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A famous quote from Winston Churchill is "Democracy is the worst form of government, except for all those other forms that have been tried from time to time". With respect to health reform, I often paraphrase that market based health reform is the worse option given the alternatives. The history of "health reform" is really a timeline of failed national health insurance congressional proposals since the 1910s when the US began its 100 year deviation from European nation states that embraced some form of federal government financing of health insurance. Economics has always been at the heart of the US health policy debate over national health insurance. This essay sets out to provide a narrative foundation of health economic actors that have fought hard for their market dominance and will likely determine whether the US will finally join the 'community of nations' with federally financed compulsory national health insurance or continue to write the history towards an undiscovered country of market based health reform.

Every health care markets class I've taught begins with an economic history of how physicians in the US went from 'doctors on horseback' to the Uber monopolists of high technology craftsmen they are today. A key message can be found in the actions of organized medicine during the last 150 years. These actions have been anything but random in the profession's desire to create a truly monopolist guild. Fortunately for me, one of the best texts on the subject by Paul Starr has been out of print since Starr won the Pulitzer for *The Social Transformation of American Medicine* in 1982. Since most of my students weren't conceived until after 1982, the material is 'new to them' as well as critical to understanding why the US does not have a national health insurance program. Starr recounts how legislative attempts

S. T. Parente (✉)
Department of Finance, Carlson School of Management, University of Minnesota, 321 19th Avenue South, Room 3-122, Minneapolis, MN 55455, USA
e-mail: sparente@umn.edu

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in national health insurance in 1910s, 1930s, 1940s, 1960s and 1970s all ran into the vastly well financed and politically savvy American Medical Association (AMA).

On a parallel track, health economics by the 1970s was an emerging economics field with founding members Herb Klarman, Victor Fuchs, Martin Feldstein and Kenneth Arrow inspiring a second generation of economists at RAND, the fledging National Center for Health Service Research and a handful of health economists in academia starting to break out from strictly public finance, labor and industrial organization fields of study. By the late 1970s and 1980s, health economics influenced one of the largest reversals in the monopoly power of physicians and their hospital workshops described by Mark Pauly. This reversal was driven by fixing their reimbursement rates through prospective payment for inpatient care at first in New Jersey and then across the nation in 1982 for the entire Medicare program.

In 1992, Bill Hsaio led the charge for Medicare's implementation of RBRVS for physician payment schedule that later was adopted by commercial insurance carriers as the central pricing point for non-institutional provider payment. Although health reform as designed through an extension of Alain Enthoven's managed competition ideas failed during the Clinton Administration by 1994, the foundation was laid for health economists creating the operating plan for the Patient Protection and Affordable Care Act (ACA) in 2010. The Massachusetts health reform of 2006, with economist Jon Gruber as chief architect, provided the prototype for ACA with Obama campaign and Administration economic advisor David Cutler as advocate in chief.

Starting in the early 1990s, the AMA suffered a loss of membership from specialties who chose to have members support their own societies and journals and not the AMA journals and their associated AMA dues. While this yielded autonomy to powerful specialties in anesthesiology, cardiology, dermatology, neurology, orthopedic surgery and radiology, it is also greatly diminished the AMA speaking with one uniform voice for all physician specialties. Instead, the AMAs monopoly power on the eve of ACA came to primary care specialties and academic medical centers who were in a less financially advantaged position for positive margins and monopoly pricing compared to more lucrative and largely AMA unallied medical specialties.

By the ACA formation era of 2009–2010, the AMA had suffered a quiet civil war that undermined their prior monopoly power. Up until the wide spread growth of large physician group practices, the AMAs principal revenue was from dues paying physicians. By 2009, the largest share of revenue was the licensure of the AMAs Current Procedural Terminology (CPT) list of procedures codes to government and private payers. Thus, any growth in an insurance program utilizing the CPT technology yielded additional revenues to the AMA with a price mechanism designed by health economists. It was as if Uwe Reinhardts' half-joke prophesy came true about the true end of the cold war. He suggested at the 1990 Association for Health Services Research Annual meeting that once the Soviet Union saw the US successfully institute the most comprehensive price control mechanism in the form of DRGs, Mikhail Gorbachev knew the cold war was lost since the US beat the Soviets at socialist price fixing.

Arguably, the biggest political sea change in 2010 when ACA was passed was not the excellent political skills of House Speaker Nancy Pelosi. Instead the AMA abandoned century old position opposing health reform. The AMA supported Obama Administration health reform based on the narrow interests of their remaining constituents of primary care physicians and academic medical institutions. These groups were promised greater reimbursement and increased investment in medical education and grant funding, respectively, in exchange for the support of ACA.

