

ECONOMIC COMMENTARY

Federal Reserve Bank of Cleveland

The Government's Role in the Health Care Industry: Past, Present, and Future

by Charles T. Carlstrom

In 1965, Congress enacted Medicare and Medicaid to ensure that poor and elderly Americans would not be denied access to health care. In that year, 5.9 percent of the nation's total output was spent on medical services. By 1992, this share had soared to approximately 14 percent, and by the year 2000, it is projected to reach almost 19 percent.¹ The growing fraction of the economy devoted to health care is one reason why many advocate a major overhaul of the current system.

A second is that although federal and state governments are projected to spend \$365 billion this year providing medical care for the poor and aged, 15 percent of the population still lacks health coverage — a situation many find deplorable.² A third criticism stems from the fact that 91 percent of private health insurance is handled through employers.³ This has created what is known as "job lock," or the reluctance of workers to change jobs or industries because they fear losing their medical benefits. Although it is hard to quantify the impact of job lock on the economy, public opinion polls suggest that between 10 and 30 percent of workers feel tied to their current companies for this reason.⁴

These problems have led to increasing pressure on the federal government to pass some type of health care reform package. Congress, the administration, and the American public are currently

debating what form this legislation should take. Before adopting any new system, however, we need to understand the forces — both market and government — that have shaped and are currently shaping our approach to health care. This *Economic Commentary* examines these forces by looking at the history of medical care in the United States since the early part of the century.

■ Health Care: 1913 to 1966

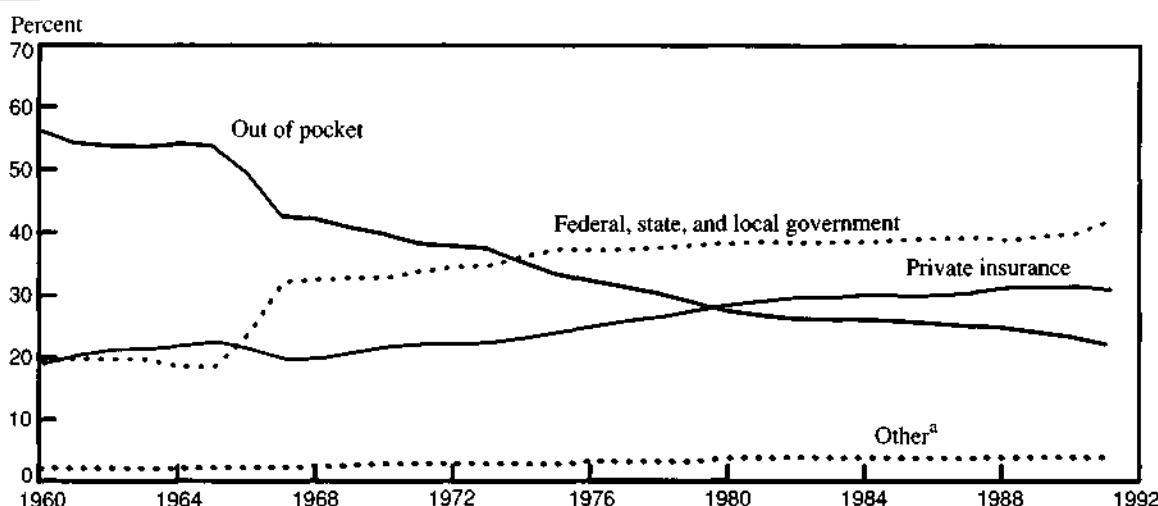
Many claim that the market for health care is unlike that for most goods and services. While this may be true, prior to the Depression, the health care market in the United States operated much like any other, with customers paying doctors and hospitals directly out of their own pockets. The major difference between health care and other goods and services today is insurance: Third-party payers now contribute 78 cents of every medical dollar spent.

The U.S. health insurance industry can trace its roots to 1929, when Baylor Hospital began offering prepaid hospital coverage to 1,200 teachers. This was the beginning of what later became known as Blue Cross.⁵ The dramatic growth in health insurance did not occur until World War II, however. By 1943, 43 Blue Cross plans were in effect nationwide.

