Fresh Thinking on Health Policy
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100 Years of Market Distortions

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Introduction

It is often said that the market has failed in health care. Health economists usually understand this to mean that the health care sector varies from the textbook model of a "perfect market." If pressed, economists will concede that there is no "perfect market" in any industry -- that every market suffers from some shortcoming. Perhaps it is lack of perfect knowledge, transaction costs, information asymmetries, existence of externalities, and so on. All markets have failed, because all markets vary from the perfect market model. But health care, they say, is further from the perfect model than most other industries.

Perhaps, but there are very few markets that have been as endlessly tinkered with as health care. For the past one hundred years various interest groups have used the tools of government to "correct" the imperfections of the market and, not coincidentally, improve their incomes and standing in the market at the same time.

In this paper we define a market distortion as the use of governmental authority to stifle competition, enhance market position, subsidize favored activities, raise barriers to entry, control or distort prices, mandate behaviors, or impede the free flow of information. We are not worried here about market domination that results from vigorous competition, nor are we looking at private efforts to gain market share by under-pricing products, or enhance profits by over-pricing products. These activities should be self-correcting over time, provided there are no artificial barriers to competition. Here we focus strictly on the use of government's policing power, usually to the advantage of one competitor over another.

After one hundred years of such governmental interventions in the health care market, we are left with an industry that is too expensive, too bureaucratic, and too indifferent to the needs and desires of consumers. In most cases, the solutions proposed for fixing these problems involve yet more tinkering, more laws, more regulations, and more distortions.

The failures in the health care system are the direct result of the distortions created by government policy. The real solution lies in reducing these distortions and allowing the market to work as it does in every other area of our economic lives.

The Early Years – 1900 - 1929

Prior to 1900, there was a reasonably well-functioning market in health care. There was an ample supply of doctors and hospitals, from a variety of disciplines, providing care at a reasonable cost at the convenience of their patients. There were commercial medical schools educating working class men and women. In fact, women represented nearly 20 percent of all the doctors in some cities.[1] There were homeopaths and eclectic physicians as well as allopathic physicians.

It would be a mistake to romanticize these "good old days" of health care. Medicine was in its infancy, and the care physicians were able to provide was extremely limited. It can, and has been, argued that medicine needed to become more professional and science-based -- that eliminating second-rate medical schools and increasing the level of training of physicians was necessary to foster a modern medical regime. Certainly the scientific progress we have seen in medicine would astound even the best practitioners of the time. But that can be said of other industries, such as telecommunications and transportation, as well.

There were few constraints on the practice of medicine prior to the twentieth century. As late as 1901, only 25 states required independent examinations for a medical license. The rest required a diploma from a medical school, but since there were few regulations on medical schools, diplomas were easy to come by.[2] The number of medical schools in the country had grown dramatically, from 70 in 1870, to 100 in 1880, to 133 in 1890, and 160 by the turn of the century.[3] Because there were few barriers to entering the medical profession, there was an ample supply of physicians, which kept fees low enough that people could afford to pay directly for the services they consumed.

Health insurance was virtually nonexistent. Merchant seamen had been subject to compulsory hospitalization coverage since 1789,[4] and railroads, logging camps, and coalmines often provided prepaid health care services to their employees. Personal accidental injury policies were not unusual in the late 19th century and immigrant benefits societies provided industrial sickness funds to their members.[5]

Also in the early 20th century, there was a sustained campaign to enact Workman's Compensation laws across the country. This campaign was strongly supported by employers who wanted protection from liability for workplace injuries, and to better manage and predict the expense of industrial accidents. The first law requiring companies to provide workers' compensation was passed in 1902, and by 1921 all but six states had enacted similar legislation.[6]

Around the turn of the century, the American Medical Association (AMA) began a drive to increase the professional reputations -- and incomes -- of its members. In 1901 it reorganized from a direct membership association into a confederation of state medical societies, which were in turn confederations of county societies. Any physician who wanted to belong to the county society automatically became a dues-paying member of the state society, and hence, a member of the AMA. Physicians were motivated to join their county societies in part because the local societies agreed to defend member physicians from malpractice litigation and often could influence hospital privilege policies. The AMA's efforts were astoundingly successful. In 1900 it represented only 8,000 of the 110,000 physicians practicing medicine in the United States. By 1910, it represented half the profession.[7]

This new power enabled the AMA to aggressively strengthen professional licensing laws at the state level. It also began to take control of medical education by requiring standards of accreditation for medical schools, as recommended by the landmark Flexner Report in 1910.[8] These standards were built into state accreditation laws. In a single generation, from 1900 to 1925, the

number of medical schools was cut in half, as were the number of medical students. The impact on minorities and women was even more profound. African-American medical schools shrunk from seven to two, and women and Jews were largely excluded from medical education.[9] Most of the schools that survived were affiliated with hospitals and universities, and medical education became inseparable from hospital-based clinical training and research-oriented universities.[10]

***Market Distortion #1** -- The medical profession forms a cartel to reduce competition and raise prices, through the use of state licensing laws.*

The results of those efforts should not be surprising. The number of physicians per capita declined from 173 per 100,000 in 1900 to 125 per 100,000 in 1930.[11] Medical education took longer and was more expensive in 1930 than it had been in 1900. The increased cost of entry and the reduced number of physicians combined to raise the cost of services. Also, since new doctors were now required to intern in hospitals, modern physicians became more oriented toward expensive hospital-based treatment than their predecessors had been.

The expense of hospital-based care delivered by a new elite of well-trained physicians began to place the cost of medical care out of the reach of many people. Indeed, in the 1910s, the cost of health care treatment was considered a minor problem compared to the loss of wages due to sickness for most workers. A 1919 study estimated that sick workers lost two to four times as much in wages as they spent in health care costs.[12] By the late 1920s medical costs were 20 percent higher than lost earnings for families making less than $1,200 a year, and 85 percent higher for families making between $1,200 and $2,500.[13] The increase in medical costs was alarming enough that an independent commission was created with $1 million in grant money from eight foundations to study the issue. This Committee on the Costs of Medical Care (CCMC) was created in 1926 and developed the first estimate of national health spending: $3.66 billion in 1929, or 4 percent of national income. Interestingly, only 23.4 percent of this amount went to hospitals, while 29.8 percent went to private physicians.[14]

Discussion

The transformation from horse and buggy medicine to the science-based system we have today did not require the market distortion initiated by the AMA (using state licensure to eliminate competitors and raise barriers of entry to the profession). Allopathic medicine could have continued on the "high-tech" road it was traveling, but without these distortions it would have co-existed with other "high touch" disciplines, which would have had to prove their worth in the market.

Not only did this distortion limit competition and raise prices beyond the financial ability of many patients, it also encouraged a knowledge gap between the patient and the physician. No longer were patients deemed competent to pick their own practitioners, they were required to choose from only those doctors the state government said were worthy of the title.

