

Balancing the Goals of Health Care Provision

Martin Feldstein¹

I am delighted to see so many of you here at this lunch. When I first started working on the economics of health care more than 40 years ago, there were only a handful of economists thinking about these issues. That has changed dramatically, with hundreds of economists doing important and exciting research, teaching courses on health economics, and helping governments develop better health care policies.

It is very good that this has happened. Health care economics is an enormously important subject. Health care spending absorbs nearly one-sixth of GDP in the United States and an even larger fraction of government budgets. But its importance is more than just about dollars. Health care economics is important to all of us as patients and potential patients.

I am pleased and flattered to have been invited to talk today. Although I am no longer an active researcher in this field, I follow the current research with interest. I also have the opportunity as a member of the board of directors of two health care companies—Eli Lilly and the Hospital Corporation of America—to follow developments in the field.

I believe that health care is a subject to which economists can make an important contribution. Health care is different from other economic activities because of the nature of the risks that individuals face as health care consumers. While most families spend relatively little on health care, a small fraction of families are faced with very large health care bills. This leads to the use of insurance to finance such bills. But insurance drives a

¹Professor of Economics, Harvard University, and President of the National Bureau of Economic Research. These remarks were presented at the meeting of the American Society of Health Economists session of the Allied Social Sciences Associations, Boston, Massachusetts, on January 7, 2006.

wedge between the cost of producing care and the cost to the patient at the time that that care is rendered. When patients pay only a small fraction of the cost of care at the time of care, they naturally want a much higher level of spending. So insurance is necessary because of the skewed distribution of spending but also damaging because it distorts the care that patients consume. As economists we naturally ask: What is the design of that insurance that best balances these two effects?

We live in a humane society. We do not want people to go without care because they cannot afford to pay for it. Society therefore steps in to provide free care for large groups of the population and to subsidize insurance for most others. What form should that government intervention take?

Breakthroughs in pharmacology have made it possible but very expensive to treat some diseases that were previously not treatable or not treatable with as high a probability of success. Should private insurance cover such expensive treatments? If it does not, should the government pay the bill?

I want to frame my discussion of these and other issues of health care provision and financing in terms of three conflicting goals of health care policy:

- Preventing the deprivation of care because of a patient's inability to pay;
- Avoiding wasteful spending;
- Allowing care to reflect the different tastes of individual patients.

It is not possible to realize fully all three of these goals. There are tradeoffs among them, as there usually are among other aspects of life. We can achieve one goal more fully only by a less complete achievement of one or both of the others.

But these three goals should condition and inform the design of a good health care system. I will discuss these goals in more detail and use them to consider the reform of Health Saving Accounts and the design of new types of insurance.

I will start with the goal of Preventing deprivation of care because of an inability to pay. This does not mean that care must be free for all. Although free care would achieve that goal, it would lead to strong conflicts with the other two goals.

Fortunately, most people can pay for small and medium size health bills. It is the very large bills that can be a barrier to care for many people. That's why health insurance—especially some form of major risk insurance—makes sense.

Even the extremely expensive care for cancer and some other diseases made possible by the new forms of drug therapy is sufficiently rare that the insurance premiums required to pay for the expected cost of care is not likely to be large relative to individuals' incomes. Pharmaceutical research is, of course, likely to add to the number of diseases that can be treated in this way, adding to the actuarial costs. But at the same time pharmaceutical research is working on developing ways of identifying which patients can benefit from which treatments. These developments in targeted pharmacology will reduce the number of wasted treatments and thus keep costs down. They may also reduce the cost of drug development (by reducing the sizes of the samples needed to prove efficacy), thus lowering the cost of the drugs themselves.

But there will inevitably be treatments that are both very expensive and of low probability of success. Avoiding deprivation of care because of an inability to pay does not mean providing every possible treatment, regardless of how low the probability of success. At a certain point, we would all agree that would be too much wasteful spending, in violation of the second of the goals.

Moreover, individuals differ in their willingness to pay through insurance for treatments that have low probability of success. That's why it is important to allow care to reflect different individuals' taste, a subject to which I will return in a few minutes.

I will turn first however to the important goal of avoiding wasteful spending. There is widespread concern about the fact that health care spending has increased much more rapidly than GDP or personal incomes. It is important, however, to recognize that this rise in health care spending is not the same as an increase in health care cost . The important difference is that the rise in spending is on new types of care rather than higher costs for the old type of care. Treatments have changed and become more effective. For many conditions, the cost of effective treatment has actually gone down. And even for those conditions for which the cost of success has gone up, I would much rather be a patient now than 10 or 20 years ago.

Estimates by my colleague David Cutler and others indicate that the value of the improved health over the past several decades has exceeded the increased cost of that care. But while that is true in the aggregate, it is not likely to be true at the margin. There have been inframarginal gains in health and health care but at the margin we are undoubtedly spending more for care than the value to patients of the resulting health improvements.

If patients and their doctors increase spending until the marginal value to the patient of care is equal to the marginal cost to the patient at the time of that care—*i.e.*, to the cost net of insurance – then the system is providing care that, at the margin, costs a dollar but is worth only (say) 20 cents or whatever the coinsurance rate may be.

