

WORKING FOR Health Care

Employer-sponsored health insurance is commonplace, but it may be one of many factors distorting the market for medical services

BY BETTY JOYCE NASH

The Northern Neck Free Health Clinic in Kilmarnock, Va., serves up medical care to the working poor. “I have right here a 28-year-old with breast cancer,” says Jean Nelson, executive director. The patient lacks health insurance because she works part-time, ironically, at a hospital. The free clinic itself can barely afford to insure its employees. “Our premiums are incredible, but you don’t bring in employees to a free health clinic and not give them health insurance.”

Health coverage in the United States is built around employer-sponsored insurance plans. Employees receive access to group health plans at a cheaper rate than they could buy individually. Of course, workers get the benefit of insurance at the expense of higher wages, but they’re not taxed on the insurance as they would be on the added pay. This “third-party” payment system has complicated the economics of health care enormously, economists say.

“When consumers are out there, they’re using someone else’s dollars to order very expensive services,” says Chris Conover, who researches health care at Duke University’s Terry Sanford Institute of Public Policy. “[There’s] not the price and cost discipline you see in most other markets.”



Markets and Health Care

The United States spends more on health care for each person than any other industrialized nation, all of which offer some form of guaranteed health coverage. In 2002, the United States spent \$1.6 trillion, or \$5,440 per person, 9.3 percent more than in 2001. Health spending grew 5.7 percent faster in 2002 than the overall economy, according to the Centers for Medicare & Medicaid Services (CMS). Health care’s share of the gross domestic product jumped to 14.9 percent in 2002

after nearly a decade in the 13 percent range.

Of that \$1.6 trillion, more than half came from private payers. Employer-sponsored insurance, with its tax subsidy, has become the cornerstone of the U.S. health insurance market. Today, about 175 million people are covered through an employer plan, down from nearly 178 million in 2000, with about 242 million covered by a private plan of some sort and 74 million covered by a government plan. Workplace insurance dramatically shaped the system, says David Cutler, an economist at Harvard University and author of *Your Money or Your Life: Strong Medicine for America’s Healthcare System*.

“It led to insurance being tied to work, for good (more risk pooling) and ill (people locked into their jobs),” says Cutler. The downside of workplace insurance is that low wage and part-time workers often aren’t offered health insurance. An upside, though, as Keith Crocker and John Moran point out in an article in the *RAND Journal of Economics*, is that workers are less mobile when insurance is bundled with employment. That creates more commitment to insurance pools, providing “more complete insurance of health risks than would be

available in a competitive market.”

But overall, the economic consequence of employer-paid insurance is troubling: Consumers never see the true costs of medical care because they don't pay with their own dime.

That's thrown the market out of whack. Markets work when buyer and seller let the invisible hand determine price, right? But in the health-care market, consumers buy medical care while employers and insurance firms pay for it and still other participants provide goods and services.

The third-party payment system has contributed to several commonly identified economic problems. The first is moral hazard. Since people aren't paying the full cost of health care, they aren't as sensitive to price. They tend perhaps to buy more than they need and don't shop for the best buy, inasmuch as that's possible in health care.

Third-party payment for medical care, subsidized by tax policy, is illogical, observes economist Milton Friedman in an essay on “How to Cure Health Care” published in *The Public Interest*.

“Why single out medical care? Food is more essential to life than medical care,” he writes. “Why not exempt the cost of food from taxes if provided by the employer?” Friedman argues that the tax exemption of employer-provided care has fueled the inflation in health care spending. He says employees would be better off buying their own insurance policies or paying for medical care with the higher pay they'd get if they didn't get tax breaks on medical benefits.

The second problem is the issue of adverse selection. If healthy people forgo insurance as costs rise, employers may drop plans altogether as only the least healthy people remain in the pool. Adverse selection ultimately will drive insurers out of unprofitable markets, further depressing competition. Regulations enacted to guarantee access can work in reverse. They can make insurance unaffordable, says Tom Miller, formerly a health-care analyst at the Cato Institute and now senior economist with the Joint Economic Committee of the U.S. Congress.

