Can US Health Care Costs be Contained?

I. Basic Issues Involved in US Health Care

This short reading reviews the issues surrounding the health care revolution that is going on in America. We will begin by looking all the way back to the 1960s to an important paper written by Kenneth Arrow on health care. Arrow wanted to know whether the US could avoid socialized medicine by first redistributing income and then simply having people purchase their health care in private markets. We will see that he was not particularly optimistic that this solution would work.

Fifty years later the US is embarking on a radical change to its health care system. There are some who welcome this change and see it as long overdue. They point to successful programs elsewhere in the world and hope that the US could emulate these. Perhaps we can refer to these people as "progressives". There are other people who vociferously oppose the changes being instituted to the US health care system. They see this as one more aspect of American life that is being subjected to heavy-handed centralized control by Washington. They fear that such regulation will eventually reduce choice, create long lines at the hospital, and destroy the quality of the US health care system. Perhaps we can refer to these people as "conservatives". Both sides of the argument agree that health care costs in America are skyrocketing and that something must be done to "bend the cost care curve". They differ however on why the costs are rising and how the costs curve can be bent.

The first group spoken of above seeks to control costs mainly by eliminating administrative waste, instituting more aggressive preventative medicine plans, directly holding down costs by refusing to pay more through public insurance programs, and reducing insurance costs by requiring healthy Americans enroll in insurance programs either privately or through insurance exchanges set up by each state. The second group in the paragraph above seeks to reduce costs by allowing insurance to be sold across state lines, reducing the awards on medical malpractice insurance cases, reducing red tape in the operation of hospitals, and streamlining administration through tax incentives.

A central aspect of the problem of health care expenditures is that it is paid for by third parties, namely insurance companies and the government. The consumer of health services pays of course an insurance premium, but once this has been paid, there is no incentive to economize. Indeed, there is every motivation to utilize health services at
every opportunity. Insurance attempts to handle this problem by use of co-payments, which include both deductibles and co-insurance.

A deductible occurs when the consumer must pay a limited minimum amount in order to receive the service. The fixed deductible must be paid before any insurance is paid. This is much like a registration fee in Taiwan or a two part tariff, but it can be different for different services. The deductible is useful in keeping people from going to the doctor everyday for any pain or ache. It guards against *moral hazard*. It is regressive, since higher income persons do not have to pay a higher deductible. This is because there are not many rich people and they tend to get sick less often. They also are much less willing to sit waiting for a doctor since their opportunity cost of waiting is higher. A deductible will typically be $250 up to $5000, and may vary depending on how many family members you are insuring. That means you will pay that $250 to $5000 before insurance begins to pay for your care.

The other manner in which health insurance companies (and the government) limit use of medical services is through co-insurance. This is where individuals are required to pay a percentage of the medical procedure’s cost, say 20-30% of an amount like $10,000, after which insurance pays the rest.

The out-of-pocket costs are therefore the deductible plus the co-insurance.

Here is an example using an appendectomy.¹

- **Appendectomy** (阑尾切除術, 盲腸切除術)
- Total cost -- $30,000
- Deductible -- $2500
- Coinsurance -- $3000
- Total, out-of-pocket -- $5500

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¹ This $30,000 figure is not bad since a recent study looked at over 19,000 people who had an appendectomy in California in 2009 and found that the median cost was $33,611 with a low of $1529 and a high of $182,955. See [http://archinte.jamanetwork.com/data/Journals/INTEMED/23597/ilt120007_818_819.pdf.png](http://archinte.jamanetwork.com/data/Journals/INTEMED/23597/ilt120007_818_819.pdf.png)
II. Arrow's Oft-Quoted Analysis

Health care is an especially challenging subject since it deals with a complex service being offered for sale to people who typically have it, at least partially, paid for by a third party. In addition, the service being offered involves considerable uncertainty. First, there is the uncertainty of ascertaining the illness precisely. Second, there is the uncertainty of choosing the best team of health specialists having the right motivations and most efficient treatment. Third, there is the uncertainty of evaluating the quality of the service before and after it has been rendered and whether the treatment has been efficacious after all.

The provision of health care is not like a simple standard good being produced by a firm and sold in a competitive market. Certainly, there are elements of the standard competitive model at play, but there are many other aspects which fall short of our typical model. Arrow (1963) discusses how that the market for medical care (not health care, which is a broader term) falls short of the competitive standard. He claimed that informal institutional structures and conventions arise to fill the gaps missing due to a lack of competition.