The irony of the passage of ACA is the roots of the law lie far more with Republican market based health reform solutions than the single payer and Medicare for all national health insurance programs proposed by Democrats since the end of World War II. The hallmarks of ACA ranging from insurance exchanges, to the individual mandate, to pay or play policies for employers, high risk pools and the partial capping of the tax exclusion were all supported as market based solutions by Republican officials for nearly 30 years. The only exception was a federally controlled Medicaid expansion which the Supreme Court in June 2012 determined to be coercive and left to be an option for Governors to decide to implement. As a result, there are many issues in ACA implementation Republicans can inform just as easily as Democrats. It is with this economic history in mind, I discuss a set of topics for consideration. Adequately addressing these topics with a market based construct could guide ACA (or its proposed Republican replacements) to a successful future or to Shakespeare's Undiscovered Country "from whose bourn no traveler returns". From this undiscovered country, no physician monopolist can walk back to the world that existed prior to ACA, DRGs and RBRVS.

The first topic of five to address is health insurance exchanges (HIXs). In their most basic form a HIX would serve as a vehicle to post prices for health insurance similar to what ehealthinsurance.com practices today as well as 12 years ago in 2000. However, the ACA version of exchanges assigned them the role of subsidy dispenser at the state or federal level (depending on current IRS rules) to expand health insurance to those at 100–400 % of the federal poverty line (FPL). As proposed by ACA, competition can only increase if insurers start offering new products or state insurance commissioners allow out of state offers of health insurance. Without these exceptions to the current individual insurance status quo it is unlikely true premium competition will emerge to lower premium prices sufficient to keep health care price inflation close to the general inflation insurance rate. However, if HIX was to be the vehicle that would have allowed interstate sale of health insurance, new national and regional market entrants could have lowered the premium price through robust competition.

A second issue for market-based reform is the reaction of employers. The individual insurance market and small group market will likely morph into one with or without ACA. Removing or capping the tax exclusion will lead (slowly) to employers providing a fixed and predictable dollar contribution to employees to purchase health insurance. The Cadillac tax left on its own will phase out most of the exclusion (without additional special interest exemptions for unions etc.) by about 2025 because the exclusion is indexed to general inflation in ACA statue from 2018 onward. Thus, in 2020 the exclusion is more Buick priced and by 2025 it will be closer to Kia pricing—meaning the share of tax exemption for consumers will be far less. The only reversal would be if health inflation was vastly lower than general inflation—but that is nearly improbable given decades of past trends. The notion of an individual mandate coupled with employer health insurance contribution has been the status quo in Switzerland for two decades and appears to operate without sufficient glitches for government intervention to control the market or private employer abandonment of health insurance benefits provided as vouchers to employees.

A third issue is the organization of services delivery. The ACA proposes a set of service delivery Accountable Care Organization (ACO) pilots for Medicare patients to pay providers for successful patient outcomes, not just services rendered. One of the principle charges of physician ACO advocates is the 'health care system is broken due to fee-for-service (FFS) reimbursement'. In contrast to the physician fixed salary approach of a Kaiser Permanente model, FFS has been the dominant growing form of provider reimbursement because it is relatively easy for an insurance company to operate and it does not put any fixed constraints on an insurer to pay for services not rendered. Even the newest form of health insurance,

consumer driven health plans, relies on FFS for reimbursement. With respect to services delivery, the downside of FFS is that it rewards transactions of care and not the outcome of care. The problem with moving away from FFS is simply the paucity of comparatively easy reimbursement mechanisms to adequately pay physicians for outcomes. Why? Good outcome metrics are rare and in most cases impossible to gauge until hours if not weeks after the care is rendered or prescribed. The closest mechanism might be to pay physicians a subsistence salary and then provide a reward of 40 % of their income/bonus (something more than a 15 % withholding of reimbursement commonly practiced in the heyday of managed care) when the aggregate 'outcome' metrics of all their patients seen in a given time period improves significantly and consistently. To measure outcomes adequately you need minute by minute tracking of implanted 'outcome' sensors that the best science fiction and speculative fiction writers can dream up coupled with civil libertarians going on a permanent holiday to Venus. More likely we will have cold fusion and warp drives before we have adequate outcomes based reimbursement that is a mainstream form of provider payment.

The future of good care management does not have to be consigned to ashes due to a FFS dominated role. The FFS system can be adapted to require clinical data taken from the point of care to better managed patient care, or at least release critical clinical data from hospital servers to a larger set of servers where a patients' complete clinical picture can be aggregated to inform care management. From the vantage point of its health informatics advocates, this is the promise of health information technology. And yet, it is a physician monopoly approach to data in that it is seen as the last frontier of monopoly right. Spend any time talking to health informatics experts and one finds a distinctive care delivery information technology vision where the future linked care systems are sharing data with other care systems. But these physician futurists are not running their hospitals. Those in charge of hospitals see the release of clinical data as the biggest potential malpractice liability risk in generations.

