PRI CENTER FOR MEDICAL ECONOMICS AND INNOVATION

COVERAGE DENIED

ISSUE BRIEF PART FOUR

Driving a Wedge Into the Healthcare System

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Executive Summary

- Payers fail to mitigate financial risks associated with expensive healthcare products and services because the system is predicated on providing pre-paid healthcare, not effective insurance services.
- The adverse outcomes of rising costs and declining quality are the inevitable result due to the incentives of the U.S. third-party payer system.
- The growing role of the government as a third-party payer, which now represents over 50 percent of all spending, compounds the cost and quality problems.

Introduction

The first three parts of PRI's *Coverage Denied* series linked many of the healthcare industry's core problems to the inherent flaws of the health insurance system. Specifically, these studies documented that the U.S. healthcare system suffers from the problems of declining quality, rising costs that are causing worsening affordability problems, and inadequate risk mitigation services that are failing to alleviate patients' exposure to bankrupting financial costs from expensive medical care. Each one of these failures is the inevitable outcome of the current third-party payer financing system.

This system requires patients (or their employers) to pay monthly premiums to health insurers who then pay the expenses associated with a wide variety of healthcare products and services on behalf of patients. Most of these expenses are not actual financial risks in the true sense of the word. Therefore, when patients pay their premiums (or employers pay these premiums on their behalf) these expenditures are simply pre-paying future medical expenses. Consequently, the U.S. health financing system is more accurately described as a pre-paid expenditure model rather than an insurance model.

This pre-paid expenditure model is incompatible with establishing an efficient health insurance market, as it exposes patients to unnecessary financial risks. Further, since pre-paid healthcare expenditures empower third-party payers rather than patients, the inevitable result is a fundamental misalignment of the healthcare system's incentives. Consequently, the expected results of our current pre-paid financing system are inadequate insurance services, rising costs, and declining quality; precisely the outcomes that plague the current healthcare system.

Due to this causal link between the ineffective health financing system and the adverse outcomes for the healthcare system, improving patient outcomes requires reforms that improve how healthcare is financed – in other words, creating a true health insurance system.

Transforming the current pre-paid expenditure system into an effective health insurance system requires a deeper understanding of the economics driving the adverse outcomes just described. The purpose of Part 4 of the *Coverage Denied* series is to provide this analysis. Based on the results from this study, the remaining parts of the research series will suggest reforms that will improve the underlying economic incentives of the health insurance system and, consequently, lead to improved outcomes in the healthcare system.

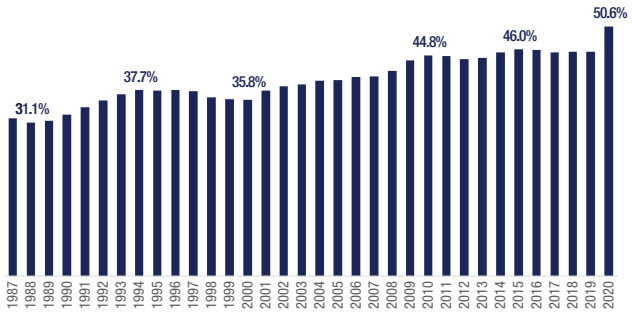
The Rise of the Third-Party Payer

The U.S. has two types of third-party payers – government payers and private sector payers, which has led to the development of two healthcare systems. The first system is a socialized healthcare system where the government serves as the third-party payer. The second system is a private pre-paid healthcare system. Given the size and scope of the public third-party payer systems, both the public and private systems are meaningfully impacted by the government payer system.

The socialized healthcare system covers people over age 65 (Medicare), low-income families (Medicaid and Children's Health Insurance Program or CHIP), veterans (through Veterans' health programs), military personnel (TRICARE), and other miscellaneous government programs. The approximately 8.6 percent of U.S. residents without health insurance[1] are also generally part of the socialized system – though ineffectively – since the federal government reimburses a large share of hospitals' uncompensated costs of care for the uninsured. For instance, the Kaiser Family Foundation (KFF) estimates that hospitals spent $42.4 billion, on average, in uncompensated care costs between 2015 and 2017.

Out of these costs, KFF estimates that "at least $33.6 billion in public funds were paid to providers to help defray" these costs in 2017. In total, government healthcare expenditures have grown to over one-half of total national healthcare expenditures as of 2020, see Figure 1.