“That's a factor in the cost of care

and people being priced out of the market. [You do] all these things in the hope you'll make insurance affordable for most people. But it generally drives the cost higher in that market.” For example, the 48-hour maternity mandated hospital stay seems sensible, but not everyone needs it and it pushes costs higher for everyone.

“You load the cost into the system and... you are in effect shifting the cost to those other purchasers,” Miller says. “If you look at the cross-sectional dynamics of the uninsured, they tend to be younger, healthier and not have as much money to buy a deluxe policy. [They're] less likely to pick up on a more expensive policy.”

Another complicating factor is asymmetric information. It's difficult for people to observe the quality of goods and services they purchase in the health-care market. How would a person know, for example, whether a heart condition warranted angioplasty or surgery? How good are the drugs, doctors, and procedures at solving medical problems?

“There's that physician who has to play the agent for us,” says Mike Morrissey, a health economist at the University of Alabama at Birmingham.

Information flow in health care is also a problem. While medical technologies have flourished, health care lags other industries in using information technology to improve outcomes and efficiency. “It's taking a long time for the industry to get its act together,” Conover notes. Further complicating the system are doctors' individualized practices and unique role within the hospital. Though they usually have no economic stake in health facilities, they nevertheless, have the hospital at their disposal.

Enter Managed Care

Markets began to work, to some degree, during the managed-care revolution of the mid-1990s. Escalating costs in the late 1980s sent premiums up by 17 or 18 percent. The recession of the early 1990s pushed managed care to the forefront as big purchasers of health benefits hired insurance firms to manage care and benefits aggressively.

Dates That Shaped the Market

1789 Congress establishes U.S. Marine Hospital Service funded by contributions from seamen's wages.

1847 The Massachusetts Health Insurance Co. of Boston began to insure against sickness.

1939 Revenue Act of 1939 establishes employee tax exclusion for compensation for injuries, sickness under workers' compensation, accident, or health insurance.

1943 War Labor Board ruled that World War II's wage freeze did not apply to fringe benefits.

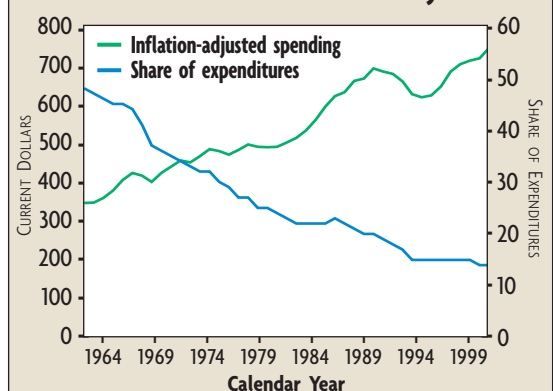
1965 Congress establishes Medicaid and Medicare to cover poor people and people over 65.

“Historically, health care didn't function anywhere near traditional textbook models,” Morrissey says. For example, competition in hospital markets tended to lead to higher costs rather than lower costs, as hospitals engaged in “medical arms races” to install the latest advances in equipment.

“What we've seen with the advent of managed care beginning in the mid-1980s through the mid-1990s was that managed care really did put health-care markets back on their textbook feet,” he says. Selective contracting allowed volume discounts and accompanying lower prices. The rate of premium increase declined steadily.

“By the mid-'90s they believed if they hadn't slain the cost dragon they had at least curbed it,” notes Robert Hurley, an associate professor of health

Health Care Spending and Consumers' Out-of-Pocket Payments



SOURCE: Centers for Medicare & Medicaid Services

administration at Virginia Commonwealth University. But from 1996 through today, premiums have gone from no change in 1996 to the 13.9 percent increase in 2003. The ability of health plans to extract discounts dried up as consumers and providers alike demonstrated they didn't like the restrictions of managed care.

Much employer-sponsored coverage was through managed care in the 1990s. Those plans have dwindled, however, and serve only about 24 percent of insured people today. Preferred-provider plans dominate the health insurance market and with a broader panel of providers, prices can't be negotiated.

