

7. Health Care

State governments should

- preserve and strengthen health savings accounts, beginning with repealing laws that obstruct them;
- enact tax reforms to treat health expenditures no differently than nonhealth expenditures;
- allow consumers to purchase health insurance regulated by the state of their choice;
- allow patients and providers to avoid the costly medical tort system through voluntary contracts; and
- liberalize Medicaid.

The federal government should

- preserve and strengthen health savings accounts,
- enact tax reforms to treat health expenditures no differently than nonhealth expenditures,
- deregulate health insurance by allowing consumers to purchase health insurance regulated by the state of their choice,
- liberalize Medicare and Medicaid, and
- liberalize the regulation of pharmaceuticals and medical devices.

Too Important Not to Leave to the Market

A widely accepted premise in health policy discussions is that health care is a special case of market failure and that government intervention is, therefore, necessary. In America's health care system—the world's freest—that would seem to be the case. Medical inflation consistently outpaces general inflation. Consumers have few health insurance choices.

Health insurance premiums continue to climb by double digits year after year. Millions of Americans are unable to afford health insurance. Even those with insurance have their choices restricted by reimbursement rules, networks, and gatekeepers. Losing a job often means losing coverage. Doctors have little time to spend with patients. Prescriptions are too expensive for many people. Cost shifting is rampant. Competition is scant. Litigation threatens to drive doctors out of practice and deny patients access to care. And repeated efforts at reform seem to make no difference.

Careful observation, however, reveals that such supposed examples of market failure are actually manifestations of government failure; that is, the problems in America's health care sector are the result of government attempting to influence behavior or otherwise restrict individual liberty. Unsurprisingly, health care markets respond to such intervention as economic theory suggests markets would. The extent of America's health care difficulties can be explained by the fact that, according to University of Rochester health economist Charles Phelps, "the U.S. health care system, while among the most 'market oriented' in the industrialized world, remains the most intensively regulated sector of the U.S. economy."

Government involvement in the health care sector is harmful to patients and is a large and growing encroachment on individual liberty. The solution is to restore individual liberty by expanding the number of health care decisions made by individuals and reducing the number of decisions made by government.

The Third-Party Payer System

The primary way government interferes in health care markets is through policies that make the purchaser of health care someone other than the consumer. The result is America's "third-party payer" system: patients (the first party) consume medical care, and suppliers (the second party) are most often paid by some third party to the transaction. The two policies that created this system are the federal tax code (more precisely, the tax treatment of employment-based health insurance) and government health programs (principally Medicare and Medicaid).

Since World War II the federal government has exempted employer-provided health benefits from taxation. The immediate results were two-fold. First, the price of employer-provided health insurance (including any medical care financed through such "insurance") dropped relative to that of other goods and services. If a worker's wages are taxed at 35 percent, the same pretax dollar can buy either \$1 of health benefits or \$0.65 of

something else. Not taxing employer-provided health benefits the same as other forms of consumption makes the price of health insurance and medical care appear much lower relative to that of other forms of consumption. Thus, workers purchase more coverage and consume more care than they otherwise would. (This tax benefit initially applied only to third-party insurance, not to savings that individuals put aside for their health care expenses, also known as self-insurance.)

The second result has been that most Americans (roughly 60 percent in 2003) get their health insurance through their employers, and most of their medical bills are paid by employers or insurers. Such third-party payment magnifies the effects of the tax code and creates instability in the health care sector. Already encouraged to overconsume health care by distorted prices, workers are further insulated from the cost of their choices because someone else is writing the check. Since workers have few incentives to be cost-conscious, prudent consumers, demand for health care rises dramatically, and prices rise along with it.

In fact, third-party payment guarantees that prices will continue to rise. If government lowered the price of apples relative to that of other goods, consumers would buy more apples. However, as demand rose, so would prices. Consumers would eventually respond to higher prices by putting the brakes on their consumption, and prices would stabilize. But if a third party paid their apple bills, consumers would keep consuming and the price of apples would continue to climb. Double-digit percentage increases in health insurance premiums have become commonplace, even while overall inflation remains at or below 4 percent. From 1958 to 2002, there were only two periods (the high-inflation eras of 1973–74 and 1979–80) during which prices for nonmedical items rose faster than prices for medical care.

