Estimate of the Situation

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The Affordable Care Act: Real World Impacts and Options, Part II

"It is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail."— Abraham Harold Maslow

Flawed from the Start

Listen carefully to the words used in the debate surrounding "The Affordable Care Act" and it becomes clear that we need to better define our topic. Not all participants are talking about the same thing. Very different meanings have been assigned to two terms that are central to the debate: "health care" and "cost".

This is important because if we cannot agree upon the meaning of the words used in the debate, we can never agree on solutions or even on the nature of the problem.

What is "Health Care"?

When most Americans talk about health care, they have in mind "the physician directed diagnosis and treatment of a patient's illness or injury." When central planning advocates talk about health care, they have in mind a grand vision that includes patient care, *plus everything that might contribute to population health status*, a definition which includes virtually everything in the biosphere. This latter vision, variations of which have been taught in graduate schools of administration and academic medical centers for decades, has become an immense problem. *The Affordable Care Act* is an effort to bring that vision into being by "reforming" what central planners like to call "our health care system."

The idea of an American "health care system" is itself a fiction, created by central planners over the last half century or so. Virtually all of American medicine's current shortcomings stem directly from the decades-long and largely successful effort to convert what had been relatively simple, low cost, voluntary, cooperative arrangements between entrepreneurial private practice physicians, independently operating hospitals, and patients into a centralized system controlled by Third Party Payers with establishment of a "Single Payer System" (government operated) as the ultimate goal. Not only has this vision produced an explosion in the cost of care, it has substantially diminished acceptance of individual responsibility for one's medical, financial, and social condition.

The key assumption upon which *The Affordable Care Act* was built is the long-cherished conventional wisdom, treated as revealed truth by many in the health care establishment, that fee-for-service medicine is the root cause of the health care cost explosion.

This shared conviction has been acted upon by government policy makers, major insurers, national hospital and physician associations, large teaching hospitals, national systems, and other powerful decision-makers for more than half a century. *It is also completely wrong and the primary reason for the health care cost explosion.*

Here are a few selected examples of "expert" thinking on this topic.

- "There is widespread agreement among policymakers, payers, and health care leaders that the current fee-for-service method of paying for care is one of the drivers of the unsustainable growth in health care costs." *Hospital Readiness for Population-based Affordable Care*, Health Research & Educational Trust, Chicago: April, 2012
- "This antiquated model [fee-for-service] is the culprit behind exponential health-care cost growth." Judith Barnes, Director of Health Policy, Bipartisan Policy Center, *The Atlantic*, "Moving Away from Fee-for-Service", May 7, 2012
- "The current fee-for-service system raises the cost of care by 20 to 30 percent for services that provide little or no health benefit." Victor R. Fuchs, Professor Emeritus of Economics and Health Research and Policy, Stanford University, *The New York Times, Room for Debate*, "Competing for Better Outcomes and Lower Costs", June 28, 2012
- "A new study suggests that global budgets for health care, an alternative to the traditional fee-for-service model of reimbursement, can slow the growth of medical spending and improve the quality of care for patients." David Cameron, Harvard Medical School Communications, *Harvard Science*, "Moving beyond health care's fee-for-service, Global budget payment model lowers medical spending, improves quality," July 11, 2012

It all sounds so professional and official *but if "fee-for-service" pricing is the root cause of the health care cost explosion, why aren't consumer costs for lawn care, dry cleaning, auto repair and virtually every other service sold on "fee-for-service" also exploding?* The problem is *not* how fees or charges are generated; it is how they are paid.

What Caused the "Health Care" Cost Explosion?

In economics, elasticity in demand refers to the degree to which demand for a good or service varies with its price. There is a significant amount of elasticity in demand for primary health care.

My first hospital office more than forty years ago was in a Midwestern teaching hospital situated directly across the hall from that of the Chief of Medicine. His stock introductory message to each new crop of first-year residents was direct. "Eighty percent of all human disease is self-limiting," he would say, leaning back in his chair with his feet up on his desk. Most of your patients will get better with or without your efforts-just don't screw it up!"

Now I don't pretend to know if Fred's "eighty percent" number was accurate. I do know that his comment was in no way intended as a disparagement of sick people who truly need medical care. However his central

point, which is that most patients will recover without medical intervention, is not only true but essential to understanding one of the principle reasons that national health care costs have exploded. *Much clinically unnecessary care demand is generated by patients who don't have to pay for it.* It is necessary to spend only a few minutes in any major hospital's Emergency Department to confirm this observation's validity.

When most Americans talk about the cost of health care, they have in mind their out-of-pocket costs for insurance premiums, co-insurance, and deductibles. When central planners talk about the cost of health care, they mean total expenditures in aggregate. Most Americans do not understand that their costs are increasing in part because of cost shifting by Medicare, Medicaid, Preferred Providers, HMOs and other "payers" that pay less than charges (and, in some cases, less than cost) for care.

Even without cost shifting, the insurance model is a very bad way to pay for basic care. Claims against an automobile, homeowners, or life insurance policy are initiated as the result of an external event over which the insured has no control such as an accident, a fire, or death. In the case of insurance for medical services, the insured controls the claims initiation process just by showing up for treatment. This opens the door to disaster, but it is only part of the problem.

Most of us, at some point in our lives, will need care for an illness or an injury. However, as this recent Newsweek Article points out with devastating clarity, most of us do not need "standard model" health insurance.

Consider this: The total cost of "health care" in the United States can be calculated using the formula shown below:

$$N \times U = C$$

Where:

- N = Number of health care service units
- U = Unit health care service cost
- C = Total health care cost

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 any desirable service, such as health care, are shielded from the real costs of 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 ("N" in the above formula). However, as many *Affordable Care Act* supporters are about to discover, 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 ("C" in the above formula). 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 is a futile last ditch effort to preserve a mathematically unsustainable Third Party Payer-controlled reimbursement system that is doomed by demographics in the near term. National health expenditures in the U.S. reached $2.7 trillion in 2011. Of that amount approximately $555 billion was expended by Medicare and $398.6 billion by Medicaid, both of which are technically bankrupt when generally accepted accounting principles are applied. Medicare's Trustees estimate that Medicare's fictional "Trust Fund" will exhaust its "reserves" which consist entirely of Federal IOUs, non-marketable GAS (Government Account Series) securities in approximately 12 years. Medicare will survive for that long only if unrealistically optimistic GDP growth estimates are realized and impossible cuts in Medicare spending are achieved. Moreover Medicaid, even before the ACA adds millions of people to its rolls, consumes an average of 21% of state revenue, and threatens to bankrupt states from California to Illinois and beyond.

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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