The value of medical licensing is dubious at best. Certainly it is no assurance of quality of care or even professional competence. A medical license allows anyone with an M.D. to do brain surgery, for instance -- even a psychiatrist who hasn't held a scalpel since medical school. To measure competence, other standards, such as Board certification, must be used. A certificate of competence issued by a relevant specialty group is far more useful than a state-issued license.

And, as we will see throughout the Twentieth Century, the problem created by the original distortion was called a “crisis,” and commissions were formed to recommend additional governmental interventions -- and additional distortions.

The Formative Era, 1930 -- 1949

The onset of the Depression reduced incomes and added to the difficulty of paying for hospital-based care. Paul Starr writes, "in just one year after the crash (of 1929), average hospital receipts per person fell from $236.12 to $59.26."[15] Total national spending on health care fell from $3.6 billion in 1929 to $2.8 billion in 1935, though, indicative of the state of the economy at the time, it rose as a percent of the GNP from 3.6 percent to 4.1 percent.[16]

Physicians could tighten their belts and wait for the economy to turn around. That was not so easy for hospitals, which had to pay salaries and maintain facilities. Private hospitals were especially hard hit, filling only 62 percent of their beds in 1931, while government hospitals maintained 89 percent occupancy.[17] It is not surprising that it was the hospital sector that organized the first serious effort at pre-financing health care. Baylor Hospital in Dallas began the prototype Blue Cross plan in 1929. It provided schoolteachers with coverage for 21 days of hospitalization for $6 a year. The Depression gave other hospitals a strong impetus to begin similar plans to assure a revenue stream during the economic troubles. Such plans were begun in St. Paul, MN, Cleveland, OH, and Washington, DC, and endorsed by the American Hospital Association (AHA) by 1932. The Blue Cross logo was adopted in 1933, and the first state enabling law was enacted in New York in 1934, with twenty-five states enacting them by 1939,[18] by which time the whole movement was absorbed into the AHA.[19]

Blue Cross, and later Blue Shield (organized to provide physician/surgical services in 1939), insisted they were not insurance companies, but "pre-paid hospital (or medical) service organizations." They were organized not under state insurance laws but under separate enabling acts that provided them with special tax-exempt status and immunity from many of the regulations that apply to insurance companies. They were set up as non-profit organizations with boards of directors that were dominated by the hospitals or physicians they were created to serve. The participating hospitals and physicians agreed to bear the risk of insolvency by providing free service if the plan ever ran out of money, and they usually discounted their charges below what they would charge other insurers.

Importantly, the Blues did not provide payments to their subscribers but provided "service benefits" through a third-party contract, i.e. a customer would pay a "subscription fee" (not a premium), and the Blue Cross plan would pay the hospital directly for services delivered to the subscriber. In contrast, an insurance policy is a bilateral contract that "indemnifies" an insured against a "loss," i.e. if the customer experiences a covered event (a loss), the insurance company makes a payment for an agreed upon benefit directly to the customer.

***Market Distortion #2 --** Through state enabling laws, hospitals formed vertically integrated payment systems.*

The Blue Cross service benefit concept would set a benchmark for the way health insurance would be organized in the United States. Throughout the Depression and into the war years, Blue Cross had, if not a monopoly, certainly an overwhelming dominance of the market. Blue Cross and/or Blue Shield covered some 6 million people in 1940, and 19 million in 1945, while all the "commercial" insurers combined covered just over half that many (3.7 and 10.5 million, respectively). Another 2.3 million were covered by "other" plans, usually Health Maintenance Organizations (HMOs) or health cooperatives.[20]

In 1940, only 12 million of a total population of 132 million had any health insurance at all, and these were most commonly "hospital expense" policies, which paid hospitals a flat dollar-per-day for inpatient care. Only 5 million were covered for surgical expenses, and 3 million for non-surgical physician expenses. Comprehensive "major medical" coverage did not exist in 1940.

The entrance of the commercial insurers into the health care business in the mid-1940a helped generate growth in coverage. While the Blues doubled their enrollment between 1945 and 1950 (from 18.9 million to 38.8 million), enrollment by the commercials nearly quadrupled, from 10.5 million to 37 million.[21]

Discussion

Blue Cross plans were a collaborative effort of hospitals to ensure their own revenue. The hospitals owned the plans, retained majorities on the boards of directors, provided exclusive discounts to the plans, and guaranteed the plan's solvency. These favored conditions were not available to any other insurer, and would have been considered anti-trust violations except for the "state action" doctrine, which allows anti-competitive behavior when it is regulated by state government. The hospitals had persuaded the state legislatures to adopt enabling legislation allowing these special arrangements.

The early market domination of the Blues, as aided by state law protections, dictated the shape of health insurance benefits from the start, regardless of whether this design was efficient or rational. All plans would look like "prepaid health services" plans, even though the original purpose of that approach was to keep a stream of revenue going to the hospitals. For instance, commercial insurance companies could not arrange for “participating providers” to provide “service benefits,” but they developed “assignment of benefits” instead. When a customer “assigns” his benefits to a doctor or hospital, the patient never sees that money, he is simply notified that a certain payment has been made, and that he may be responsible for some balance. This sort of arrangement is what is meant by the expression “third-party payment.”

Even as late as 1965, Medicare would model itself after Blue Cross Blue Shield, with Part A mimicking the Blue Cross hospital benefits and Part B imitating the Blue Shield physician benefits.

The "service benefit" approach to health coverage developed by Blue Cross Blue Shield has become so universal in America that it is hard to imagine any other approach. But without the influence of the Blues, health insurance might have developed in radically different ways. For instance, there might have been “Schedule of Allowances” policies similar to current Accidental Death and Dismemberment (AD&D) insurance -- break an arm, you get $500, a leg gets $750, a heart attack gets $10,000, and cancer gets $25,000. The patient is then responsible for settling with the provider. At a minimum true “indemnity” coverage (in which the insured is paid the benefit, not the provider) would probably have prevailed.

Without getting into a discussion of whether this is a better structure, it is interesting to consider how differently health care would have evolved if this kind of insurance prevailed. With each covered event, the insured would have a sum of cash to spend for treatment, anything not spent would be his to keep and any excess cost would be paid for by the insured. Such a system might have discouraged the growth of large medical centers and physician specialists, in favor of community clinics and non-physician providers.