Blue Cross originally based its premiums on the cost of insuring specific geographic areas, with each resident

When Medicare and Medicaid were passed in 1965, less than 6 percent of the nation's output was devoted to health care. Today, that figure exceeds 14 percent and is rising rapidly. This article looks at some of the reasons behind the relentless ascent in medical costs over the last several decades and examines how government policy has both contributed to and tried to rein in these costs.

FIGURE 1 SOURCES OF PERSONAL HEALTH CARE EXPENDITURES



a. Includes philanthropy and industrial in-plant spending for health care.

NOTE: Personal health care expenditures are equal to national health care expenditures minus outlays for public health, research, construction, and administrative costs.

SOURCE: "Trends in Health Spending: An Update" (footnote 2), table A-4, p. 52.

charged the same amount. This practice, known as the community ratings system, was gradually superseded by experience-rated premiums, which were based on the expected cost of insuring an individual or subgroup. Thus, payments began to depend on a person's age, sex, and health status.

The advent of experience ratings was inevitable in light of adverse selection. Adverse selection refers to the greater incentive under community-rated plans for those with generally poor health or chronic illnesses to purchase medical insurance. Because of this selection bias, insurers could not charge actuarially fair premiums to normal healthy individuals, who were thus driven even further out of the market. To bring them back in, it became necessary to move toward an experience-rated system. Insurance companies hence started spending resources to ascertain the risk class of individuals, which effectively priced some people out of the market.

The makings of our present employer-based health insurance system began with the passage of the individual income tax in 1913. At that time, employees were not taxed on company-paid fringe benefits (which would come to include health insurance). Firms, however, could deduct

the cost of these benefits from their corporate income taxes.⁶

The substantial growth in employer-paid health insurance also occurred during World War II. Since wages were frozen, companies started offering lucrative benefit packages — including medical insurance — to attract the best workers. Even after wage controls were lifted, most companies continued to provide health benefits, probably because of their tax advantage. Recognizing the potential revenue being missed, the Internal Revenue Service stipulated in 1953 that employers' contributions to individual health policies were no longer deductible. Congress, however, quickly reversed this ruling with the enactment of section 106 of the Internal Revenue Code of 1954.

The move by insurance companies toward experience ratings reinforced the growth of employer-provided health coverage. Experience ratings enabled certain groups, such as large firms, to obtain insurance at cheaper rates. This is because a large group formed for non-health reasons in effect forms a "community" and minimizes the potential for adverse selection.

Unfortunately, experience ratings also hurt some groups, particularly small em-

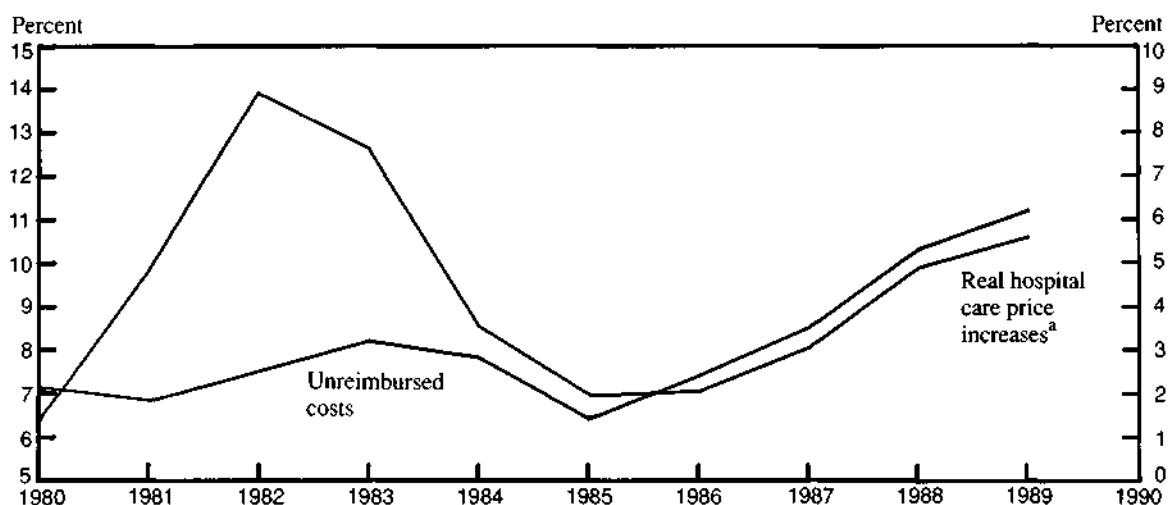
ployers, the unemployed, and the aged. In 1965, Congress and President Johnson responded by passing Medicare and Medicaid. Medicare provides health insurance for the aged, while Medicaid provides coverage for the poor.

