25. Health Care

Congress should

- increase the number of medical savings accounts;
- create a universal tax credit for health care;
- avoid additional health care regulations, particularly restrictions on managed care and mandated insurance benefits; and
- complete Medicare reform.

On September 14, 1997, at a meeting of the Service Employees International Union, President Clinton claimed that he had achieved nearly 60 percent of what he had sought to accomplish through his 1994 health care plan. The president acknowledged that his attempt to remake the American health care system with a single piece of legislation may have been ''too ambitious'' but said that he was now accomplishing his goal ''a step at a time.''

Even allowing for a certain amount of presidential hyperbole, there is all too much truth in Clinton's claim. Over the last three years Congress has shown itself willing to enact major portions of Clinton's health care plan, in some cases even going further than the original proposals, in increments.

But bad health care policy adopted incrementally is still bad health care policy. Slowly but steadily, the federal government is assuming control over the American health care system.

The reason for the lamentable condition of the debate over health care reform is the failure of opponents of government-controlled health care to articulate a vision of free-market reform. There are, after all, still serious problems with the American health care system. Health care still costs too much, and after a period of relatively stable health care costs, those costs are once more beginning to rise. Approximately 41 million Americans lack health insurance, more than when President Clinton launched his

health care proposal. More and more Americans find themselves forced into restrictive managed care plans, with their choice of doctors or treatments limited. All of the problems can be remedied by genuine free-market health care reform.

The ultimate reason for most of the problems facing the American health care system is that we do not have a free market in health care. We have—by and large—privately owned health care. But the health care market does not operate the way markets should operate.

There are two common characteristics of successful markets: (1) on the provider side, a wide variety of providers in competition with one another on the basis of price and quality and (2) on the consumer side, consumers attempting to receive the maximum quality and the lowest price, attempting to ''get the best deal for their dollar.'' Unfortunately, the American health care system exhibits neither of those characteristics. Providers have become increasingly cartelized, using government regulatory requirements to limit competition and mandated insurance benefits to guarantee a supply of customers. On the consumer side, because our third-party-payer system insulates consumers from the cost of their health care decisions, there is a strong incentive to ignore the cost of health care and overuse health care goods and services.

Medical Savings Accounts

The centerpiece of market-oriented health care is medical savings accounts (MSAs). With MSAs, only a modest portion of health funds is paid to the insurer for catastrophic insurance covering all expenses over a high deductible, perhaps $3,000 per year. The rest, perhaps $2,000 per year, is paid into an individual account for each worker. The worker can use the funds in the account to pay medical bills below the deductible amount. The funds can be used for whatever medical services or treatments the worker chooses. Whatever account funds the worker doesn't spend on health care can be withdrawn at the end of the year and used for any purpose.

With MSAs, therefore, workers are effectively spending their own funds for routine health care. As a result, they have full market incentives to control the costs of that care. They seek to avoid unnecessary care or tests, look for doctors and hospitals that provide good quality care at the best prices, and consider whether a health care or service is worth the cost. That, in turn, stimulates real cost competition among doctors and hospitals. Since consumers choose among them on the basis of cost as

well as quality, as in a normal market, providers compete to minimize cost as well as maximize quality.

As part of the 1996 Kennedy-Kassebaum legislation on health insurance portability, Congress enacted a limited experiment, allowing up to 750,000 MSAs. Congress followed that by allowing up to 590,000 Medicare recipients to participate in MSAs. However, those experiments contain the seeds of their own failure. By limiting the number of MSAs available, Congress greatly reduced the incentive of insurance companies to market the product. Therefore, it has become extremely difficult in some parts of the country to purchase an MSA policy. Congress compounded the problem by restricting MSAs to the small group and individual insurance marketplace. Moreover, the small number of MSAs means that there will not be sufficient market penetration to have a significant impact on overall health care costs.

Consequently, the next Congress should quickly pass a new MSA bill to fix those problems and finally offer MSAs to everyone.

A Universal Health Care Tax Credit

MSAs offer a starting point for free-market health care reform. But Congress should quickly go beyond MSAs to enact a fundamental change in the tax treatment of health care benefits.

A tax system should promote economic efficiency and be perceived as fair, and it should cost as little as possible to administer and comply with. In 1994 corporate America received more than $74 billion worth of tax subsidies for employee health insurance, according to the most recent Congressional Budget Office study of employment-based health insurance. At the same time, federal tax law prevents any of that tax subsidy from going directly to individuals. Worse yet, the current tax law allows employers, not consumers, to determine the selection of health care benefits. Approximately 48 percent of workers are offered only one health insurance plan. This one-size-fits-all tax policy forces many working Americans to accept the only health plan offered by their employer, or pay higher taxes. Individuals, not employers or government, should have the ability to choose something as personal as health care. That is why the current tax policy for health insurance should be reformed.

One way to reform the current tax subsidy would be to make health insurance tax deductible for all individuals. That policy would allow all Americans to deduct the cost of health insurance, regardless of whether it is purchased through an employer or individually. However, that policy could encourage overconsumption of medical care relative to other goods

and services, or savings. In particular, higher income families would be encouraged to overconsume health care because the value of the health insurance deduction rises with a family's marginal tax rate. That would further distort the health care marketplace.