FIGURE 1. GOVERNMENT EXPENDITURES SHARE OF TOTAL HEALTHCARE SPENDING 1987 - 2020



Source: CMS National Health Expenditure Data

The private system, which by definition of the government's growing share of expenditures is declining, is dominated by the current employer-centric health insurance model. The employer-based model links employee health insurance benefits to their place of work. Employers provide health insurance services through the purchase of health insurance from a private payer or the company using its own funds to cover the healthcare costs for their employees. A much smaller share of the private market purchases their health insurance through the individual (or non-group) market. Employers control the private system because healthcare benefits are only tax deductible for employees if these benefits are provided from their workplace.

Incentives Drive Behavior

As Parts 1 through 3 of this series have documented, the rise in third-party payer control has not corresponded with an improvement in healthcare quality but has, unfortunately, corresponded with excessive healthcare inflation. Based on the current structure of the health insurance system in the U.S., some combination of these outcomes is the inevitable result due to the adverse incentives this system establishes.

Incentives drive all economic behavior – including behavior in the healthcare industry. Consumers in a competitive market search for the goods and services that provide the right combination of attributes including price, quality, and convenience. Consumers respond to the prices and information about these products in predictable ways – they are incented to purchase products that offer a better combination of the desired attributes and avoid products offering a worse combination of attributes.

Suppliers compete with one another to provide consumers with the products that offer the best combination of these desired characteristics—those who are successful earn healthier profits relative to those who are less successful. The desire to earn healthier profits also drives suppliers to innovate. Perhaps those innovations will improve production efficiencies and reduce costs. Perhaps they will create products and services that consumers did not know they wanted at prices they never dreamed they could pay.

When these market incentives are empowered to drive the demand-side and supply-side of the market, a market process that encourages continual innovation develops that leads to steady increases in quality and continual decreases in price.

The cost and quality of healthcare goods and services respond to the interaction of consumers and suppliers, just like in any other market. The consumers in this instance are patients while the suppliers are doctors, healthcare providers, pharmaceutical manufacturers, and medical device suppliers.

While patients are the consumers in the market, as we have identified in the introduction, they are not in control of the demand side of the market. The third-party payers are in control of the market. Therefore, the discipline of the demand-side of the market now has incentives that differ from the incentives of the actual consumer. This discrepancy makes all the difference with respect to generating efficient outcomes.

The Economics of the Third-Party Payer Wedge

An argument against the economic logic detailed above is that healthcare is not a typical good. After all, when an emergency healthcare situation arises, patients do not have an opportunity to shop around for the best provider. Nor can they defer service. During an emergency, patients are at the mercy of the healthcare providers, making market analogies irrelevant.

This argument fails to withstand scrutiny, however.

First, most healthcare services are not emergency situations, so the crisis scenario does not apply for most patients. Most healthcare interactions are scheduled appointments and treatments where patients can select the right provider for themselves. Second, the purpose of establishing a vibrant and efficient health insurance market is to mitigate the financial risks that can arise from emergency situations. While emergency services are unpredictable from a patient perspective, this is not the case for insurers operating in an efficient market. With the financial risk spread across a large population, the costs are predictable. Further, insurers are not in a weak negotiation position vis-à-vis the providers due to the long-term repetitive relationship enabled by the large population of patients that the insurer represents.

There is, consequently, nothing unique about healthcare that negates the ability of a properly incented consumer from disciplining the market. Another way to envision that there is nothing unique about healthcare is to imagine if another form of insurance, automobile insurance, worked like health insurance.

As opposed to purchasing insurance just to cover the costs from major automobile accidents, automobile owners would pre-pay all their routine and emergency costs with an automobile insurer. Now, the costs of routine maintenance such as oil changes and tune ups are run through the auto insurer in addition to the costs from accidents and major breakdowns.

Under such a scenario, car consumers would have little incentive to shop for the best deal when it came to changing the car's oil, getting a tune up, or performing any other routine maintenance service. The cost for routine maintenance services would be expected to increase. Additionally, because a car owner would not bear the costs that result from improper maintenance, the incentive to properly maintain cars would decline. The number of major car repairs, and the cost of these repairs, would all be expected to increase as well.

Automobile insurance companies, trying to arrest the rising costs of car repairs and car maintenance, would begin to increase the number of rules and regulations. The result would be significant market distortions in the automobile insurance market, skyrocketing costs of repairs, and an increase in the quantity of major repairs. In short, both the automobile insurance market and the automobile repair market would become much more inefficient to the point where people might even begin to wonder whether the automobile repair market is special, needing the government to mandate prices and repair schedules.