Since third-party payers end up paying those higher costs, they have attempted to constrain unnecessary spending with administrative controls that interfere with patients' medical decisions and how providers practice medicine. In other words, they create bureaucracies to constrain the consumption of patients who would constrain themselves if spending their own money. Managed care is a predictable outgrowth of third-party payment. Moreover, third-party payment diminishes national savings because people have less incentive to save for their future health needs. The distortions created by the tax code alone impose a deadweight loss on the economy of \$106 billion per year.

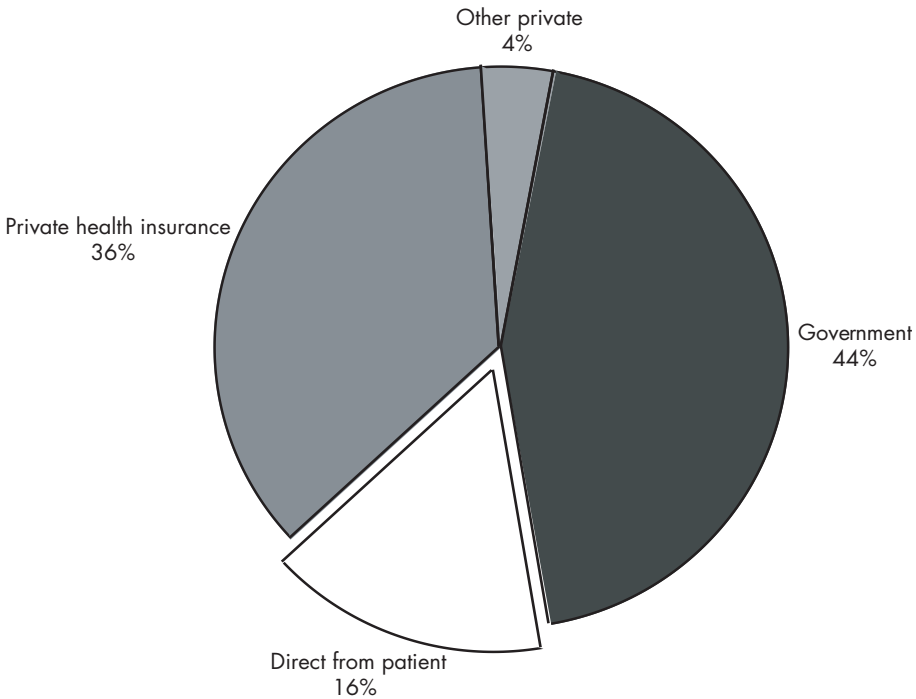
Government health programs (chiefly Medicare and Medicaid), which provide medical care to roughly 27 percent of the population at reduced

or no cost, have similar effects on consumer behavior. (Medicare and Medicaid are examined more closely in Chapter 8.) All told, 84 cents of every dollar spent on personal health care in the United States comes from someone other than the patient (see Figure 7.1). Despite enjoying the world's freest health care system, the United States pays for a greater share of its health care through third parties than do 17 other developed countries, including Canada and other socialist systems.

Tax Reform Is Health Care Reform

The primary goal of health care reform must be to eliminate government-imposed incentives for third-party payment. Ideally, the tax code would treat health expenditures like any other expenditure. If government imposes a tax, its purpose should be to raise revenue, not to favor some behaviors over others. However, merely repealing the current tax exclusion is politi-

Figure 7.1
Sources of Payment for Personal Health Care Expenditures, 2002



SOURCE: Centers for Medicare & Medicaid Services.

cally unfeasible and would amount to an enormous tax increase, as previously untaxed activity would become subject to taxation. (The exclusion provides a tax break estimated at \$189 billion in 2004.)