"Employers haven't been as supportive, consumers have been unhappy and providers have made it clear they're not going to take what they have in the past," Hurley says.

Regulations can also impede market function. "Some providers in any given state, be they hospitals, physicians, or nursing homes, are very good at understanding their market and have been able to go to state legislatures to seek protection," Morrisey notes. Along with mandated benefits, there are "willing provider" laws. Those laws say, "If I'm willing to live by conditions of contract,

you have to accept me," and ultimately weaken selective contracting.

In Greenville, S.C., for example, one hospital sued to be included in the provider networks of two health plans, previously under exclusive contracts with a competing system. The Center for Studying Health System Change reports: "Consumers now have equal access to both hospital systems, but plans' ability to hold down costs may have been weakened."

Prices Rise, Demand Drops

The number of working-age Americans who receive health insurance through an employer fell from 71 percent in 1987 to 68 percent in 2000, according to research by Harvard University health economist David Cutler, despite the booming economy of the 1990s. Recent Census Bureau estimates put the percentage of working-age people who are covered by employment-based insurance at about 66 percent in 2002. Premium hikes and a changing employment picture share blame as part-time and low-wage jobs replace higher-paying ones, especially in Fifth District states formerly reliant on manufacturing. As lower-wage service industry jobs proliferate, the number of people

covered by employer coverage could continue to slide.

But what Cutler found was that premium costs affect insurance decisions hugely. Twenty percent of uninsured workers who are offered coverage decline it, citing cost as the reason. For every \$10 increase in monthly employee premium, 0.4 percent of employees opt out.

And health premiums are climbing. Premiums rose 13.9 percent between 2002 and 2003, the third straight year of two-digit increases and the biggest jump since 1990, according to the Kaiser Family Foundation and Health Research and Educational Trust.

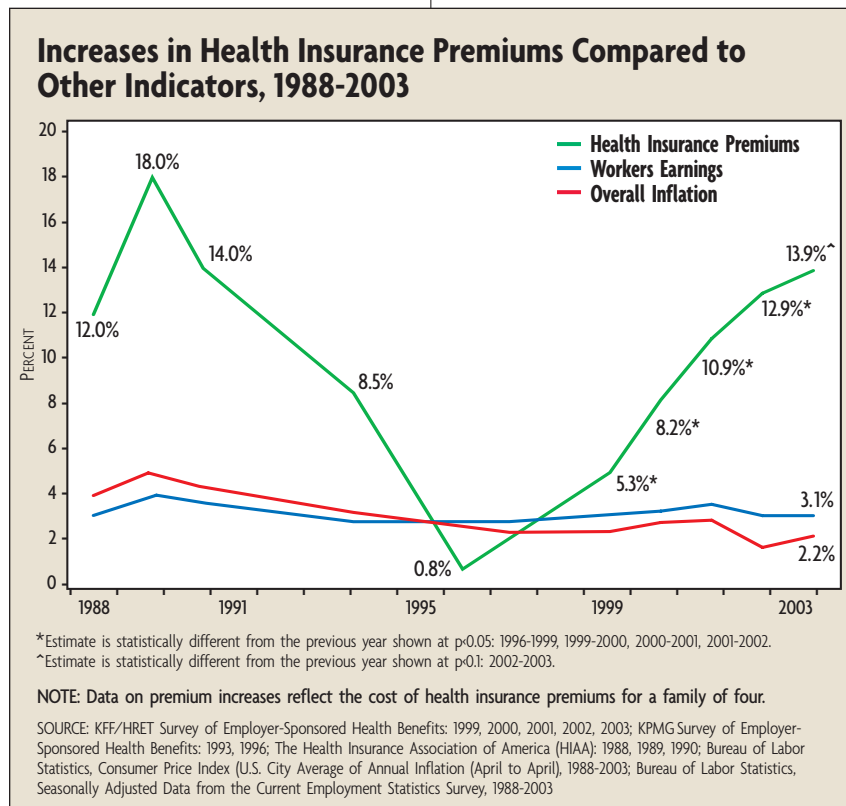
Some employers have either dropped coverage altogether or require workers to pay a bigger share — to save money and to heighten consumer awareness of the true costs of medical care. If people pay more out of pocket, then they're less likely to use medical services and prescription drugs excessively, the thinking goes.

