

## **17. Medical Care**

After nearly a year and a half of debate, tens of millions of lobbying dollars, and smothering media attention, the debate over President Clinton's plan for health care reform has ended, "not with a bang but a whimper" (*T. S. Eliot*). While the president's proposal for a government takeover of health care is unlikely to be repeated in the 104th Congress, there remain significant problems in the American health care system that must be addressed. Thus, Congress should

- **establish medical savings accounts,**
- **create tax fairness by replacing current tax exclusions with a universal health care tax credit,**
- **send Medicaid back to the states,**
- **deregulate the health care system.**

Most important, health care continues to cost too much. In 1993 Americans spent \$884.2 billion on health care, amounting to 13.9 percent of gross domestic product. That represents a 7.8 percent increase in health spending over 1992. Although recent trends indicate that the increase in health care costs may be moderating, the relative price of medical care and real health care expenditures per capita are both still increasing at a rate greater than the average increase over the last 30 years.

At the same time, 39 million Americans continue to lack health insurance. Millions more worry that if they lose **their jobs**, they will lose their insurance. While most uninsured Americans will be without insurance for only a short time, a way must still be found to enable more Americans to obtain and keep health insurance coverage.

Postelection polls indicate that health care reform remains a priority for the American people. Congress should, therefore, take this opportunity to enact genuine market-based health care reform.

## Principles for Health Care Reform

Health care reform is an extraordinarily complex issue. However, Congress can start in the right direction by adopting four simple principles.

1. Government policy should not attempt to influence the means by which health care is *financed*. In other words, government policy should be neutral with respect to whether any specific method of treatment is financed by employer-provided insurance, individual insurance, or direct patient payment. Among other things, that means that there should be no monopoly purchasing cooperatives, no government-defined standard benefits package, and no state mandates on insurance coverage. In addition, the current preference in the tax code for employer-provided coverage should be either eliminated or broadened to equalize treatment for individual policies, out-of-pocket payment for care, and payments made through a medical savings account.
2. Government policy should not attempt to influence the means by which health care is *provided*. That means that government policy should not pick winners and losers among types of providers, through subsidies, mandates, or restrictions. That includes any bias for or against home care, physician care, or alternative therapies. It also means that the government should not attempt to choose among health maintenance organizations, preferred provider organizations, and fee-for-service medicine. Specifically, Congress should resist the temptation to impose "any willing provider" requirements on managed care.
3. Any government subsidies for either health insurance or health care should be on budget, transparent, and subject to periodic review. Congress should not attempt to hide subsidies behind employer mandates or community rating.
4. Congress should focus on those health reforms that are properly the responsibility of the *federal* government. Federal tax and regulatory policy *must* be remedied through federal regulation. Insurance regulation, on the other hand, has traditionally been the responsibility of state governments. Most states have already reformed the small-group insurance market to require portability and *renewability*. Congress should resist the temptation to impose a single national policy on insurance regulation. Such difficult issues as how to best handle preexisting conditions should be left to state experimentation.

By following those simple principles, Congress can develop sound health care reform proposals.

### ***Medical Savings Accounts***

Medical savings accounts would allow an individual to save money in a tax-exempt account, in much the same way he can in an individual retirement account (IRA) now. He could use that money to pay routine, low-dollar medical expenses. Then, instead of an expensive first-dollar insurance policy, the individual or his employer could purchase a relatively inexpensive catastrophic insurance policy to protect against major medical expenses.

For example, today it costs an employer more than \$4,800 to provide health insurance for a typical American worker, spouse, and two children. Wouldn't it be better if, instead, the employer bought a catastrophic policy (with, say, a \$3,000 deductible) for approximately \$1,800 and paid the worker the \$3,000 difference? The worker could then put that money in a medical savings account, without paying taxes on the additional income. Any money in the account that wasn't spent would roll over to the next year. Since 90 percent of Americans spend less than \$3,000 per year on health care, in a very short time there would be a tidy pool of money available for the worker to use in the future.

