The Monster We Created
How unintended incentives have created excessive benefits consumption

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May 2005
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Introduction

The cost of health care consumption is gobbling up company profits and wreaking havoc on government budgets. If this was a traditional movie plot, frightened townspeople would first gather to find the person responsible for creating such a monster. Was it the chemical producer who spilled radioactive material long ago? Was it the kind, nurturing conservationist who fed and raised the creature when it was cute and small? Was it the general who could have captured it when it was half its current size? Or was it the mayor for ignoring early warning signs (like footprints as big as a house) to avoid panic during his re-election campaign?

As the story goes, all parties spend precious time blaming each other, while the creature continues to grow and gain strength. Inevitably, the monster becomes too big and too strong to be conquered by any known weaponry. Next comes arguments about how to control the monster – do we feed it to keep it happy? Or try in vain to destroy it? Who will pay for the immense supply of food? Who will bear the burden of the inevitable battles?

If we follow the usual tale, an unlikely hero will emerge. While generals and politicians quarrel about crusades and control, an unassuming, nerdy, absent-minded scientist quietly goes about the business of finding small clues. His clues lead to an understanding of how the creature became so large in the first place and, fortuitously, discovery of the creature’s potential weaknesses. Ironically, the future of civilization depends not on whether the generals and politicians can mount a successful attack on the monster, but on whether the ideas of a soft-spoken nerd will be heard in time.

At the risk of finding wisdom in ‘B’ grade horror movies, the analogy appears justified. While health care consumption looms ever larger and more menacing, experts seem most intent on finding the right party to blame for its growth – and assigning responsibility for feeding its incredible appetite. For the most part, stakeholders are unwilling to accept responsibility for their own contribution to the problem. And we have yet to find our soft-spoken hero – in this case, an economist – or perhaps we haven’t yet heard his or her ideas.

The monster is not what it appears

The myth:

Our health care crisis is primarily a health problem.

We assume the monster is bigger because its appetite has grown through dramatic increases in disease and disability. More and more services are consumed because more and more problems have arisen. Scientific advances in treatment require additional resources. Consequently, we accept that disaster looms because we are becoming an ever-sicker and older society. However, while aging trends are very real, and the incidence of many diseases has increased, disease alone has not fueled the growth of health care consumption.
The truth:

Consumption, our monster, has grown because we have created an ideal set of economic incentives to encourage it to do just that. We have created a system that encourages and rewards greater consumption.

The recipe for excess consumption

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When the consumer is not compelled to pay the full price for a commodity, but can shift part of the burden to someone else, the quantity demanded will increase. This is known to economists as the “law of demand.”

1) Setup a system of health coverage that is tied to jobs and subsidize it.

A wage freeze imposed during WWII forced employers to find other attractive ‘fringe’ benefits to attract workers. Health care coverage was one of those benefits. Under pressure, legislation was passed to allow health coverage to be offered, but not treated as (taxable) compensation. Thus, our employer-sponsored system was born.

This legislation had several significant consequences. First, it shaped the unnatural and illogical tie between employment and health insurance that endures today. This leads to decisions about employment (staying or leaving) that are influenced by a factor completely unrelated to a person’s work. Second, it created an unfortunate, but inevitable, trade-off between wages and health care insurance. As the provider of both, employers must sacrifice one for the other. A recent analysis of benefits and compensation showed that wages are lower when health insurance is offered (1).

2) Make sure someone other than the consumer pays the bill.

Third-party payment always leads to more demand. When the consumer is not compelled to pay the full price for a commodity, but can shift part of the burden to someone else, the quantity demanded will increase. This relationship between the price and the quantity demanded is known to economists as the “law of demand.” More than any other factor, this phenomenon contributes significantly to the growth in consumption of medical care. Without natural market forces (where the consumer pays the full cost for his or her choice of service) excessive consumption will always result (2). When individuals are not required to pay the full cost, consumption of health care services is 30 to 45% higher than when they are required to pay for the full cost of care (3).

3) Give employees value only from spending, not saving.