The number of working-age adults with no health insurance increased by 2.4 million in 2002, the biggest jump in more than a decade, says John Holahan, an economist who studies the issue for the Urban Institute. Overall, there are 43.6 million uninsured Americans, or 15.2 percent of the population. Many of those people lost benefits after losing a job, or changed from a large to small firm that doesn't offer insurance or can't pay the higher premium costs. Eight of 10 of the uninsured come from working families, according to a report issued by The Kaiser Commission on Medicaid and the Uninsured.

Workplace-provided insurance is shifting as the job market shifts. "Whether you'll see job gains in industries with employer-sponsored insurance is a big unknown," Holahan says.

Fifth District: Challenges for Coverage

Some Fifth District states face difficulties in health spending and access, partly because of below-average household income, minority populations, and shifts in employment. For example, while North Carolina boasts many high-technology jobs, the state is reeling from massive layoffs in the textile industry



A Subscription Prescription

A patient wrenches his back just before heading to the airport for a trip. He calls his doctor, who prescribes a muscle relaxant, and the patient stops to fill it en route. An hour later, he's checking in when his cell phone rings. It's the doctor, giving him the lowdown on the medicine and instructions to minimize discomfort during his trip. After he hung up, a fellow passenger turns and asks incredulously, "Was that your doctor you were talking to?"

These days, quick, personal medical service is astounding. But for \$68 a month (for a person over 36), if you live in Norfolk, Va., you, too, could have it. Dr. David Grulke and his two partners run a subscription medical practice that he says has freed him from the hassles of paperwork and impersonal, hurried patient care. Sound expensive?

"But in reality this is a modest expense for something we think is a great value," Grulke says. "We want people who are committed to their health and who ask questions and [want] to be educated. They're easy to take care of. Patients who don't take their medications and don't show up for appointments—they're a liability." Grulke handles no insurance, but patients need to carry it for lab work, hospitalization, and procedures referred by Grulke.

In 2002, Grulke quit his previous practice, which had been bought by a corporation along with 13 others. After the purchase, Grulke says he spent half his time doing paperwork after hours, much of it associated with information required by the company. He spent less time absorbing medical details crucial for good care. And he saw between 36 and 42 patients each day.

Now, Grulke and his two partners limit the practice to 600 patients apiece, about 20 to 25 a day, and set aside 15-minute slots for a typical visit, rather than 10. He has gone back to allotting an hour for an annual physical for new patients, 45 minutes for an established patient, rather than the 20 minutes prescribed by the corporate owner. He also sets aside a 15-minute slot every hour for those who need a same-day appointment.

Grulke has practiced internal medicine for 26 years and neither he nor his partners have been threatened by legal action. But he's grateful that he cut his daily patient load when he did. "It's only a matter of time if you see 40 people a day because you're gonna miss the x-ray that showed up lung cancer. We have time to think. If the patient's not getting better, they have easy access back into the practice."

It may seem like an ideal way to practice medicine, but it sounds like a recipe for adverse selection, and eventually, losing money as the sickest people dominate the practice. But Grulke says he's happier and making more money than before, and when a doctor knows intricate details of a patient's condition, it saves money for everyone in the long run. Those patients don't show up in the emergency room or take inappropriate medication and develop even more problems. Half of Grulke's patients are over 65 and some of the ones who are under 65 have health issues. But he also has healthy patients and nearly all his patients want to learn about any medical condition they might have, he says. "They want to find out what to do about it."

But what about the people who can't afford this boutique care? Grulke replies that even the state would save money if it paid him his monthly fee to care for Medicaid patients because they wouldn't wind up in the emergency room.