■ The Continued Growth of Health Insurance

The dramatic impact of Medicare and Medicaid on the nation's health care system is illustrated in figure 1. The percentage of medical expenses that consumers pay out of pocket fell from 56 percent in 1960 to 22 percent in 1991, while the fraction picked up by federal, state, and local governments more than doubled, from 21 percent to 43 percent.⁷ In other words, every percentage-point increase in the government's share of medical outlays led to an almost equal decline in direct spending by consumers.

The expansion of third-party payments — both government and private — has boosted the demand for health care. A comprehensive study by the RAND Health Insurance Experiment, conducted in the late 1970s and early 1980s, looked at the effects of various cost-sharing provisions of several health insurance plans. The results showed that each percentage-point decline in the coinsurance rate, with an annual maximum of \$1,000, produced

FIGURE 2 UNREIMBURSED SHARE OF COSTS AND REAL HOSPITAL CARE PRICE INCREASES



a. Adjusted for inflation as measured by the Consumer Price Index.

SOURCES: "Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals Cost Shift?" (footnote 21); *Source Book of Health Insurance Data*, Health Insurance Association of America, 1992; and U.S. Department of Labor, Bureau of Labor Statistics.

an uptick in expenditures of between 0.1 and 0.2 percent.⁸ Although other factors may be at work, the RAND estimates alone imply that the 34 percent decline in out-of-pocket spending since 1960 corresponds to a 3.4 to 6.8 percent rise in health care outlays, or approximately \$50 billion in 1994.

The growth of medical insurance has strengthened the demand for health care in other ways as well. Because third parties are footing more and more of the bill, and because doctors are facing increasingly steeper costs due to malpractice insurance, the practice of defensive medicine has become widespread. Defensive medicine refers to the incentive for doctors to order excessive tests and procedures — which they do not pay for — to reduce the likelihood of being named in a malpractice suit. The cost of defensive medicine is estimated to be between \$4 billion and \$25 billion per year.⁹

■ Market Initiatives to Slow Health Care Spending

The problems associated with third-party payments have led to attempts by the private market to slow the growth of health care spending. The primary move in this direction has been the development and growth of health maintenance and preferred provider organiza-

tions (HMOs and PPOs).¹⁰ Each of these groups has attempted to control health care costs in a number of ways.

One is by giving the health insurer more control over the physician providing the care. Since doctors who belong to a managed care network are governed by the same group that pays for their services, the incentive to practice defensive medicine is minimized. A second way these organizations have tried to keep a lid on costs is by stressing preventative care. Most HMOs pay for periodic physical examinations and other routine procedures. They have also developed other cost-controlling techniques that have become common restrictions for most health plans. These include requiring patients to attain prior approval by a primary care physician before receiving specialized services, and stipulating that certain surgeries be performed on an outpatient basis.¹¹

Studies assessing the effectiveness of managed care in cutting costs have shown that HMOs with fully integrated financing and delivery systems reduce hospital usage by 20 percent. For PPOs and more loosely structured HMOs, that figure is between zero and 8 percent.¹²