***Market Distortion #3** The federal government exempts fringe benefits from the wage and price freeze, encouraging more compensation to be paid out in the form of benefits, not wages that would encourage non-group health insurance*

During the war years, with so many workers in military service, labor was in short supply, but federally-imposed wage and price controls prohibited companies from raising pay to attract quality workers. Companies were left with only one reward to attract prospective employees -- "fringe" benefits. Employers began providing health insurance and other benefits to attract

workers, especially after the War Labor Board decided to exempt pension and insurance contributions from the wage and price controls.[22] In 1943, the Internal Revenue Service ruled that such benefits were not to be considered taxable income. This ruling was built into the newly revised Internal Revenue Code in 1954.[23]

Discussion

The tax advantage is the primary, though not the only, reason health care came to be an employer responsibility. Other reasons included: The interest employers have in maintaining a healthy workforce; the ease of marketing on a large scale; the protection against "adverse selection" (i.e. people are in the group for reasons other than gaining insurance); and the fact that there is already a financial relationship between employer and employee.

While all these other advantages are important, they are not exclusive to the employment relationship. Banks or credit unions also have large numbers of customers, would be exempt from adverse selection, and have financial relationships with their customers. Health insurance might easily have evolved as an added service provided by banks to their own customers. But only employment-based groups are eligible for the considerable advantage of, not just a tax deduction, but an exclusion from income for every penny spent by the employer on health coverage, without limit.

The consequences of the employment-based exclusion are profound. Not only did it encourage employers to put their compensation dollars into health care instead of wages, but the effect of this new spending on health insurance resulted in higher health care costs than would otherwise have been the case. And it made individual health insurance comparatively even more expensive and less affordable.

The problems of selection and the cost of marketing means that individual coverage will usually be more expensive than group coverage for similar populations and benefits. But when the government adds an unlimited tax exclusion for the group coverage, and no tax advantage at all for individual coverage, anyone who wants coverage will try hard to affiliate with a group. The only people left behind to purchase individual coverage are those unable to access group coverage, and thus are likely to be substandard risks.

***Market Distortion #4** The federal government gives tax break only to employer-sponsored health insurance – not to individual insurance, and not to direct payment*

***Market Distortion #5** The federal government puts seed money only into hospital construction, tilting health care delivery to expensive high-tech institutionalized care*

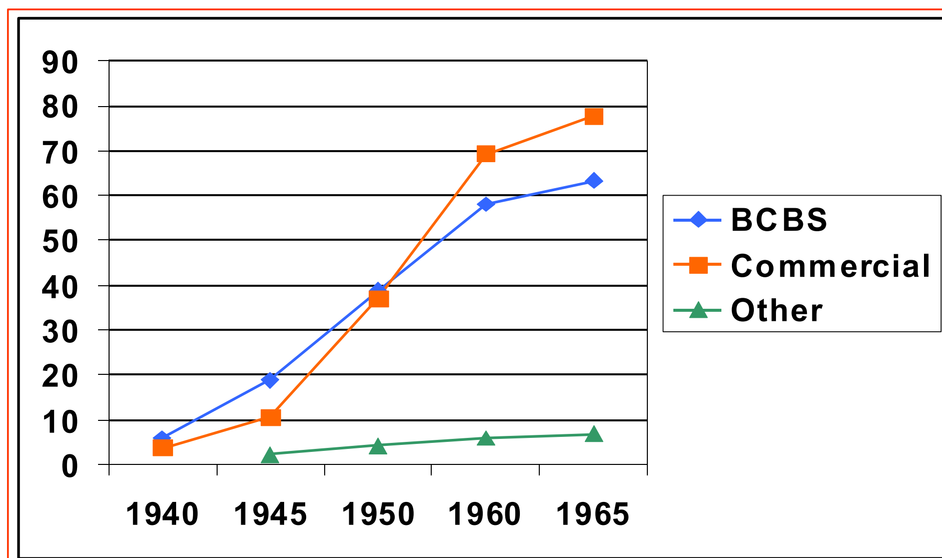
***Market Distortion #6** The federal government provides an anti-trust exemption and an exception to the interstate commerce clause of the constitution exclusively to the insurance industry*

While the wage freeze and tax-free nature of employer-sponsored health insurance contributed substantially to the growth of health insurance and increasing health care costs in the post war years, there were a number of other federal actions that also contributed. These included:

The Hill-Burton program (the Hospital Construction and Survey Act of 1946). Hill-Burton provided $3.7 billion in federal funding for hospital construction, which was matched by another $9.1 billion in state and local funds.[24] These funds were aimed at inpatient facilities, subsidizing costly institutional care at the expense of other models of care such as neighborhood clinics, physician offices, or visiting nurse programs.

The McCarran-Ferguson Act of 1947. This law exempted the insurance industry from many of the federal anti-trust and bankruptcy laws, and required that only the states should

regulate insurance. McCarran-Ferguson applied to all forms of insurance, not only health care, but it singled out the insurance industry for special treatment that was not available to other segments of the economy, and helped reinforce the idea that the best way to pay for health care was through insurance.[25]



The Taft-Hartley Act of 1947. Taft-Hartley created a structure for joint labor/management provision of health and welfare trusts and made it possible for workers who were not regular employees of a company (such as construction workers) to gain benefits by negotiating agreements with the whole industry.[26]

Discussion

These laws, when combined with the tax exclusion, encouraged further growth of high-tech institutional care paid for by employer-sponsored health care insurance. Both on the financing and the delivery side of the health care system, decision-making was taken away from the patient in favor of a new management elite. They laid the foundation for a system of third-party payment that would lead inevitably to excessive consumption and inflation.

By 1950, over half the population (75.6 million out of a population of 151 million) had gained some form of health insurance. The Blues had 38.8 million, commercial insurers had 37 million, and 4.4 million were in other kinds of plans, such as HMOs. All were covered for at least hospital inpatient care, 54.1 million also had surgical care coverage, and 21.6 million were also covered for non-surgical physician expenses. [27] Collectively bargained coverage grew even more impressively, covering 2.7 million workers in 1948, 7 million in 1950 and 12 million in 1954. [28]

The Growth Era, 1950 - 1965

In the early 1950s, Congress began to tinker with the tax code to make people behave the way Congress would like them to in health care -- a practice that continues today. Prior to 1954, taxpayers could take a deduction for medical expenses (including insurance premiums) that exceeded 5 percent of their adjusted gross income (AGI). The reorganization of the Internal Revenue Code in 1954 lowered that threshold to 3 percent of AGI. Later changes included: an additional deduction of $150 for the first $300 in premium, enacted in 1965; elimination of the $150 deduction and raising the AGI threshold back to 5 percent in 1982; and raising the threshold to 7.5 percent in 1986. [329]

Market Distortion #7 *The federal government tinkers with the tax code to influence behavior*

Discussion

The tax advantage of having individual health insurance wasn't nearly as great as having an employer plan, since the employer plan was completely exempt from taxation, both for income and for payroll (FICA) taxes. But enrollment in the individual market grew steadily until the tax law changes of the early 1980s. The numbers of people with commercial individual policies went from 17.3 million in 1950, to 22.2 million in 1960, to a peak of 33.8 million in 1980, after which time it has steadily dropped. [30]