So far, though, the fee-for-service medical practice is rare. A spokesman for the American Medical Association, Toni Xenos, says the AMA has no estimates of how many doctors do business this way.

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alone, 8,315 in 2003. "We're very much in this transition because we used to be a manufacturing state," Conover says. "That's changing—[there's a] shift toward services, lower-paid jobs." Manufacturing jobs have higher rates of coverage than service jobs, he notes. Firm size and industry type influence insurance decisions. Large firms are more likely to offer coverage than small. Firms with highly paid workers typically will offer coverage while those with low-wage workers and high turnover probably won't. Regional differences account for still more insurance variability. Employers in the Northeast are more likely to offer health coverage than those in the South and West, according to Linda Blumberg of the Urban Institute.

Other coverage issues lie in simple demographics. All Fifth District states except West Virginia have a higher pro-

portion of African Americans than the national average. And African Americans are uninsured at a relatively high rate—20.2 percent in 2002 compared to 10.7 percent for white people.

Three Fifth District states, Maryland, North Carolina, and Virginia, saw uninsured rates rise between 2001 and 2002, by 1.5 percent, 1.6 percent, and 0.9 percent respectively, according to the Census Bureau.

And people make less money in three Fifth District states and Washington D.C. than the U.S. median of \$42,409. The three-year average median household income in the Carolinas is about \$38,400; in West Virginia, about \$30,000; and in D.C., about \$41,313, according to the Census Bureau. Also, more people were out of work in 2003 in three Fifth District states than in the nation as a whole. Nationally, the jobless rate was 6

percent in 2003, while in North Carolina the rate of unemployment was 6.3 percent; South Carolina, 6.4 percent; and Washington, D.C., 6.6 percent.

These factors translate into fewer people insured by employer-sponsored plans. And even those insured may pay more for health care in some Fifth District states. Employers in the Greenville, S.C., area, for example, back away from subsidizing rich benefit packages, according to Hurley. He studies health-care markets for the Center for Health System Change, a project of the non-profit Robert Wood Johnson Foundation. One of the project's study areas is the Greenville metropolitan area.

Half of privately insured people in families in the Greenville area faced out-of-pocket costs of \$500 or more in 2001, compared to 36 percent of similarly insured people in metropolitan areas of 200,000 or more.

"It reflects the benefit designs, [they're] more meager for people there," Hurley notes. "We attribute that to low levels of unionization." He adds that the burden on workers has been even greater in the soft economy, with some employers dropping coverage altogether.

Going without health insurance can be expensive, as uninsured people tend to forgo preventive health care. Taxpayers foot the bill, of course, for charity care and for lost economic potential. Even relatively healthy young adults from 19 to 29, who represented 30 percent of the uninsured in 2002, use acute care services and are at higher risk of pregnancy, injuries, and some chronic diseases such as HIV.

And people without insurance are more likely to die prematurely, among other factors. A 2003 Institute of Medicine study found that uninsured people received health-care services

valued at about \$99 billion in 2001, taking into account money paid from their own pockets, insurance paid, and any workers' compensation payments or charity care received. Charity care totaled \$35 billion in 2001, mostly funded by taxpayers. The study further estimates the potential economic value at between \$65 and \$130 billion annually, including higher expected lifetime earnings, because of improved productivity and better educational outcomes.

Placing a Premium on Health Care

Health-care spending has grown since the 1960s as people have become more insulated from costs. But over the same period, the field of medicine has made substantial advances in lengthening peoples lives through managing chronic illnesses like cancer and cardiovascular disease. For example, many medical specialties such as oncology and critical care

medicine weren't developed until the 1970s and 1980s. Today, life expectancy is close to 80 years, compared to 45 in 1900, having declined pretty much steadily since the mid-1950s.

