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MEDICARE'S NEW READMITTANCE FINES

By Christopher Westley

"In a Country where Clamour always intimidates and faction often oppresses the Government, the regulations of Commerce are commonly dictated by those who are most interested to deceive and impose upon the Public." Adam Smith, from a letter to François Alexandre Frédéric, le duc de La Rochefoucauld, dated November 1, 1785.

What if the unintended consequences are actually intentional?

That's the thought I had recently upon learning about upcoming fines to be levied by Medicare on hospitals that readmit patients due to complications within 30 days of an initial discharge. The logic is straightforward: If hospitals do not make a patient well the first time, then they suffer the additional cost of a fine.

It is sort of like what would happen if I went to a private arbitrator to address my claim that a mechanic working on my car charged me for repairs that were not done or not done correctly. (In a truly free market, mechanics would have strong incentives to comply with decisions of such individuals.) The arbitrator would rightly make the mechanic do the work correctly and possibly fine him for engaging in fraud.

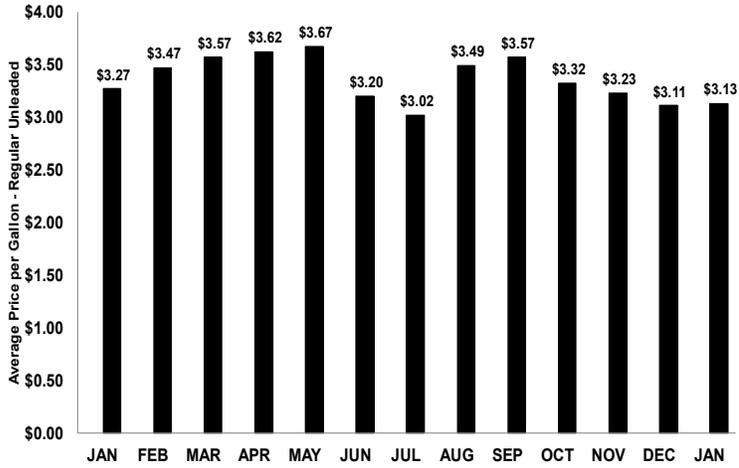
But in Medicare's case, when *it* is the monopoly arbitrator, the fines are significant. The government

estimates that about 2,200 hospitals will be fined an average of \$125,000 over the next year. This is about the same amount of money that will purchase the average home in Ohio.

It is all in the name of efficiency and contract enforcement and I'm sure it all seems logical on paper. Under the current system—also devised by Medicare—hospitals have perverse incentives to maltreat patients and cause readmittances to maximize Medicare disbursements. One obvious solution is to eliminate the bankrupting Medicare system and move toward more market-based health care. By strengthening the payment-consumption link, market forces would penalize hospitals that engage in such practices. Over time, the fine would take the form of lost market share while competition for patients would create incentives to increase the health care quality and lower its price.

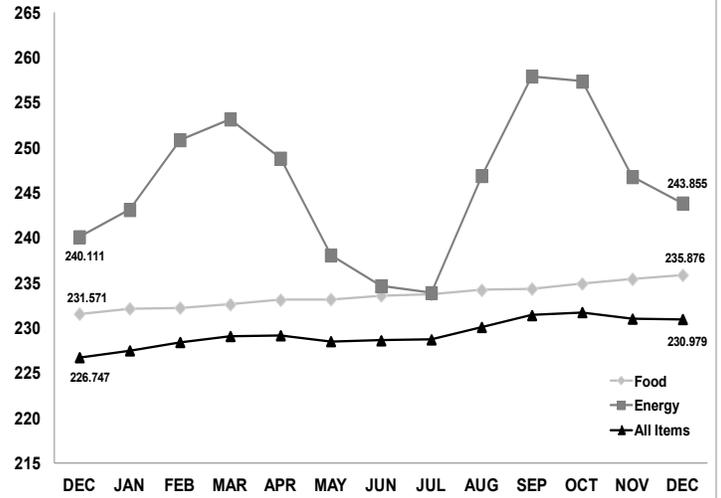
Anyone who ponders the role of the payment-consumption link in markets would not be surprised by such an outcome. When consumers are paying for goods and services out of their own resources, the link is strong as both producers and consumers have incentives to maximize quality and minimize unnecessary costs. But when a third party exists between the producers and consumers, these incentives are weakened, as exemplified by the delivery of healthcare first in the 1940s when health insurance companies were forced into the

