

# U.S. Health Care: A Call for Time and Debate, Not Action

By Dr. Timothy G. Nash, Dr. Keith A. Pretty, and Mr. Will Freeland

“Distrust and caution are the parents of security.” Benjamin Franklin

## Introduction

Numerous polls indicate the vast majority of Americans are satisfied with their health care. In fact, the Gallup organization released noteworthy data early this September from a series of public opinion polls on health insurers and health care they conducted between 2006-2008. The report sheds light on why the President is having an uphill battle to reform our health care system. Simply put, the data shows people seem to like their health insurance. According to Gallup, 82% of Americans covered by Medicaid and Medicare and 87% with private insurance view the quality of their health care as good or excellent. When asked to rate the actual insurance plan, 74% of Americans on government plans and 75% with private insurance rate their insurance plan as good or excellent. In addition, a late September Rasmussen Poll showed only 42% of Americans support the President’s health care proposal with 59% of senior citizens opposing it. The President is correct that our health care system is in need of change, even reform. The question is to what degree? While the Gallup poll certainly does not indicate a need for “historic change,” it doesn’t address all of the legitimate concerns the President and others have regarding rising costs, efficiency, competition and the effect “change” will have on our general standard of living now and into the future. We have analyzed as many of the pressing

issues in the current health care debate as possible in this paper and hope to offer a calm, rational solution to our short and long term needs as individual citizens and as a nation.

## The Problem

Spiraling costs and inefficiencies threaten the very structure of our health care system and are at the heart of the current debate. In 1966, health care in general consumed roughly 5% of U.S. GDP, and Medicare/Medicaid represented 1% of total government spending. Today, health care consumption represent 16.8% of GDP, and Medicare/Medicaid now consumes 20% of total government spending. Furthermore, studies show that the government spends eight times more on health care than on education and 78 times more on health care than is spent on law enforcement. These figures create real concern over the health care spending value proposition and government spending in general.

Since its inception in 1965, the Medicare tax rate has been increased seven times to cover rising costs. Couple these rising costs with the declining birth rate relative to working and retiring Americans and you get a fuller, and bleaker, picture of the issue. Today, there are 3.7 Americans paying into Medicare for every 1 receiving benefits. For Americans in their mid-40's, the ratio will drop to 2.4 to 1 by the time they retire, insuring future tax increases and more urgent debates regarding the system's financial solvency if things do not change. According to the American Enterprise Institute, Medicare will have a \$37.8 trillion dollar shortfall between projected spending and revenue over the next 75 years. Medicare is the focal point of the long-term entitlement spending crisis, a fact those who advocate a public health care plan prefer not to mention. But the issue must be addressed.

A recent *Atlantic Monthly* article reported an increase in per capita health care spending from 2000 to 2005 in Canada of 33%, France 37%, and the United Kingdom 47% (each have government-run health care systems). Costs in the United States rose 40% over the same period. These figures show U.S. cost increases are in line with supposedly more cost efficient government-run systems. For an example closer to home, those who claim government-run plans lower costs and increase coverage should consider Massachusetts. In 2006, under Republican governor Mitt Romney, Massachusetts passed into law one of the most far-reaching attempts to reform health care since the Clinton plan of the early 1990's. The Romney plan predicted health care insurance premiums would decline by 25-40% with greater state involvement. However, the projection now is that health care insurance premiums in Massachusetts will have increased annually at 8.8% (2007-09) since the adoption of the Romney plan in Massachusetts while the national average over the same period increased only 5.7%. Nationally, health care premiums for a family of four average \$12,700; a family of four in Massachusetts pays \$16,897.

According to the latest U.S. Census Bureau figures, 45.6 million Americans do not have health care insurance, down from 47 million in 2006. Out of control costs and the fact that more than 15% of the U.S. population are uninsured represents the crux of today's health care problem and a reason for change. Once again we ask the question -- how should change take place? According to June O'Neill, former director of the Congressional Budget Office (CBO), an in-depth look at the 45.6 million uninsured American reveals the following facts:

- Most of the uninsured are young and healthy

- 12 million Americans are eligible for Medicaid and the State Children's Health Insurance Program (S-CHIP) but have not enrolled
- 10 million “Americans” are at least technically not Americans with 5.6 millions being illegal immigrants and 4.4 million being legal immigrants but not citizens
- just under 20 million have household incomes of \$55,125 or higher with 15.5 million earning household incomes in excess of \$66,000

Other studies take considerable chunks out of the 45 million uninsured. Professor Mark Pauly of the University of Pennsylvania and Professor Kate Bundor of Stanford University published a study showing that almost 75% of uninsured Americans could actually afford health care insurance but chose not to purchase it. Finally, research conducted by Cato Institute policy analyst Michael Tanner finds most Americans who are uninsured do not remain that way for prolonged periods. Tanner concludes that of the uninsured only 30% remain so for more than a year, approximately 16% for two years, and less than 2.5% for three years or more.