In a scenario where the employer pays health insurance premiums, the employee is receiving coverage in lieu of wages or other benefits. While there is intrinsic value to the employee in being free from worry about unanticipated health expenditures, the actual monetary value of the benefit increases as use of health care increases. Because it is already an ‘earned benefit,’ there is no economic incentive to the employee to restrict or avoid care. In fact, because of the connection between employment and health insurance, there is documented evidence of the use-it-or-lose it phenomenon when one’s employment is likely to end (4).
4) **Design benefits that do not share consequences.**

In an effort to make benefits attractive and protect employees from unforeseen health crises, policies have evolved such that employees share almost none of the monetary consequences of poor health. When there is no cost (see number 2 above), consumption of the benefit increases. For example, when disability insurance covers 100% of salary, the rate of disability claims is higher than if the coverage is 80 or 90% of salary. Similarly, if an employee is not reimbursed for unused sick time (see number 3 above), he or she will realize greater value from using sick time than saving it. Not surprisingly, higher salary reimbursement during disability also increases the use of health care services (5). As another example, few employers recognize employees for their participation in healthy lifestyle activities or compliance with medications, yet many cover the full cost of cardiac bypass and gastric bypass surgeries.

5) **Provide limited ‘up-side’ opportunity for the well.**

As large companies replaced self-employed and family businesses in the past half-century, people became less connected to the success of the organization. Unlike self-employed workers who make more when they achieve more, workers in large companies (especially knowledge workers) often receive limited pay-for-performance incentives or meaningful profit sharing (6). Thus, employees are less and less aware of how their personal health is an attribute essential to their future success. The more people can connect their energy and effort to a potential reward (money, opportunity, advancement), the more they will value their own human capital, including wellness.

Shielded from the true cost of health care, workers are also largely unaware of how health care expenditures affect the corporate bottom line. Excess consumption (and costs) of health care reduces what might be available for other types of rewards. Though largely unrecognized, both the individual and the firm have a vital stake in the worker’s human capital in health.

6) **Pay providers for quantity, rather than quality or outcomes.**

When someone else pays for a service, people are less concerned about the value they get – compared to when they pay themselves. Ironically, fee-for-service medical practices make more money if the patient doesn’t improve and needs to return. Although intentional misdiagnoses are certainly rare, multiple follow-up visits are not. The system encourages additional office visits whether they are necessary or not (doctor gets another reimbursement, patient feels reassured, and insurance pays). This tendency is not a condemnation of physician motives, but rather an observation about natural, underlying economic incentives within the current system. If patients paid for each visit, and doctors were paid by the outcome, it is almost certain that more efficient methods of follow-up (phone, e-mail, nurse follow-up) would become the rule (7).

7) **Pay providers to be in-person technicians, rather than advisors.**

Few industries have been slower to adopt new technologies of communication and delivery as the medical service industry. This is not the result of a collective techno-phobic personality flaw. This is the result of economic incentives. Arrangements rarely allow a provider to be reimbursed or financially rewarded for advice over the phone or via e-mail, even when it may be medically appropriate. Reimbursement does not occur unless the patient visits the office. Hence, in fee-for-service plans, the person ‘must be seen.’ Additionally, reimbursement for a conversation is far lower than reimbursement for a test, procedure, or treatment (8). Consequently, the perception is that providing value (and making money) equates to ‘doing something,’ even when a conversation might be sufficient.
8) **Continue to add, and pay for, more parties to join the equation**

Frustrated by ever-growing costs, many employers and government agencies have added more programs – disease management, case management, predictive modeling – that purport to contain costs. However, this only adds to the number of additional parties who have a vested stake in ever-increasing financial resources being directed into the medical care industry. This does not make the system more efficient and actually adds to the underlying problem. Because the exchange between the provider and the patient is not a direct transaction (someone else will pay the bill), there are fewer natural pressures constraining demand. Adding more third-parties does not alter the tendency for higher consumption, but does add to the overall cost of care (9).

**Other factors that contributed to growth**

In addition to describing the economic ecosystem that so effectively promoted growth in consumption, it is important to acknowledge other factors that are often mentioned as reasons for expanding health costs. These factors do contribute to growth, but also exist within the primary context of economic incentives that allow them to contribute.

A good example is the development of advanced technologies to detect and treat disease. Some experts estimate that half of the increase in costs over the past 30 years can be attributed to newly developed, technological treatments (10, 11). However, economic incentives that encourage use of more expensive techniques (through higher reimbursement) and discourage consumers from questioning the incremental value of more expensive options allow such advances to grow with few of the normal checks and balances seen in other industries. As Moore’s law stipulates, technological advances in other industries have led to lower costs for many consumer products (think computers, cell phones and MP3 players). For these types of products, price decreases 30% as technology doubles in speed and capacity every 18 to 24 months. There is no Moore’s law for healthcare; and although not admitted publicly, the ‘business’ of medicine actually has significant incentives to limit the use of equally effective, less-costly techniques (for example in cardiac care) because the hospital loses revenue.

