The Role of Third-Party Payers in Medical Cost Increases

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ABSTRACT

From the 1970s until the recession of 2008–2009, medical expenses in the U.S. rose at a rate significantly faster than inflation. This is commonly believed to be the result of market imperfections. However, federal and state governments have long suppressed the functioning of the market system in the medical industry. Third-party payment, with its moral hazard, has increased demand and thereby driven up prices. Medical suppliers that work with relatively low levels of third-party payment have seen significantly lower price increases over time. The Patient Protection and Affordable Care Act (PPACA) has increased the usage of high-deductible insurance, but has other features that work against cost containment.

Increasing Demand through Third-Party Payment

In order to function properly, insurance can only cover insurable risks. For a risk to meet this qualification, it must share three common characteristics: the chance of a loss is small; the magnitude of the loss is financially devastating to an individual; and when the risk is spread over a large group of people, premiums are affordable. For example, getting hit by a car is an insurable risk because the chance of such an occurrence is small; the required medical services are too expensive for many individuals to afford; and when the risk is spread over a large group, the premiums are affordable. Yet, many of the services covered by health insurance do not fit this definition, and instead involve predictable expenses or minor care.[1,2] In fact, the Patient Protection and Affordable Care Act (PPACA) mandates coverage of immunizations, alcohol misuse screening and counseling, blood pressure screening, depression screening, diet counseling, obesity screening and counseling, tobacco use screening, anemia screening, breastfeeding comprehensive support and counseling, folic acid supplements, and iron supplements, among other "preventive" services.

Some argue that medical care needs to be treated differently from other market transactions because proper health is essential to life. Yet food is essential to life, and grocery insurance does not exist—nor should it. If this insurance did exist, consumers would become less sensitive to price increases. Grocery stores could then raise the prices of their products, and grocery insurance premiums would increase in order to account for the change in prices. That a good or service is "necessary" does not make it insurable.

Unlike health insurance, other forms of insurance have not typically stepped outside of their proper role. For example, automobile insurance does not cover predictable or inexpensive services such as emissions testing or oil changes. The reason health insurance has been able to expand beyond its original market function is the extensive intervention of government.

Insurance for illness began around 1260 with the German *Knappschaftverein*. These were voluntary, charitable organizations that "provided short- and long-term sickness insurance and pensions."[3,4] Modern-form health insurance plans did not appear until 1850, when the Franklin Health Assurance Company of Massachusetts created the first form of health insurance in the United States in order to cover injuries related to railroad and steamboat accidents.[5] However, despite growing popularity, few Americans owned health insurance until the mid-twentieth century; most medical payments came directly from patients' pockets.

During World War II, politicians inadvertently increased the number of insured individuals by enacting wage and price controls: employers, who could not offer higher wages to attract workers, offered benefits including health insurance.[6] In 1943, the U.S. Supreme Court boosted demand for insurance further by ruling that employer-provided health insurance was exempt from taxation. If employees were in a tax bracket of 20 percent, for example, and their employer offered them $10,000 each, then each employee would receive $8,000 after taxes. However, if employers offered them $10,000 each in health insurance benefits, then each employee would receive 100 percent of this benefit. Even if some employees did not make full use of the benefits available, the sizable taxes the employee would have to pay to receive the compensation as cash meant that there were advantages to obtaining insurance through an employer. The high federal income tax rates that prevailed from World War II until the Kennedy tax cuts reinforced the advantages of such nonmonetary compensation.

In addition, employer-provided health insurance takes advantage of risk-pooling effects. Insurance companies selling to individuals who are independently seeking insurance face a significant adverse selection problem: those who are most likely to become ill are first in line for insurance, and unless the insurer can adequately screen for risk and structure premiums accordingly, the insurer will not be able to profitably sell insurance. The insurer can avoid this costly screening process by insuring groups assembled for some

purpose other than to obtain health insurance. Since large companies represent attractive risk pools, the increasing fraction of the U.S. population employed by large companies in the first half of the 20th century probably contributed to the trend toward employer-provided health insurance.

Thus, employer-based health insurance proliferated. Thomasson observes that total enrollment in health insurance in the U.S. grew from 20,662,000 in 1940 to about 142,334,000 in 1950.[7] Within two decades, this type of insurance covered more than 50 percent of the U.S. population. Through government mandates and union pressures, health insurance became extremely comprehensive, and by 2010, 83 percent of Americans owned some form of health insurance.[8]

Insurance and Moral Hazard

Health insurance reduces price sensitivity because patients do not pay for medical care at the point of service. Third parties provide the bulk of medical payments in the U.S. Insurance companies pay for these services using patients' monthly premium payments or, in the case of government-funded health insurance, tax revenue. This separation of consumption and payment makes people act as though they are receiving low-cost or even free services. A patient may opt for a procedure that costs taxpayers or insurance policy-holders $1,000 even though the value to the patient is only $200. Litigation aggravates the problem as patients and their attorneys seek large numbers of radiology procedures and other tests in an effort to locate one result to bolster a case. Some plaintiffs, for example, may obtain 5 to 10 MRI scans of the spine, which are unnecessary medically, but are demanded in the hope of obtaining an incidental finding that leads to a large settlement (L.R. Huntoon, personal communication, 2014). Additionally, because insured patients lack price sensitivity, physicians have little incentive to consider the full cost of services provided.

