How to Make Health Care Unaffordable and Inaccessible

Whether it's Medicare for All or some other variant of a single-payer plan, the leading 2020 Democratic presidential candidates are in agreement that more government control will make health care more affordable and accessible.

The presumption behind these plans is that there is currently too much freedom in the health care industry, and only more state intervention will reign in costs and make health care more accessible to more people.

But the opposite is true.

Indeed, if one set out to intentionally make health care more expensive and less accessible, the surest way to do so would be to implement the kind of market-distorting interventions the government has been enacting for decades.

If I wanted to make health care unaffordable and inaccessible, the best place to start would be to inflate demand while restricting supply.

Demand

The most reliable way to inflate demand for a good or service is for the consumer to be insulated from all or most of the cost of the product at the point of purchase. If I wanted to make something more expensive, I would see to it that a significant share of it was purchased through third-party payments.

Currently, in the US nearly 90 percent of medical care expenses are paid by a third party other than the consumer. Consumers now only pay 10.5 percent of medical care expenses directly, and the rest is paid by Medicaid, Medicare, and

insurance companies.

The share of health care expenses being paid by a third party has increased significantly over the past several decades. According to an analysis by economist Mark Perry:

> *almost half (47%) of health care expenditures in 1960 were paid by consumers out-of-pocket, and by 1990 that share had fallen to 20% and by 2009 to only 12%.*

Third-party payment systems destroy normal market forces. People will undoubtedly be less careful shoppers when someone else is picking up the tab. Moreover, for those paying hefty monthly insurance premiums so they pay little out of pocket at the point of service, health insurance plans work as a de facto pre-paid expense. Because we've already paid big premiums and pay little more for the actual medical care, we are incentivized to get our money's worth when we do see a doctor or need a hospital stay.

Unnecessary Testing and Treatments: Expensive and Deadly

When patients are largely insulated from the cost of care at the point of purchase, there will inevitably be a tendency to demand more medical treatment and testing than may be necessary. And because doctors are paid on a fee-for-service basis, they have the incentive to oblige.

A 2017 study published by the Public Library of Science found physicians self-reported that a

> *median of 20.6% of overall medical care was unnecessary, including 22.0% of prescription medications, 24.9% of tests, and 11.1% of procedures.*

Such unnecessary care comes with a devastating price tag.

PBS reported in 2017 that unnecessary care has cost America's health care system at least $200 billion annually and stunningly generated "mistakes and injuries believed to cause 30,000 deaths each year."

More unnecessary care not only means billions in unnecessary costs but also, tragically, tens of thousands of deaths every year.

Health Insurance Costs

If I wanted to make health insurance more expensive, I would restrict consumer choice, incentivize employers to substitute more generous health benefits for salary, and require all plans to include pricey bells and whistles regardless of whether or not consumers wanted them.

The tax exemption for health insurance incentivizes employers to offer more generous health benefits rather than higher salaries as a form of compensation. Additionally, federal law requires that several services and providers be included in all health insurance plans. States add on dozens more of such mandates. Some estimates say that states have enacted more than 2,000 different coverage mandates over the last 30 years.

Forcing people to pay for mandates consumers don't need – drug counseling for non-users or pastoral counseling for atheists, for instance – limits choice and drives up insurance premiums. It's like forcing all car buyers to purchase a Cadillac when many would be happy with – or can only afford – a Ford Taurus. Moreover, no two states impose the same set of coverage mandates, restricting consumers' ability to purchase insurance from another state. This narrows the risk pool from a potential national pool of consumers to several smaller risk pools segregated by state.

These factors, however, are not the only ones driving up health insurance premiums. Thanks to Medicaid and Medicare

offering reimbursement rates to providers well below their costs of services, hospitals and doctors are compelled to engage in cost-shifting by requiring much higher reimbursements from their private insurance patients.

According to the Centers for Medicare and Medicaid Services (CMS), the two programs combined accounted for 37 percent of total national health care expenditures in 2017.

The American Hospital Association, however, calculated that Medicare and Medicaid combined for $77 billion in "underpayments" to hospitals in 2017, with underpayments being defined as payments lower than the cost of providing care.

Such massive cost-shifting plays a significant role in the rising price of insurance premiums.

Supply

If I wanted to make health care unaffordable and inaccessible, I would make every effort to restrict supply.

On this score, the American Medical Association plays a vital role. As reported by *The American Conservative*, "The American Medical Association (AMA) artificially limits the number of doctors, which drives up salaries for doctors and reduces the availability of care."

For more than a hundred years, the AMA has been successfully lobbying governments to enact laws that would restrict the number of new doctors in the country. AMA activities have included dramatically decreasing the number of medical schools across the U.S. and turning the process of becoming a doctor into a monumental feat that "requires navigating a maze of accrediting, licensing, and examining bodies."

