The History of the Failures of Health Budgeting; The Ratchet Effect and Healthcare Spending

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Abstract:

We know that healthcare costs are rising, and there are many reasons for this: Increases in income, advances in medical technology, an increase in the number of doctors available and in specialization, and increased knowledge of the importance of taking care of oneself. However, there is another factor that may be contributing to the rising costs that has been overlooked, and that is the ratchet effect developed by economist Robert Higgs.

The theory concludes that when there is a crisis, the government creates an agency to help reduce the impact of the crisis, but after it is over, the agency remains and continues to be used for purposes other than its original intended purpose, even though it is no longer needed, thus creating costs to society that never existed before. When the next crisis comes, this agency can be used again to intervene as the opportunity cost of intervening a second time is much lower since the building for the agency already exists and employees already work there who know how to handle a crisis.

Many attempts have been made by the government to reduce healthcare costs, but if this factor is contributing to those costs and no one realizes it, any attempts to reduce healthcare spending will never work because this factor is not being addressed.

With this in mind, I hypothesize that when we look back through history during times of crises, we will see an increase in government healthcare spending that not only increases for a short period of time and then drops back to its original level, but instead remains at a higher level than before each healthcare reform or healthcare crisis.

Introduction

Healthcare spending has been continually increasing since 1960 from 5.0 percent of gross domestic product (GDP) in 1960 to 17.4 percent in 2013 (Catlin and Cowan, 1). There are several different reasons for this including increases in income, advances in medical technology, an increase in the number of doctors available and specialization, and increased knowledge of the importance of taking care of oneself. There is one factor, however, that may have been overlooked, and that is the ratchet effect developed by economist Robert Higgs. The theory concludes that when a crisis occurs, the government creates an agency or administration to help save the economy from disaster, but once the crisis is over, the newly created agency or administration never dissolves and part of the spending that contributes to GDP comes from running the agency or administration even though it is no longer necessary. The motivation for this paper is to see if the ratchet effect may be why healthcare spending has not decreased, despite the government's many attempts to control the budget.

Increases in income cause an increase in spending on normal goods, and because healthcare spending has increased over time, it is reasonable to assume that part of the increase may be due to more people having more money.

Also, now that there are more and better medical technologies available, people know that more can be done to detect and prevent health problems in the future. For example, before a colonoscopy can be done, a patient must drink almost a gallon of fluid that flushes everything out of his or her system so that the doctor can get a clear view of the person's internal organs. Some companies have come up with smaller-sized cleansing treatments reducing the amount of discomfort a patient must go through before a colonoscopy. With less suffering involved, more

people will be inclined to take their doctor's advice and get a colonoscopy sooner rather than waiting until later to avoid the suffering involved with drinking the larger container of fluid.

Another factor affecting health care spending is simply the availability of doctors and also specialization of labor. With more doctors in practice, it is possible that more patients will be seen, as long as they can afford and want to be seen, and this would increase healthcare spending. Along with more doctors being available, there are now doctors who specialize in certain fields of medicine, such as gastroenterology. Specialization increases the likelihood of a proper diagnosis because a specialist better understands one region of the body than a primary care physician who studied the whole body. Knowing that there is a greater chance of receiving a more pinpointed diagnosis and more specific treatment, people may be more inclined to go to a doctor when they would not have before and this would also cause an increase in spending.

There is also the fact that there is more knowledge about the human body and health in general so people are more aware of the importance of taking care of oneself in order to live a long healthy life. One of the steps toward this is visiting a physician more often to see if any health problems arise and to treat them as soon as possible because not treating them right away can make the problem worse and also may make damage from the problem irreversible, whereas early detection could prevent damage or further damage.

All of these factors are reasonable explanations for the increase in health care spending, but the ratchet effect should not be overlooked. If the ratchet effect does play a role in healthcare spending, any attempts to reduce spending will not be successful because there would be an underlying problem not being addressed. According to the theory developed by Robert Higgs, the government creates some form of government infrastructure to help alleviate the effects of a crisis. Once the crisis is over, however, the infrastructure never dissolves and is used for other

government purposes. When another crisis comes along, the cost of intervening again is lower because the largest costs associated with creating the infrastructure – constructing the building, finding and hiring enough employees to run the administration, etc. – have pretty much already been covered. The pattern continues, increasing government involvement over time creating a ratchet effect. The problem with this is that although the government may have helped at a time of need, the spending caused by running these infrastructures is a factor that was not planned for and increases healthcare spending unnecessarily.