Gasoline Prices January 2012 - January 2013 (3 County Average - Calhoun, Etowah, Talladega)



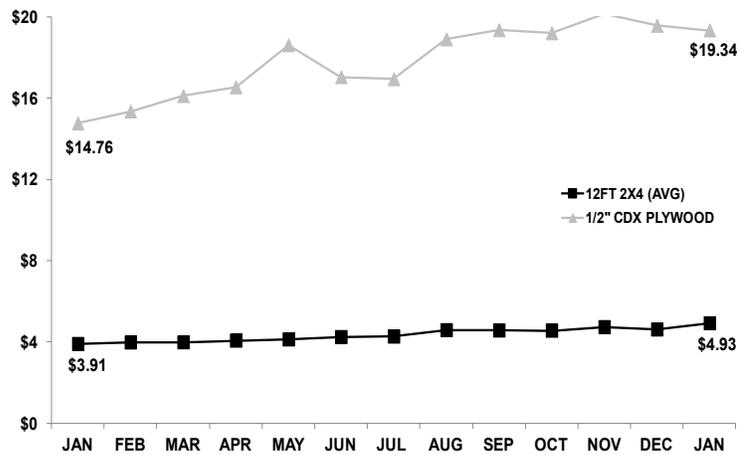
Source: AAA Alabama

Consumer Price Index - U.S. Average December 2011 - December 2012



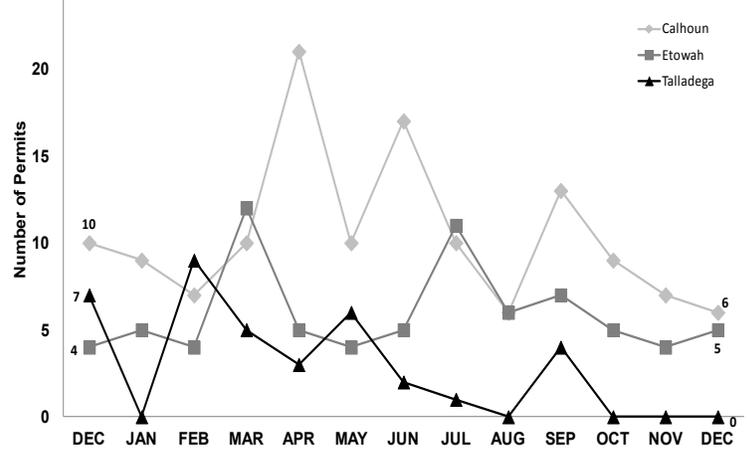
Source: Consumer Price Index

Lumber Prices January 2012 - January 2013 (3 County Average - Calhoun, Etowah, Talladega)



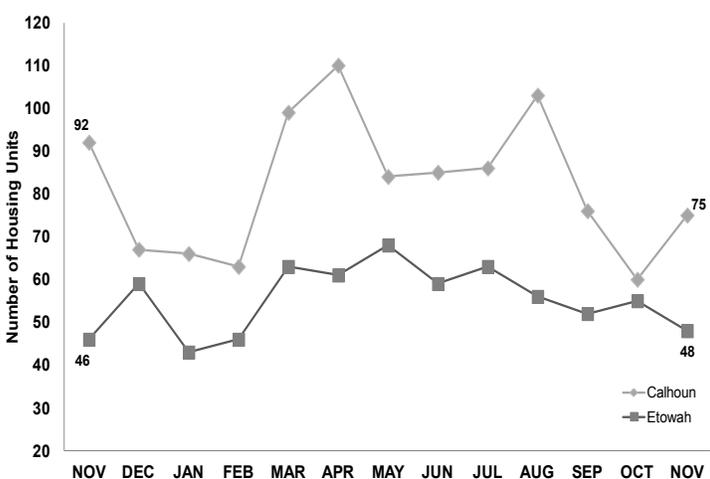
Source: Phone Surveys

Building Permits December 2011 - December 2012 (New Construction)