## The Solution in the Short Run

Based on the above analysis, we believe the vast majority of Americans currently uninsured can be insured while bringing down health care costs and increasing efficiency if the following five suggestions are adopted. Our plan provides needed time to ponder and debate a rational, long-term solution like the one proposed toward the end of this paper.

### 1. Invention and Innovation

All reform proposals should be focused on innovation in medical technology, pharmaceuticals, and the organization of firms in the health care industry. The greatest

progress in medical technology and pharmacology has taken place in the free market and not under government-control. Breakthroughs ranging from biosynthetic insulin and new cancer therapies to first-ever treatments of severe sepsis are being discovered. The U.S. is the undisputed leader in the treatment of most forms of cancer with survival rates that are the envy of the world. Reform proposals must not inhibit advances that will improve life expectancy and quality of life for Americans.

The average life expectancy at birth in the U.S. today is 78; in 1928, it was 57. In the last two decades of the 20<sup>th</sup> century, new medicines accounted for 40% of the increase in life expectancy according to a Columbia University study. In the fifty countries examined in the Columbia study, new medicine was responsible for 5 months of every additional year of life expectancy.

It is essential to recognize the prerequisites for innovation. Adequate funding alone is not enough. A reform plan that focuses on facilitating innovation through government directed capital investment is not one that maximizes and leverages human creativity and ingenuity. Innovation in health care, much like any other field, requires a stable system of rules that allows entrepreneurs to plan effectively; markets that are largely free from government intervention, which clouds the signals that prices communicate; unbiased competition governed by the blind eye of the impartial law; capital markets that are allowed to flow freely; and a system that embraces both profit and loss, rewarding prudent business decisions and penalizing poor ones.

Only a plan that embraces free markets and innovation through spontaneous order can provide these elements, which are absolutely necessary to maximize human potential. History has proved that centralized decision-making by enlightened bureaucrats is

systemically flawed. Planners lack the requisite information and incentives necessary to foster the market's maximum potential. Of particular concern are the criteria used by planners and politicians in choosing the "winners" who are to receive government capital investment and monopolies and the "losers left to fend for themselves on an uneven playing field. Tempted with favors, contributions and other enticements offered by firms most able to supply them, bureaucrats may very well award funds to less innovative firms and not to those with the most potential for breakthroughs in health care technology. Planners also lack the incentive to take big risks in research and development. These planners have no profit incentive that compensates taking big risks with the potential of big rewards. The incentive is to avoid errors and in so doing, planners promote stagnation, the safe route, the status quo, and not the entrepreneurial risk-taking that is the heart of any vibrant economy.

A free market relies on the self-interest of entrepreneurs and venture capitalists, not bureaucrats and politicians. Only a free market system can insure the continued progress in medical technology that has so dramatically increased our life expectancy and standard of living.

## 2. Tort Law Reform

Lawmakers and analysts who claim that medical liability lawsuits do not contribute significantly to rising health care costs are wrong. If one considers a 2006 Harvard School of Public Health study, you would find that 4 out of every 10 medical malpractice lawsuits filed in the United States each year are "without merit." Medical providers must defend against these lawsuits, which impose costs on doctors, hospitals, and insurers who often go out of business or pass the cost of said lawsuits on to the consumers of healthcare.

A recent Massachusetts Medical Society survey published in November 2008 found that 83% of Massachusetts physicians said the fear of being sued was the main reason for their practicing defensive medicine. The study went on to say that doctors reported 18-28% of tests, procedures, referrals and consultations, and 13% of hospitalizations were ordered to avoid lawsuits. Studies indicate the annual cost of defensive medicine could be as high as \$200 billion annually. According to the consulting firm Towers Perrin, the tort system imposed \$252 billion in costs on the U.S. economy in 2007 alone. Many experts believe that costs will decline sharply if plaintiffs who file frivolous lawsuits were simply required to pay the legal costs of defendants found to have done nothing wrong, which is common practice in most of Europe. Many politicians are eager to impose limits on how much doctors can earn, but are unwilling to impose limits on how much lawyers can earn from often frivolous lawsuits.