Economists from across the political spectrum understand that one of the major factors driving health care costs is our third-party payment system that insulates consumers from the cost of their health care decisions. Medical savings accounts would establish an incentive for consumers to act more responsibly in purchasing health care services. There are numerous studies that show that health care consumers can and do make cost-conscious decisions when given a financial incentive to do so.

For example, the RAND Corporation conducted a study of changes in people's health care decisionmaking based on the size of the consumer's copayment. The study found that an individual who had to pay 50 percent of the cost of health care spent 25 percent less than an individual with no copayment. The study also showed that, contrary to the assertions of some critics, those reduced expenditures are not caused by individuals' forgoing truly necessary health care. Health outcomes were virtually identical. Rather, the savings result from reduced utilization of optional services and cost-based selection among competing providers.

Moreover, health expenses paid out of a medical savings account would entail no insurance administrative cost. Insurance is a very inefficient way

to pay for small or routine **health** expenses. It costs approximately as much to process a \$50 claim as it does to process a \$50,000 claim. Medical savings accounts would cut insurance companies out of the vast majority of health care transactions. That would reduce both the overall cost of health care and the paperwork burden on doctors.

Medical savings accounts would also increase the quality of medical care by strengthening the relationship between the physician and the patient. One of the great tragedies of medicine today is that the *medical* ethic, under which the doctor is responsible to the patient, has been replaced by a *veterinary* ethic, under which the doctor is responsible not to the patient but to whoever is paying the bill. Medical savings accounts would reverse that trend.

Finally, although medical savings accounts are not a "silver bullet" that would instantly solve the problem of Americans without health insurance, they would be a major step on the road to universal access. Of the 39 million Americans who lack health insurance, half are uninsured for four months or less, 70 percent for one year or less. Medical savings accounts would provide those individuals with a pool of money to be used for health care and health insurance during short **uninsured** spells. Moreover, because medical savings accounts would belong to the individual and be completely portable, people would no longer fear that the loss of a job might lead to the loss of insurance.

## ***Tax Fairness***

Current federal and state tax laws exclude from taxable wages the cost of health insurance provided by an employer. Therefore, the vast majority of Americans, those who receive health insurance through their employer, do not pay federal, state, or Social Security taxes on the value of their policies. Moreover, the employer can deduct the **full** premium cost as a business expense. In short, the entire cost of employer-provided insurance is paid with *before-tax* dollars.

However, those Americans not fortunate enough to receive employer-provided health insurance face entirely different tax laws. Part-time workers, the self-employed, the unemployed, and everyone else not receiving employer-provided health insurance—including most employees of small businesses—are unable to deduct *any* of the cost of health insurance. (Individuals may only deduct out-of-pocket medical expenses if they itemize deductions and the expenses exceed 7.5 percent of their adjusted gross

income. Less than 5 percent of American taxpayers are eligible for that deduction.)

The difference in tax treatment creates a disparity that effectively doubles the cost of health insurance for people who must purchase their own. For example, a person working for a small business that offers no health insurance would have to earn \$8,214 to pay for a \$4,000 policy.

Congress should replace the current tax exclusion with a universal health care tax credit. The credit should be available to cover payments for individual policies, direct patient payments, and contributions to medical savings accounts. The credit could be made refundable to assist in extending coverage to low-income individuals.

### ***Send Medicaid Back to the States***

Health costs are consuming an ever-greater portion of state resources. Medicaid, the federal-state health care plan for the poor, is now the second largest budget item in many states, and it accounts for a nationwide average of over 14 percent of total state expenditures. If current trends continue, state expenditures on Medicaid will have increased more than 480 percent from 1990 to the year 2000.

A substantial portion of that cost has been driven by federal mandates on the states. The federal government mandates that state Medicaid programs provide coverage for inpatient and outpatient hospital services, physician services, laboratory and x-ray services, nursing facility services for adults, home health care services for individuals eligible for nursing facilities, family planning services, rural health clinic services, prenatal care, nurse-midwife services, early and periodic diagnostic and treatment services for children under the age of 21, and services of certified pediatric or family nurse practitioners. States must also provide transportation to those services.