The Regulatory Era, 1965 - 1980

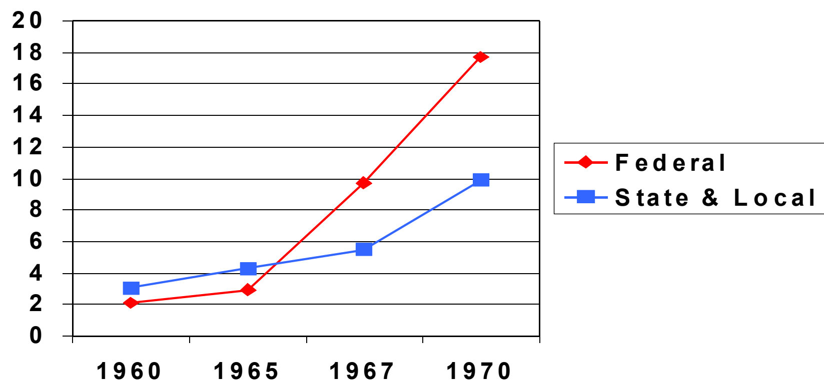
All of the previous distortions created a system of high-tech, high-cost employer-financed health care, which greatly disadvantaged people not connected to an employer -- the poor, the self-employed, and the elderly. Not only were these groups left out of the subsidies available to employer-based groups, but the upward pressure on costs and the emphasis on expensive institutional care made health care more difficult for them to afford. By dividing the population into two distinct groups -- workers and non-workers -- government distortions also prevented the informal cross subsidization which exist in most other segments of the economy.

The Great Society was fixated on eliminating unfairness in America, and one of the greatest disparities was the advantage afforded to working people in obtaining health care, compared to the poor and the elderly who were not associated with employment-based groups. At this point in history, there might have been many ways to rectify the disparity. Extending a refundable tax credit to all Americans might have been one. Building a health insurance system based on non-employment groups might have been another.

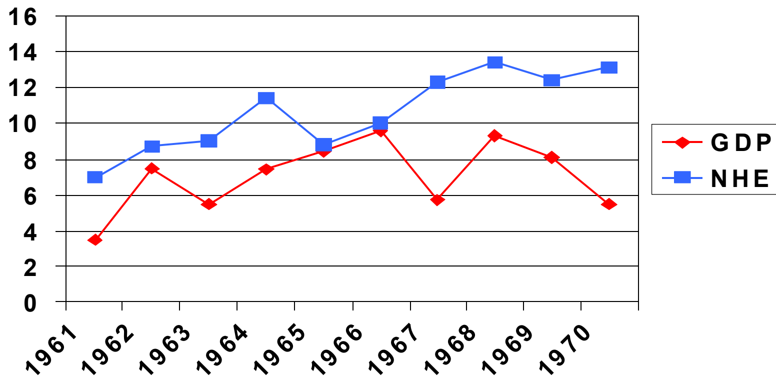
But the opportunity to create a National Health Insurance plan for at least a portion of the population was too good to pass up for some. So it was decided to create new federal programs that would serve in the place of the employer for those not associated with the workplace.

Market Distortion #8 -- *The enactment of Medicare and Medicaid in 1965 resulted in an unprecedented surge of new spending on health care, but more importantly, it substituted government spending for out-of-pocket spending.*

The creation of Medicare and Medicaid in 1965 would launch the nation on a health care spending spree. Prior to the enactment of these programs, the federal government had played a very limited role in the direct provision and financing of health care. As late as 1960, over half of total patient care costs (actual payment for health care services, not premiums or taxes) were paid directly out-of-pocket, with the balance split almost evenly between private third party payers and various levels of government. Out of a total expenditure of $23.9 billion in 1960, consumers paid directly for $13.3 billion (55.6 percent), while the federal government paid only $2.1 billion (8.8 percent). [31]



Annual Percentage Change in Spending, 1961 --1971
National Health Expenditures, versus Gross Domestic Product



This ratio would change dramatically in just a few years with the enactment of Medicare and Medicaid in 1965. In 1967, out-of-pocket spending had dropped to 36 percent of the total, private third party rose to 27 percent, and government spending had risen to 37 percent of the total.

Most of the increase in government spending came from federal funds. In 1965, state and local governments spent $4.3 billion, while the federal government spent only $2.9 billion. Two years later, state and local rose 28 percent to $5.5 billion, but federal spending went up 234 percent to $9.7 billion. By 1970, state expenditures would rise to $9.9 billion, and federal spending would reach $17.7 billion -- over six times what had been spent five years earlier. [32]

Where 56 percent of all personal health care spending was out-of-pocket in 1960, twenty years later the portion would drop in half to 27 percent. Federal expenditures made the difference, rising from 8.8 percent of the total in 1960 to 29 percent in 1980.

Market Distortion #7 -- *Medicare resulted in an unprecedented increase in health care spending, so a series of additional regulations were added to try to control those increases, including wage and price controls, health planning and certificate of need programs, and hospital rate setting systems.*

Discussion

Insurance coverage insulates people from the cost of their health care and encourages them to consume more services than they otherwise would. But there is a price to be paid in the form of increased premiums. Employer-based health insurance doubly insulates people from the cost of care, first by removing them from the cost of the care provided, but also by removing them from the cost of the premiums which pay for the insurance. But still there is a consequence – in the form of lower wages. Public programs like Medicare and Medicaid apply yet a third level of insulation. Not only are beneficiaries exempt from the cost of the care and the cost of the premiums, but they are also exempt from the problem of reduced income because the taxpayers cover the cost of excess utilization.

The further away from the cost of care a population becomes, the more inflationary will their behavior be.

The infusion of new cash into the health care system, and the fact that beneficiaries could consume services with no constraint at all, resulted in three decades of medical inflation rising at twice the rate of the economy as a whole. Some commentators were nearly hysterical.

In *Blue Cross: What Went Wrong?* (1974), Sylvia Law wrote:

> *"The crisis in medical care has arrived…the nation now spends a larger portion of its GNP on health care than does any other country in the world -- $67.2 billion, or 7 percent of GNP in 1970."* [33]

Kenneth Friedman and Stuart Rakoff were similarly agitated a few years later when they wrote:

"The thrust towards greater government regulation of health services arises primarily from a single source; astronomical increases in cost. Total expenditures for health services have more than tripled since 1965, exceeding $118 billion in FY 1975. The proportion of GNP devoted to health care has grown from 5.9 to 8.3 percent." [34]

More recently, Stuart Altman reminisced:

"*When I was 32 years old, I became the chief regulator in this country for health care. At that point, we were spending about 7 ½ percent of our GDP on health care. The prevailing wisdom was that we were spending too much, and that if we hit 8 percent, our system would collapse.*" [35]

The enactment of Medicare and Medicaid unleashed a tidal wave of new health care spending. Increased demand and relatively constant supply of services naturally raised prices. But rather than addressing this highly predictable outcome, policy-makers scrambled to impose more governmental restrictions:

Wage and price controls were imposed by President Nixon in August, 1971. They were removed for most of the economy in January, 1973, but retained for health care until April 30, 1974. [36]

Legislation creating **Professional Standards Review Organizations for Medicare** was enacted in 1972. These were intended to supervise physician practice to ensure appropriate treatments and lengths of stay, and restrain costs. [37]

The Federal HMO Act of 1973 provided seed money for HMOs that met certain federal qualifications, such as being not-for-profit, using community-rating, providing a minimum set of benefits, and exempted HMOs from state insurance regulations on issues such as capitalization and reserves, board composition requirements, and advertising restrictions. It included a "dual-choice" provision that required employers with over 25 employees to offer HMO options to their workers.[38]

The National Health Planning and Resources Development Act of 1974 required states to establish elaborate bureaucracies to control the growth of hospitals and other health care facilities. These agencies included Health Systems Agencies (HSAs), State Health Planning and Development Agencies (SHPDAs), Statewide Health Coordinating Councils (SHCCs), and a host of other committees and agencies. These efforts were designed to implement Certificate of Need (CON) programs, through which hospitals and other facilities that wished to make capital outlays would have to get prior approval from the agencies.[39]

The Employment Retirement Income Security Act (ERISA) of 1974 was the sleeper in this pile of new laws. Very few people at the time, or for many years later, realized the broad implications of this law. It took two decades of Supreme Court decisions before many observers woke up to its significance. ERISA distorts the market by exempting all employer-based health plans from the normal remedies used to enforce contracts, and by strongly encouraging employer-based plans to self-fund their benefits, rather than acquire them from an insurance company. It greatly advantages employer-based coverage over any other form of health care financing. [40]

The Pregnancy Discrimination Act of 1978, amended the Equal Employment Opportunity Act of 1972 and required employers with 25 or more employees to include maternity benefits in their health plans. [41]

The states also weighed-in with efforts at controlling the health care system through the 1970s. Hospital rate-setting systems were adopted in 30 states; [42] At least 38 states established Certificate of Need programs; [43] Virtually every state enacted mandated benefits on health insurance plans; [44] At least 15 states established high risk pools for people who couldn't get private cover-

age; [45] 20 states set up guaranty funds to cover the claims of failing insurance companies.

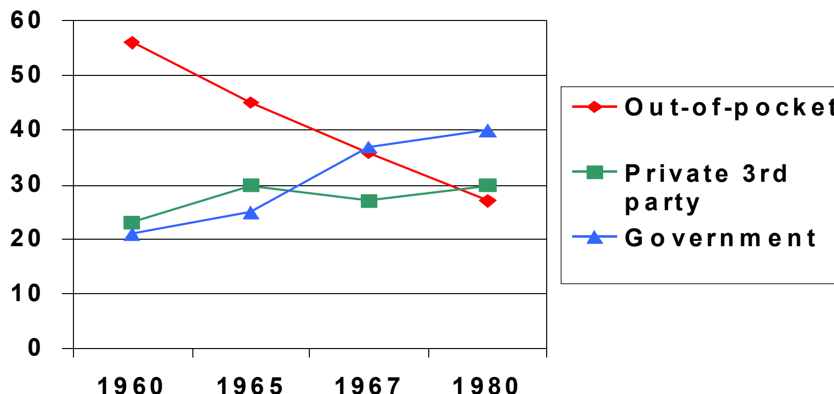
***Market Distortion Overload** -- All of these provisions are designed to reduce costs by limiting the supply and controlling the price of services – precisely the wrong remedy at a time of artificially inflated demand*

Discussion

Naturally these efforts did not work particularly well, though many of them (ERISA, HMOs, CON) still linger to haunt us today. The thinking behind price controls and health planning is especially puzzling. Excess demand induced by Medicare spending had outstripped the supply of services and caused a surge in health care prices -- as predicted by basic economic theory. So the government response was -- not to lower demand or increase supply, but create a vast bureaucracy of health planning agencies to further reduce supply! Small wonder health care inflation got worse during these years.

After all this activity, the United States spent $214.7 billion on healthcare, or 8.6 percent of its GNP in 1980. Ever year since 1965, the country had endured increases in health care spending in excess of ten percent, with 1974 and 1975 as high as 14.5 percent. In only two years, 1973 and 1978, did health spending rise less than the overall GNP. In most years health spending exceeded the growth in GNP by 4 - 6 percentage points. In 1979, 27.9 million people were enrolled in Medicare, and 21.5 million in Medicaid. [46] Private insurance plans (including self-funded and HMOs) covered 183 million, of which 148 million now had comprehensive, major medical policies. [47]

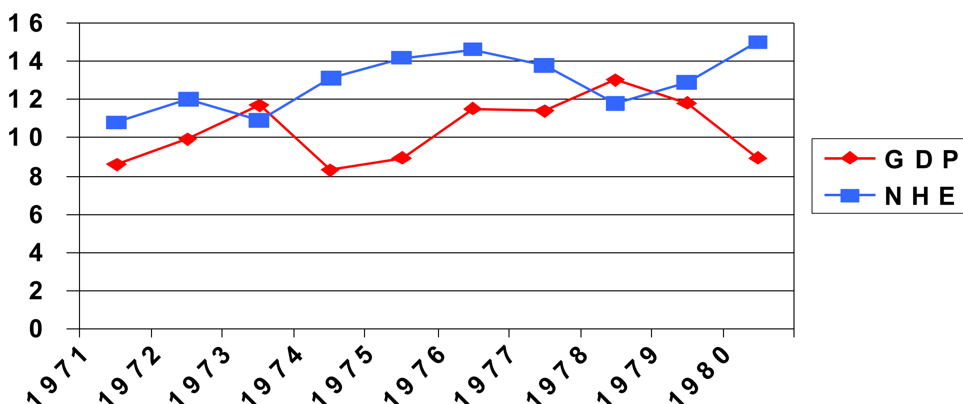
Sources of Spending, Percent of Total



The Competitive Era, 1981 - 1999

After a decade of ever-increasing but futile attempts at government control and regulation of the health care system, employers had had enough. Health care spending had not slowed. In fact, the growth of National Health Expenditures reached a zenith in 1980 and 1981, growing at a record 15 percent in 1980, only to be topped the follow-

Health Spending versus GDP, 1971 - 1980



ing year at 16 percent. In just two years, the total amount spent on health care in the United States had grown by one-third! The business community concluded that if insurance companies, health care professionals and the government couldn't get a handle on health care costs, they should all step aside and let business do it.