Fundamental tax reform will be necessary to eliminate the differential tax treatment of health-related and other expenditures. (For more on this topic, see Chapter 11.) The current federal income tax should be replaced with a flat, low-rate tax system that treats health and nonhealth expenditures identically. Individuals would then make health care decisions according to what provided them the greatest value, not the greatest tax benefit. Moreover, health insurers would have to compete aggressively for customers, and the control that insurers and employers currently have over patients would disappear. Fundamental tax reform may take many years. Nonetheless, America will not have a free health care market until the differential tax treatment of health expenditures is eliminated.

Health Savings Accounts

In 2003 Congress took a giant leap toward health care reform with the creation of health savings accounts. Cato Institute scholars first proposed health savings accounts in the 1980s and were leaders in popularizing them among the public and policymakers. Although health savings accounts do not eliminate the price distortions that follow from the differential tax treatment of employer-provided health benefits, they greatly reduce the incentives for third-party payment.

Health savings accounts extend preferred tax treatment to self-insurance via a personal savings account dedicated to routine medical expenditures. The savings account is coupled with a low-cost, high-deductible health insurance policy for catastrophic expenses. Individuals and their employers deposit funds in the health savings account tax-free. Whatever the account owner does not spend grows tax-free.

Health savings accounts will rein in health care costs by encouraging patients to curb their consumption. People are much more careful consumers when spending their own money than when spending someone else's. With built-in incentives for consumers to make wise choices, many of the restrictions that insurers have placed on patients will begin to disappear. Because workers own their health savings accounts, they will have coverage when they switch jobs and be better able to afford insurance on their own. Health savings accounts will also make health insurance more affordable for the uninsured. Seventy-three percent of enrollees in a pilot

health savings account program that began in 1997 previously had no health insurance.

As enacted, health savings accounts work as follows: Any American under the age of 65 who is covered by a qualified high-deductible health plan and who cannot be claimed as another's dependent for tax purposes is eligible to open a health savings account. A qualified individual health plan must have a deductible of at least \$1,000 and a limit on out-of-pocket expenses (including deductibles and copayments) of \$5,000. For families, the deductible is at least \$2,000 and the out-of-pocket limit is \$10,000. Only preventive care coverage is allowed below the deductible, though coverage for accidents, disability, dental, vision, and long-term care is also permitted.

The health savings account owner, her employer, a family member, or any combination thereof may contribute to the account. Annual contributions are limited by the health insurance deductible, with an upper limit of \$2,600 for individuals and \$5,150 for families. Contributions are permitted until the owner turns 65. Those aged 55–64 may make additional “catch-up” contributions of up to \$500 in 2004, with the limit rising \$100 annually until it reaches \$1,000 in 2009. Health savings account funds may be invested in a variety of vehicles, including checking accounts, money market accounts, mutual funds, and certificates of deposit. Whatever funds the holder does not spend remain in the health savings account and grow tax-free.

Money withdrawn from a health savings account for medical expenses of the account holder, her spouse, or dependents is never taxed. However, health savings account funds spent on nonmedical items are subject to income taxes and an additional 10 percent tax. Upon the account holder's death, health savings account funds are transferred tax-free to the spouse or taxed as income if someone other than a spouse is the beneficiary.

Health savings accounts will be a disruptive influence. Consumers spending their own money will reveal different preferences (among insurance companies, medical professionals, pharmaceutical companies, and even public policies) than consumers who are spending someone else's money. Interest groups disfavored by consumers will try to save third-party payment by thwarting health savings accounts. Health savings accounts had barely been enacted before bills were introduced in Congress to repeal them. It is incumbent upon the federal and state governments to protect health savings accounts from defenders of the status quo and to strengthen those accounts so they may reform America's health care system from within.

How to Improve Health Savings Accounts

Many states have enacted health insurance regulations—requiring first-dollar coverage for certain treatments—that effectively prohibit many residents from opening a health savings account. Those regulations should be repealed, or at least rendered null with regard to health savings accounts. Further, states should allow residents to deduct their health savings account health insurance premiums from their state taxable income.

