

The declining share of out-of-pocket costs is meaningful because it has fundamentally altered the underlying incentives of the system. But focusing on the allocation of expenditures by source provides a distorted view of who pays the actual costs of health care.

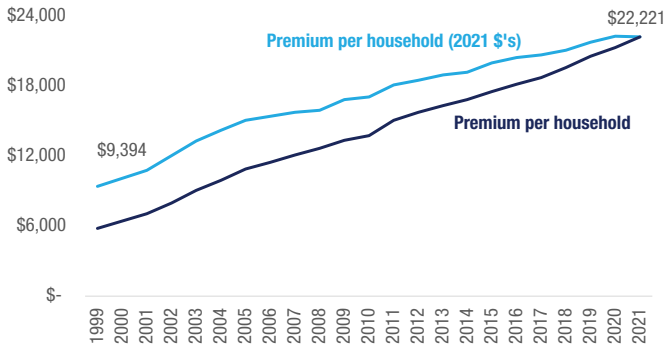
Clearly when patients pay expenditures "out-of-pocket," they are covering these healthcare costs. For patients with private insurance, the remainder of the costs will then be covered by the health insurer or private payer (e.g., a self-insured employer plan).

But insurers and private payers simply use revenues from premiums to pay for these health care costs. In some instances, patients directly pay the premiums making it relatively easy to assert that patients have both paid their out-of-pocket costs and paid the premiums. Since the premiums cover the remaining medical expenses, patients are the actual "source of all funds" even though a large share of the expenditures are booked through the insurance company. This logic still applies when private insurance premiums are paid on behalf of patients by their employers, or their employers are serving as the insurer. The costs that employers are paying on behalf of patients are mostly borne by workers through a combination of lower wages, fewer hours of work, or fewer employment opportunities.[1]

As a result, the costs paid by insurers are paid out of patients' pockets in the same way that the expenditures officially labeled as "out-of-pocket" are. With respect to the private expenditures, patients are the ultimate source of all funds.

Recognizing this reality is important because the costs patients have been paying via premiums have been growing quickly, as depicted in Figure 2.[2] Figure 2 illustrates that the average annual premium for an employer-sponsored plan for a family in 2021 was $22,221 and has been growing exceptionally fast. Premiums grew 4.0 percent annually adjusted for inflation between 1999 and 2021, compared to the inflation-adjusted annual economic growth of 1.9 percent during the same period. The large and growing premium costs are significantly more burdensome to patients than the out-of-pocket expenditures, which tend to be the focus when talking about patients' costs.

FIGURE 2
AVERAGE ANNUAL PREMIUMS FOR EMPLOYER-SPONSORED FAMILY HEALTH COVERAGE COMPARED TO OUT-OF-POCKET EXPENDITURES PER HOUSEHOLD
1999 - 2021

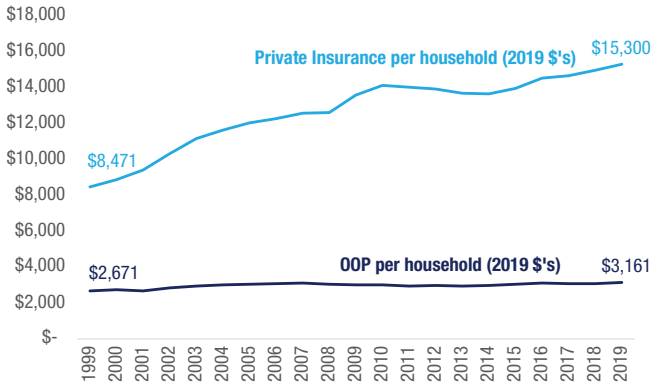


Source: Kaiser Family Foundation 2021 Employer Health Benefits Survey

In 2019 (the latest data available), overall out-of-pocket expenditures per household were $3,161,[3] and have been growing 0.8 percent annually adjusted for inflation between 1999 and 2019.

Since the KFF survey is not directly comparable to the expenditures as measured by the CMS, Figure 3 compares the private insurance expenditures per household derived from the CMS NHE database to the out-of-pocket expenditures per household from the same source.[4] Figure 3 confirms that out-of-pocket expenditures per household have been growing significantly slower than the total private insurance expenditures per household. Adjusted for inflation, employer premium expenditures per household have been growing 3.0 percent annually and reached $15,300 as of 2019, as shown in Figure 3.

