

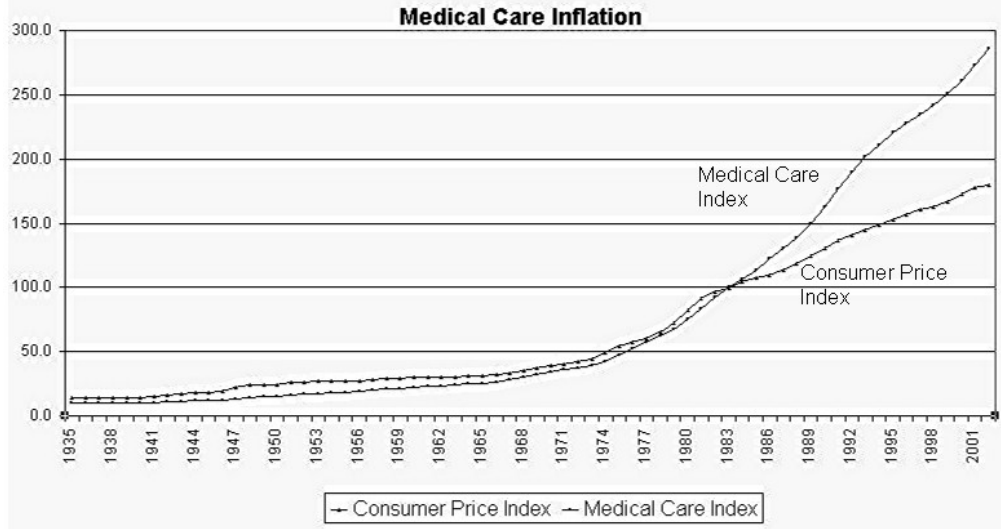
Medical Care Inflation

August 2003

By Richard B. Warner

The number of American people who do not have health insurance coverage is a matter of great concern to policymakers. We hear increasing calls for adoption of some plan for universal health coverage. Last winter the American Medical Association adopted a resolution calling for health coverage for all Americans by 2009. Politicians at both the presidential and the congressional levels are offering variations on the same theme.

As health care has become so expensive, people have come to rely as much as possible on insurance to finance their care. As universal coverage is made into an absolute value, attention is focused on questions of who would provide the insurance. Would it be a government monopolized “single payer” system? Or would all employers be mandated to provide health insurance for their employees with the federal government providing insurance for people who are not employed? Or might we encourage more individual ownership of health insurance through the use of tax credits? Unfortunately, framing the issue in terms of the urgency of achieving universal coverage distracts attention from what is a more fundamental question: How have the prices of both medical care and the insurance that would pay for it gotten as expensive as they have?



The accompanying graph of sixty-eight years of price data drawn from the Bureau of Labor Statistics illustrates two facts. First is that we live in a constantly inflationary environment with the Consumer Price Index rising dramatically and steadily since the early 1970's. That was when President Nixon ended the last vestiges of linkage of the U.S. dollar to our gold reserves and allowed the only limit on dollar creation to be the wisdom of the Federal Reserve Board of Governors. The second fact is that medical care price increases have been in the vanguard of that inflation since the early 1980's.

If we would construct an index of health insurance premiums, we would find that it rises even more precipitously than the CPI and the Medical Care Index. All of this should make us wonder, what is this inflation and what policies aggravate it?

A helpful perspective on inflation could be gained by graphing these indices in a different way, which would illustrate the loss of dollar buying power in relation to the goods and services purchased. To do so we would merely need to invert the graphs to see that the overall value of a dollar is 23% of what it was in 1972 and for medical purchases it has held only 14% of its value.

To look at the matter in terms of the value of a dollar, it is further helpful to think of the various ways in which

dollars are experienced. When I make a purchase, I will use some combination of three kinds of money. For most items I will spend MH, money I have. For some purchases I will spend MEH, money I expect to have (credit). Finally, I might be able to spend ME, money to which I am entitled (insurance or government entitlement).

If I am spending MH, I will likely exercise more discretion in my purchase than I will if I am spending ME. I will search out the best value for my MH, and I will be more conscious of the price of the purchase. I will demand that I get my money's worth, and I will not continue spending on something that does not offer enough value. If I am spending ME, I might exercise more discretion if I know that I will have to pay more MH (in taxes or health insurance premiums) in the future to have access to the ME. But since my own MH contribution to the ME pool is relatively diluted, I am not nearly so motivated to shop wisely. In fact, if I think I am already paying a high price in MH to have access to the ME, then I may feel entitled to get my fair share of the ME and be motivated to spend more freely.

Too often we think of prices, particularly for medical goods and services, as simply set by the sellers. We pay too little attention to the role of the buyers in agreeing to pay the prices asked by the sellers. When individual patients are using mostly insurance or entitlement benefits to pay for prescriptions and services, their role in restraining the rise of prices is diminished. The key to restraining medical inflation is having patients participate with their own MH in some significant part of the price of each medical transaction.

Based on this way of thinking, here are some policies that can contribute to the effort to contain medical inflation:

- + Make prescription benefits percentage-based coinsurance rather than fixed dollar co-payments. Even tiered co-payments only influence the choice of whether to get a prescription. They do not encourage the patient to shop for the best total price. If everyone were doing so, the collective effect would be to hold down pricing.
- + Use percentage-based coinsurance for physician services for the same reason.
- + Indemnity benefits that pay a certain amount toward a provider's fee but allow discretion in the setting of charges above that amount would allow more flexibility in how providers set their charges. That would allow them to offer individualized discounts to patients in need.
- + Open up the market for personal savings accounts, tax advantaged accounts that encourage saving money to use for coinsurance, deductibles and discretionary medical purchases. This would allow people to rely less on health insurance, and they would be able spend less on insurance premiums.
- + Encourage employers to make defined contributions toward their employees' health insurance premiums and saving accounts. Allow the employees to choose from a variety of plans and pay with their own money the marginal dollars above the employer's contribution for the premium. This will bring more realism to peoples' expectations of their insurance.
- + Encourage incentives for individuals and insurance companies to achieve more longitudinal relationships, rather than changing after a few years to other plans. In this way insurance plans would be able to reward younger and healthier customers to build up credits that could offset premiums later in life. Also, there would be more incentive to take prudent preventative measures.

The thrust of this analysis is to suggest that an important factor in health care and health insurance both becoming so costly has been our reliance on health insurance plans that have sought to spare people all but the least costs of their health care. To place the highest priority simply on achieving universality of health insurance coverage may only aggravate that inflation further. Whatever financing plans are developed, if they do not sufficiently consider the role of individuals in containing inflation, they will likely bring about more inflation. Our goal should be to achieve health insurance coverage that is both equitable and sustainable.

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This article is reprinted from The Kansas Physician, August, 2003