

Concepts Underlying Incentives in Health Care

Risk Pooling, Adverse Selection and Moral Hazard. At a very basic level people want to reduce risk and ensure a comfortable standard of living over time. The challenge is that income and expenses are often quite volatile; people may get a raise one year and be laid off the next. Savings, credit markets and insurance markets are all tools that can be used to deal with these types of fluctuations. Medical care being one of the largest and most unpredictable expenses that people are likely to face, health insurance is a crucial tool that people must have access to.

Without access to insurance or credit markets, people will use their savings to protect themselves in the event of a serious medical condition. There are two problems with this approach. First, it is often difficult to save enough to protect against the cost of catastrophic injuries or illness. Second, it is very difficult for people to know whether they have a high or low risk of serious medical problems. As both a mechanism for collective saving and risk pooling, health insurance solves these problems. With health insurance it is as if each person faces the average financial risk of lifetime medical costs. While health insurance has the very attractive features of helping people to reduce risk and ensure a comfortable standard of living, it has two main drawbacks—adverse selection and moral hazard.

Although people cannot make exact predictions of what medical problems they will face, they have much more information about their general level of health than anyone else. People who are generally sicker may correctly feel that they have a greater level of risk than others. This gives rise to adverse selection, as it is more likely that these types of people will choose to purchase health insurance. Adverse selection causes the aggregate level of pooled risk in the insurance plan to be higher and therefore costs may be higher than expected. This is a serious problem for insurance companies and they go to great lengths to develop screening mechanisms that are designed to exclude people with inordinately high levels of risk.

The second problem, moral hazard, comes in two forms. First, individuals without any type of health insurance face a strong disincentive with regard to risky behavior; they may be less likely to engage in dangerous sports if they know they must pay the full cost of treating an injury. By removing the risk that they will have to pay this cost, individuals may be more likely to engage in risky activities. Secondly, because individuals are not paying directly for the medical care, they have no incentive to choose the most cost-effective level of care. Pressures on health care providers to turn a profit and on doctors to avoid malpractice suits exacerbate this perverse incentive. The result may be that patients either overuse medical services, select expensive and unnecessary care or both. To prevent this problem insurance companies use deductibles and co-pays to reintroduce cost-based incentives into individual decision-making on risky behavior and level of medical care.

Structure of the Current Health Care System. The current structure of the health care market can be broken down into five groups: health care providers, government sponsored health care programs, insurance companies, consumers with coverage and consumers without coverage. The incentives faced by each group determine the way it interacts with other components of the system.

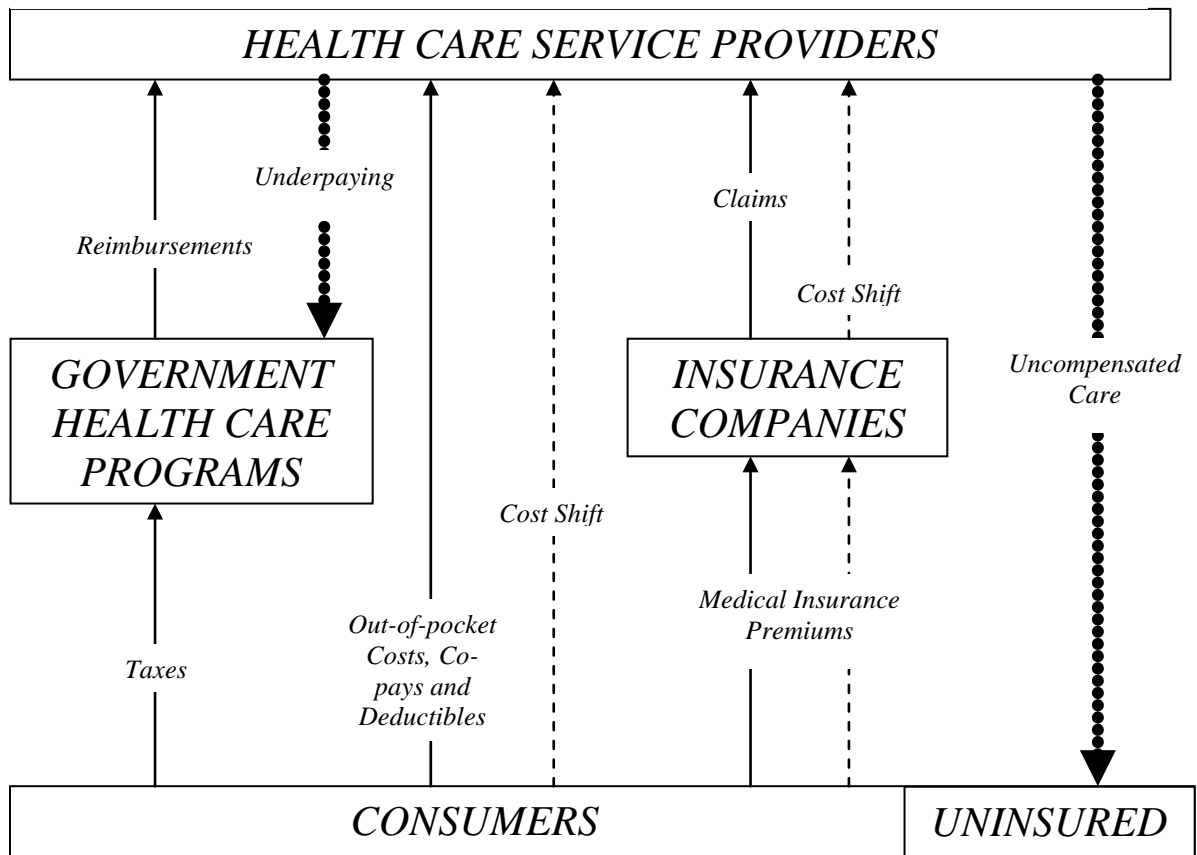
In a simple world, consumers would purchase health care services directly from providers. As described previously, the risks associated with medical care create demand for insurance. Thus, direct purchases of services typically come in the form of relatively small out-of-pocket costs, co-pays or deductibles. The main flow of funds is channeled through insurance companies in the form of medical insurance premiums.