### 3. Interstate Commerce – Allow for Across State Borders Sales of Health Insurance

Americans are able to purchase life insurance, automobile insurance, and homeowners insurance across state borders in order to get the best value for each dollar spent. If the same opportunity to purchase across state borders were afforded to individual consumers of health insurance, we believe the result would be dramatically lower average prices across the system, increased quality and coverage, and greater competition and efficiencies. Most Americans do not realize that they cannot purchase health insurance from another state like they can life and automobile insurance; furthermore they do not realize that many states have excessive regulations and mandates that lead to inefficiencies and high costs. Open trade among the states, or interstate competition, made the U.S. the world's most efficient

consumer-driven marketplace. Even states compete against each other in attracting business with variations in regulations and taxes. Why do we not allow the same with health insurance? Allowing companies to sell health insurance across state lines is an excellent idea and has been brought before the U.S. Congress since at least 2005. Consider that a 25-year-old male in New Jersey paid \$5,880 annual year for health care coverage while the same person would have paid only \$1,000 for duplicate coverage in Kentucky in 2006. There are 1300 insurance companies across the United States providing health care insurance plans. We believe that Americans should be able to choose the best policy option from any of these providers, not just ones located in their own state. A University of Minnesota study estimated that if an individual from New Jersey could purchase health insurance across state lines in a national market, 49% more New Jerseyans would purchase health care and much of the individual and small group market would then have coverage. Allowing companies to compete across state borders would produce a more rational regulatory policy in all states and reduce costs considerably.

#### 4. Tax Treatment

In the book Economics: Private and Public Choice by James Gwartney and Richard Stroup, the authors note that employee health insurance purchased through a company plan is tax-free. Yet medical bills and personal health insurance policies must be paid for with after-tax income. This encourages third party payment of medical bills and low co-payment insurance plans. Their solution to this inequity is to equalize the treatment of out-of-pocket medical costs and the direct purchase of health insurance with health insurance purchased through an employer plan. This problem can be corrected by making out-of-pocket medical

expenses and the purchase of personal health insurance fully tax deductible. However, deductibility may not be of much value to low income taxpayers or for those filing their federal income tax on a 1099 EZ form. These taxpayers would probably be better served by tax credits, which would ensure greater consumer choice and a market-based health care system.

## 5. Technology

Management information systems in the health care business need to catch up with those in consumer-driven market facing industries like banking. The health care industry needs to improve data collection and decision making or the government will mandate a common standard of reporting and disseminating data. We need to arm consumers, doctors, and hospitals with information. A standard needs to be created calling for a high level of transparency on services performed, pricing, results and customer satisfaction. This free flow of information would create a more competitive market in health care where consumers would vote for their health care with their feet and their checkbooks. A consumer armed with the relevant data and freedom of choice will prevent entrenched hospitals from hiding behind bureaucracy and red tape. New computer systems need to be developed that are sophisticated enough to take information and provide alternatives relative to quality, treatment and cost. Many barriers to entry exist in health care simply because computer information systems often have trouble communicating across a single hospital, let alone throughout the industry. Private health care organizations and associations can and should lead in the development of such standards before they are mandated by the government. The

business case for consumer-driven information systems in health care is obvious; where the mandates will come from is not.

## The Solution in the Long Run

If we want to improve efficiency and avert a long term health-care crisis, the current system must be reformed. The following proposals are based on research by Gwartney and Stroup and will lead to more direct payment (and less third-party payment) of health-care expenses, lower the cost of catastrophic insurance protection (higher cost for low deductible, high co-payment coverage), and promote greater reliance on expanding the supply the medical services not stimulation of demand.

### 1. Enhance Market-Based Competition

The U.S. health care system is experiencing rising prices and out-of-control expenditures because public policy relative to health care is devoid of rational economic thinking. Health care in America is lacking a system of incentives that cause consumers and providers to economize and send market-based pricing signals. Third-party payments of health care expenses and employer subsidized health care insurance need to be curtailed or eliminated. If consumers were more responsible for obtaining and paying for their own insurance, health care markets would be more efficient and less costly to obtain for all consumers, especially people without jobs. If market-based reforms are not allowed to be implemented by the private sector, the government will certainly intervene with more regulations, including price controls and rationing to counter soaring costs. Intervention of this type has occurred in numerous countries and surely will be modeled here without such reforms. We believe it is impossible to centrally regulate the health

care industry as it is too large, varied, and complex. We also believe the results of such central regulation would be inefficient and ineffective. True reform can only be realized by a free market-based solution led by private sector invention and innovation.