Arrow begins his article by exploring the issue of whether it is necessary to have the government directly control a market to achieve optimality, or whether instead it is only necessary to use monetary transfers and a change in the distribution of purchasing power to achieve optimality. In effect, he offers a highly abstract argument concerning socialism versus capitalism – though he doesn’t say so as such. He couches his arguments in two optimality theorems – (1) competitive markets create optimal solutions in the sense of being Pareto Optimal, and (2) any optimal state corresponds to a competitive equilibrium for some initial distribution of purchasing power. Thus, if we can decide on what we mean by an optimal state, then we can achieve this state using a competitive market coupled with a government policy of redistribution of purchasing power. In effect, if the conditions for competition exist (at least potentially) in the medical industry, then we can achieve a generally accepted optimum state (including possibly non-interference) by transferring money (or not) from the rich to the poor. There would be no reason to nationalize the medical industry and no reason to turn to socialism. Despite the abstract language, it is clear that the question Arrow is asking is whether doctors and nurses will retain private practice or whether they will be forced to become civil servants. The key to answering this question is whether or not the medical industry looks to be at least potentially competitive.

Arrow is not particularly optimistic about the medical market having the potential of being competitive. For one thing, there is a large class of phenomena which affect the market, but which are not bought or sold. Arrow claims that an important precondition of competition is that all such phenomena be capable of being marketed. He calls this
marketability. Common externalities are an example of this. If private and social costs do not agree, then externalities can arise. These externalities are not marketed – they have no explicit exchange prices – and therefore they can threaten the existence of competition.

The market for medical services is not like our common textbook type commodity. Here is a short list of differences Arrow feels are significant.

A. Demand is not stable.

Obviously Arrow is speaking of the microeconomic demand of the individual. Certainly the community has a constant demand for medical services. Indeed, this demand should increase with the average age of the population. Demand for medical services is also affected by the risk of the procedure and its expectation for success. Most goods do not involve such a large element of risk in the outcome of consuming them.

B. Role of the Physician is complicated.

The doctor is the center of the supply of medical treatment. In particular, the doctor is expected to make decisions for the patient while at the same time setting aside the issue of what treatment is most profitable. As Arrow says, the treatment is expected to be supplied by the objectives needs of the case. Overall, profit seeking is considered with suspicion when applied to medical services. Arrow claims that there is little price competition between doctors and there is little use of advertising. Often doctors are expected to work together to help the patient. This would be unheard of in a typical market for goods.

C. Product Uncertainty in Medical Industry

Often it is difficult to assess the quality of the service being rendered in the medical industry. Treatment that fails can be blamed on the complications of the illness and general lack of an effect treatment. On the other hand, treatments that are highly successful can be attributed to the skill of the doctor. This makes it difficult to assess the relative effectiveness of doctors. There is also the problem of spurious correlation. A great doctor may see only very sick cases and therefore may have a very low recovery rate. Other doctors who have poor skills may accept only those patients that have great chance for success and therefore have a high recovery rate and excellent recommendations for past patients. Arrow also stresses the fact that there is a great asymmetry between the information the doctor has and the information the patient has. Naturally, this has led to the well known admonishment that one should always seek a second opinion. Much of this information asymmetry can be eliminated by using a family doctor over many years – one that understands the patient and can give advice freely and can engender a sense of trust.
D. Supply Conditions.

Supply of medical workers is usually restricted by a licensing requirement.

Arrow then turns to a comparison of the medical industry in the US with the competitive standard both deterministic and one with uncertainty. In addition, most medical students are subsidized. This raises the private benefit to the entering student. This should reduce the price of medical treatment, but it is balanced by a rationing of admission. High cost of medical education is probably due to the high quality standards that are instituted. Arrow notes the declining ratio of doctors to all medical workers and offers this as weak evidence that substitution is possible in the industry.

I should point out that in my view Arrow does not adequately discuss the long term hazards of being a doctor – in terms of mental health, sustained tension, poor working hours, and risk of malpractice. These are qualitative aspects which must be offset by price in some way.

E. Pricing Policies

Arrow points out that the medical profession relies greatly on price discrimination (by income) and has a strong insistence on fee-for-service as opposed to prepayment. There is even stronger opposition to contracts which bind a patient to a particular group of physicians (Arrow calls this closed-panel practice). Some economists have discussed the problem of price-fixing.

Arrow next considers to what extent the medical industry differs from a competitive industry. We will not go into these details. Instead we will focus on some important aspects and special terms used in health economics.

III. Common Terms in Health Care Economics

**capitation** -- A method of payment to a provider of medical services according to the number of members in a health benefit plan that the provider contracts to treat. The plan sponsor agrees to pay a uniform periodic fee for each member. (Capitation means by the head, or per person.) Because the fee is independent of how many services are performed, the doctor has an incentive to keep costs low. The doctor's incentives not to render only minimal treatment include professional integrity, the risk of malpractice suits, loss of business if patients are dissatisfied, and the risk of simple illnesses becoming more severe and costly to treat.
fee for service -- Payment to providers of medical services according to the services performed. The fee for each procedure or treatment is individually billed by the provider and paid in full by the patient, insurer, or other health benefit plan sponsor.

**all-payer system** -- A health care system in which all public and private third-party payers of medical bills are subject to the same rules and rates for payment. The uniform fees, in effect, bar health care providers from charging more to persons or firms who are more able to pay in order to make up losses from artificially low payment caps by some payers.