The tendency to overconsume medical care as others bear the cost is an example of *moral hazard*. More generally, moral hazard is a term used by economists to describe the tendency to take on more risk as the costs are shifted to others. In medical care, the overall effect is to shift the demand curve for medical services to the right, raising the equilibrium price. The level of distortion in the quantity of these services demanded varies with the price elasticity for each service. For example, a decline in out-of-pocket price due to insurance would be expected to have little effect on the number of heart surgeries purchased, but a large effect on the number of cosmetic surgeries.

Overuse, to whatever extent it is occurring, implies an efficiency loss since consumed services are worth less to the patient than what it actually costs to provide them. For every dollar of services consumed, on average the patient only pays 11 cents out of pocket.[9] On average, then, patients would have an incentive to consume medical care services up until the value of the service is worth 11 cents on the last dollar spent.

In a free market, prices "restrain costs by providing incentives for the individual to use a given good or service only to the extent that its incremental value to that individual is greater than its incremental costs."[10] In our current system, patients are unintentionally consuming medical services that have marginal costs that exceed their marginal value. For some services, the ratio is even smaller than the $0.11:$1 average. Herrick indicates that for hospital care, patients pay an average of only 3 cents out of pocket for every dollar spent.[9] For some patients, and some services, the monetary cost may well be zero, which means that the price rationing system has been replaced by some other form of rationing.

That rationing alternative could take a variety of forms. One is rationing by "willingness to wait." Where the out-of-pocket cost to patients is very low, this form of rationing is likely to be more significant. Herrick cited studies showing that two-thirds of Medicaid patients were unable to obtain appointments for urgent ambulatory care within a week. Emergency rooms visits entail infamously long waits. Herrick says that those Medicaid patients who turned to emergency rooms faced average waits of 222 minutes.[11] Thomas Sowell writes of the long waits customary in countries with government-provided medical care:

> In 2001, more than 10,000 people in Britain had waited more than 15 months for surgery. In Canada, a 2004 study showed the median waiting time from receiving an appointment with a specialist to actually being treated was 15 weeks for ophthalmology and 24 weeks for orthopaedic surgery. This does not include the waiting time between being referred to a specialist by a general practitioner and actually getting an appointment with that specialist, these additional waiting times varying by province from 7 weeks in Manitoba to 12 weeks in Prince Edward Island.[10]

As moral hazard makes patients "poor shoppers" and increases demand overall, insurance companies will increase premiums. Government mandates on what must be included in health insurance coverage (famously expanded in the misnamed "Patient Protection and Affordable Care Act") further drive up costs. According to researchers from the Kaiser Family Foundation, the average cost of annual premiums for family coverage in 2013 was 4 percent higher than in 2012 and 80 percent higher than in 2003.[12]

Government payers have an even worse cost-containment record than privately provided medical care. Anderson points out, "since 1970, the costs of Medicaid have risen 35 percent more, and the costs of Medicare have risen 34 percent more, per patient, than the combined costs of all health care in America apart from these two flagship government-run programs."[13]

Furthermore, insurance and government-provided medical care causes the behavior of physicians to change

in a way that does not necessarily benefit the patient. Specifically, because people with third-party payers behave in a manner consistent with the fact that someone else is footing their bills, physicians who accept insurance do not have to compete for patients on the basis of price.

Also, the low Medicare fees function as a price ceiling, inducing physicians to compensate by increasing the volume of services. Visits are rushed, and many physicians hire those who have less medical training (e.g., nurse practitioners or physician assistants) to increase the number of patients seen per day.

Moreover, because these physicians have to deal with third-party payers, they have to allocate their resources toward costly administrative expenses. In other words, funds that could have gone toward the quality of care are instead going towards files, staff, and office space.[14] Third-party payers themselves introduce another layer of expenditures, relative to out-of-pocket systems: the companies must cover the expense of administering insurance plans, providing cushions for contingencies, and delivering a profit to the owners who put up their expertise and capital.[8]

Health insurance and Prevention

Insurance (particularly if comprehensive) gives people an increased incentive to seek out medical help. As we have shown, this can lead to moral hazard. But proponents of insurance mandates, subsidies, and other government interventions have argued that by lowering the out-of-pocket costs of medical care, people may be able to catch minor ailments before they become deadly or require expensive treatments. John Edwards, for instance, stated that "study after study shows that primary and preventive care greatly reduces future health care costs, as well as increasing patients' health."[15]