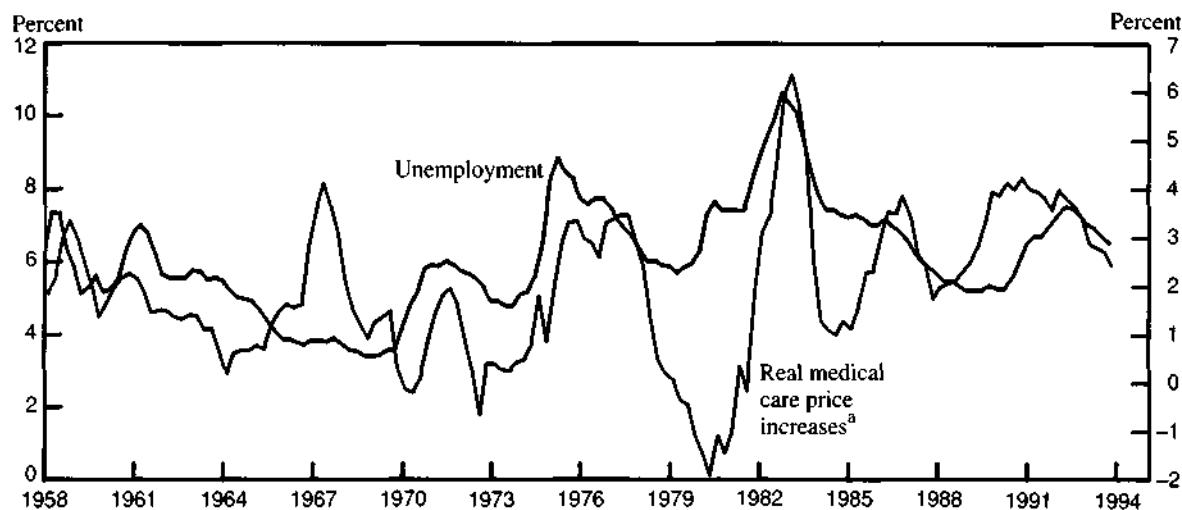
■ Government Initiatives to Slow Health Care Spending

Since the passage of Medicare and Medicaid, the federal government's health care policy can best be characterized as a series of ill-fated attempts to control costs. These reforms were seen as necessary because the increase in the price of health care continued to far outstrip that of most other goods and services.

The federal government's approach to HMOs has been both inconsistent and unproductive. First, the tax exclusion for health insurance has tended to dampen the growth of these organizations. A recent Congressional Budget Office (CBO) study notes, "Because workers who receive health insurance as a fringe benefit are shielded from much of the cost of that insurance, they have been slow to switch to lower-cost providers of insurance and health maintenance organizations As a result, the rapid growth in the consumption of medical services and in medical expenditures has been able to proceed relatively unchecked."¹³

Congress, however, has also passed legislation aimed at encouraging the growth of HMOs. The HMO Act of 1973, for instance, required employers with traditional health plans to also

FIGURE 3 UNEMPLOYMENT AND REAL MEDICAL CARE PRICE INCREASES



a. Adjusted for inflation as measured by the Consumer Price Index.

SOURCE: *Economic Report of the President*, transmitted to Congress in February 1994.

offer an HMO. Moreover, it mandated that companies contribute at least as much to the HMO as they did to their regular plan.

An unintended consequence of such legislation is that it increases insurance costs for small and medium-sized firms. By siphoning off workers to managed care networks, HMOs limit the number of people covered by a company's traditional health plan. Thus, it becomes more difficult for certain firms to reach the critical mass necessary to enable them to either self-insure or purchase health insurance at a reasonable rate.¹⁴

The major provisions of the HMO Act have since been changed. The section requiring employers to offer an HMO alternative was repealed in 1993, while the provision regarding equal managed care and traditional plan contributions was amended in 1988 to give companies more flexibility in determining their HMO contributions.

Nonetheless, the 1973 legislation was successful in the sense that HMOs' share of the private insurance market shot up from 3 percent in 1980 to 17 percent in 1989.¹⁵ The costs of such legislation may have been high, however. The same benefits could probably have been achieved simply by eliminat-

ing the tax subsidies for employer-provided health insurance.

Other federal legislation aimed at reigning in health care costs include the certificate-of-need (CON) laws, passed in 1974. These stipulated that legislators in all states receiving federal health dollars (every state except Louisiana by 1980) review and approve any planned capital investments by local health care institutions. Capital expenditures include the expansion of existing facilities or the purchase of major medical equipment.