If physicians choose a standard of care that reflects the total cost of the incremental unit of care—*i.e.*, if they ignore the effect of the insurance on the net cost to the patient—

as some providers encourage them to do, they create frustrated patients who feel (correctly) that they are being denied care that could help them.

What is the solution to this problem? Part of the solution is some form of major risk insurance in which patients have a large deductible or high coinsurance rate. A deductible of \$5,000—which is less than 10 percent of median family cash income—would leave most families paying for all of their health care out of pocket with no insurance reimbursement. Their decisions about the desired standard of care would therefore not be distorted by insurance. And while no one would welcome a medical bill for the year as large as \$5,000, most families would also not be deprived of care by an inability to pay since their maximum annual payment under the deductible is less than 10 percent of family income. The same principle would lead to lower deductibles for families with lower incomes.

But a significant fraction of families—and a larger fraction of health care spending—would exceed a \$5,000 deductible. With no out of pocket payment above that level, there would be both wasteful spending and, to the extent that physicians restrict what patients would otherwise want, patient frustration as well.

Raising the deductible to, say, \$10,000 would reduce the problem of wasteful spending but would clearly create a substantial financial burden for many households and a barrier to appropriate care for some.

I think an appropriate compromise is to replace the deductible with a high coinsurance rate. For example, instead of a \$5,000 deductible, the insurance policy might take the form of a 50% coinsurance rate on the first \$10,000 of spending. Patients would still be protected against paying more than \$5,000 out of pocket. But with a 50% coinsurance rate on \$10,000 of spending, there will be fewer patients and fewer dollars that face no out of pocket cost.

This may not be the best structure for the insurance policy. Determining that requires more analysis than I have done. It would depend on the distribution of potential spending levels, the sensitivity of spending to different coinsurance rates, and the value that individuals place on limiting the maximum out of pocket cost of health care. In principle, the optimal policy might involve a combination of deductibles and different coinsurance rates for different ranges of spending. These levels might also be related to the income of the family.

There is a lesson in this for the possible reform of Health Savings Accounts. I am an enthusiastic supporter of the Health Saving Account legislation. I think however that it could be improved significantly and that failure to improve it might lead to its eventual rejection by the political process

Let me remind you about how the HSA plan works. A Health Saving Account is similar to an IRA or 401(k) in that funds are contributed out of pretax income (by the individual or a combination of the individual and his or her employer) and enjoy the advantage that the income of the account (interest, dividends and capital gains) accumulates tax free. Even better than an IRA or 401(k) account, the funds that are withdrawn from a Health Saving Account to pay for health care broadly defined are never subject to tax. The balance in the fund is carried forward just as an IRA would be.

The amount of money that can be deposited in a Health Saving Account each year is equal to the size of the deductible in a major risk insurance policy that the individual chooses, up to a maximum of a bit more than \$5,000 for a couple. The policy must also provide protection by a maximum out of pocket amount that is incurred by paying the coinsurance above the deductible.

The HSA legislation thus provides a strong incentive for individuals to shift from the common type of health insurance policy with a low deductible and low coinsurance rate.

Such traditional policies substantially distort the choice of care but provide a very significant tax benefit to the individual. The HSA option provides an opportunity to enjoy a similar or larger tax advantage without buying such distorting health insurance. Individuals could regard their HSA as just another type of IRA, paying out of pocket for their health care costs up to the deductible, and enjoying the tax free accumulation of funds.

There are however two problems with the HSA legislation in its current form. First, the \$5,000 maximum deductible will leave far too many dollars of health spending without an effective restraint. As I said a few minutes ago, it would be better to have a 50 percent coinsurance rate on \$10,000. Other combinations might be even better but a 50% coinsurance rate on \$10,000 is easy to understand.

The HSA approach will only succeed if individuals find it attractive. For lower income families, the risk of a \$5,000 deductible (or of out of pocket payments of 50% on the first \$10,000 of health spending) might be larger than they are willing to accept. Under the HSA rules, such a family could select a policy with a lower deductible and put less money into their Health Saving Account. Such a family with an income of \$30,000 could decide to put \$3,000 into their HSA (including their employer's contribution) but would then have a deductible of only \$3,000. Such a family would be even more likely to spend above the deductible amount, removing any discipline at the margin. It would be better to allow such a family that deposits \$3,000 to the HSA to have a 30 percent coinsurance rate on \$10,000 of spending. Although there must be a lower limit on the coinsurance rate to make sure that it has a favorable incentive effect, a 100 percent coinsurance rate (i.e., a deductible) on a low amount is certainly wrong.

The second problem with the HSA legislation in its current form is suggested by the existing bad debt problem that hospitals now face with uninsured patients. Nonprofit and investor owned hospitals all across the country are experiencing a significant problem of

bad debts, i.e., of patients who do not pay their hospital bills after receiving care. This is particularly true for uninsured patients. It is also true for insured patients who do not pay the coinsurance and deductibles called for by their policies.

