THE HERITAGE LECTURES

218

Assuring Affordable Health Care for All Americans

By Stuart M. Butler, Ph.D.

The Heritage Foundation

The Heritage Foundation was established in 1973 as a non partisan, tax-exempt policy research institute dedicated to the principles of free competitive enterprise, limited government, individual liberty, and strong national defense. The Foundation's research and study programs are designed to make the voices of responsible conservatism heard in Washington, D.C., throughout the United States, and in the capitals of the world.

Heritage publishes its research in a variety of formats for the benefit of policy makers; the communications media; the academic, business, and financial communities; and the public at large. Over the past five years alone The Heritage Foundation has published some 1,500 books, monographs, and studies, ranging in size from the 927-page government blueprint, *Mandate for Leadership III: Policy Strategies for the 1990's*, to the more frequent "Critical Issues" monographs and the topical "Backgrounders," "Issue Bulletins," and "Talking Points" papers. Heritage's other regular publications include the *SDI Report, Business/Education Insider, Mexico Watch,* and *Policy Review*, a quarterly journal of analysis and opinion.

In addition to the printed word, Heritage regularly brings together national and international opinion leaders and policy makers to discuss issues and ideas in a continuing series of seminars, lectures, debated, briefings, and conferences.

Heritage is classified as a Section 501(c)(3) organization under the Internal Revenue Code of 1954, and is recognized as a publicly supported organization described in Section 509(a)(1) and 170(b)(1)(A)(vi) of the Code. Individuals, corporations, companies, associations, and foundations are eligible to support the work of The Heritage Foundation through tax-deductible gifts.

Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

The Heritage Foundation
214 Massachusetts Avenue, N.E.
Washington, D.C. 20002-4999
U.S.A.
202/546-4400

Assuring Affordable Health Care for All Americans

by Stuart M. Butler, Ph.D.

The United States spends over 11 percent of its gross national product on health care. That translates into more than $2,000 per person each year – more than the per capita GNP of many countries. Yet although the U.S. spends far more than any other country on health care, there are gaping holes in the system's coverage, and health care services are gripped by runaway inflation. As many as 37 million Americans lack adequate insurance against health care cost, and many others who have insurance still dread the financial impact of a serious disease.

How can America be spending so much on health, and yet have a system with so many shortcomings? The reason is that the system has been built upon unsound foundations. Each time we have tried to deal with a particular health care need, we have added on a new component without addressing the underlying problems. But when a house is built on bad foundations, adding on extra rooms leads to continuous and expensive repairs – and the possibility of collapse.

PROBLEMS WITH THE U.S. HEALTH SYSTEM

There are three serious underlying problems with the current health care system. First, it actually invites runaway costs. For historical and tax reasons, health care benefits are provided to most Americans through their employers. These benefits are tax-free income, and most employees pay little or none of the premium costs out of pocket, and they have little knowledge of the actual costs of the services they use. For the worker, these services are essentially "free," and so he or she has little reluctance to demand them. Similarly, the hospitals and doctors who provide health care services know that the patient will pay little or none of the costs. Consequently, they have little incentive to avoid prescribing costly procedures, even if these are of marginal benefit. The net result is a tendency for prices in the health care area to rise very rapidly because neither provider nor consumer is sensitive to cost. Consumers not covered by tax-free employer plans, on the other hand, generally have to pay for their health care in after-tax dollars. Thus a self-employed person, a worker in a small business not covered by a plan, or the dependent of a worker not included in a company plan faces much higher costs for the same insurance than someone covered by a company plan. This tax dynamic within the insured health care market also pushes up costs for all Americans, insured or uninsured, rich or poor.

The second problem is that the direct and indirect assistance provided by government does not channel the greatest help to those who need it most. The tax code, as mentioned, favors company-based health plans. Thus individuals purchasing their own insurance for

---

Stuart M. Butler, Ph.D. is Director of Domestic Policy Studies at The Heritage Foundation.

He spoke on October 2, 1989, at Meharry Medical College, Nashville, Tennessee, at their conference, "Health Care for the Poor and Underserved."

ISSN 0272-1155.

health care needs and employees and dependents not covered under company plans face higher costs for obtaining protection. This cost differential tends to make insurance comparatively more expensive for lower skilled workers and their dependents. In addition, Medicaid is linked to the welfare system. Thus a poor family which stays intact and off welfare is, in many states, ineligible for most government-funded health services.

Third, we in the U.S. are very reluctant to require households to protect themselves against health care needs. Thus we find many individuals and families, particularly among the young, who decide to use their income for other objectives than health care insurance, even though they have the means to obtain insurance without cutting back on other necessities. Often these are individuals who are healthy. They are playing Russian roulette with their continued good health.