Unfortunately, CON laws may have had exactly the opposite effect of that intended. Since the demand for health care is inelastic, limiting its supply leads to an even greater increase in prices. Moreover, a 1991 CBO study states that many believed "CON in most states was applied in an erratic and politically motivated way that was not consistent with cost-consciousness and the orderly adoption of new technologies."¹⁶

In 1986, the requirement that states adopt CON laws in order to receive federal funding was dropped. Nonetheless, most states have kept these laws on their books.

■ Slowing the Growth of Medicare and Medicaid

Medicare and Medicaid costs have been climbing even more rapidly than those of the medical industry as a whole. For that reason, the 1980s saw Medicare and most state Medicaid programs shift from a retrospective cost-based reimbursement method to a prospective payment system (PPS) to compensate hospitals for treating patients covered by these plans. PPS was also designed to give hospitals more incentive to control costs by reimbursing them at a rate independent of their actual expenses.

Before 1981, states were required to reimburse hospitals for treating Medicaid patients according to Medicare's reasonable-cost methodology. The Omnibus Budget Reconciliation Act of 1981 allowed states to adopt the PPS approach, with reimbursement based on the expenses of an "economically and efficiently operated hospital."¹⁷

By 1985, 40 states were using PPS. Medicare shifted to the PPS approach in 1983, with hospitals reimbursed a *prespecified* amount for each patient based on diagnosis, treatment, and certain characteristics of the institution providing the care.

One complication of PPS was that the revenues hospitals received for treating Medicare and Medicaid patients were usually less than the actual costs incurred. It is estimated that in 1991, only 88 percent of hospitals' total Medicare costs were reimbursed. For Medicaid, this share was an even lower 82 percent. Physician reimbursement under Medicaid was also restricted by PPS. In 1989, Medicaid paid doctors an average of 69 percent of Medicare rates.¹⁸

These controls have led many health care providers to stop accepting Medicare and Medicaid patients. A 1991 CBO study found that 25 percent of U.S. physicians refuse to treat Medicaid patients. For those providing reproductive-related services, this share rises to 45 percent. Doctors have also reported that hospitals discourage them from admitting Medicaid patients. As a result, indigent patients are more likely to seek care in a hospital emergency room, where treatment is even more expensive.¹⁹

Although hospitals do not get sufficient funding from Medicaid or Medicare to recoup their total costs, they are willing to treat these patients if enough revenue is received to cover their variable operating expenses. Hospital administrators must then recover their fixed overhead costs by adjusting the bills of private providers and individuals paying out of pocket. This practice is known as cost shifting.

Cost shifting has always existed, because hospitals have traditionally provided a certain amount of uncompensated care (charity cases plus bad debts). The practice became even more prevalent during the 1980s as Medicare and Medicaid began picking up less and less of their "full share." Figure 2 demonstrates that since at least 1985, the growing fraction of unreimbursed hospital costs can explain the rise in real hospital care price increases.²⁰ In 1985, 6.4 percent of hospital costs were not reimbursed. Of this figure, 5.5 percent was due to uncompensated care and 0.6 percent to Medicare and Medicaid. By 1989, unreimbursed expenses had risen to 11.2 percent of total

costs, with 6 percent due to uncompensated care and 5 percent to government payers.²¹

Figure 3 suggests that uncompensated care has traditionally been an important factor in the price of health care. Real medical care price increases have tended to move with the overall unemployment rate. Since higher unemployment translates into more uncompensated care, it also leads to higher health care prices.

■ Conclusion

The history of America's health care delivery system reveals that many of its attributes are traceable to the subsidies provided by employer-based benefits and government insurance programs such as Medicare and Medicaid. These programs have in turn contributed to the relentless ascent in health care spending over the postwar period and ultimately to a series of unsuccessful attempts by the government to control costs.

To help reverse these trends, several changes could be made at the federal level. First, Congress could reconsider the tax incentives for employer-provided health care. Second, government health insurance programs could be designed to enable us to move away from experience ratings toward a community-rated system. Various subsidy programs, including vouchers, could be used to offset the cost of purchasing private insurance.

Although community ratings have been touted as both more efficient and more equitable than experience ratings, many argue that a return to the old system would be inefficient because of adverse selection. However, their objection ignores the 43 percent of government-directed health care spending that could be used to enhance the functioning of the private sector.