FIGURE 3
AVERAGE ANNUAL EXPENDITURES PER HOUSEHOLD HEALTH INSURANCE PREMIUMS FOR EMPLOYER-SPONSORED HEALTH COVERAGE COMPARED TO OUT-OF-POCKET EXPENDITURES ADJUSTED FOR INFLATION 1999 – 2019



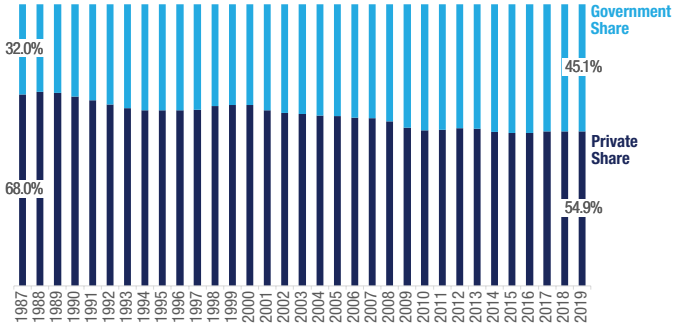
Source: Author calculations based on data from CMS, NHE and U.S. Census

These expenditure discrepancies demonstrate the problem of not attributing the premium expenditures to patients. Focusing exclusively on the officially labeled out-of-pocket expenditures ignores the largest share of the costs that the average household with private insurance is paying. Using the total expenditures per household, every household with private insurance is spending nearly $18,500 annually on healthcare, which was approximately 27 percent of the 2019 median household income ($68,703).[5]

Most households are not receiving $18,500 in healthcare services during the year. The gap between payments and services is supposed to reflect the "insurance services" patients receive. But insurers are exerting control over how most dollars are spent and are paying for many services that are not financial risks (issues raised in Part 1). As a result, the payments for insurance services are ineffective —patients still face large financial risks. In addition to not receiving effective financial risk services with respect to health care, the separation between payer and recipient creates disincentives that are driving the quality and affordability flaws of the current system. These disincentives are worsened by the fastest growing "source of funds" for healthcare spending – the government sector.

Between 1987 and 2019 (the latest data available) the average annual growth in total government healthcare expenditures was 7.6 percent (6.8 percent since 1999) compared to overall average annual private expenditure growth of 5.7 percent (4.8 percent since 1999). The consistently faster growth in expenditures has propelled government-funded healthcare expenditures to expand from around one-third of all expenditures in 1987 to nearly one-half as of 2019. The difference is even more dramatic compared to 1960, when government expenditures accounted for less than one-fifth of all healthcare expenditures.

FIGURE 4
PRIVATE SECTOR'S SHARE OF HEALTHCARE EXPENDITURES VERSUS THE GOVERNMENT SECTOR'S SHARE OF HEALTHCARE EXPENDITURES 1987 - 2021



Source: CMS, NHE

Just as with private health insurance, individuals bear the costs of these expenditures. To benchmark how large these costs are, total government healthcare expenditures of $1.7 trillion cost every household $13,312 in 2019. While the ultimate payer is not as clear as in the private markets, ultimately taxpayers and patients are financing these costs. Yet, like the private market, it is the government payer that has the majority power over how the money is spent—not the patients who are the ultimate funders.

Patients Are Disempowered Payers

This transformation in how healthcare is financed has pushed health insurers into the role of expenditure gatekeepers rather than providers of efficient risk management services and created many of the adverse outcomes plaguing our current healthcare system. Simply put, the problems of rising costs and declining quality are inherent to any third-party payer system.

An analysis by Laffer, Arduin, and Winegarden (2009) demonstrated that the current third-party payment system with a large and growing government role is a primary cost driver because it creates a large and growing healthcare wedge. The healthcare wedge is defined as

> an economic separation of effort from reward, or consumers (patients) from producers (health care providers).[6]
>
> The health care wedge occurs when the government or a third party spends money on healthcare separating the patient from the transaction…in the sense that the costs are no longer his concern. This separation—how far the supplier and consumer are separated from one another—is what the economic wedge is measuring. The wedge measures the deadweight loss from this separation in higher costs that do not improve efficiency.[7]