The result of these problems is the system we have today, in which many Americans find it financially difficult to obtain the protection they need against the financial impact of illness. The very rich and the very poor, who are insulated by income and tax breaks on the one hand and welfare-based government assistance on the other, generally have adequate protection. It is the child of a worker in a large company not covered by the firm's plan, the employee of a small firm, or some similar blue-collar or even middle-class individual who risks falling into the gap of an uninsured illness.

"SOLUTIONS" THAT WILL NOT WORK

Many ideas have been put forward to address this problem. Increasingly, pressure is building for some kind of national health insurance system in America. I believe that eventually the U.S. will have a "national health system," in the sense of a system that assures each citizen of access to affordable health care. At issue is the kind of national system we should have. Unfortunately, many of the seemingly attractive proposals being offered have such serious side effects that they would be a step backward.

Government-Funded Systems

Consider the government-funded national health systems such as those found in Britain and Sweden. The system in Canada, now so fashionable as a proposed panacea, is similar to these European models established many years ago. In these systems, all citizens have virtually free access to hospitals and physicians, and government pays the cost. In Britain, even millionaires and royalty can, if they wish, receive free medical care.

The problem with these systems is that, with government controlling the purse strings and a system that is free at the point of consumption, demand for services always outstrips the supply. Thus Britain has for many years functioned on a triage principle. Rationing based on such factors as age and political sensitivity in practice determine who gets what services. In addition, long waits – sometimes months or even years for services that would be treated as urgent in the U.S. – are endemic to the British system. Canada is twenty-five years behind Britain, but we are beginning to see the same system of rationing and shortages slowly emerge within the Canadian system.

Employer Mandates

While most Americans would be reluctant to accept the endemic shortages and explicit rationing of a national health service, many are drawn to the idea of requiring employers to provide full coverage to workers and their families and mandating large employers to subsidize the health care needs of small firms and the unemployed. Such proposals admittedly are politically attractive. There always has been an assumption in the U.S., usually encouraged by politicians, that services provided by an employer are somehow the proverbial free lunch. A budget-strapped federal government understandably is drawn to the idea of shifting the potential cost of programs to the private sector. Unfortunately, there are serious hidden costs associated with such a mandated benefits strategy.

The underlying problem with the approach is that costs may be hidden, but they are still there. If an employer is required to provide medical care coverage for an employee and his family, you may be sure that the potential cost of this mandate will be taken into account in hiring practices. Thus when a job applicant mentions that he has four or five children and his wife is without work, for example, the employer translates that into an enormous potential health care cost. Thus there will be a strong tendency for firms to avoid hiring the very people that the mandated benefits strategy is designed to help. With mandated benefits, the danger is that someone with a job but no insurance today will end up tomorrow with no insurance and no job either. Similarly, a mandated benefits approach would tend to put the greatest hardship on small employers, precisely those who generate the most jobs and create the most employment opportunities for the least skilled Americans. Thus a mandated benefits approach would have the unintended consequence of eliminating economic opportunity for many lower paid Americans without significantly increasing the health care services available to them.

These practical considerations regarding mandated health care benefits, moreover, fail to deal with a deep philosophical issue: Why should employers have the responsibility for the good health of their employees? Employers are not expected to guarantee an adequate diet for their employees, nor are they expected to provide good clothing, good shelter, or a good education. It may seem pragmatic to require employers to provide care, but unfortunately recent debate over mandated benefits has been accompanied by the thesis that employers have some moral responsibility for the health needs of employees. Yet there is no ethical argument for this – and a far stronger argument for households themselves to take the primary moral responsibility for meeting their own health needs.

THE HERITAGE PLAN

The fundamental defects of the existing system and the serious flaws in most solutions to the problem of uninsurance has led The Heritage Foundation to propose a national health system based on very different foundations. Developed in detail in a new monograph, *A National Health System for America*, the Heritage plan aims at achieving four related objectives:

- ♦ ♦ All citizens should be guaranteed universal access to affordable health care.
- ♦ ♦ The inflationary pressures in the health industry should be brought under control.

◆ ◆ Direct and indirect government assistance should be concentrated on those who need it most.

◆ ◆ A reformed system should encourage greater innovation in the delivery of health care.

The Heritage plan has several key components:

1) Change the tax treatment of health care.