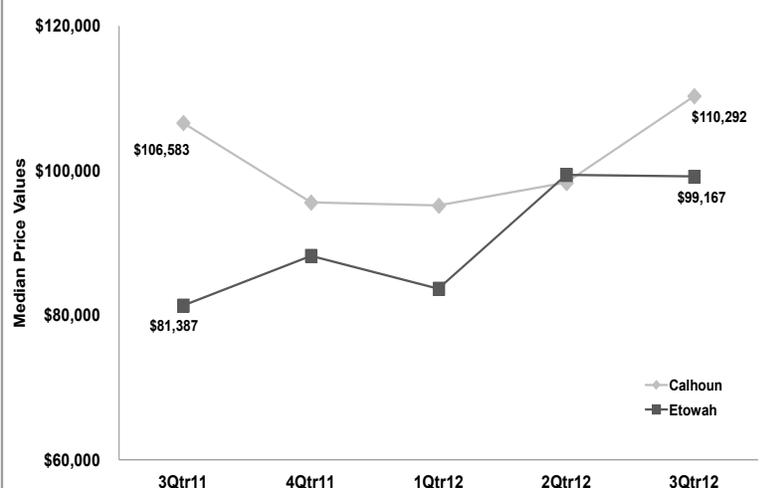
Source: Data submitted by municipalities within the three counties

Housing Units Sold November 2011 - November 2012



Source: Alabama Center for Real Estate, University of Alabama

Median Home Prices 2011 - 2012



Source: Alabama Center for Real Estate, University of Alabama

workplace and eventually cartelized, and then in the 1960s when the government found that those wartime interventions crowded significant numbers of people out of healthcare markets or otherwise made them unable to access healthcare.

The result is yet another situation in which one form of government intervention creates unintended consequences that require further interventions. Formally discussed by Ludwig von Mises in his 1926 classic *Liberalism*, the interplay of interventions and subsequent government growth especially applies to healthcare markets in which interventions favoring insurance companies cause problems that lead to the creation of Medicare and Medicaid, both of which contribute mightily to the off-budget obligations of the federal government that now exceed \$220 trillion and justify further intervention today in the form of the Affordable Care Act (also known as ObamaCare).

Unsurprisingly, Medicare's advocates during the heady days of the Great Society argued that increased state control of private health resources would result in a healthier society and falling health costs over time. Instead, it only weakened the payment-consumption link further, perverting the normal incentives of producers and consumers of healthcare to maintain quality and minimize cost.[1]

This particular intervention of penalizing readmittances is based on the assumption that fixing a broken down body is similar to fixing a broken down car and will create its own new round of unintended consequences. Just three that come to mind include: (i) an upward pressure on prices for all other hospital services to compensate hospitals for readmittance fines, (ii) the outright rejection of patients that hospitals consider likely readmittance threats, and (iii) increased tendencies to simply let patients die when healing them is likely to result in readmittance fines.

It's ironic that hospitals may favor death in a way that is worse than any economic calculation Ralph Nader once accused General Motors of making in his 1965 book, *Unsafe at Any Speed*. At least back

then, consumers could opt out of buying Corvairs once its tire pressure problems were connected to highway deaths. Hospitals will become known as places to die—unsafe at any blood pressure—and anyone who tries to exit this relationship with them will face another fine by the Feds for doing so. [2]

Of course, all of these possibilities may be intended as necessary to create a political environment conducive to the establishment of a National Health Service. Surely, advocates of state control have figured out by now that unintended consequences actually work in their favor, and that their failures eventually create a public aversion to the *private* sector and, consequently, a justification for further government growth. The government failures that lead to 9/11/01 have had a similar effect on government growth since that fateful date. Why wouldn't this apply to other areas of potential state power?

This theory has been spelled out by many economists. Robert Higgs argued in *Crisis and Leviathan: Critical Episodes in the Growth of American Government* [3] that government grows at a given rate until a crisis of some sort appears. It then ratchets up its growth in response to the crisis. Post-crisis, due to the creation of new constituencies that are dependent on it as well as of interest groups that now depend on it for their funding, government's scope in society does not revert to its previous level. Bryan Caplan, in his *The Myth of the Rational Voter: Why Democracies Choose Bad Policies* [4], pointed out that despite the greatest government failure in U.S. history (9/11/01), the public's faith in government and willingness to tolerate its expansion grew enormously.