In addition, beginning with the 1984 Budget Reconciliation Act, Congress began mandating expanded eligibility requirements. Since then, virtually every federal budget has brought additional mandates on eligibility. Today states must provide coverage to recipients of Aid to Families with Dependent Children, SSI recipients, and pregnant women and children in families with incomes up to 133 percent of the poverty level.

Finally, states wishing to experiment with reforming their Medicaid system, including the use of vouchers and managed care, must receive a waiver from the federal government. Although the Clinton administration

has been better than its predecessors at granting such waivers, the process remains extremely lengthy and cumbersome.

The current federal-state **Medicaid** program should be eliminated and replaced with a block grant to the states. The block grant should be a flat amount for each state rather than a matching percentage so that any higher spending and marginal costs would be borne completely by the states. States should be **specifically** allowed to use block grant funds for vouchers for the poor and lower income individuals to use for health insurance. That should include the options of managed care and medical savings accounts. Current mandates for types of coverage and benefits as well as eligible populations would not be included.

### ***Deregulate the Health Care System***

There should be a complete review of federal health care regulation and a repeal of regulatory requirements that are responsible for increased health care costs. Those regulatory requirements are mandated by a wide variety of programs and agencies. One hospital in San Diego recently reported that it must file 65 different annual reports with 39 governmental bodies, ranging from the Environmental Protection Agency to the Bureau of Narcotics Enforcement.

In addition to imposing a paperwork burden, federal regulations often attempt to **micromanage** the way medical providers conduct their businesses, frequently mandating unnecessary and expensive procedures and personnel. For example, Medicare rules require hospitals to provide 24-hour nursing service, furnished or supervised by a registered nurse in each department or unit of the facility. Medicare also requires hospitals to use only licensed laboratory and radiological technicians. Medicare even requires hospitals to have a full-time director of food and dietary services. Alternatives to hospitals, such as rural health clinics and community health centers, must also meet stringent administrative and staffing requirements under Medicare rules.

Federal tax laws restrict the ability of medical facilities to participate in cooperatives and other arrangements that could save money on such services as laundry, housekeeping, and management.

The Clinical Laboratories Improvement Act imposed a host of new regulatory requirements on clinical laboratories. The Occupational Safety and Health Administration has added yet more requirements, including detailed restrictions on where a technician can hang his lab coat. The cost of complying with the new regulations is estimated to be as high as

\$40,000 per laboratory. Recent inspections indicate that as many as 84 percent of laboratories are currently in violation of CLIA requirements.

## **Conclusion**

This is a menu for free-market health care reform: establish medical savings accounts, create tax fairness, return Medicaid to the states, and deregulate the health care industry. By doing those things, the 104th Congress can establish a vibrant, healthy free market in health care. It can expand access to care, hold down costs, and maintain the quality of the best health care system in the world.

## **Suggested Readings**

- Butler, Stuart, ed. *Is Tax Reform the Key to Health Care Reform?* Washington: Heritage Foundation, 1990.
- Goodman, John C., and Gerald L. Musgrave. *Patient Power: Solving America's Health Care Crisis*. Washington: Cato Institute, 1992.
- Health Care Solutions for America. *Federal Tax Policy and the Uninsured: How U.S. Tax Laws Deny 10 Million Americans Access to Health Insurance*. January 1992.
- Helms, Robert, ed. *Health Policy Reform: Competition and Controls*. Washington: American Enterprise Institute, 1993.
- Liebowitz, Stan. "Why Health Care Costs Too Much." Cato Institute Policy Analysis no. 211, June 23, 1994.
- Newhouse, Joseph, et al. "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance." *New England Journal of Medicine*, December 17, 1981.
- Tanner, Michael. "Health Care Reform: The Good, the Bad, and the Ugly," Cato Institute Policy Analysis no. 184, November 24, 1992.
- \_\_\_\_\_. "Laboratory Failure: States Are No Model for Health Care Reform." Cato Institute Policy Analysis no. 197, September 23, 1993.
- Wasley, Terree. *What Has Government Done to Our Health Care?* Washington: Cato Institute, 1992.

—Prepared by Michael Tanner

