# Estimate of the Situation

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## The 60-Year Mistake

Although the very idea is anathema to many in the health care establishment, health care is no more immune to economic forces than any other service.

Thus far, all efforts to control the explosive growth of health care costs (including the "Affordable Care Act") have been on the supply side (hospitals and physicians). *They were doomed to fail because the problem lies on the demand side*.

It is axiomatic from a policy perspective that if you want more of something, you subsidize it. If you want less of something, you tax it. Whenever consumers of a desirable service, such as health care, are shielded from the real costs of making the consumption decision, demand for that service will be virtually infinite—and so will be the aggregate cost of its consumption.

Increasing access to insurance for millions of Americans (which is what The Affordable Care Act purports to do), can only result in a very large increase in service demand. However, as many Affordable Care Act supporters are learning, access to insurance is not the same thing as access to health care. The Affordable Care Act promises insurance access even as it requires hospitals and physicians to ration care delivery according to centrally mandated rules, the enforcement of which must add to the administrative cost of care. This is great for politicians who reap the benefits of promise making—but not so much for the physicians and hospitals who must either deny care delivery or face increasingly draconian reimbursement penalties.

Every health care reimbursement scheme undertaken in the last half-century has insulated the consumer of health care services from paying (or even knowing) the real cost of the service provided. That includes the Medicare program's original "cost based" reimbursement scheme (which paid only "allowable costs"), HMOs, negotiated rate PPOs, DRG reimbursement, the Prospective Payment system, bundled payments, pay for performance, etc. All systems do what they are designed to do. Today's third party reimbursement system is designed to subsidize demand and hide costs. That is exactly what it is doing and it does it very well.

The end result is that in most cases there is no practical connection between the price that appears on a patient's hospital bill and the reimbursement the hospital receives for care. Even worse, there is little connection between the cost the hospital incurs in providing care and the "reimbursement" received for its delivery. Medicare, for example, will pay the hospital for Aunt Jane's stay through a complicated statistics-based formula that has no real world connection to the charges or costs actually generated during Aunt Jane's stay. Aunt Jane will, nevertheless, be informed that Medicare has paid her bill. The Third Party Payer system has devolved into a monstrosity so byzantine that only a few specialists in hospital finance departments, insurance companies, and the CPA firms that specialize in health care even pretend to understand it. Members of the general public and most elected officials understand it not at all.

The Patient Protection and Affordable Care Act manages to worsen a very bad situation on both the demand and supply side of the equation. It fuels service demand by expanding the number of "insured" people even as its resource-consuming regulations constrain health care delivery and drive up unit costs for hospitals and physicians. This is public policy insanity. It is time to rethink our health care assumptions before the health care system is totally destroyed and the nation spends itself into oblivion in pursuit of an impossible dream.

It is time to replace the dysfunctional and failing Third Party System with an alternative market-based approach that provides price transparency, cost reduction, and reintroduces the idea of personal responsibility.

It is time for a Plan "B".

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