The result of such restrictions is a worsening doctor shortage that is "bad for patients and the country" but "definitely good for doctors' pay."

The United States could see a shortage of up to 120,000 physicians by 2030, which would affect patient care across the nation, according to a 2018 report published by the AAMC (Association of American Medical Colleges).

And it may be worse than that. In a 2016 survey by the Physicians Foundation, 46.8 percent of survey respondents are considering an early retirement for reasons unrelated to age or physical health. Combine these shortages with the added stress on the system of the aging baby boomer generation, and access to care could reach crisis levels.

Government Restrictions on Facilities and Providers

Another key player in restricting the supply of medical care is Certificate of Need (CON) laws. CON laws, which are still active in 35 states plus DC,

> *require providers to first seek permission before they may open or expand their practices or purchase certain devices or new technologies,*

as the Mercatus Center at George Mason University describes.

> *The applicant must prove that the community "needs" the new or expanded service, and existing providers are invited to challenge a would-be competitor's application.*

For instance, in my home state of North Carolina, home of some of the nation's most restrictive CON laws, Mercatus estimates these restrictions drive up health care spending by more than $200 per capita per year and have deprived the state of more than 50 hospitals that would exist now absent the CON restrictions.

Yet another avenue for restricting the supply of medical care

is scope of practice limitations. As discussed in a 2018 *Forbes* article,

> *Scope of practice laws, or SOPs, specify the tasks members of different occupations can perform, as well as the level of oversight required. They vary by state and occupation.*

When certain tasks require a certified physician, for instance, the cost of that service is higher than if a nurse practitioner performed it because of the physician's higher salary and opportunity costs.

Forbes highlighted research showing that health care costs are lower in states that allow nurse practitioners to do more. Specifically, the article notes a study that found

> *the price of child well-care visits is 3% to 16% less in states where nurse practitioners are free to work independently. Other research finds that eliminating restrictions on nurse practitioners would result in annual savings of $543 million nationwide in emergency room use for ambulatory care-sensitive situations.*

Creating Monopsony Power for Hospitals

If I wanted to make health care unaffordable and inaccessible, I would create policies that encouraged the consolidation of hospitals and providers into large networks.

Provisions in Obamacare did exactly that, creating incentives for hospitals to merge and to acquire physician practices. As *US News & World Report* pointed out in 2016, Obamacare was "specifically designed to foment such consolidation" and,

> *[n]o part of health care was supposed to be spared – doctors, hospitals, insurers, pharmaceutical companies and others were*

> *given regulatory and financial incentives to merge.*

In that regard, Obamacare has been a success. A 2018 study published by the National Council on Compensation Insurance (NCCI) determined that 2017 was a record year for hospital mergers and acquisitions. The study also noted:

> *In addition to mergers, hospitals are also buying up provider practices. Between 2015 and 2016, hospitals acquired 5,000 physician practices.*

When based on market forces, such consolidation can frequently lead to greater efficiencies and lower prices for consumers. But as the NCCI study found, this hasn't been the case with hospital consolidation.

According to the study, the operating costs of providing care have fallen, but the research also showed

> *that hospital mergers increase the average price of hospital services by 6%-18%.*

Larger provider networks mean greater bargaining power with private insurance companies. The hospital can become a regional monopsony – the term economists use for the single purchaser of a good or service.

As such, these larger hospital systems can command higher reimbursement rates from insurers, because the insurers fear losing out on what is oftentimes the sole provider in a geographic area.

Government Intervention Means More Bureaucracy

Finally, if I wanted to make health care unaffordable and

inaccessible, I would encourage greater government intervention as a means to increase compliance costs and bureaucracy.

When a good or service is rationed according to government administration rather than market forces, a spike in administrative costs will naturally follow.

The number of health care administrators grew by 3,200 percent from 1975 to 2010. Compare that to the 150 percent growth of physicians during that time, a rate that largely tracked population growth in general.

The growing number of administrators is driven by ever more complex regulations. The regulations are often inspired by government cost control measures put in place to rein in prices set spiraling by previous government interventions.

We are told that "something" must be done to make health care in America more affordable and accessible for more people.

But what if that "something" being proposed is just more of the same of what is causing ballooning health care prices and shortages in the first place?

The trouble with the health care industry is not too much freedom and a lack of state meddling. Indeed, if a person set out to intentionally make health care unaffordable and inaccessible, they could find few better paths than the one the US government set out on decades ago.

By opposing government programs like Obamacare and Medicare for All, libertarians are accused of opposing affordable care for millions of citizens. But the opposite is the case. Instead of arguing over the next government program to address the problems in health care caused by previous government intervention, we should instead be making the case for why freeing the health care market from state interference is the best way to make health care more affordable and accessible

for more people.

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