To combat the problem of adverse selection, insurance companies may raise premiums on riskier consumers and may in some cases price them out of the market entirely. If they meet qualifications, such people may be able to obtain subsidized health insurance through various government programs. If they do not qualify, then they can access emergency room services even if they are unable to pay. In this way, laws that prohibit hospital ERs from denying care act as a sort of informal social health insurance program.

Both formal and informal social health insurance programs have the same problems with moral hazard and adverse selection that private sector insurance companies do. Unfortunately, the tools to address these problems are not available to the government and are certainly not available to ERs. In order to deal with the added cost that is associated with these problems, health care service providers shift some of the cost onto insured or privately paying consumers while at the same time seeing profit margins squeezed. The government can meet these cost pressures by either raising taxes or using its bargaining power to underpay providers. As it is more politically expedient to do so, it typically chooses to underpay, further adding to the cost shift burden on insured consumers.

The cost shift phenomenon puts constant upward pressure on the cost of health insurance premiums and medical care in general. The risk is that if costs rise at a greater rate than the ability of consumers to pay, more consumers will be priced out of the market and forced into either formal or informal social health insurance. This creates the potential for a vicious cycle—more people without insurance pushes costs up making insurance less affordable which leads to more and more people without insurance and so on. (*See diagram 1*)

Diagram 1: The flow of cost shifting in the health care system



Health Care Reform Principles

Adopted by the SDCTA Board of Directors on September 18, 2009

Ensuring access to quality health care is an issue of major concern for the San Diego County Taxpayers Association (SDCTA). Not only is it important to provide such access on ethical grounds, it is economically beneficial as investments in health care generate long-lasting improvements in productivity. For instance, having health insurance has been conservatively estimated to reduce morbidity by 5% and increase annual earnings by 15%.ⁱ For California alone, this translates into billions of dollars of economic gain for comparatively small investments in healthcare.ⁱⁱ Unlike other types of investment, government spending on health care is an essential component underpinning sustainable growth and a greater level of welfare for society. As a public good, the government plays an important role in promoting access to quality health care. While California has invested in improving health care technology through initiatives such as the Stem Cell Research program, support for the University and Institute research system, and the implementation of Research and Development Tax Credits, many remain concerned that not all Americans have access to quality care at a price they can afford.

There is widespread recognition that the health care system in the United States is in dire need of reform. Certainly there are many different problems associated with the current system. The California Health and Human Services Agency laid out ten major problems in a recent policy document.ⁱⁱⁱ From a taxpayer perspective the most significant problem is the so-called hidden tax. Healthcare providers—especially hospitals—are legally prohibited from denying care even when they are not compensated for the services they provide. At the same time, government programs such as Medicaid chronically underpay providers for services. In an effort to maintain profitability, healthcare providers shift this cost onto those who are either able to pay out-of-pocket or those with health insurance. It is estimated that this cost shifting has led to 17% higher health insurance premiums.^{iv}

The incentives built into the United States' health care system have created a situation in which portions of the population do not have medical insurance and health care providers are not adequately compensated for the services they provide. Over the years, piecemeal attempts at reform have by and large resulted in a continuation of the status quo. SDCTA supports effort to address health care reform in a comprehensive fashion.

SDCTA has found that the most effective means to address complex public policy proposals is to define a series of principles that articulate what it believes is in the best interest of the taxpayers. These principles serve as benchmarks that when applied to public policy result in a means to objectively assess whether SDCTA is willing to support proposed reform measures. It also provides SDCTA with a mechanism by which it may constructively influence proposals before they are voted on by legislators and/or reach the ballot.