The automobile analogy exemplifies that the adverse incentives that pervade the healthcare financing system do not arise because healthcare is unique. They arise because the financing system obstructs the healthcare market by empowering third-party payers rather than patients to serve as the demand-side of the market even though the interests of patients and the interests of payers will often diverge.

With third-party payers controlling the demand-side of the market, the true consumer in the market (the patient) is separated from the healthcare provider. An economic wedge (e.g. healthcare wedge) now separates the consumer and supplier in the healthcare industry. This wedge diminishes the incentive and ability of patients to monitor costs.

Patients lack the incentive to monitor costs because they bear only a fraction of the expenditures when purchasing any healthcare service and have already pre-paid a large share of their expenditures through the high annual premiums they paid (either directly or indirectly).

Patients lack the ability to monitor cost because payers —whether private health insurers or government healthcare programs—are the entities that are in control of how the money is spent. Since the payers control the money, providers must respond to the interests of the payer, not simply the interests of their patients. And because providers are also accounting for the interests of the payer when making care decisions, patients have lost control over the quality, cost, and types of healthcare services they receive regardless of whether the payer is the government or a private company.

There is, consequently, nothing unique about healthcare that negates the ability of a properly incented consumer from disciplining the market.

This loss of control is problematic. As Milton Friedman (2001) noted, "two simple observations are key to explaining both the high level of spending on medical care and the dissatisfaction with that spending. The first is that most payments to physicians or hospitals or other caregivers for medical care are made not by the patient but by a third party—an insurance company or employer or governmental body. The second is that nobody spends somebody else's money as wisely or as frugally as he spends his own."[2]

Despite the disincentives to monitor costs, the need to control expenditures still exists. In response, payers implement a wide array of expenditure containment policies that are often neither "wise nor frugal" from the patients' perspective but control overall costs for the third-party payers.

Expenditure containment policies are not wise because they are typically established based on population averages. As such they are incapable of reflecting the personal needs of individual patients. Instead, they reflect the population average perspective, which leads to outcomes that fail many patients whose needs will often differ (perhaps substantially differ) from these averages.

These expenditure containment policies are not frugal for patients because controlling costs means something different for third-party payers (whether the payer is the government or a private organization) than for patients. For payers, cost overruns are tolerated to the extent they can be passed along through higher premiums, much of which is hidden from patients with government or employer-based insurance. Further, because the payers are focusing on covering the pre-paid healthcare expenditures, they implement cost control programs that focus on the instances where the incurred medical costs are the highest. Put differently, cost controls are imposed on patients at the exact time when they need the insurance service the most.

Essentially patients are pre-paying a share of their expected healthcare costs and only some of the potential financial risks that could arise should expensive healthcare services be required. If those financial risks are realized, then patients are exposed to an excessive amount of these costs. Consequently, the current system fails to provide the fundamental service that health insurers are supposed to provide —insurance. Further, due to the misalignment of incentives, the current system meaningfully contributes to the adverse outcomes of out-of-control costs and declining healthcare quality.

Government-Provided Healthcare Compounds the Problem

The reality that one-half of the current industry is socialized worsens the adverse incentives that are inherent to all third-party payer systems. The federal and state governments, as the payer, set the terms for the expenditures in the socialized portion of the healthcare system. These terms serve the interests of government and have focused on controlling cost at the expense of health providers' financial viability.

For instance, Medicare administratively sets their payment rates for hospitals based on reported costs. However, as a poll conducted by the Medical Group Management Association demonstrates, "more than two-thirds (67%) of medical practices" report that Medicare's reimbursement rates do not cover the cost of delivering care.[3] The shortfalls are significant. Medicare pays 84-cents per dollar of actual expenditures and Medicaid pays 88-cents on the dollar, according to the American Hospital Association.[4]

It is not just inadequate reimbursement rates either. Dunn et al. (2021) estimate that combining the costs of negotiating with payers and the revenue never collected (e.g., denied payments for already provided treatment), "physicians lose 17% of Medicaid revenue to billing problems, compared with 5% for Medicare and 3% for commercial payers."[5]