**single payer plan** -- A method of paying health care providers whereby all fees are paid by a government or a designated administrator. The government establishes standard fees without regard to the providers' actual service costs in particular cases. This is the system used in Canada.

**national health insurance** -- A form of health insurance where every individual in a country is provided health insurance either through a national health insurance program administered by the government (e.g., Great Britain, Canada), or they are guaranteed coverage through private insurers by legislation. (also universal coverage, socialized health insurance)

**primary care physician (PCP)** -- The medical doctor assigned to or selected by a member of a managed care plan as the practitioner who usually treats the member or authorizes treatment by specialists. Because of the primary care physician's role in referring patients to specialists, this doctor is sometimes termed the gatekeeper.

**health maintenance organization (HMO)** -- A medical group practice plan that acts as both an insurer and health care provider. Group participants are entitled to services from participating physicians, clinics and hospitals for a flat monthly or quarterly fee.

**point-of-service plan (POS plan)** -- A health maintenance or preferred provider organization's program that allows members to seek treatment from providers outside
the network (that is, providers not employed by or under contract with the organization) at a reduced benefit level, commonly 60% to 70% of in-plan coverage, or at a higher premium.

**closed panel health maintenance organization** -- One of two types of HMO approved by the Health Maintenance Organization Act. (The other is the independent practice association.) Under this form, the HMO employs a group of medical professionals at a central location or contracts with a medical group to provide services exclusively for the HMO's members. Tight control of medical services is maintained because of the close affiliation between the employer HMO and its medical personnel.

**IV. The Patient Protection and Affordable Care Act (aka Obamacare)**

This section reviews some of the major features of the Affordable Care Act. This act is still a matter of great controversy in the US. There is a wide diversity of opinion about the act and its future consequences.

**Key provisions**

-- prohibiting health insurers from refusing coverage based on patients' medical histories

-- prohibiting health insurers from charging different rates based on patients' medical histories or gender

-- repeal of insurance companies' exemption from anti-trust laws

-- establishing minimum standards for qualified health benefit plans

-- requiring most employers to provide coverage for their workers or pay a surtax on the workers wage up to 8%

-- restrictions on abortion coverage in any insurance plans for which federal funds are used

-- an expansion of Medicaid to include more low-income Americans by increasing Medicaid eligibility limits to 133% of the Federal Poverty Level and by covering adults without dependents as long as either or any segment doesn't fall under the narrow exceptions outlined by various clauses throughout the proposal,
-- a subsidy to low- and middle-income Americans to help buy insurance
-- a central health insurance exchange where the public can compare policies and rates
-- allowing insurers to continue to dictate limits on evaluation and care provided consumers by their physicians ("managed" or "rationed" care)
-- avoidance of capitating or regulating premiums which are routinely and in accordance with this law, charged by an insurance company for coverage, which might make the coverage non-affordable with regard to a consumer’s income
-- requiring most Americans to carry or obtain qualifying health insurance coverage or face a fine for non-compliance
-- a 5.4% surtax on individuals whose adjusted gross income exceeds $500,000 ($1 million for married couples filing joint returns)
-- a 2.5% excise tax on medical devices
-- reductions in projected spending on Medicare of $400 billion over a ten-year period
-- inclusion of language originally proposed in the Tax Equity for Domestic Partner and Health Plan Beneficiaries Act
-- inclusion of language originally proposed in the Indian Health Care Improvement Act Amendments of 2009.
-- imposing a $2,500 limit on contributions to flexible spending accounts (FSAs), which allow for payment of health costs with pre-tax funds, to pay for a portion of health care reform costs.

Questions:
#1. Liberals and conservatives have different health care reform plans. Explain.
#2. What are the functions of the medical deductible and co-insurance?
#3. What was Arrow's main assertion and does the US medical system satisfy this?
#4. Health care is not like the usual good sold in the marketplace. Explain.
#5. Discuss the main provisions of the Affordable Health Care Act.
#6. Why did some people feel the individual mandate was unconstitutional? Was it?
#7. Health care costs in the US are out of control. Using the graphs below explain.
Some graphs showing US health care costs:

Graph 1  International Comparisons

SOURCE: Data from OECD, Health Data 2012, June 2012. Compiled by PGPF.
NOTE: Per capita health expenditures are for the year 2010, unless otherwise noted. Comparison uses Purchasing Power Parity, which adjusts exchange rates to account for cost of living differences between countries.
*Japan and Australia data from 2009.
Graph 2  Health Care Expenditures as a Percentage of GDP

Graph 3  Chronic Health Care is a Big Money Hole

Sources: Medical Expenditure Panel Survey, 2006 and Robert Wood Johnson Foundation, Chronic Care: Making the Case for Ongoing Care, February 2010.
Graph 4  Older Population Growing in US

Figure 3: Population Over 65 as Share of Working Age Population

Source: Congressional Budget Office.