In contrast, a FFS insurance approach to health information technology could easily be to require hospitals and physicians to 'attach' available clinical data from their electronic medical records at the point of care to the FFS claim for reimbursement. An even better FFS approach would be to pay providers in seconds if adequate clinical information was provided. Physicians would respond since the average time from claim submission to payment at one large commercial insurer is over 45 days. This could be an even greater threat to physicians and hospitals because the data repository for outcomes and rewards will be insurance companies who have decades of experience analyzing data for setting premiums and managing care as best they can with the limited metrics available. I see insurers in the end as having the superior monopoly position, not because of technical skill compared to providers but because of their unmatched ability to provide the financing for health care at price points substantially higher than the consumers' willingness to pay from their personal savings. Essentially, once hospitals and physicians abdicated taking a lead role in financing their own services in the 1930s and 1940s with early Group Health and Blue Cross Blue Shield plans as replacements, the path we are on today was set. Thus for ACOs to truly be successful and regain a position of superior monopoly pricing over insurers they should not 'partner' with Aetna, Cigna and UnitedHealth—they should seek to buy them. If that is seen as too bold a proposition than their expectations of ACOs needs to be a bit lower or they will soon become yet another failed initiative for Health Affairs to track from womb to tomb (see: managed competition, six sigma in health care, and wellness programs).

A fourth topic is the role of private insurers in public health insurance programs. From its implementation in 1967, Medicare has always relied on the purchase of services from private insurers to administrate the program. This reliance on private insurers has only increased over time with Medicare Advantage plans, managed Medicaid programs, as well as Tricare,

the private insurance provided government program for military veterans and their spouses until Medicare enrollment at aged 65. For the political left, the frequent demon caricature of private health insurer stands in ironic contrast to pragmatic reality. Without private insurers there would be virtually no Medicare or Medicaid programs today. ACA is likely to increase the role and revenue of private insurers. In terms of economics, the interesting behavior to watch is how insurers use their increasing price setting power across the entire provider reimbursement space from commercial insurance to Medicare to Medicaid. For example, let's assume for a large insurer, their employer client has provider payment of $100 for a standard office visit and their Medicare Advantage fee for the same procedure is $75 and their commercial Medicaid fee is $40. As ACA grows the number of providers in the public and private insurance market, a monopsony payer can gradually move their payments towards Medicaid levels for all clients very gradually over time to improve/maintain their margins and further erode the monopoly pricing power of physicians. Furthermore if newly forming ACOs/hospitals are acquiring physician practices and expect revenue at a certain level based on historic commercial payment rates, the ACOs may be in for rude awakening if payments start to migrate even a few percentage points closer to Medicaid payments compared to their original expectations.

The fifth and final issue is the claim that there are no real market based health reform plans if the Republicans move towards a repeal and replace strategy. The qualification for a real plan should be either proposed legislation or a document with specific policy details to be easily developed into legislation. The market based health reform plan that easily meets these criteria is the Patient Choice Act (PCA) of 2009. In comparing PCA to ACA, one of the biggest differences is Medicaid expansion. While a market based approach emphasizes expansion and tax treatment equalization of the purchase of health insurance, ACA chooses to achieve increases in insurance coverage using Medicaid and consequently crowds out some of the private insurance market in the process. This is true particularly in states with Medicaid eligibility below 100 % FPL and those with no benefits for childless adults where a private insurance high deductible health plan made available by tax credit may be a better market solution in that it does not forestall a premature declaration of market failure. Is the PCA approach the perfect solution? Not likely, but given the alternatives it may be one of the least undesirable approaches.

Another key difference between PCA and ACA is the use of exchanges. For PCA, exchanges would most likely resemble Medicare Advantage where health plans are invited to place health plan options on a web site for a federal market. There would be no state based exchanges required, though that could certainly be an option. Coordination with the IRS and Treasury would still be required to provide resources for advance-able and refundable tax credits. Engagement of a default federally managed high risk pool would be required as well along with regulating guaranteed renewability of insurance on a federal scale. But, ACAs highly prescriptive metallic plan choices, minimum loss ratio and actuarial fair value equivalent regulations would not be required.

In summary, provider monopolies have helped make the US health care market one of the most dynamic in the world by forestalling national health insurance. With the reduction in the ability for providers to create absolute monopolies and the insurers' growing role not just as monopsony but as health information technology infrastructure bedrock, it is time to eliminate tax distortion and have the market move forward towards a more efficient system with greater consumer access to insurance products. While the ACA has many components that may be a step backwards towards a market based solution it also has many pieces that, over time, make a market based approach inevitable particularly with the now optional expansion of the Medicaid program for states to decide. If repeal ever becomes a political option, viable

replacement legislation exists. If and when that occurs, US citizens will still enjoy expansion of coverage through a design advocated by many health economists over several decades and the undiscovered country we find might be okay enough to call home for a while.