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Hotels and Airlines Do It: Why Not Hospitals?

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By UWE E. REINHARDT

Sometime during the 1990s America's business leaders must make a crucial choice: They must profess their impotence in the market for health care or demonstrate their self-proclaimed prowess.

For more than a decade, these executives have steadfastly clung to two contradictory positions. First, they claim to be hapless victims of a so-called cost shift from Medicare and Medicaid. These programs' alleged underpayments to doctors and hospitals are said to reflect themselves, dollar for dollar, in higher premiums business pays for the health-insurance coverage of employees. The National Association of Manufacturers, for example, claimed last week that in 1991 its members were billed an extra $11 billion by hospitals to recoup costs not covered by government or uninsured patients. It darkly hints that these "overcharges" help erode its members' international competitiveness.

Pricing Health Care

At the same time, executives also claim that they could perfectly well fend for themselves in the health-care market, if only the government got off their backs. Now, it is true that, during the 1970s, public health policy did repeatedly seek to climb onto the private sector's back, although usually it slid right off.

In 1971, President Nixon proposed, without success, that all businesses be mandated to provide health insurance to their employees. Next, he imposed strict price controls on the entire health sector, a regime that barely outlasted his own. In 1974, President Ford signed a comprehensive national health planning law, albeit a law without teeth. Finally, President Carter threatened to impose budget caps upon the entire hospital sector and, once again, tried to mandate business to provide all employees with health insurance, in each case without success. But all along, the nation's business leaders despaired, praying that they be left alone to handle their own affairs in the health-care market.

Along came President Reagan with the answer to their prayers. In effect, his administration told the business community: "You look after your part of the show, and we'll look after ours." The suppliers of health care were left free to put in place whatever capacity they wanted and to bargain with private payers over prices as best they could.

Ironically, on its own part of the show the "free-market" Reagan administration, in concert with Congress, imposed a regime of strict, centrally administered price controls reminiscent of pre-*glasnost* Soviet pricing. Beginning in 1983, the Medicare program phased in a nationwide fee schedule that paid each hospital a fixed amount per diagnostically defined case, with only minor adjustments for regional variations. The annual updates in that schedule are recommended by the administration and set by Congress.

The fees Medicare paid doctors remained frozen for most of the 1980s; in the Bush administration, they were made subject to expenditure targets. These fees are being phased out in favor of a nationwide fee schedule. Like the hospital fees, the doctors' fees will allow for only minor regional variations.

This two-pronged health policy is the genesis of the so-called cost shift now being deplored by business leaders. Once again, they see the government on their backs. But who's really on their backs?

Like the airlines and the hotel industry, the health sector is characterized by relatively high fixed costs in the short run and by products that cannot easily be resold among customers. Like those other industries, the health sector therefore is a natural for what economists call "price discrimination."

Under price discrimination, identical goods or services are sold to different classes of customers at different prices, depending on the customers' ability to resist high prices. In such a market, large buyers with market muscle usually can get away with prices much below fully allocated unit costs. If the sellers are plagued by excess capacity—as the hospital sector is—they will accept such low prices as long as they cover variable costs with at least some profit margin. The rest of the overhead must then be recovered from buyers with less market muscle. U.S. airlines and hotels are masters at this game.

Between 30% and 40% of the typical hospital's total patient revenue now comes from Medicare. Medicaid typically accounts for another 10%. In recent years, these two programs have used their size to exploit the potential of price discrimination, at the behest of an electorate and a business community that has called for tight controls on government spending. Incidentally, government has always gotten similarly large discounts from the airline and hotel industries, as do many large businesses. No one whines over those cost shifts, not even those who pay full costs and then some.

A graphic illustration of hospital cost shifting was recently offered on this page by Dr. Sidney Marchasin ("Cost Shifting: How One Hospital Does It," Dec. 9, 1991). The Stanford University Medical Center offered similar data in the New York Times (Nov. 11, 1990). For example, for a coronary bypass operation that costs Stanford $35,000 to $41,000, Medicare paid only about $27,000 and Medicaid a paltry $11,000. To recover its overhead, the center charged privately insured patients about $81,000.

America's insurance executives and the businesses they insure decry this pricing strategy as "unfair." The question can be asked, however, why these executives so passively accept the alleged cost shift. If they have the moxie to deal with the providers of care—as they so often claim—then why not prove it by simply saying "no" when the cost shift comes their way? On the other hand, if for some reason they cannot say "no," then wouldn't now be an opportune time to admit their impotence and explore alternatives?

So far, the most common suggestion from the business community has been that the government should pay "fair" prices for the health care it procures (like the "fair" in "fair trade," one supposes). But how does one define "fair"? And how does one ensure that everyone pays "fair" prices short of a regulatory process in which all payers negotiate a common, binding fee schedule with the doctors and hospitals within a given region? The Germans now operate such an all-payer system, and business leaders there never whine over a cost shift.

The American business community so far has opposed the all-payer approach as too regulatory. Fair enough. But, then, what is the alternative? Should Medicare and Medicaid pay doctors and hospitals their "usual" fees—that is, the much higher prices private insurance carriers have been willing to pay? One can readily imagine what would happen to the Medicare and Medicaid budgets, and how our business community would then lament runaway government spending. At the same time, do we imagine that doctors and hospitals would lower their fees to private payers if, by some miracle, government paid them more?

The cost shift is likely to go on for a while; the taxpaying electorate demands no less. But sooner or later this policy *will* flush the private payers out of the closet: They must either learn to resist cost shifts, or they must join the government in the much-loathed all-payer system. In the meantime, we shall continue to behold that sorry spectacle: frustrated, wailing executives who cannot get their act together, nor even their story straight.

Mr. Reinhardt is a professor of political economy at Princeton University.

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