Today, the federal and state governments administer three major medical insurance systems — Medicaid, Medicare, and Veterans Affairs. Programs such as Medicaid that insure otherwise healthy individuals could be replaced with a system that instead subsidizes or

purchases private coverage on their behalf. This would once again return the able-bodied to the larger community of those seeking to purchase health insurance. By enlarging this pool, the functioning of the private sector would be enhanced and the effects of adverse selection mitigated. This would enable a return to community ratings, which could be accomplished most simply through legislation prohibiting insurance companies from discriminating on the basis of a person's current health status or other health-related factors.

■ Footnotes

1. See "Projections of National Health Expenditures," Congressional Budget Office (CBO) study, October 1992, p. ix; and "Managed Competition and Its Potential to Reduce Health Spending," CBO study, May 1993, p. ix.

2. This number covers only the cost of Medicare and Medicaid. To gain some perspective on its magnitude, consider that every person in the United States must now pay an average annual tax of more than \$1,400 to provide medical care for the poor and elderly. After adjusting for inflation, this is approximately equal to total per capita health expenditures in 1973. See "Trends in Health Spending: An Update," CBO study, June 1993, appendix A.

3. See "The Tax Treatment of Employment-Based Health Insurance," CBO study, March 1994, table 1, p. 6.

4. See "An Analysis of the Administration's Health Proposal," CBO study, February 1994, p. 62.

5. The early history of the U.S. health insurance industry is discussed in David R.H. Hiles, "Health Services: The Real Jobs Machine," *Monthly Labor Review*, November 1992, pp. 3-16.

6. If employees could deduct 100 percent of their own medical expenses, the incentives for employer-paid health benefits would be minimized. Currently, families may deduct the cost of medical care to the extent that their out-of-pocket expenses exceed 7.5 percent of their gross income.

7. The breakdown of total government health care expenditures in 1991, the last year for which these data are available, is as follows: Medicaid, 48 percent; Medicare, 40 percent; Veterans Affairs, 4.9 percent; other, 7.1 percent. See footnote 2, "Trends in Health Spending: An Update," tables A-4 and B-1. These numbers assume state and local health care expenditures are for Medicaid.

8. See "Rising Health Care Costs: Causes, Implications, and Strategies," CBO study, April 1991, p. 34.
9. See Charles T. Carlstrom, "Enterprise Liability: A Prescription for Health Care Reform?" Federal Reserve Bank of Cleveland, *Economic Commentary*, July 1, 1993.
10. PPOs differ from traditional plans by offering members incentives to seek care from physicians who are under contract with the organization.
11. For an excellent overview of the growth of managed care and the cost-saving measures they employ, see Thomas P. Burke and Rita S. Jain, "Trends in Employer-Provided Health Care Benefits," *Monthly Labor Review*, February 1991, pp. 24-30. See also "Health Maintenance Organizations: Benefits and Enrollments," *Monthly Labor Review*, April 1991, pp. 11-19.
12. See footnote 8, "Rising Health Care Costs: Causes, Implications, and Strategies," p. 38.
13. See footnote 3, "The Tax Treatment of Employment-Based Health Insurance," p. xi.
14. The relative difficulty small firms face in obtaining cheap insurance has led President Clinton to suggest that the government form (and control) regional alliances. This would

allow many small firms to pool together in order to obtain insurance at a cheaper rate. However, the private market has already successfully instituted such organizations, raising doubts about how much government involvement is necessary. One such private initiative is offered in Cleveland by the Council of Smaller Enterprises (COSE).

15. In addition, PPOs' share of the market increased from essentially zero to 10 percent. See footnote 11, "Trends in Employer-Provided Health Care Benefits," p. 28.

16. See footnote 8, "Rising Health Care Costs: Causes, Implications, and Strategies," p. xvii.

17. Ibid, p. 42.

18. Ibid.

19. Ibid.

20. Real hospital care price increases equal nominal hospital care price increases minus overall inflation for all goods and services. Real medical care price increases are likewise adjusted for overall inflation.

21. See "Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals Cost Shift?" CBO paper, May 1993, table B-2, p. 34.

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