Former Secretary of HEW (Health, Education and Welfare, now Health and Human Services) Joseph Califano summarized the thinking:

> *"My conviction that the key to health care cost containment rests in an aroused private sector in no small measure relates to the contrast between the frustration of trying to get government to deal with this problem and my recent experience with Chrysler Corporation. In 1984, Chrysler cut its health care bill to $402 million, down by $58 million from the $460 million projected in our budget."* [48]

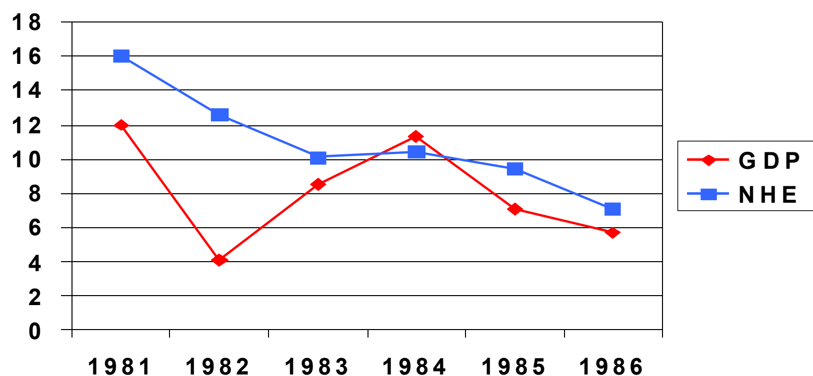
The stage was set for a new level of participation by corporate America. Self-funding of health benefits had been growing slowly through the late 1970s. HMOs had begun to gain some market presence -- by 1980 there were 235 HMOs enrolling over 9 million people.[49] Businesses across the country were forming health care coalitions to share their experience and collect the data necessary to adjust their benefit programs to control costs.

Employers had difficulty gaining access to the data they needed to better control their own health spending. Insurers had plenty of information in their computers, but it was rarely organized for any purpose other than processing claims. Plus, insurance carriers resisted providing employers with the information needed to switch to self-funding. Writing in 1979, Richard Egdahl said,

> *"Does [the move to self-funding] mean that some of the carrier's most sophisticated clients are discovering they can do a more efficient and effective job of managing the health benefits…? [Critics say] that the carriers are insufficiently flexible to meet the changing needs of their large corporate policyholders."* [50]

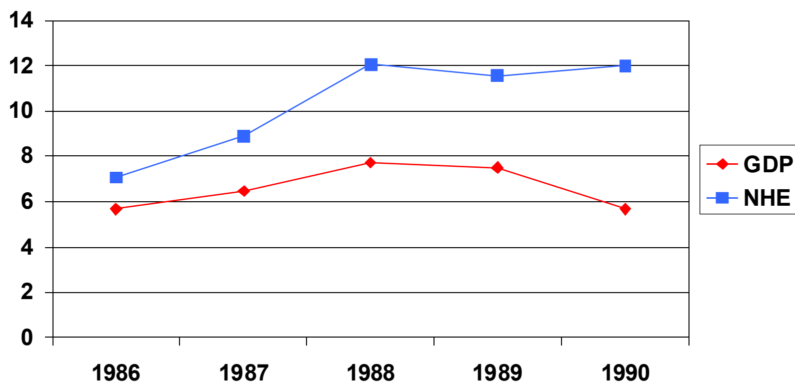
Once they had the data, employers began to change their benefit structures to emphasize cost containment. For instance, the rate of hospital inpatient admissions had been growing steadily since 1950 when it was 111.4 per thousand. It peaked at 162.1 per thousand in 1980, at which point employers began to emphasize substituting less expensive outpatient services for inpatient admissions. One author writes, "Inpatient days dropped from 278 million in 1981 to 220 million by the end of the decade, an overall decline of 21 percent. On the other hand, outpatient visits increased from 203 million in 1981 to 300 million by 1990."[51] Some of the other efforts employers used to reduce inpatient care included: second surgical opinion programs; preadmission certification programs; enhanced benefits for alcoholism and drug abuse treatment; home health care benefits; and many others. Taken together these programs decreased hospital occupancy rates from 75.6 percent in 1980 to 64.3 percent in 1985, and lowered admissions per 1000 from 162.1 in 1980 to 128.9 in 1988.[52]

Changes in utilization were only part of the story, of course. Both employers and the government also worked to control prices -- employers nego-



tiated discounts from providers, and government installed a "prospective payment system" (PPS) for Medicare. For a period of time, these efforts seemed remarkably successful and the rate of increase of health care spending dropped for five years in a row from 1981 to 1986. Margaret Heckler, President Reagan's Secretary of HHS, was famously quoted as saying in 1985, that we had "broken the back of the health care inflation monster." [53]

But costs would soon rise again as providers figured out how to counter the new pressure to cut costs. The savings from switching from inpatient care to outpatient would be short-lived as hospitals raised the price of outpatient services. Even the federal PPS system could be gamed by "unbundling" (charging separately for services or treatments that were previously packaged together) and "upcoding" (assigning the highest-paying diagnosis to each patient). [54] For the next four years (1987-1990), spending would rise again,



increasing 12 percent in 1990. Hospital occupancy, which had fallen to 64.3 percent in 1986, began to rise to 64.9 percent in 1987, 65.5 percent in 1988, 66.2 percent in 1989, and 66.8 percent in 1990. [55]

Faced with resurging costs despite their efforts in the 1980s, employers looked around for additional strategies and found managed care.

Market Distortion #??? *If "the market" is between employers and providers, it is working reasonably well. But the ultimate user is still a pawn with no "skin in the game." Consumers are not making their own decisions*

Managed care had been around for a very long time. These include the programs that started in the lumber camps and mining communities in the early twentieth century. Kaiser-Permanente began as a prepaid group practice for the workers building the Grand Coulee Dam in 1938. The Group Health Cooperative of Puget Sound was organized by farmers, unions and food co-ops just after WWII. The Health Insurance Plan of New York was organized with the help of Mayor Fiorello LaGuardia in 1946. [56] These are the kinds of plans that are included in "other" in the enrollment figures previously reported. They grew along with other forms of health care plans from 1950 - 1965, but much more slowly. Through 1965, managed care covered only five percent or less of all the people with any form of coverage.