The federal government can do much more to make health savings accounts more flexible and widely available. First, it should allow individuals to deduct their health insurance premiums from their federal taxable income. Like state deductibility, this reform would bolster health savings accounts in the individual health insurance market. Second, health savings accounts should be open to all Americans, regardless of age or health insurance status. Health savings accounts are currently allowed only with high-deductible insurance and with specified limits on consumers' out-of-pocket exposure. Those who do not want or cannot obtain health insurance deserve the same access to health savings accounts as others. Likewise, an employer who cannot provide health insurance but can contribute to her workers' health savings accounts should have that option. Consumers, such as those who have built up large balances, also should be able to choose a larger out-of-pocket limit. There is no reason to limit consumers' choices in those areas. An individual should be permitted to open a health savings account on its own or in combination with any health insurance plan.

One reason to allow greater flexibility is to encourage more Americans to save for their health needs as opposed to handing their health care dollars over to a third party. Those reluctant to switch to a high-deductible health plan should be allowed to begin saving in a health savings account that would cover their deductibles and copayments. As they accumulate savings, many would gravitate away from third-party insurance toward higher-deductible plans. In South Africa health savings accounts may be coupled with any type of health insurance, and South Africans have responded by giving health savings accounts over half of the private health insurance market.

Third, contribution limits should be increased. In the absence of a health insurance requirement, health savings account contributions would have to be subject to some other limit. In general, annual limits should be set high enough for consumers to couple a health savings account with a true high-deductible health insurance policy and have no gaps in coverage.

For example, individuals could be allowed to contribute \$3,000 per year and purchase a health insurance policy with a \$3,000 deductible, while families could contribute \$6,000 per year and have a \$6,000 deductible. “Catch-up” contributions for those nearing retirement should also be increased by raising the maximum amount and lowering the age at which such contributions may start. Given employers’ continuing curtailment of retiree health benefits and the fiscal crisis that faces Medicare in the coming decades, the federal government should encourage all Americans to save as much as possible for their health needs.

Fourth, the penalty on nonmedical withdrawals is an additional price distortion that further encourages owners to purchase medical care instead of other items. Disbursements for nonmedical expenses should be subject to income taxes with no additional penalty. Finally, the federal government should retool health reimbursement arrangements and flexible spending accounts to make them more closely resemble health savings accounts. Principally, this means balances in those “accounts” should be the property of the worker that she can carry over from year to year and take with her upon terminating employment.

Those enhancements to health savings accounts will go a long way—but not all the way—toward focusing America’s health care system on the needs of consumers. Moreover, health savings accounts will ease the transition to fundamental tax reform. By habituating Americans to controlling their own health care, health savings accounts will mitigate the fear and dislocation that would result from going directly from the current system to one in which third-party payment receives no government encouragement.

Deregulating Health Care

Third-party payment is not the only way government distorts prices and robs patients and providers of their freedom to act. State and federal governments have enacted countless health care regulations that restrict the freedom of consumers and producers—often in response to the effects of previous government failures. Those include regulations governing health care facilities (hospitals, nursing homes, etc.), health professionals (doctors, nurses, and other providers), health insurance, pharmaceuticals, medical devices, and other products (through the Food and Drug Administration), and the medical liability system. Professor Chris Conover of Duke University estimates that the costs of such health care regulations exceed their benefits by two to one and impose a net annual cost on Americans

of \$169 billion. That is the equivalent of a tax of \$1,500 per household, or of eliminating the gross state product of seven states. By increasing the cost of health care, such regulations make health insurance unaffordable for more than seven million Americans.

The federal and state governments should deregulate the health care sector wherever possible. Chapter 8 offers reforms that would decrease the amount of regulation attributable to Medicare and Medicaid. Chapter 40 discusses deregulating the Food and Drug Administration. (See below for reforms that would decrease the cost of the medical liability system.)