Another factor is the advent of direct-to-consumer marketing. While most often mentioned with regard to pharmaceutical products, there is wide-spread ‘advertising’ in the popular media of many procedures and treatments. Publicity does increase demand for products and services, but excessive demand results when consumers do not have to consider price. When commercials encourage consumers to ‘ask their doctor about the new pill,’’ additional cost is neither mentioned nor considered (12). Unlike advertising for more expensive homes or cars, consumers do not ask themselves whether the new product is superior to their current one, or whether it is worth any additional expense.

American society has also adopted a general set of beliefs that support consumption (13). These include an underlying bias toward more care rather than less, toward doing something rather than not doing something, toward entitlement for everything rather than limits on resources, and toward the right to sue. All of these beliefs push patients and providers to err to the side of more consumption. And all consumption is enabled by the lack of economic constraints that normal market forces would provide.
Taming the monster

If we choose to listen to our hero – an unassuming economist – constraints on consumption will occur when we apply market forces to both health care and human capital markets. As one would predict, the antidote to growth in consumption parallels the elements in the recipe that caused growth in the first place. Underlying all aspects of both the problem and the solution is one fundamental principle: it is human nature to act in one’s own self interest. If it is in our self-interest to spend, we will. If it is in our best interest to save, we will. Aligning some incentives with less spending, rather than aligning them all with more spending, will apply some natural constrains to monster-like growth. A few constraining steps have already begun.

Directionally, the following market forces will need to develop:

1) **Have consumers pay directly for care.**

High deductible plans appear on the surface to fit this criterion, however even high deductibles provide some incentive to spend – in order to get to the ‘covered level.’ The closer one gets to the deductible, and the more time left in the contract year, the more incentive someone has to spend ‘enough’ to reach that level. Health Savings Accounts (HSAs) – where the individual keeps the unused portion of his or her account (forever) - are a step in the right direction. Whether accounts are funded by someone else (employers, government) or by oneself, spending one’s own money puts the incentives in the right direction.

2) **Allow consumers to capture monetary benefits when there is less consumption.**

Systems that encourage ‘use it or lose it’ behavior are counter-productive. This concept is well-illustrated by comparing the HSA to its predecessor the Health Reimbursement Account (HRA). Deposits made into the HRA – which has the same tax advantages – are forfeited when the employee leaves the job. As such, value is only gained by spending the remaining balance before one quits. Rather than being a prudent consumer, this arrangement encourages additional consumption. Employers create similar incentives with paid sick-leave. If the only way to obtain value from a sick day is to use it (full pay for no work), consumption is encouraged. By contrast, if some or all of unused sick time can be exchanged for additional income (full pay for working), use of sick time is reduced (14).

3) **Create a true partnership between employers and employees – sharing good and bad consequences – in health-related benefits.**

While there are some good examples of partnership, rarely do employers apply consistent incentives across all benefits. A true partnership aligns economic incentives such that both parties share all consequences in a meaningful way. This would mean that rewards are linked as closely to performance as possible. One is paid more for achieving more, and paid significantly less when absent; it is illogical to reward someone equally for being absent or present. A large portion of employers still do not track absences, especially for white-collar workers. Their resistance to tracking is part administrative (we don’t have the system) and part cultural (we trust our employees). However, most also acknowledge that there may be abuse of an honor-system absence policy. Even if only a few workers misuse unmonitored time, dedicated workers – who show up every day – notice that their dedication is neither recognized nor valued. The underlying message is that bad behavior is rewarded and good behavior is not.

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The underlying message is that bad behavior is rewarded and good behavior is not.
Similarly, few employers devise systems that reward good health practices. Some have developed creative systems that provide additional reimbursement or lower premium costs when the employee achieves positive health outcomes. However, these practices are not the rule. Instead, the person who makes an effort to lose weight or quit smoking usually pays for that program herself, while the person needing expensive treatment for emphysema or diabetes receives care at very low cost. A common reaction to suggestions that sick individuals should pay more is that such a policy ‘blames the victim.’ However, effective economic incentives apply to all consequences, good or bad. There should be a real consequence, a cost, for ignoring one’s health condition. And there should be a reward for improving behavior (e.g., much lower cost of treatment if an individual manages what he or she can).

4) **Provide employees with an opportunity to benefit from growth in human capital.**

To be effective, the up-side of economic incentives must apply beyond day-to-day consumption of health care services and sick leave. Essentially, one must experience rewards from performance improvement that far exceed what one might earn with sub-par effort and improvement. Similar to a self-employed individual who can earn more with greater dedication or effort, there should be noticeable economic incentives to do good work. An individual who has a self-determined opportunity to grow and succeed has more incentive to stay healthy and be present than an individual who has little opportunity for advancement. An example is the quintessential image of the unmotivated government worker – where the pay is low, “but the benefits are good.” The incentive is not to achieve, but to consume more benefits in order to get value.