Furthermore, economists Art Carden and Robert Lawson argue in a 2010 paper that crises have two effects on economic growth. "First," they write, "[they allow] for the expansion of government authority as new programs which normally would have been opposed are now sanctioned by the polity. Second, [they allow] the unscrupulous and the opportunistic to slide damaging political favors past a newly-credulous public." [5]

The readmittance policy, passed in a healthcare bill written by pharmaceutical and insurance

company lobbies and mostly unread by the legislators who voted for it, is one of many policies governments impose that invite future crises and future interventions.[6] Let a few hospitals fail and a few readmittance candidates die to nudge a credulous public to favor a single payer system. Unfortunately, when the government controls so much of our healthcare provision, we all pay in one way or another.

REFERENCES:

[1] A common classroom thought experiment to illustrate this point is to ask students to consider how grocery markets would change over time if instead of making food purchases as needed to stock kitchen shelves and refrigerators, they either purchased “food insurance” to access food like they do healthcare, or obtained groceries directly via funds accessed through the tax system (arranged via the state apparatus of violence and compulsion). It is relatively easy to conclude that the presence of a third party would result in consumers losing incentives to spend their budgets wisely (and eat steak every night), while grocery stores would concern themselves more with satisfying their third-party payers than the actual consumers

[2] Readers who think this statement is hyperbolic should consider the current scandal surrounding the “Liverpool Care Pathway for the Dying Patient” in the United Kingdom in which UK hospitals receive perverse financial incentives in the millions of pounds to meet euthanizing goals set forth by the National Health Service. Hospitals participating in this program have been accused of issuing “do not resuscitate” orders without consent, allowing unnecessary deaths of elderly patients resulting in family members pulling relatives out of hospitals in an attempt to save their lives, and starving and dehydrating babies to death. For more information, see <<https://bit.ly/pathwaypeace>>.

[3] New York: Oxford University Press, 1989.

[4] Princeton, N.J.: Princeton University Press, 2007.

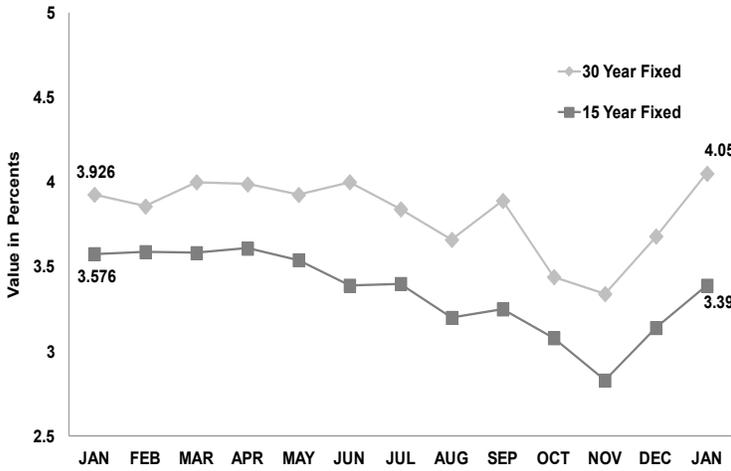
[5] See Carden, Art, and Lawson, Robert A., “Human Rights and Economic Liberalization.” *Business and Politics*, 12(2), 2010, Article 2. Available at Berkeley Electronic Press: <http://www.bepress.com/bap/vol12/iss2/art2>.

[6] To quote former Obama Chief of Staff Rahm Emanuel, “You never want a serious crisis to go to waste.” I thank William Hubbard for this insight.