Literature Review:

U.S. health care expenditures have steadily increased as a share of gross domestic product (GDP) over the last half century, increasing from 5.0 percent of GDP in 1960 to 17.4 percent in 2013. (Catlin and Cowan, 1). During this time period, about ten different budget reforms were created to help control health care costs. The first was P.L. 96-499, the Omnibus Budget Reconciliation Act (OBRA ’80) and was contained in Title IX of the Medicare and Medicaid Amendments of 1980. These amendments made modifications in the Medicare and Medicaid programs which were intended to help control the growing costs of the programs. Some changes to Medicare included removal of the 100 visits per year limitation on home health services and the requirement that patients pay a deductible for home care visits under Part B of the program. These changes were intended to encourage home care over more expensive institutional care (Longest, 264).

Shortly after this act was enacted, however, several laws were set in place including the Omnibus Reconciliation Act of 1986, the Family Support Act of 1988 and the Omnibus Budget Reconciliation Act of 1990, that expanded Medicaid eligibility to pregnant women, infants and

children; emergency treatment to illegal immigrants; and transitional assistance for families losing assistance under the Aid to Families with Dependent Children program which helped contribute to faster growth in the Medicaid program compared to the 1980s (Catlin and Cowan, 17).

P.L. 99-509, the Omnibus Budget Reconciliation Act (OBRA '86), altered the PPS payment rate for hospitals once again and reduced payment amounts for capital-related costs by 3.5 percent for part of FY 1987, by 7 percent for FY 1988, and by 10 percent for FY 1989. The legislation also set limits on how much physicians could charge Medicare for seeing Medicare clients by setting "maximum allowable charges" (MAACs) in an attempt to balance billing. It also encouraged physicians to use "inherent reasonableness" when charging for the use of anesthesia for cataract surgery and for the surgery itself to reduce payments made (Longest, 268).

P.L. 100-203, the Omnibus Budget Reconciliation Act (OBRA '87) contained a number of provisions that directly affected the Medicare program. One provision of the act reduced payment amounts for capital-related costs by 12 percent for FY 1988 and by 15 percent for FY 1989. Regarding payments to physicians for services provided to Medicare clients, the legislation reduced fees for 12 sets of "overvalued" procedures. It also allowed higher fee increases for primary care physician services and increased the fee differential between participating and nonparticipating physicians. Some provisions also affected the Medicaid program such as coverage of children up to age six with an option for allowing coverage up to age eight; removing the distinction between skilled nursing facilities (SNFs) and intermediate care facilities (ICFs); and requirements that nursing homes enhance the quality of life of each resident and operate quality assurance programs (Longest, 270).

P.L. 101-239, the Omnibus Reconciliation Act (OBRA ’89), included provisions for minor changes in PPS (prospective payment system) and a provision to extend coverage for mental health benefits and add coverage for Pap smears. As part of this legislation, the Health Care Financing Administration (HCFA) was directed to begin implementing a resource-based relative value scale (RBRVS) for reimbursing physicians under the Medicare program on January 1, 1992 (Longest, 271).

P.L. 101-508, the Omnibus Budget Reconciliation Act (OBRA ’90) contained a provision that continued the 15 percent capital-related payment reduction that was established in OBRA ’87 and continued in OBRA ’89 and another provision that made the reduced teaching adjustment payment established in OBRA ’87 permanent. One of its more important provisions provided a five-year deficit reduction plan that was to reduce total Medicare outlays by more than $43 billion between FYs 1991 and 1995 (Longest, 272).

P.L. 103-66, the Omnibus Budget Reconciliation Act (OBRA ’93), established an all-time record five-year cut in Medicare funding and included a number of other changes affecting the Medicare program. For example, the legislation included provisions to end return on equity (ROE) payments for capital to proprietary SNFs and reduced the previously established rate of increase in payment rates for care provided in hospices. In addition, the legislation cut laboratory fees drastically by changing the reimbursement formula and froze payments for durable medical equipment, parenteral and enteral services, and orthotics and prosthetics in FYs 1994 and 1995 (Longest, 273).

P.L. 105-33, the Balanced Budget Act of 1997 (BBA), contained the most significant changes in the Medicare program since the program’s inception in 1965. Overall, this legislation required a five-year reduction of $115 billion in the Medicare program’s expenditure growth and

a $13 billion reduction in growth of the Medicaid program. Other provisions established two new commissions – the Medicare Payment Review Commission (MedPAC), which replaced the Physician Payment Review Commission and the Prospective Payment Review Commission. MedPAC was required to submit an annual report to Congress on the status of Medicare reforms and to make recommendations on Medicare payment issues. The second new commission, the National Bipartisan Commission on the Future of Medicare, was charged to develop recommendations for Congress on actions necessary to ensure the long-term fiscal health of the Medicare program. This commission was to consider several specific issues that were debated in the development of the BBA (Balanced Budget Act) of 1997, but rejected. These issues included raising the eligibility age for Medicare, increasing the Part B premiums, and developing alternative approaches to financing graduate medical education (Longest, 276).