5) **Create a direct market transaction between providers and patients.**

A direct transaction between consumer and supplier creates a useful tension that requires consideration of both price and utility. Currently, providers and patients have economic incentives that operate independently from each other. For the most part, patients have unconstrained demand enabled by third-party payment. Faced with a choice of spending more or less, the patient will err toward spending more. Providers’ incentives depend on their payment arrangements. In a fee-for-service arrangement, providers have an incentive to provide more care (in which case, they align with their patients against the restrictions of insurers). In a capitated HMO model, providers have a financial incentive to provide less care when possible (creating an adversarial position with patients). Without a direct negotiation between consumer and supplier, it is almost impossible to achieve reasonable levels of consumption.

6) **Connect provider payments less to activity and more to outcome.**

Especially in fee-for-service arrangements, the current system actually rewards inefficiency and trial and error. More activity produces more revenue, with sometimes questionable value to the patient\(^1\). Patients rarely object to more services because someone else pays the bill. Having patients pay for care directly will cut down on discretionary activities to some degree. However, where possible, the system should also include some compensation related to achievement of positive health outcomes. These outcomes could include better functionality, avoided lost time from work, better clinical metrics, or avoided serious events requiring hospitalization. Incentives for results (rather than activities) would encourage efficiency and attention to optimal care instead of more care.
The artificial connection between health care and work forces some employees to make job and earnings decisions based on factors not directly related to their careers.

7) **Consider disconnecting health insurance (and other health benefits, where possible) from employment**

A number of unintended consequences have resulted from the artificial connection between work and health care in the U.S. The connection forces employers to spend considerable time, resources and expense on an activity not directly connected to their business. It causes employees to make employment and earnings decisions based on factors not directly related to their careers. It encourages use-it-or-lose-it behavior during job transitions. The connection results in (rarely mentioned) subsidies by younger, single employees to cover the additional cost of premiums for employees with families. Also, it creates illegitimate costs and barriers for employees who work in small companies. It is likely that transportable HSAs will enable employment-independent coverage through other types of cooperatives. While some find this prospect worrisome, there are a myriad of reasons to move in this direction.

**Concluding comments**

Certainly, some of these steps to constrain benefits consumption could occur sooner than others. And some represent somewhat drastic change from the current system. Drastic or not, pressure to address the increasing cost of consumption, our monster, will force some type of change in the very near future. If we follow the guidance of economic principles, change will require economic incentives and market pressures to make consumption rational and optimal, rather than the current system that encourages more consumption regardless of circumstance.

**References:**

2. This phenomenon is known to economists as moral hazard. For a compelling discussion of this topic, see Milton and Rose Friedman, *Free to Choose: A Personal Statement*. Harcourt, 1990.
4. HCMS analyses show that in the last six months before leaving a job, regardless of the level of health, individuals consume as much as three times more health and paid-time-off benefits than their counterparts who are staying.
7. While newer pay-for-performance approaches are addressing this issue to some degree, few rewards actually focus on outcomes. Most are focusing on delivery of appropriate prevention, screening and follow-up care – again activities rather than outcomes.
8. Indeed, analyses using the HCMS Research reference database (almost one million covered lives) show that less than 2% of dollars are spent on prevention and only 10% are spent on cognitive services (office visits).
References (cont.):

9  Congressional Budget Office. October 2004. An analysis of the literature on disease management programs. A recent review by the Congressional Budget Office determined that there is insufficient evidence that external Disease Management programs are cost beneficial. http://www.cbo.gov/ftpdocs/59xx/doc5909/10-13-DiseaseMngmnt.pdf. Yet, employers and municipalities continue to spend hundreds of millions of dollars on these add-on services. Adding more service providers inevitably adds to the cost and reduces the efficiency of care, without addressing the primary economic issue of a transaction paid by a third party.


12 There are conflicting opinions about the value of direct-to-consumer (DTC) marketing in educating patients. But most experts agree that demand for highly advertised medications has increased, even when the medication may not be superior to other options. For example, according to Marcia Angell, M.D., author of The Truth About Drug Companies (Random House, NY, 2004, p.124), “a large majority of DTC ads are for very expensive me-too drugs that require a lot of pushing because there is no good reason to think they are any better than drugs already on the market.”