However, additional spending on prevention does not always result in cost savings. Cohen et al. argue:

> Sweeping statements about the cost-saving potential of prevention…are overreaching. Studies have concluded that preventing illness can in some cases save money but in other cases can add to health care costs. For example, screening costs will exceed the savings from avoided treatment in cases in which only a very small fraction of the population would have become ill in the absence of preventive measures. Preventive measures that do not save money may or may not represent cost-effective care…. Whether any preventive measure saves money or is a reasonable investment despite adding to costs depends entirely on the particular intervention and the specific population in question….
>
> The focus on prevention as a key source of cost savings in health care also sidesteps the question of whether such measures are generally more promising and efficient than the treatment of existing conditions. Researchers have found that although high-technology treatments for existing conditions can be expensive, such measures may, in certain circumstances, also represent an efficient use of resources. It is important to analyze the costs and benefits of specific interventions.[15]

Thinking of prevention too narrowly can lead to high-cost methods of improving health. While health insurance covers preventive medical intervention, most prevention occurs outside doctors' offices and hospitals. The most effective preventive measures may include changes to one's lifestyle or diet, occupational and educational decisions, and other choices far outside the realm of medical intervention. There is, therefore, an inevitable tradeoff. Expenditures on Increased screenings, tests, biopsies, etc. implies, at the margin, less money for automotive brake replacements, smoke detectors, and bathroom handrails.

Limiting the Role of Third-Party Payers

Unlike physicians who rely on third-party payers, those who rarely or never accept health insurance run their practices in a much more efficient and effective manner. Since patients are paying a larger fraction of the cost out-of-pocket, they are price-sensitive, which means that the physicians have to compete with other physicians on the basis of quality and price. There is a growing national trend toward direct primary care. Physicians following this model can charge $10–$50 per month for unlimited visits, no co-pays, with all office-based procedures provided at no additional cost, and wholesale pricing on medications and labs for up to 95 percent savings.[16]

Cosmetic surgeons and nonphysicians who perform cosmetic procedures are prime examples of suppliers who do not typically accept insurance, and as a result, offer a number of advantages. Compared to the waiting rooms of typical doctors, for instance, the waiting rooms of cosmetic surgeons tend to be cleaner and roomier.[14] There is also greater consumer access to price and quality information about cosmetic surgeons.[11] As a result, there is less asymmetry of information in this market, as opposed to the market for insured medical services. And, even though the demand for cosmetic procedures has increased significantly over the years (the number of procedures performed in 2008 was 40 times the number performed in the previous two decades), prices have remained stable and have even dropped in real terms, while all other medical services have increased an average of 45 percent in real terms since 1992.[17] Prices of cosmetic surgery have tracked inflation partly because, in an effort to compete for customers, suppliers have learned to become more efficient. For example, many cosmetic surgeons reduce costs by having surgical facilities in their offices rather than in hospitals.[11] Prices of Botox and other

services that can be administered by nonphysicians have also fallen (D.M. Herrick, personal communication, 2014).

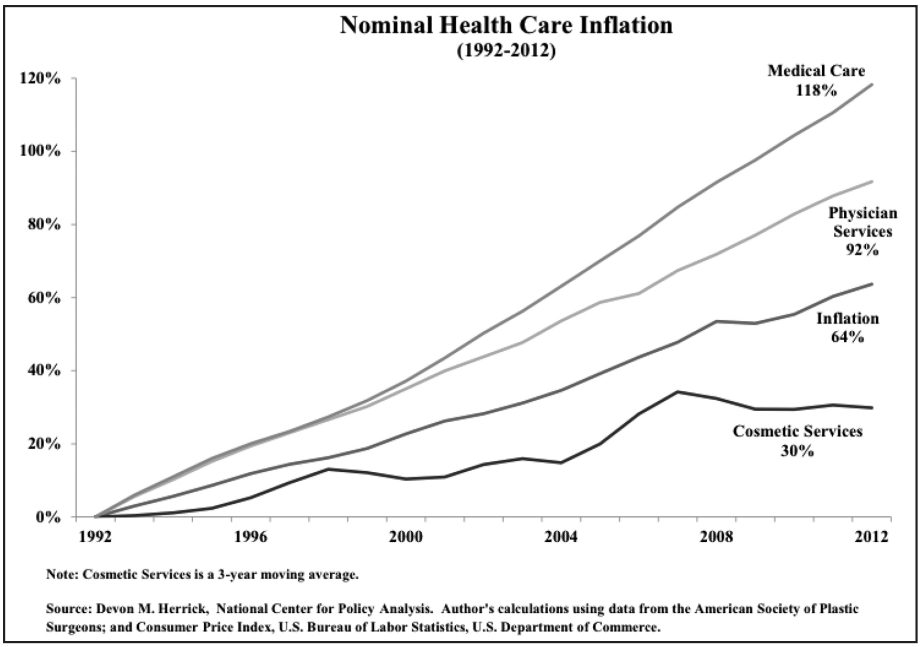

Figure 1. Trends in U.S. Medical Costs, 1992-2012[9]