In 1999, the Medicare, Medicaid and SCHIP (State Children's Health Insurance Programs) Balanced Budget Refinement Act (BBRA), changed the provisions in the Balanced Budget Act of 1997. The law increased hospice payment by 0.5 percent for FY 2001 and by 0.75 percent for FY 2002. Medicare reimburses teaching hospitals for their role in providing graduate medical education (GME).

In their paper, *History of Health Spending in the United States, 1960-2013*, Aaron C. Catlin and Cathy A. Cowan identify five health spending eras that became evident after analyzing national health expenditure data from 1960-2013. They named these eras as follows:

1) 1961-1965 (Pre-Medicare and Medicaid)
2) 1966-1982 (Coverage Expansion and Rapid Price Growth)
3) 1983-1992 (Payment Change and Moderate Price Growth)
4) 1993-2002 (Cost Containment and Backlash)

5) 2003-2013 (Recent Slower Growth)

During the first era, average annual health expenditure growth was 8.9% while annual GDP growth was 6.5%, meaning that health spending made up a large portion of GDP. The trend continues in the second era as average annual NHE (national health expenditure) growth is 13.0% while average annual GDP growth is only 9.2%. Again in the third era, NHE growth – 9.9% - is greater than GDP growth at 6.9%. In the fourth era, 1993-2002, NHE growth is 6.7% while GDP growth is 5.3%. Lastly, in era number 5, annual average NHE growth at 5.4% is still higher than GDP growth at 3.9% (Catlin and Cowan, 7).

Despite the many attempts the government has made to reduce healthcare spending by enacting all of the above budget reforms, health care spending continues to rise. One of the reasons for this is that once the government creates an act or administration, the transaction costs of repealing this law or shutting down the administration are higher than making amendments to the law or using the administration for other purposes in the future, in essence, the ratchet effect, so they do not disappear.

A great example of the ratchet effect is seen by the creation of the Medicare and Medicaid programs that came from the 1965 amendments to the Social Security Act. Three competing bills laid the foundation for Medicare Part A, Medicare Part B, and Medicaid (Catlin and Cowan, 9). Instead of the act staying specific to social security, it expanded to create governmental health insurance. The changes allowed for eligible individuals to now have coverage for hospital services and physician services, and the Medicaid portion allowed low-income individuals to have highly subsidized health insurance, all of which increase health care spending instead of reducing it (Catlin and Cowan, 9). The problem with the government providing coverage for individuals is that funding has to come from somewhere which means an

increase in taxes and this may not be a cost that people consider when they want the government to provide for them.

Some people may have an issue with this argument because maybe Americans simply want the government to spend more on health care. This may be true, but because of the ratchet effect, costs associated with the government programs themselves may not be anticipated nor wanted. For example, people may want the requirements for Medicaid eligibility to be lowered, such as the amount of income an individual can make per month, which would increase health care spending as more people are added and begin utilizing coverage, but these same people may not have thought about how this increased coverage would increase the amount in taxes they pay each year.

Another objection may be that health care spending is increasing because people are spending more on it in general. This is also true. With better medical technology, more physicians with increased specialization, and higher incomes overall, people have many reasons to seek out more healthcare but this does not change the fact that there are costs that may not be wanted. Each government agency that is created requires funding which comes mostly from taxes, and each one requires employees that need to be paid. FEMA was created on April 1, 1979 and is a good example of a government agency that was created at a time of crisis but never dissolved after the crisis. Although maybe helpful at the time, it is not needed when there is not a natural disaster, but the government has found a way to make it useful during times of calm. Even when there is a natural disaster, sadly it can take a long time for FEMA to respond after a natural disaster and yet Americans are paying money for an inefficient organization.

Healthcare spending continues to rise as time goes on due to many factors including increases in income, advances in medical technology, an increase in the number of doctors

available and specialization, and increased knowledge of the importance of taking care of oneself. However, if the ratchet effect applies to health care spending, then even though the government tries to cut spending, it will never go below a certain level. Since 1960, national health expenditures as a share of GDP has continued to rise even during recessionary periods from 5.0 percent to 17.4 percent and this trend should continue in the future.

To help counter this effect, the government could continue to try different budget reforms, but the answer may be less government involvement as originally highlighted in the Constitution. A limitation on government involvement would reduce the number of government administrations, cutting down on the number of people employed, reducing spending healthcare. If the government is not allowed to expand in the first place, then expanding in the future will not be as easy.

Works Cited

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