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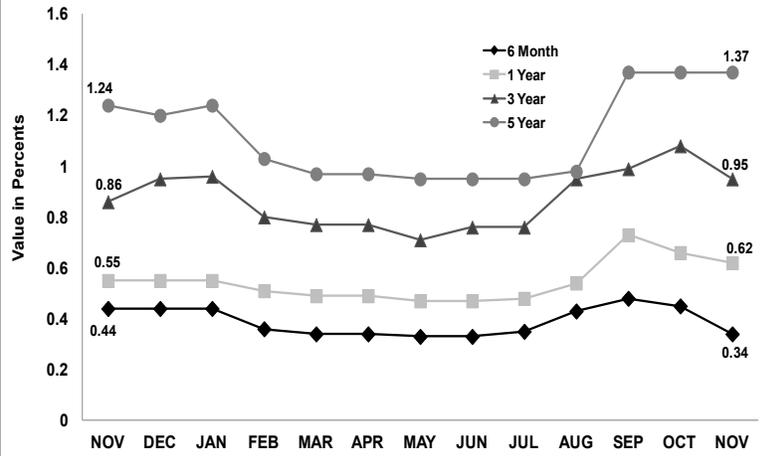
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Mortgage Rates January 2012- January 2013 (3 County Average - Calhoun, Etowah, Talladega)



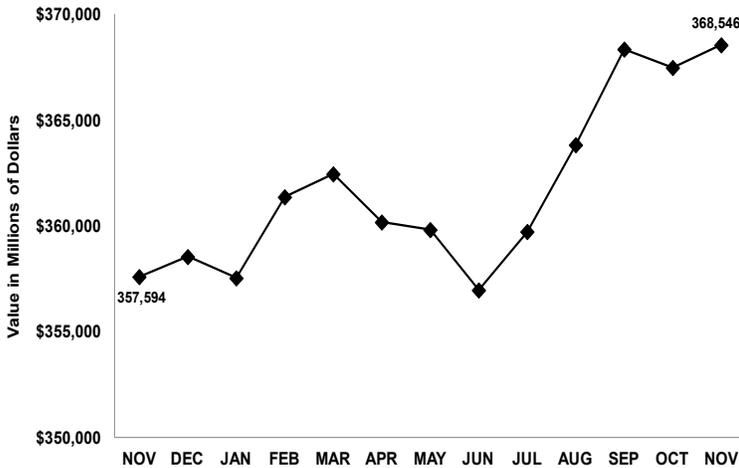
Source: Phone Surveys

Certificate of Deposit Rates November 2011 - November 2012 (3 County Average - Calhoun, Etowah, Talladega)



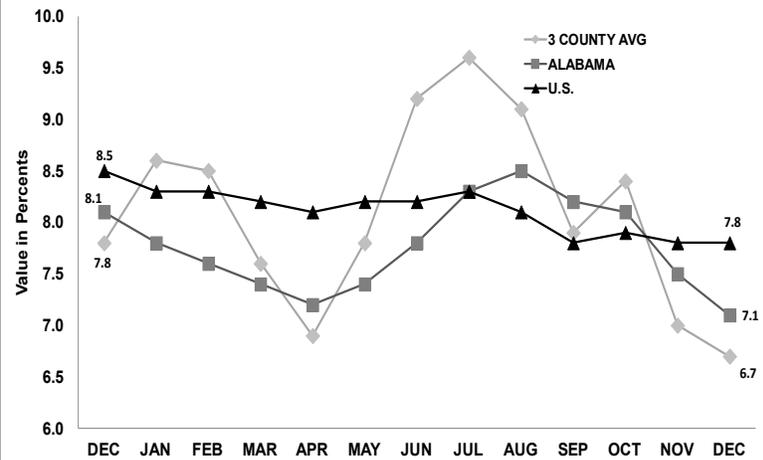
Source: Phone Surveys

U.S. Retail Sales November 2011- November 2012



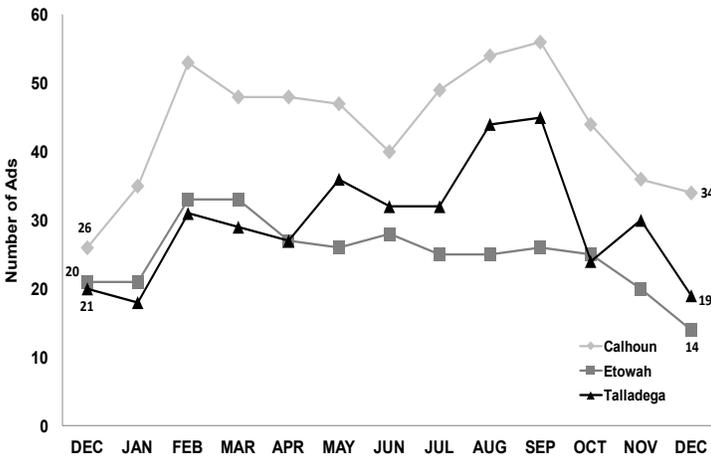
Source: Monthly Retail Trade Report, U.S. Census Bureau