As with cosmetic surgeons, laser eye surgeons rarely accept insurance, with similar cost outcomes. The price of laser eye surgery has gone down about one-fourth while the prices of every other medical service have gone up faster than consumer prices.[9] Even though the prices have dropped, however, the lasers have become faster and more precise. And, in contrast to the experience of most traditional doctors in third-party-payer practices, eye surgeons have found that their patients are careful shoppers. Dr. Brian Bonanni, a LASIK surgeon, explains that he must tell potential patients exactly how much his service is going to cost because patients tend to shop around when they are using their own money. Dr. Bonnani also notes that many patients will see three or more doctors before making a decision.[18]

More general surgery centers that have opted to cut out third-party payers and provide high-quality services with transparent pricing have appeared on the market. The Surgery Center of Oklahoma is a good example: patients are provided with prices on the center's website, and quality is high, with infection rates of 0.001 percent to 0.3 percent, compared to a national average of around 2.6%. There are many more.[19]

A free-market approach would not mean that insurance would disappear. Insurance would simply resume its market-directed role, with coverage of truly insurable risks and far less influence over medical decisions. Large-deductible health insurance with coverage for uncertain, rare, and catastrophic expenses would become the norm. A medical system that relies on insurance of this type would shift the majority of repayment responsibility to direct-paying customers. We could expect prices to decrease, quality to increase, and customer satisfaction to soar.

PPACA vs. the Free Market

As economist Roy Cordato wrote, "There is possibly no proposition in economics that is more accepted than the idea that if you want to reduce the cost of something, you foster an environment that encourages open competition and entrepreneurship and discourages monopoly."[20] Unfortunately, the government is continuing to move away from this course with its passage of PPACA.

This 2,800-page act requires insurance companies to cover a greater number of services; forces all individuals who do not already own government or employer-provided insurance to purchase their own or pay a penalty; expands Medicaid; and reduces the autonomy of medical professionals and facilities. These PPACA features aggravate the problem of moral hazard for those who remain insured, and thus tend to push prices higher. Furthermore, PPACA requires insurers to cover pre-existing conditions, which goes against the very principle of insurance and forces insurance companies to distribute the costs of these conditions across their other clients. We can already see the impact of this. While Sen. Obama promised during his campaign in 2008 that the average family would see health insurance premiums drop by $2,500 per year, the average family premium for employer-sponsored coverage has risen by $3,671.[21]

PPACA supporters have contended that a recent slowdown in the growth rate of medical expenditures can be attributed to some of its reforms, such as penalties aimed at reducing hospital readmissions. Indeed, from 2010 through 2013, the annual growth rate in national healthcare expenditures was only 1.3 percent, much lower than growth rates from 2000–2007 as well as the long term annual rate of about 4.5 percent.[22] However, Michael Tanner's early assessment indicates that the PPACA may have slowed or stopped a secular trend toward slower growth of medical expenditures. A recent report from the Centers for Medicare and Medicaid Services (CMS) showing lower estimates for future spending cited factors unrelated to PPACA as contributing to the decline. CMS also estimated that PPACA itself worked against the decline. Projections from Medicare's trustees and the Congressional Budget Office indicate that PPACA will be a significant future strain on federal finances.[22]

Some have observed that PPACA, by pushing Americans toward higher-deductible insurance plans, would mitigate some of the moral hazard. The expansion of higher-deductible insurance did not receive much attention initially, but could be one of PPACA's more important effects.[23] Price Waterhouse Coopers noted in a 2013 survey that 17 percent

of employers at that time offered "a high-deductible health plan as the only option for employees." Though this figure already represents nearly a one-third increase over 2012, "more than 44 percent are considering offering it as the only option."[24] Projecting a rather low net growth rate in medical costs of 4.5 percent, the survey credited substantial increases in deductibles and co-pays. In-network deductibles in 2009 averaged $680, while in 2013 they had ballooned to $1,230. Out-of-network deductibles rose even faster, from $1,000 to $2,110 over the same period.

Though higher deductibles can induce patients to become more cost-conscious shoppers, reducing some costs, PPACA has eliminated the reduced premiums normally associated with such plans. Co-pays have also severely increased so that many patients are getting less insurance for the dollar.[25]

Conclusion

On the whole, legislation is pushing medical care in the wrong direction. It attempts to use regulation, rather than freer markets, to resolve the problems caused by earlier regulation. The only way to reduce prices while increasing quality and accessibility is to take a free-market approach.

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