The plan would treat all health care benefits provided by employers as taxable income to the employee. Thus it would end the personal income tax exclusion for company-based health plans. But the plan would then provide above-the-line tax credits directly to households to protect them from the unreasonable financial impact of health insurance or out-of-pocket health costs. Specifically, a 20 percent credit would be provided for all insurance purchases that met basic requirements (such as covering catastrophic health costs). In addition, a steeply rising credit would be available for out-of-pocket health care spending by a family. This credit is related to health care costs as a percentage of family income. The higher expenditures were as a percentage of family income, the higher the percentage credit.

In addition, a credit would be available for households to purchase insurance or pay for health care costs for dependents. The rule for dependents under this plan, however, would be far more generous than under normal dependency tests. Thus a parent might obtain a credit for covering the health needs of older children living away from home or a grandchild not covered by some other plan, even though they might not be considered dependents under the normal definition.

Impact of the Incentives. This change in the tax code would have a very significant impact on the health care market. By shifting the tax benefits away from employer-provided services and to the individual, the plan would give the same tax incentives for all health care coverage regardless of the type of employment of the family earners. Thus the worker in a small business or one who is self-employed would have the same tax benefits for health care as the employee in a Fortune 500 company. Not only would this provide a powerful incentive for insurance to those who currently have no such incentive, but it also would allow households to shop around for the best plan to meet their needs. By obtaining a larger credit for out-of-pocket expenses than for insurance premiums, Americans would have more incentive to pay directly for routine, modest health expenditures and to reserve insurance protection for potentially heavy costs. As consumers thus became more sensitive to these incentives, they would spur far stronger competition within the health care industry, helping to keep costs under control.

This heightened competition would be a fundamental departure from the current system, in which competition spurred by the consumer is minimal. This proposed tax change also would have a dramatic effect on the current uninsured. Because it would target tax benefits to individuals, especially those with the greatest need, Americans who now lack the means to obtain insurance would have assistance – in some cases very generous assistance – in obtaining proper protection and defraying their out-of-pocket costs.

Consumer Ignorance? Many health analysts worry that a consumer-based model will not work in health care, because most Americans have little expertise in medical questions, and often such services must be purchased in an emergency situation. But these concerns overlook the way competition and consumer choice would operate in the Heritage model. In practice, there would be two levels of competition. Spurred by larger tax credits for out-of-pocket health expenses, more Americans would pay directly for routine service now often covered by insurance, such as dental work, eyeglasses, annual physicals, and treatment for minor scrapes and bruises. In these cases, the required medical knowledge is small, and consumer choice would be based on such issues as cost, waiting time, and other important, but usually nonmedical features of the service.

But competition and consumer choice would also work effectively among insurers, despite limited medical knowledge among buyers. When an individual buys a new car, he rarely has any technical knowledge of the carburetor design or the specifications of the transmission, and yet the impact of consumer choice is felt strongly by manufacturers. The reason? The car buyer is purchasing something he rates as a "package." He obtains informed opinions of the package as a whole and judges accordingly. It is this consumer choice that forces competing manufacturers to make very detailed decisions on specifications. Thus consumer choice, although limited in knowledge, forces highly informed decisions by insurers – and also by hospitals and physicians wishing to be included in an insurance package.

Bringing Down Costs. Other analysts are concerned that incentives to encourage individual insurance will mean higher insurance costs for families, since individual insurance today is more costly than group plans. Again, this concern arises from a misconception of the workings of insurance. In the first place, individual insurance today is the exception, and usually the buyer is a person who for some employment or health reason is not part of a group. That makes serving the individual expensive. But if all families were individually insured, the economies of scale would bring costs down to the cost level routinely found in today's group plans.

The second reason the fear is groundless is that, in fact, insurance probably would continue to be provided through groups, since both buyers and sellers would find it to their advantage. Very likely the larger employers would continue to administer plans, since employees would find it convenient. But the tax benefits would go directly to the employee. So a worker would not be trapped in the company plan if it did not provide the right mix of benefits for his family at the best cost. He might choose instead to join a plan administered by his union (indeed, that could be a powerful recruiting tool for unions), or just a local HMO. A farmer might turn to a state Farm Bureau plan. The point is that groups would form, and families would have freedom of choice without losing tax breaks.

A final worry about a consumer model is that insurance companies would "cream" the market. Insurers would want to serve only healthy people and ignore the rest. This is nonsense. Some insurers certainly would specialize in low-risk families, and the market no doubt be intense. That would drive down insurance costs for healthier Americans. But other insurers would specialize in higher-risk people – at a higher price. Just as it does for life insurance, the market would offer differently priced plans for different medical histories, and the services covered would be tuned to the segment of the market being sought (an improvement on the "one-size-fits-all" plans normally offered by employers). Would this