One of the obstacles to growth was the organizational structure. These plans typically were group and staff model HMOs, which implies that their physicians were on salary or contract, and that the HMOs owned their own facilities. Such a plan is expensive to build, requiring capital for physical plant and operating cash to pay wages. Also, the plans were usually not-for-profit, which makes raising capital difficult. They were also fiercely resisted by organized medicine for many years, with the AMA and local medical societies declaring that physicians who participated in them were unethical and should be barred from enjoying hospital privileges. [57]

Enactment of the federal HMO Act in 1973 helped accelerate the growth of managed care. The HMO Act provided seed money to organize

new HMOs, preempted many restrictive state laws, and required employers to offer HMO coverage if a federally qualified plan was available in their area. While enrollment grew only 35 percent from 1960 to 1970 (from 6.0 million to 8.1 million), it soared to 33.2 million in the next ten years, a growth rate of 310 percent. [58]

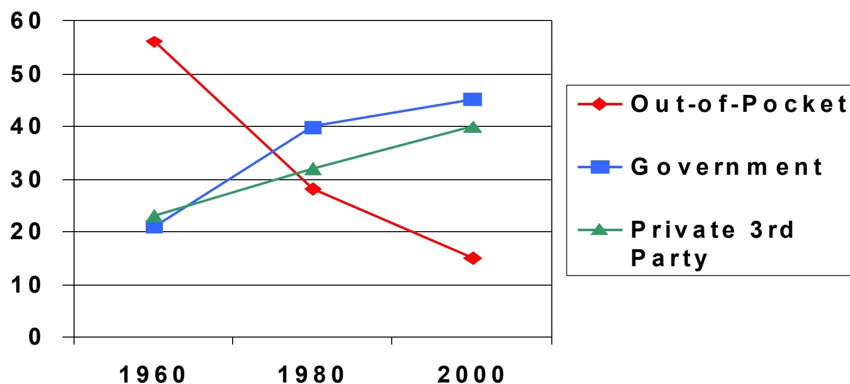
In the 1980s, managed care began to take on new forms. Insurers realized the limitations and capital burden of the traditional forms of managed care, so started organizing "Independent Practice Organizations" (IPOs) which allowed physicians to retain some autonomy and reduced the capital demands on the carrier. Not far behind were Preferred Provider Organizations (PPOs), which organized networks of physicians and hospitals, and used some managed care techniques, but paid providers essentially on a fee-for-service basis. Importantly, these new forms were usually set up as for-profit organizations, which enabled them to harness capital in the equity markets, and grow much faster than would be possible by using internal resources.

From 1984 to 1990, HMOs and PPOs, had increased their share of the private benefits market from seven percent to 34 percent. Managed care added yet another option to appeal to certain market segments, the “Point of Service” (POS) plan. POS was a combination of basic HMO coverage plus a PPO-type arrangement for people who wanted to get services “out-of-network.” With the addition of the POS option, enrollment continued to grow, reaching 65 percent of all covered persons by 1995.[59] Two different reports provide differing enrollment figures for 1997. KPMG Peat Marwick sets the percentage of managed care enrollment in 1997 at 82 percent, including 17 percent in POS plans, 32 percent in PPOs, 33 percent in HMOs, and the remaining 18 percent in FFS plans.[60] A William Mercer/ Foster Higgins report broke it out somewhat differently, setting POS at 20 percent, HMO at 30 percent, PPO at 35 percent and FFS at 15 percent. [61]

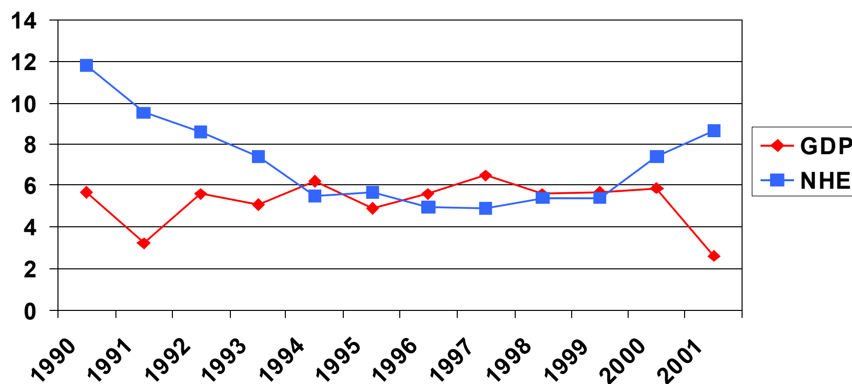
Discussion

While managed care appeared to be a market response to problems in health care, the concept was made possible only by prior market distortions, and much of the impetus for growth was in reaction to the Clinton health reform proposals of the early 1990s. The mere fact that managed care is privately-owned and profit-making does not make it pro-market. As mentioned above, if the health care market consists solely of health plans and employers, than managed care was a successful free-market approach. But this is like saying the real estate market consists solely of seller’s agents and buyer’s agents, and as long as they are happy, it doesn’t matter how the actual seller and buyer feel about it.

Over time the giver and receiver of health care services had been cut out of the deal. And they were not happy. At least in the real estate parallel, the seller and buyer have both chosen who their agent will be, but in managed care there was very little choice. Workers were stuck with the health plan chosen for them by their employer. Doctors thought they had to sign-up for a managed care contracts, or go out of business. Managed care in a few short years went from just one-third of the market to 85 percent or more.



Even that figure is understated, since most "indemnity" or fee-for-service plans also featured elements of managed care such as utilization review and preadmission certification. The term "managed care" is no longer particularly useful in describing a benefits program. The term ranges from staff model HMOs, which put their doctors on salary and own their own hospitals, to loose PPOs that are nothing more than discounted fee-for-service plans. Conversely, there may be little distinction between an independent practice association (IPA) HMO, and many PPOs. It might be more useful to think in terms of "lightly, slightly and tightly" managed care programs, with probably one-third of the enrollment in each of the categories.



***Distortions ad finitum** -- The federal and state governments continue to micromanage health benefits and health services.*

Employer sponsorship of health care and the rise of managed care, which were both encouraged by federal law, have brought their own problems. So, Congress continues to enact additional laws to fix the unintended consequences of the previous ones. Some examples include:

Any number of new federally "mandated benefits" have been proposed or enacted on such topics as minimum maternity stays in the hospital, post-mastectomy hospital stays, mental health parity, and coverage of contraception.

The states, too, continue to enact mandated benefits, with some 1,800 discrete requirements on the books today. They also continue to distort the market with rating restrictions and other requirements that impede normal market functions.

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 [62] required that people leaving their jobs be allowed to continue their employer plan coverage for a period of from 18 to 36 months, depending on the circumstance, provided the terminated employee pays the employer's premium plus two percent for administrative costs.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires group plans to accept any new employee with pre-existing conditions and limits the waiting period allowed for pre-existing conditions. It also requires guaranteed issue of individual coverage for certain "eligible individuals." [63]

On the health care delivery side, the distortions are now uncountable with the EMTALA Act,[64] the Stark One and Two laws,[65] COBRA's regulations on emergency medicine,[66] and a host of other laws and regulations. On top of the laws and regulations, it has become a crime, not just a civil tort, to make billing errors with Medicare or to prescribe drugs that the Drug Enforcement Agency thinks are inappropriate. [67]

Discussion

COBRA and HIPAA are trying to remedy the problem of portability in an employer-based system. But they haven't worked very well for a number of reasons:

1. The period of unemployment is exactly the time when the worker can least afford to pay

for his own coverage, let alone an extra two percent;
2. The people who continue their coverage are almost universally higher-cost individuals who view 102 percent of employer cost as a good deal. Healthy people can usually find less expensive coverage in the individual market;
3. The excess expense of covering the higher-cost former employees is passed back to the employer in the form of higher, "experience-rated" premiums;
4. The burden on employers of keeping track of, not only former employees, but their spouses and dependents for years after the employment relationship has been severed, is onerous; and
5. For HIPAA, the rules of individual eligibility are so complex as to be almost useless and the guaranteed issue requirements allow small employers to enter and exit the market as the needs of their workers (who often are also relatives) change. This raises premiums and increases instability in the small group market.