"On average, given the extraordinary costs of illness and premature death, society is better off exchanging more money for better health," writes Sherry Glied, an economist at Columbia University's Mailman School of Public Health, in the *Journal of Economic Perspectives*. She also points out that there has been little variation in the annual rate of growth in per capita real health expenditures, increasing only slightly faster in the five years following the introduction of Medicare and Medicaid in 1965. Glied suggests that the introduction of new and expensive technology most likely explains the growth of health-care costs, largely because of increased demand. "...although the measured price of medical services has

Better Data, Better Care

While medical innovations help us live longer, healthier lives, the health-care industry is behind the curve in using information technology to improve efficiency and patient outcomes, analysts say.

Indianapolis-based insurer Anthem Blue Cross and Blue Shield is working to change that with the help of Dr. Richardson Grinnan, a former physician. Grinnan uses "Informatics" to study claims data. The idea is to better understand variations in medical practices and costs in hospitals and among physicians. An insurance company has a bottom-line interest in good care, Grinnan notes.

"Anytime you deliver quality care, it's going to be the most affordable care," he explains.

Change in hospital and physician cultures comes slowly. Tradition is likely to hold sway. Grinnan tells the story of a doctor in a hospital who had mentioned to an administrator that good outpatient congestive heart failure management would prevent many hospital admissions. The administrator replied, "Why would you do that?"

To encourage participation in the informatics program, Anthem puts up money. The company adjusts the future year's contract by 1 percent, which can amount to

\$500,000 to \$1 million for a large hospital, Grinnan says. "That money helps underwrite infrastructure and activities to make sure that the care process is being reinforced," he says.

One of the motivations for Anthem's quality emphasis is the significant press coming out of the Institute of Medicine and other respected organizations saying there's too much variation in practice. "There are slightly less than 50 percent of the people receiving the best practices as promulgated by the evidence," Grinnan notes. Measuring outcomes and processes is the way of the future, he says.

"If we start managing resources correctly, we will be able to improve health outcomes, we'll reduce medical errors, [have] fewer malpractice suits, and [insurance] rates will go down," he says.

In Anthem's year-old program, hospitals need to computerize orders, for example. Most medication errors occur because of problems in transcribing, Grinnan says. Orders can be misinterpreted, just plain illegible or even have a decimal point in the wrong place. Order-entry programs have reduced medication errors by half. Another step toward reducing errors is by matching medication bar codes with codes on patient

identification bracelets.

Grinnan has been in medicine his entire life; his father was a doctor. "[I was] always impressed with how hard my dad worked," he remembers. He finished medical training in 1975, almost 10 years after government reimbursement, Medicare and Medicaid, came on line. He witnessed waste and even back then was intrigued about how to use resources in a logical way.

"The spirit [then] was just to use everything that's available...without a whole lot of rigor placed on what we should be focused on," he says. "I just had a sense that couldn't last forever."

Anthem's program, called the Quality-In-Sights Hospital Incentive Program, is the first of its kind in the nation. However, Grinnan has been applying informatics to measure quality of care since the mid-1990s. His medical management group analyzes practice patterns and compares data to established best practices. For example, the team studied variations in hospital admissions for asthma patients. Through education about asthma control and proper use of peak flow meters, emergency room visits and hospital admissions for asthma patients fell by 30 percent.

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been rising, the quality adjusted cost of medical treatment for many widespread conditions ... has declined," she writes.

It's worth noting that in 1962, 46 percent of health spending was paid by people out of their own pockets. By 2002, people paid only 14 percent of health spending out of pocket, according to the CMS. Between 1965, the year Medicare and Medicaid legislation passed to guarantee medical care for elderly and poor people, and 1970, the government's share of total health spending grew from nearly 12 percent to 24 percent. During that same time, out-of-pocket payments fell from 45 percent to 34 percent.

Today, health care swims in a fast current of expensive prescription drugs, an aging population and increased utilization, a nursing shortage, cost shifting from Medicaid, and the constant development of expensive, gee-whiz medical technology. No wonder we're drowning in costs. And, of course, medical malpractice insurance and claims, rising dramatically, don't help. Doctors often order unnecessary and expensive tests. "To know that all your clinical decisions can be Monday morning quarterbacked? That's not going to contribute to a very efficient system," notes Conover.