While not using the same terminology, many other studies have linked this separation of the patient from the provider as a primary driver of the declining quality and affordability of the U.S. healthcare system. Summarizing the problems with the U.S. third-party payer system, Goodman (2014) notes that the out-of-pocket payments have become so small that there is "no such thing as a market-clearing price in health care. There are only 'reimbursement rates.' Blue Cross pays doctors one fee. Aetna pays another. And so forth. No doctor and no patient ever really see a real price for anything."[8]

In fact, according to Goodman, "third-party payment changes the doctor patient relationship. A Blue Cross patient, for example, is not the real customer of the doctor. Blue Cross is. Whether a test is ordered and what tests are ordered is more likely to be determined by Blue Cross's preferences than the patient's preferences. In a third-party payer system, doctors increasingly become the agents of the third parties rather than agents of their patients."[9]

According to Singer (2013), and "contrary to 'conventional wisdom,' health insurance—private or otherwise—does not make health care more affordable. The third-party payment system is the principal force behind health care price inflation. This should come as no surprise."[10] Describing these disincentives more bluntly, Hyman and Silver (2018) note that

> helping patients and consumers isn't the top priority for third-party payers of either type.
>
> This goal matters to them only when, by pursuing it, they can get what they really want: money, bigger budgets, reelection, or something else they care about. Unfortunately, helping patients and consumers only occasionally makes payers better off. Payers rarely care about the well-being of patients or consumers.[11]

Schlomach (2009) similarly notes that "people are not paying for their own health care. Consequently, the market for health care is highly distorted, even to the point of not being a legitimate market."[12]

Conclusion

The disincentives from this payment system drive up costs, drive down quality, and expose patients to excessive financial risks. Improving the healthcare system consequently requires an understanding of how the third-party payer disincentives lead to these adverse outcomes. This is the subject of Part 4 of this series. Before performing this analysis, given the political attention, it is important to explicitly analyze how these disincentives plague the pharmaceutical market. This analysis is performed in Part 3 of this series.

Endnotes

1 See for instance, Baicker K and Chandra A "The Labor Market Effects of Rising Health Insurance Premiums" Journal of Labor Economics Volume 24, Number 3, 2016; and Gruber J "The Incidence of Mandated Maternity Benefits" The American Economic Review, Vol. 84, No. 3, June 1994. While empirical research illustrates that workers bear most of these costs, by definition, the costs must be borne through a combination of workers, customers (through higher prices), or owners through lower profits. While these impacts net out across the economy, the distribution of these costs can become distorted. While understanding these impacts are important, they do not change the point that patients are bearing these costs. To remain focused on this main point, these distributional issues are not discussed above.

2 "2021 Employer Health Benefits Survey" Kaiser Family Foundation, November 10, 2021, https://www.kff.org/health-costs/report/2021-employer-health-benefits-survey/.

3 The different definitions of a household and family will alter the dollar values. Since the family and household estimates are not combined in the paper, no attempt to reconcile these differences are made.

4 Total premiums per household are estimated by dividing the total expenditures on employer sponsored private health insurance by the estimated number of employee households based on Table 22 of the CMS NHE database. The estimated number of employee households is estimated by the total number of enrollees in employer sponsored insurance divided by the average household size based on data from the U.S. Census.

5 https://www.census.gov/library/publications/2020/demo/p60-270.html.

6 Laffer A, Arduin D, and Winegarden W "The Prognosis For National health Insurance: A Colorado Perspective" Independence Institute, August 2009.

7 Ibid.

8 Goodman JC "Who is Paying The Health Care Bill? Not the Patient. *Forbes*, October 8, 2014.

9 Ibid.

10 Singer JA "Health Care's Third-Party Spending Trap: Contrary to "conventional wisdom," health insurance-private or otherwise-does not make health care more affordable." *Reason Magazine*, December 10, 2013, https://reason.com/2013/12/10/health-cares-third-party-spending-trap/.

11 Hyman DA Silver C "Overcharged: Why Americans Pay Too Much For Health Care" Cato Institute July 3, 2018.

12 Schlomach B "Removing the Middleman: What States Can Do to Make Health Care More Responsive to Patients" Goldwater Institute, January 13, 2009, https://goldwaterinstitute.org/wp-content/uploads/cms_page_media/2015/2/10/Removing%20the%20Middleman.pdf.

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