Principle #1 – Access to Quality Health Care for All Americans

Reform proposals should seek to remove or lower barriers that prevent Americans from accessing care.

There are three major barriers to access—cost, willingness, and availability. Because the cost of health care is often a significant barrier, reforms should seek to make health care services and medical insurance more affordable. There are two regulatory tools that can be used to achieve this goal. First, the national government can help insurance companies to mitigate the risks of catastrophic losses due either to health emergencies or the costs of chronic care. By providing government-sponsored reinsurance (insurance for insurers) to health plans governments can effectively lower medical insurance premiums and expand coverage for all Americans. Second, government can provide subsidized insurance for low-income Americans that are still unable to afford health insurance.

Although subsidized health insurance products for low-income populations and government-sponsored reinsurance programs can reduce the number of uninsured, such regulatory tools will have no impact on those who are simply unwilling to purchase health insurance despite being able to afford it. To overcome this barrier and achieve more widespread coverage, the national government should require all Americans to obtain some basic level of medical insurance. So long as effective enforcement mechanisms are included, such a requirement is likely to be the only effective means of expanding coverage to this group of uninsured.

Given that the ultimate goal is for all Americans to get the care they need, in a medically appropriate and cost-effective setting, subsidizing health insurance and requiring coverage will be ineffective if the necessary medical services are simply not available. To the extent that the private market does not provide a sufficient level of access in certain localities or for certain groups of people, governments should create incentives that support market development for these segments or locations. Critical public services, such as emergency and trauma, should continue to receive public support.

Principle #2 – Minimize Costs to Taxpayers

Ensuring access to quality health care for all Americans will result in a significant reduction in cost shifting and the so-called hidden tax. However, reducing the number of uninsured in the United States is only part of the solution.

Reforms must address the other major source of the hidden tax—underpayment by government run insurance pools such as Medicaid. Reform packages that incorporate subsidized insurance products for low-income populations should minimize costs to taxpayers by pooling the risk of participants and using market power to achieve lower rates from providers. However, there is a fine line between protecting taxpayers and generating cost shifting. It is clear now that government run insurance pools have crossed that line and are excessively contributing to the hidden tax. Reform packages should be careful to structure government run insurance pools to achieve appropriate payment for providers while protecting the interests of taxpayers.

Because the criteria by which individuals are admitted to government run insurance pools is based on the inability to acquire insurance in the private market, such pools do not screen out high-risk individuals. This may lead to higher overall costs for taxpayers. Reforms that create government run insurance pools should protect taxpayers by mitigating costs associated with high-risk individuals.

The ability of taxpayers to pay for health care reforms is limited. As such, any systems created by health care reform packages should seek a reduction of waste and inefficiencies in the healthcare delivery system eliminate overly bureaucratic processes, and reduce administrative costs for patients, providers, and insurance companies.

Principle #3 – Preserve the Benefits of a Competitive, Market-Based Health Care System

The Association strongly supports health care reform plans that preserve and promote a market-based health care system. If certain areas or groups of people are not served to minimum state standards, market based incentives should be utilized to extend access and care to these populations. Should government expand its involvement in the health care market, it should attempt to preserve incentives for innovation. Improving health care service and technology requires massive amounts of investment from private sector companies. If private companies are not assured of a reasonable return on their investment, the pace of innovation will slow and consumers of health care could suffer.

Health care reform packages that create government run insurance pools should take into account the fact that such pools will compete directly with private insurance companies. Such reforms should make every effort to mitigate the negative impact on private business and avoid “crowding out”. It is important that eligibility criteria are designed such that participants are only those people who would not have otherwise been able or willing to purchase private insurance products. Additionally, it is crucial that such pools be fully funded and properly monitored. Under-funded pools are much more likely to underpay providers, thus generating cost shifting and further distorting the market. Similarly, placing too much of the funding burden on one tax source can create unwanted market distortions. As such, it is essential that financing schemes for reform packages take into account the impact on the economy regional and state economies.

Principle #4 – Incentivize Appropriate and Cost-Effective Consumption of Medical Services

Under the current system in which hospital emergency departments act as defacto universal insurance, the sickest and poorest people use the emergency room for primary care regardless of whether that is the most medically appropriate or cost-effective setting for providing such care. Providing alternatives that enable all Americans to get the care they need in an appropriate setting is an essential component of any reform effort. To the extent that excessive consumption of medical services is a concern, expanding medical insurance coverage to currently uninsured populations will only exacerbate this problem. Reforms should take care to structure the system such that there are incentives for doctors and patients to make medical decisions based on what is best for the patient’s health. At the same time, the system should incorporate incentives that encourage patients to seek care in the most appropriate and cost-effective setting. While it is important to protect people from financial ruin due to health problems, exposing people to the benefits and consequences of their consumption decisions will help to ensure an appropriate and cost-effective level of health care consumption. Reforms should also align the financial interests of providers with the medical needs

of patients. In doing so, the State can generate beneficial health outcomes. To this end, compensation to providers should be tied to the quality of service provided.