Such nonpayments could become much more severe with Health Saving Accounts. An individual with a \$5,000 deductible (or whose coinsurance reaches \$5,000 with a 50% coinsurance rate) may not have cash on hand to pay the bill when he is discharged from the hospital. While many individuals would accept the obligation and pay the bill, perhaps by drawing on their Health Saving Account, others may simply put off payment and eventually not pay.

The advantage of the out of pocket payment as a discipline on excessive spending is of course lost if individuals simply ignore the deductible or copayment. The impact on the financial soundness of hospitals of not collecting the first \$5,000 of each hospital bill would of course be very serious.

One simple remedy to this would be to allow hospitals (and other health care providers) to have easy access to the HSA balances of individuals who have not paid within (say) three months of the time of care. It is important to the attractiveness of the HSA system to allow individuals the choice of paying out of pocket if they prefer rather than from their HSA account. But easy access to the HSA accounts by providers without the full legal procedure of collecting bad debts would be very desirable and a strong incentive for individuals to pay their bills.

Let me turn now to the third goal that should shape the design of health care: allowing health care to reflect the different tastes of individual patients.

It was not too many years ago that a physician could make decisions about medical

care by asking themselves what would produce the best health outcome for his patient. Economists, myself included, argued that that was not good enough. Doctors had to take the costs of care into account, performing at least an implicit cost-benefit analysis to decide what care was appropriate. The rise in the cost of care, especially the cost of hospital inpatient care, brought about that change. Under pressure from hospital administrators, insurance companies and employers, doctors developed protocols of appropriate care that reflected costs as well as outcomes.

Unfortunately, this approach has generally led to one size fits all medicine. A doctor generally prescribes the same treatment for any patient with a particular disease or presenting with particular symptoms. Of course, doctors differ in their perception of the efficacy of different treatment or diagnostic procedures and that leads to different behavior among different doctors. But, with certain important exceptions, the preferences of the patients do not play a significant role in this process. Those exceptions, for example the treatment of prostate cancer or breast cancer, seem to me to be about balancing risks and other outcome measures and not balancing costs and outcomes.

And yet for every other kind of good or service, we assume that an important function of the market is to reflect differences in consumers' preferences. Of course, everyone wants good health. But some of us are more willing to make greater sacrifices to achieve that good health than others. This is not a question of money or ability to pay. We all know that health is hurt by smoking, by being overweight, and by not exercising. And yet millions of Americans smoke, are overweight and do not exercise. These habits may be hard to change but millions have changed them. So addiction is not an excuse. It seems reasonable to conclude that individuals enjoy smoking enough to accept the potentially adverse long term health effects. Ditto for food. And for not exerting themselves.

We should not be surprised therefore if taste differences about health also imply that some individuals are willing to pay more in order to get better health outcomes. This

may involve paying more for more complete routine checkups, or for more complete diagnostic examinations when there are symptoms, or for more expensive care of adverse medical conditions.

How does this fit with the other goals of health care provision – preventing the deprivation of care and avoiding wasteful spending? For patients whose spending is within a deductible limit, there is no conflict. If their physician and hospital are willing, they can buy whatever they want and are willing to pay for. It would certainly be a mistake to prevent them from doing so.

An advantage of the high coinsurance rate is that individuals can indicate their preference by willingness to pay. They may of course be paying only 50 cents to buy a dollar's worth of care, suggesting that it would be appropriate for the provider to provide some restraint on what they buy. But that should not be done to the point where all individuals are forced to accept the same care.

The problem is more difficult when the coinsurance rate is at a low level or when the patient is not paying at all. Under those circumstances, there is no way to know patient's preferences and the physician and institutional provider must determine what the patient gets. But that should be seen as an undesirable outcome, denying patients and their physicians the opportunity to adjust care to different preferences. That suggests that it would be desirable to design the financing system to avoid such situations. That might involve, for example, arrangements in which patients express their preferences by the type of coverage they select or the style of the Health Maintenance Organization (HMO) that they join. Even if they are not paying out of pocket at the time of care, they can express a desire for more complete preventive care or diagnostic exams or treatment by the selection of different policies or different HMOs.

This should also be the framework for solving the problem of the very expensive

treatments that are now becoming possible There are some treatments that physicians (and patients if they knew enough) would agree should always be done even though they are very expensive because they produce favorable outcomes with high enough probability relative to the cost of the treatment. These should be part of any standard health insurance policy or should be covered by a government catastrophic risk plan. If they are not mandated or government provided, there is the temptation for individuals to reduce their insurance premium by selecting insurance without such coverage in the knowledge that society would pay for the care if they met the medical conditions.

But for those treatments that are more questionable – offering lower probabilities of success or only small increases in life expectancy in exchange for very large costs – individuals should have the discretion in advance when they buy insurance or choose an HMO plan. Just as some insurance plans now include a wider range of drugs than other plans, the same could be applied to the very expensive treatments for various diseases. How this is to be done in practice and what its consequences are for the cost of care remain to be worked out.

So there is still much work for economists to do in thinking through how to balance the different aspects of the three health care goals. I hope that some of you here will rise to that challenge.

January 2006