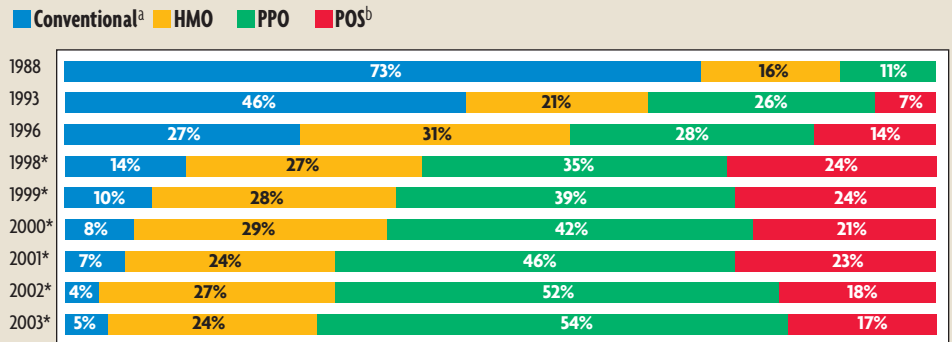
Blockbuster drugs also exacerbate costs, but as some popular drugs, such as Prilosec, go off patent, premium costs will level off, says Gary Claxton, a health analyst at the Kaiser Family Foundation. Health-care spending growth in 2003 is predicted at 7.8 percent, down from the previous year's 9.3-percent level, according to CMS.

The spending cycle and premium increases depend also on the insurance business cycle, says Claxton of KFF. "In the late '90s, it was not very profitable," he notes. "In the last few years, they've been raising premiums faster than the costs are going up to help raise profitability."

Health economist Morrissey says premium prices also depend on the job market. When jobs are plentiful and employers are looking for workers, they worry about the quality of the health plan and make sure people have lots of choice. Then premiums rise because choice is expensive.

The rate of increase will moderate

Health Plan Enrollment For Covered Workers, by Plan Type, 1988-2003



*Distribution is statistically different from the previous year shown: 1996-1998, 1998-1999, 1999-2000, 2000-2001, 2001-2002, 2002-2003.

^aConventional health insurance provides for hospital, surgical, medical, major medical, comprehensive, catastrophic, and dental plans. Rates depend on which plan you buy into, the level of coverage you and your employer choose, and whether you purchase individual or family protection.

^bA point-of-service (POS) plan offers managed-care benefits within a network of medical providers but also allows you to receive care outside of the network whenever you wish. When you receive out-of-network care, you pay more.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002, 2003; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996

in the next two years, he says, but as jobs increase, premiums will start to swing to the other end of the cycle.

Policy Options Proliferate

Still, the problem of access to affordable health care vexes nearly all stakeholders in the health business. Solutions saturate the airwaves as politicians promote variations on policies that include tax credits, tax free savings, and universal health coverage. While it's unlikely that the United States will sever its ties to employer-sponsored health insurance anytime soon, economic theory suggests that moving away from third-party payments could lead to a more efficient health-care system.

A policy including tax credits to buy higher-deductible insurance, more money and better access for high-risk pools, flexible regulations, and proper incentives could guide people in a new direction, Miller says.

For example, the Medicare bill passed late last year contained a health savings account provision. People under 65 can contribute to an account if they have a qualified health plan—one with a high deductible—and the investment is tax-free as long as it's used to pay for medical expenses.

This plan replaced the Medical Savings Account (MSA), a pilot program created in 1996 to promote the idea of tax-free savings for health care and expired at the end of 2003. The U.S. General Ac-

counting Office found that four of every 10 people who established MSAs in 1997 had previously been uninsured. Premiums for the higher-deductible policies are generally lower. The accounts are owned by the employee and fully transferable. Savings accounts also increase choices. Health-care shoppers could spend money on alternative therapies that may not be covered by traditional insurance.

The idea is to encourage consumers to spend their own money on care. By shopping around and researching options, they make personal choices. "The general indications are that people will spend less and spend better," Miller notes.

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