Reforms should structure the system such that there are incentives to reduce the need to practice defensive medicine (medical practices designed to avert the future possibility of malpractice suits). Also known as medical tort reform, actions to disincentivize litigation and to incentivize doctors basing their decisions on medical, and not legal, reasons would ultimately reduce the costs of providing health care, and these savings can be passed on to taxpayers.

Principle #5 – Incentivize Preventative Care, Healthy Lifestyles and Personal Responsibility for Health

From reduced productivity of workers to the burden on taxpayers to fund public health programs, health problems have negative impacts on all of society. As such, individuals have a responsibility to be good stewards of their health. With the looming costs associated with obesity, diabetes and an aging population, it is essential that health reform proposals incorporate incentives that help people to get preventative care and develop healthy habits. Preventative care and healthy lifestyles can reduce system-wide health care costs.

Principle #6 – Create a Fair and Equitable System

The responsibility of ensuring access to quality health care for all Americans should not fall on, nor exclude, any one segment of society, whether it is employers, providers, individuals or the government. Health care systems that disproportionately burden or benefit particular groups are ultimately untenable. Reforms should ensure that the costs and the benefits of health care are shared in a fair and equitable manner.

Principle #7 – Benchmarks to Measure Effectiveness and Efficiency of System

Reform plans should incorporate benchmarks to measure cost, quality and access and include mechanisms to improve the system when objectives are not being met.

Access: The ability to obtain needed medical care. Access to care is often affected by the availability of insurance, the cost of the care, and the geographic location of providers.

Adverse Selection: People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.

Benefit Package: The set of services, such as physician visits, hospitalizations, prescription drugs, that are covered by an insurance policy or health plan. The benefit package will specify any cost-sharing requirements for services, limits on particular services, and annual or lifetime spending limits.

Co-insurance: A method of cost-sharing in health insurance plans in which the plan member is required to pay a defined percentage of their medical costs after the deductible has been met.

Cost Shifting: Increasing revenues from some payers to offset losses or lower reimbursement from other payers, such as government payers and the uninsured.

Comparative Effectiveness: A field of research that analyzes the impact of different options for treating a given condition in a particular group of patients. These analyses may focus only on the medical risks and benefits of each treatment or may also consider the costs and benefits of particular treatment options.

Defensive medicine: Medical practices designed to avert the future possibility of malpractice suits. In defensive medicine, responses are undertaken primarily to avoid liability rather than to benefit the patient. Doctors may order tests, procedures, or visits, or avoid high-risk patients or procedures primarily (but not necessarily solely) to reduce their exposure to malpractice liability. Defensive medicine is one of the least desirable effects of the rise in medical litigation. Defensive medicine increases the cost of health care and may expose patients to unnecessary risks.

Premium: The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.

Purchasing Pool: Health insurance providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should balance low and high risk individuals such that expected costs for the pool are reasonably predictable for the insurer and relatively stable over time.

Reinsurance: Reinsurance is insurance for insurance companies and employers that self-insure their employees' medical costs. Through government-funded reinsurance programs, federal or state governments pay for a portion of the high costs experienced by insurers. By limiting insurers' exposure to very high health costs, reinsurance programs enable insurers to lower the premiums they charge to employers and individuals. This type of program is a form of subsidy to the insurer that lowers the premium cost for all purchasers. The Healthy New York program and the Healthcare Group of Arizona are examples of state reinsurance programs.

ⁱ Hadley, Jack. (2003). "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work and Income" *Medical Care Research and Review*, Vol. 60 No. 2, (Supplement to June 2003)

ⁱⁱ 15% of total personal earnings in California in 2002 was \$173 billion. A 5% decrease in California's death rate in 2001 would have saved 11,640 lives. Given the US Environmental Protection Agency's standard figure for the value of a statistical life (\$6 million) and assuming an average lifespan of 75 years, the value of this decrease in the death rate is \$931 million.

ⁱⁱⁱ California Health and Humans Services Agency. *Top 10 Indicators: California's Health Care System is Broken*. January 2007. <http://www.chhs.ca.gov/docs/Top%2010%20Indicators%20010807.pdf> (Accessed on 5/8/2007).

^{iv} Dobson, Allen et al. "The Cost-Shift 'Hydraulic': Foundation, History, And Implications." *Health Affairs*, 25, No. 1: 22-33. 2000

^v Term definitions from the Henry J. Kaiser Family Foundation Glossary of Key Health Reform Terms. Available: <http://www.kff.org/healthreform/upload/7909.pdf>