With regard to health insurance, the federal and state governments should allow purchasers to buy health insurance regulated by the state of their choice. Currently, purchasers are largely bound to the regulatory regime of the state where they reside (large employers can opt for federal regulation). If free to choose health insurance policies without regard to state borders, consumers will avoid regulations that impose unwanted costs and favor states whose regulations better meet their needs. For example, it has been estimated that states have enacted 1,823 separate requirements that insurance cover particular items. If a consumer lives in Minnesota but does not want to purchase all 60 types of coverage mandated there, she could choose to purchase health insurance regulated by Idaho, which has the fewest mandated benefits (13) or by a state whose laws are aligned more closely with her needs. Consumers could also avoid other costly regulations, such as price controls that increase the cost of coverage for many individuals. The *Wall Street Journal* has noted that regulations in New York make health insurance about 10 times more expensive there than in neighboring Connecticut. Millions of Americans shopping online for health insurance and health insurance regulation would put enormous pressure on states to deregulate. The federal government should give Americans this right immediately, but states can do so for their own residents without waiting for Congress to act. Such regulatory choice could serve as a model for deregulating other areas of the economy.

Medical Liability Reform

Torts are an important protection against those who do or would injure us, yet many people complain—with some reason—that the medical liability “system” in the United States is out of control. Frivolous lawsuits are brought too often, damages are exorbitant, and the aggrieved patients receive only a fraction of the monetary awards. Many specialists (neurosurgeons and obstetricians, to name two) report that they cannot afford the

rising cost of medical liability insurance. Conover estimates that the U.S. medical liability “system” costs Americans \$81 billion per year net of benefits.

Many observers have called on the federal government to correct the situation through federal medical liability reforms. As discussed in Chapter 18, Congress is not constitutionally authorized to impose substantive rules of tort law on the states. Although the federal government may enact technical procedural changes, state legislatures are the proper venue for correcting excesses in their civil justice systems. The fact that medical professionals can avoid states with inhospitable civil justice systems gives them significant leverage when advocating state-level medical liability reforms, and gives states incentives to enact such reforms. That some states have done so demonstrates that they have the ability.

What reforms should states consider? Arbitrary caps on damages may reduce the costs of frivolous lawsuits, but they foreclose adequate relief in extreme cases and prevent patients from bargaining for greater protection. So-called loser pays reforms would often reallocate the costs of frivolous lawsuits to the correct party; however, this rule deters less affluent patients from seeking legal redress for legitimate grievances.

A more patient-friendly and liberty-enhancing reform would be to allow patients and providers to avoid the costly medical tort system through voluntary contracts. Providers could offer to lower their prices if the patient agreed to certain limits on compensation in the event of an injury. If not, the patient could pay the higher price or seek a better deal from another provider. As John Goodman and Gerald Musgrave argue in *Patient Power*, this could lead to any number of innovations. For example:

[O]ne sensible way to cut down on the litigation costs for simple negligence would be to have the hospital take out a life insurance policy on a patient prior to surgery. The hospital and the patient (or the patient’s family) could agree that if the patient dies for any reason, the beneficiaries will accept the policy’s payment as full compensation, even if there was negligence. The same principle could apply to other injuries, such as disability leading to a loss of income. Litigation costs would be avoided, and life insurance companies would have incentives to monitor the quality of hospital care.

In cases of ordinary negligence, patients could choose the level of protection they desired, rather than have that level (and the resulting higher prices) imposed on them by the tort system. Only in cases of intentional wrongdoing or reckless behavior would tort rules apply. As Goodman and Musgrave note: “The current legal system ignores contractual waivers

of tort liability. What is needed is a legal change requiring the courts to honor certain types of contracts under which tort claims are waived in return for compensation.’’

Suggested Readings

- Cannon, Michael F. ‘‘Health Savings Accounts: Making the Healthcare System Work for Women.’’ Independent Women’s Forum Position Paper no. 401, March 18, 2004.
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- Friedman, Milton. ‘‘How to Cure Health Care.’’ *Public Interest*, Winter 2001.
- Goodman, John C., and Gerald Musgrave. *Patient Power*. Washington: Cato Institute, 1992.
- Miller, Tom. ‘‘A Regulatory Bypass Operation.’’ *Cato Journal* 22, no. 1 (Spring–Summer 2002).

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