The more recent disputes over "patient bills of rights" followed the same pattern -- trying to fix an unworkable situation. As long as the consumer and the payer are separate parties, there will be conflict. The interests of the consumer/employee are not the same as the interests of the buyer/employer. The consumer/employee may value health care services more highly than the buyer/employer is willing to pay for. Or the consumer/employee may make different judgements about what should or should not be covered than the buyer/employer. The system we have fallen into precludes these value judgments from being exercised in health care.

If all these interventions produced a health care system that was efficient, effective and affordable, a case might be made that government has done the right thing and we should accept the results despite any misgivings we might have about the role of government.

In fact, we have the very opposite. One hundred years of market distortions has produced a system that offers questionable quality at extremely high costs. Physicians are demoralized, patients feel like cogs in a machine, hospitals fight against competition, information systems are primitive. Bureaucracy prevails and regulations rule.

Winston Churchill,

"Americans can always be counted upon to do the right thing, after all other possibilities have been exhausted"

The Consumer Era, 2000 - ????

What we experienced in the 1990s was a clumsy effort at coming up with the right balance between access, cost, and quality. For many years costs had gone up too fast, so employers stepped in with managed care programs to curtail further increases. Then patients got upset that cost had become more important than access and quality. They felt their best interests were being sacrificed in the name of cost control, so government wanted to step in with "patient protections" to correct the balance.

How to find the balance is the right question, but the wrong parties are making the decisions. The right balance is an individual value judgment that will vary from person to person and from time to time. The only way to accommodate these individualized values is through a market mechanism.

Restoring effective market functions to the health care system will take time, but other industries have been deregulated with great success, and health care can be as well. At this writing we are already well into a new era of health care reform -- The Consumer Era.

It is far too early to tell how the Consumer Era will develop. It began with the enactment of Medical Savings Accounts (MSAs) in 1996. [68.] These were available only to small employers and the self-employed -- not the most innovative segments of the benefits market. The program was very tentative and restrictive, and did not fare well in the market.

But it did force a re-thinking of the role consumers could play in controlling health care resources. As the “managed care backlash” unfolded, human resource executives in large companies began to explore how MSA principles could be applied to their own benefit programs. They drew on their successful experience with pension programs which had gone from “defined benefit” programs (traditional company-paid retirement plans that promise s certain level of monthly benefits regardless of the state of the economy or the solvency of the company) to “defined contribution” approaches like 401-Ks that pre-fund a set amount of annual contribution which is then the property of the employee and fully portable as workers move from job-to-job.[69.] In revising pension programs, employers were able to move from virtually unlimited and unknowable future obligations to a pre-funded and fixed annual liability.

To replicate this experience in the health arena, employers created what the Internal Revenue Service later termed “Health Reimbursement Arrangements” (HRAs). Using existing tax laws, employers created MSA look-alike programs with higher deductibles and “personal health accounts” that would roll over from year to year and build up if not spent. The funds were “notional” (unfunded) accounts that were allocated to each employee, but not owned by them.

These firm pressed the IRS for private letter rulings that would clarify that such programs were in compliance with current tax law. Under this pressure, the IRS went further than most people expected and issued a comprehensive Notice and Revenue Ruling in June, 2002 that laid out the rules of the road for HRAs. [70.]

Armed with this new guidance, increasing numbers of employers began establishing HRA programs, and the infrastructure to implement them.

This change of mind set by benefits executives at large corporations encouraged Congress to enact Health Savings Accounts (HSAs) as part of the Medicare Modernization Act of 2003. [71.] When Congress was considering MSAs in the mid 1990s, most large employers were at best indifferent or more often hostile to the idea. They had put their eggs in the managed care basket, and viewed MSAs as a distraction. Seven years later, managed care had become a dead-end, and companies were looking around for alternative approaches.

Now, HSAs are sizzling in the market. In two years they have attracted over 3 million customers. [72.] According to Professor Regina Herzlinger, they are being adopted at a faster rate that IRAs were,[73.] and certainly faster than HMOs or 401-Ks ever were.

But this is just the beginning of a total transformation of the American health care system. Once patients control the money, they will (and already are) demand information so they can spend their money wisely. Once they have both money and information, they will demand changes in the way health care services are delivered. It will become more accountable, convenient, efficient, affordable, and of better quality.[74.] There will be a thorough housecleaning of a system that is bloated wit waste, bureaucracy, and inefficiency.

Conclusion

After 100 years of intervention from all levels of government, it is small wonder that people say, "the market doesn't work in health care." The market has been so thoroughly distorted that it is a miracle there is any market response left at all. But market principles are impossible to kill off altogether. Whenever there are willing buyers and willing sellers, they will find each other and somehow arrange an exchange at a mutually agreeable price.

Economists will tick off a series of ways in which health care fails to meet the model of a perfect market. There are "externalities" (that is, we each have an interest in making sure everyone is vaccinated against polio and small pox), there are "information asymmetries" (the buyer and seller are not equally well informed about the services being offered), and so on. But none of these issues is unique to health care. Services like higher education and products like computers are similarly complex and important to the national well-being.

What has been unique to health care is the third-party payment system we created through the course of the century, and have been struggling with ever since. If the health care system doesn't work like a well-oiled marketplace, it is due to the financing system we developed, and that in turn is due to misguided, shortsighted, and often inadvertent attempts by government to control the market.

We have already started down the path of "The Consumer Era." The enactment if Health Savings Accounts and Health Reimbursement Arrangements has begun to put control of resources (money) back in the hands of the end-user and away from the third-party payers.

The current experiments with these programs will help define what is the optimal balance between direct payment for services and insurance coverage.

The second step is underway. That is the development of patient support services and information systems to help empowered consumers spend their funds wisely.

Once armed with money and information, American consumers will have a profound impact on how health care services are organized and delivered. They will demand efficiency, accountability, affordability, and convenience. We can not predict exactly what that will mean, except that the health care system will become as streamlined and consumer-friendly as every other area of American enterprise.

Greg Scandlen is the founder and president of Consumers for Health Care Choices, a national advocacy organization based in Hagerstown, Maryland. The ideas in this paper were developed over several years of public speaking on this topic, and are available as a presentation.

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