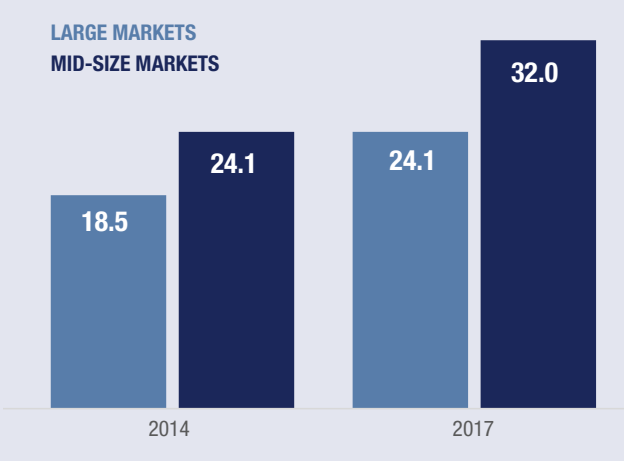
With respect to the 50 percent of patients who are covered by the socialized healthcare system, several studies have documented how government below cost reimbursement rates significantly curtail patient access to care.

Hsiang et. al (2019) performed a meta-analysis of audit studies, finding that "Medicaid insurance is associated with a 1.6-fold lower likelihood in successfully scheduling a primary care appointment and a 3.3-fold lower likelihood in successfully scheduling a specialty appointment when compared with private insurance."[6] In the Dunn et al. (2021) analysis the authors demonstrated that physicians viewed the incomplete payments and higher costs associated with getting reimbursed as a tax, which deters their ability to treat low-income patients. Specifically, they claim that since payments for medical care are frequently incomplete, "physicians incur large costs from this incompleteness—especially when submitting bills to Medicaid" which "depress doctors' supply of care to Medicaid patients. Their willingness to participate in Medicaid responds just as much to billing difficulty as to the reimbursement rate."[7]

Access issues do not just impact patients with Medicaid either; they also impact Medicare patients. Cossman et. al (2014) examined access issues for patients with Medicare and Medicaid in Mississippi finding that while 7 percent of offices were not accepting new patients with private insurance, 15 percent were not accepting new Medicare patients and 38 percent were not accepting new Medicaid patients.[8]

Based on a survey of physicians in 15 large metro areas and 15 mid-sized metro areas, the access issues have worsened over time.[9] Figure 2 presents the growth in the average wait time for patients to see a doctor in the surveyed large and mid-size markets for 2014 and 2017. For the large markets Medicare and Medicaid patients had to wait 24.1 days in 2017 and a much higher 32.0 days in the mid-size markets. These wait times were up 30.0 percent and 32.8 percent, respectively, from 2014.

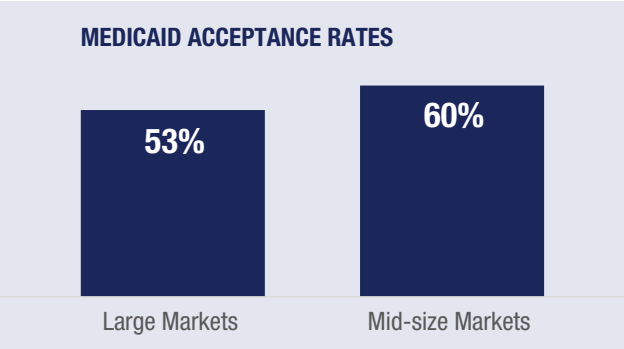
FIGURE 2. AVERAGE WAIT TIME TO SEE A DOCTOR 2014 - 2017 (IN DAYS)



Source: Merritt Hawkins

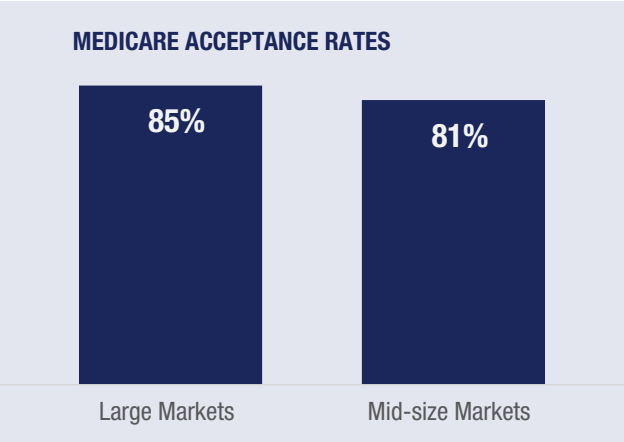
Beyond waiting a long-time for an appointment, patients must navigate the specter of not being seen at all. Many doctors will not accept new Medicare and Medicaid patients, as depicted in Figures 3 and 4. Figure 3 shows that the average acceptance rate for Medicaid patients was 53 percent in large markets and 60 percent in mid-sized markets. Figure 4 shows that the average acceptance rate for Medicare patients was 85 percent in large markets and 81 percent in the mid-size markets.