Unemployment Rate December 2011 - December 2012 (3 County Average - Calhoun, Etowah, Talladega)



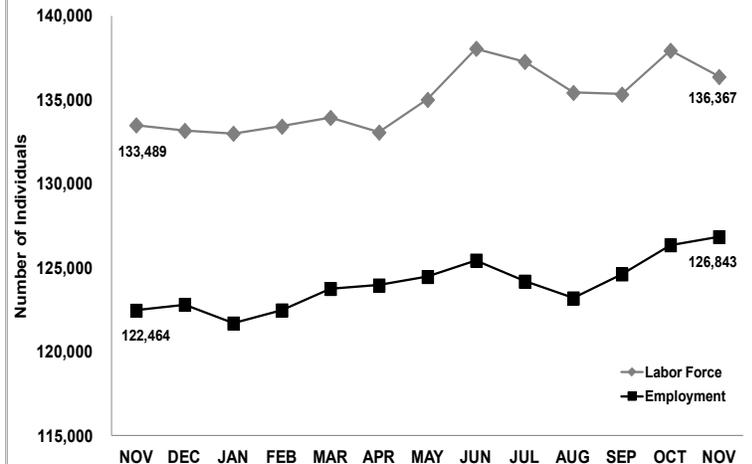
Source: Alabama Department of Industrial Relations

Help Wanted Ads December 2011- December 2012



Source: Phone Surveys

Civilian Labor Force & Employment November 2011 - November 2012 (3 County Average - Calhoun, Etowah, Talladega)



Source: Alabama Department of Industrial Relations



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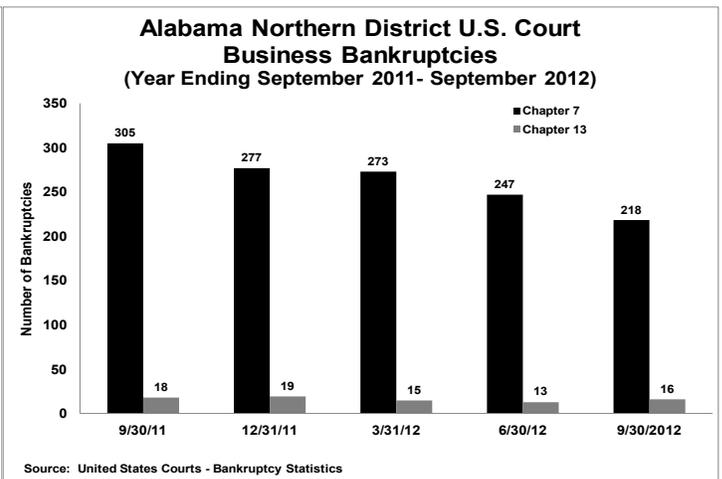
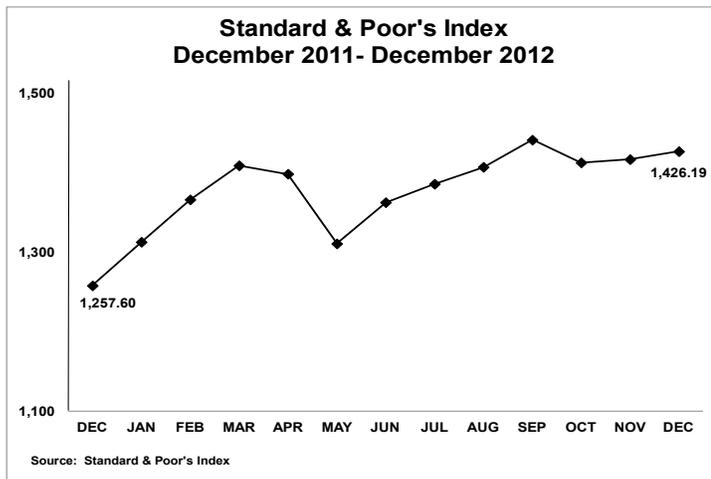
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