## 2. Enhance Consumer Choice

On average, U.S. consumers pay less than 16% of their total health care costs out of their own pocket. If health care reforms were structured in such a way that consumers spent their own money, they would be more frugal and thoughtful in their choices, providing suppliers at all levels stronger signals and incentives to reduce costs and enhance quality. If this is true, how can a system that will enhance consumer choice and provide more robust competition be developed? We suggest that three changes to our current health care public policy must come out of Washington to enhance consumer choice.

First, our public policy must encourage greater use of health savings accounts (HSA's) for the payment of medical bills. Health savings accounts allow qualified individuals to make tax deductible deductions of \$2,850 per year for a single person and \$5,650 for a married couple to a savings account which will cover future bills. We propose that employers making contributions in an employee's name to an HSA be allowed to deduct it as a business expense.

Second, reforms must encourage purchase of catastrophic health care insurance void of multiple mandates while discouraging purchase of policies with small co-payments and payment of first-dollar expenses. Insurance is designed to protect against catastrophic risks. These insurance "pooled" dollars would insure against loss from an unpredictable and/or uncontrollable loss. The

premiums of those not suffering losses under such a program will offset the losses of those negatively impacted (just like home-owners or automobile insurance). HSA's were created to be used with high deductible, modest co-payment insurance plans that can be purchased at a reasonable cost. Severe injuries or catastrophic illnesses like diabetes or cancer generally fall into these categories. Gwartney and Stroup note that high deductible policies as an example cover all or most medical expenses above \$3,000 per year and are relatively inexpensive to purchase in a competitive market. In 2005, a policy of this nature was \$1,600 a year and would be affordable to most Americans with the proper tax credit structure in place.

Third, public policy must shift as much of Medicare as possible from a reimbursement system to a defined benefit plan. Individuals covered by Medicare would receive a set dollar amount to directly pay medical bills and to purchase private medical insurance. All medical patients would be required to have a catastrophic insurance plan. Money not used in a given year would be rolled over for use the next year or into the future. This would allow for greater choice in medical services and the optimal payment system for each individual.

## Conclusion

If politicians and the American public paused and reflected on insurance in general, they would discover that all other insurance they purchase is made to protect against potential catastrophe. Automobile insurance does not cover gasoline or tune-ups, and home owners insurance does not call for the reimbursement of utilities or food. These policies are sought to protect against the potential of catastrophic loss from a fire, accident or the like. Why should we not have similar choices with health insurance? Consider the following areas in our current health care industry

where most transactions take place directly between consumer and provider with little if any third party insurance involvement. They provide reason for optimism regarding the above noted reforms. According to an Eye Surgery Education Council survey released in 2003, Lasik eye surgery has had a declining cost curve since 1995, with 93% of the patients satisfied with the results and 85% saying the surgery improved their quality of life. According to George Mason University Economics Professor Alex Tabarrok, "Laser surgery has the highest patient satisfaction ratings of any surgery and continues to improve in quality over time." In their book, *The Business of Health* (2006) Robert L. Ohsfeldt and John E. Schneider determined medical service fees increased 73% and health care costs increased 71% from 1992 to 2005, while the Consumer Price Index increased only 40% and the cost of cosmetic surgery increased only 20%.

The current U.S. health care system does not take full advantage of the efficiencies of market forces while many reform advocates exaggerate the case for greater government involvement in and regulation of our health care system. We often fail to consider that when normalized for murder and obesity (factors outside of the influence of health care insurance) U.S. life expectancy is the highest in the world according to Ohsfeldt and Schneider. While our proposed reforms will not provide universal care, they will go a long way toward resolving our health-care problems in a sound economic manner that will not harm the efficiencies, productivity and foundation of our current health care.

Dr. Keith A. Pretty is President and CEO of Northwood University; Dr. Timothy G. Nash holds the David E. Fry Chair in Free Market Economics at Northwood University; Mr. Will Freeland is a Senior Economics Major at Northwood University.