FIGURE 3. AVERAGE ACCEPTANCE RATE FOR NEW MEDICAID PATIENTS 2017



Source: Merritt Hawkins

FIGURE 4 AVERAGE ACCEPTANCE RATE FOR NEW MEDICARE PATIENTS 2017



Source: Merritt Hawkins

The pernicious impacts are not contained to patients in the socialized system. To offset the revenue losses caused by the government's uneconomical reimbursement levels, providers increase prices and shift the costs onto private insurers. Given that the government sector is a bit more than one-half the market, providers must charge private insurers more than $1.14 for every dollar of cost just to break even. This cost shift creates adverse cost implications for patients participating in the pre-paid healthcare system.

Many studies have directly linked the government's Medicare and Medicaid expenditures to the problems of rising healthcare prices and rising quality distortions that limit the efficiency of the healthcare market.

Finkelstein (2007) illustrates that of the six-fold increase in per capita healthcare spending that occurred between 1950 and 1990, one-half of this increase could be explained by the impact of Medicare.[10] Expanding on these results, Brown and Finkelstein (2008) show that Medicaid imposes a powerful crowding out effect on private insurance purchases.[11] Specifically, they find "that the provision of even very incomplete public insurance can crowd-out more comprehensive private policies by imposing a large implicit tax on private insurance benefits, thus potentially increasing overall risk exposure for individuals."[12] These results show that the growing government involvement in the healthcare industry has helped drive up overall healthcare expenditures and reduce the efficiency of the private insurance markets.

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The combination of the growing socialization of healthcare via government-provided services and the dominance of the healthcare market by third-party payers – due in large part to the tax treatment of healthcare benefits – are driving the observed problems. As Milton Friedman (2001) noted, "the effect of tax exemption and the enactment of Medicare and Medicaid on rising medical costs from 1946 to now is clear. According to my estimates, the two together accounted for nearly 60 percent of the total increase in cost. Tax exemption alone accounted for one-third of the increase in cost; Medicare and Medicaid, one-quarter."[13]

Supply-Side Restrictions Amplify the Adverse Consequences of the Third-party Payer Wedge

On the supplier side, doctors and other medical providers receive no incentive to provide higher quality services for less cost. No positive benefit accrues to those who do so. There are costs to doctors, however. One of the most important disincentives for doctors to monitor costs is the tort liability threat. While estimates vary, based on a literature review by Schneider (2019) the cost of defensive medicine is between 5 percent and 9 percent of the U.S. healthcare budget annually.[14] Relative to total health consumption expenditures of $3.9 trillion in 2020, these estimates imply between $197 billion and $354 billion in healthcare expenditures annually due to the pernicious impacts of defensive medicine, as illustrated by Figure 5.

FIGURE 5. ESTIMATED COSTS DUE TO DEFENSIVE MEDICINE
2020

Source: Author calculations based on Schneider (2019) & CMS National Health Expenditure data

As a result, the current healthcare system blinds both patient and doctor to the cost of care. Meanwhile, litigation risks incentivize doctors to run additional tests to limit their liability exposure.

Providers, like all suppliers, are not incentivized to engender competition as that would pose a threat to their bottom line. Instead, they seek to stifle competition by pushing for supply-side regulations. For example, scope-of-practice laws are a potent way to discourage competition. Scope-of-practice laws restrict the tasks that nurses, pharmacists, physician's assistants, nurse practitioners, and other healthcare professionals may perform. These laws vary by state and effectively limit the number of primary caregivers, a problem which is particularly serious in rural areas. Due to this restriction on the supply of primary caregivers, patients face soaring costs and longer wait times.

Another supply-side restriction is certificate-of-need laws. Certificate-of-need laws mandate that healthcare providers acquire approval from state regulators before adding new healthcare services, investing in technology, or expanding physical facilities. Because certificate-of-need laws impede providers from quickly expanding the scope of care provided, these laws have led to a decrease in access to and quality of care, and an increase in costs for patients.

Conclusion

The incentives driving the people and organizations participating in the healthcare market are not properly aligned to benefit patients or even providers. With these misaligned incentives properly understood, it is possible to correctly diagnose the problems in the healthcare industry and develop a methodology to assess how proposed reforms will impact the healthcare and health insurance industries. The subsequent studies in this series will do just that.

Endnotes

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