Another way to remove the current distortion in the health insurance market would be to eliminate the tax subsidy for employment-based health insurance altogether. That policy would give consumers greater control over their health care plans. Repealing the tax exclusion would raise government revenues by $74 billion ($44 billion in income tax revenues and $30 billion in Social Security payroll taxes), according to the CBO. Those tax revenues could be returned to Americans by reducing the marginal income tax rate. According to CBO estimates, eliminating the tax subsidy would reduce the income tax liability for families without employment-based health insurance but would increase payroll taxes on most families with employment-based insurance. Those estimates, however, do not account for the fact that if the tax exclusion were removed, workers currently receiving employment-based health insurance could bargain with their employers for higher take-home pay. But until workers realize that they are receiving lower take-home pay in return for health benefits, it will be virtually impossible to repeal the current tax exclusion for employment-based health insurance. The majority of Americans who currently receive a tax subsidy for employer-sponsored health insurance would not be willing to give it up totally, even to help cover the uninsured.

The best way to reform the tax treatment of health insurance would be to implement a flat tax or national sales tax. Either of those taxes would render neutral the federal government's tax treatment of all goods and services, including health care. However, in the absence of fundamental tax reform, the most politically viable policy solution would be to implement a universal tax credit for health care.

Given the political difficulties of reforming the tax treatment of health care as part of comprehensive tax reform, the next best policy would be to eliminate the current tax exclusion and replace it with a universal tax credit. Unlike current tax exemptions, a universal tax credit would be neutral—it would not discriminate against those who purchase health insurance individually by giving a preference to those who purchase insurance through employers, nor would it reward those who pay for health care services through insurance rather than out-of-pocket. A universal tax credit would render neutral the government's treatment of health insurance taxation, thus allowing individuals to purchase health insurance and health care in the way that best meets their needs.

The credit amount should be a flat amount for all taxpayers. A flat tax credit for health insurance would most benefit lower income families. Here is why: The CBO estimates that the average tax subsidy for employment-based health insurance was $690 per family in 1994. The subsidy amount ranged from $10 for lower income families to $1,390 for families earning over $200,000. The universal health insurance tax credit policy would correct that by increasing the amount of subsidy for middle-income workers.

Second, by capping the total amount of the tax credit, we can minimize the amount of distortion caused by granting a tax preference to health care as opposed to other goods or services. While it is important to treat all health care equally, which the tax credit does, it is also important not to dramatically expand current distortions in the system.

While the tax relief for some families will be lower than that provided by the current exclusion, those families can compensate by moving to a low-cost, high-deductible policy combined with a tax-deductible MSA. Such high-deductible insurance plans make more economic sense in any event, leading to less health care consumption and lower costs.

In determining the amount of the tax credit, the first question to ask is, ''Should the new universal tax credit be budget neutral?'' Some advocates of less government would answer no. In fact, they would argue that there should be no ceiling placed on the amount of money that Americans can exclude from taxation for health insurance. But in today's political environment, where politicians seem unable to use projected budget surpluses to provide even modest tax relief, it is difficult, if not impossible, to implement a tax credit policy for health insurance that costs more than today's employer-sponsored tax subsidy. For that reason, we recommend a *budget-neutral* universal tax credit for health insurance.

A budget-neutral universal tax credit for health insurance could be implemented by distributing the current $74 billion tax subsidy equally among some 108 million families, at an average of $690 per family in 1994 dollars.

In designing the universal tax credit policy, four rules should be followed:

1. The health insurance tax subsidy should be distributed as tax credits, not refundable vouchers. Tax credits should be used because they are much more efficient than vouchers. If the tax subsidy were handed out in the form of vouchers, many Americans might come to view the health insurance voucher as a ''right,'' the way they

view Medicare. And if health care costs continue to climb as they have during the past few decades, consumers will likely demand higher voucher amounts to offset increased health insurance costs. Credits, on the other hand, have several advantages: they make the cost of health care more obvious to taxpayers; they lead consumers to demand more for their money; and they give consumers greater control over their health care choices. At the same time, credits reduce the amount of red tape necessary to distribute taxpayer-financed health care dollars.

2. The tax credits should be administered by the federal treasury and should be tied to the existing tax system. Under the universal tax credit policy, all taxpayers would qualify for a credit against their annual income tax for all or part of the amount they spent on (a) health insurance, (b) out-of-pocket health care costs, and (c) contributions to an MSA for the previous year. Also, the tax credit should be made available on all tax forms, including the E-Z forms. That would help lower income citizens who do not typically itemize their tax deductions. The tax credit could also be refundable.
3. Tax credits should go directly to individuals—not special-interest groups, such as the insurance industry—in order to avoid interest-group pressures. In the past, special-interest groups have heavily influenced programs that have relied on the federal government for monetary disbursements. For example, special-interest groups, including the American Medical Association, the American Hospital Association, BlueCross and BlueShield, and the American Nursing Home Association designed the Medicare program's administrative provisions. Senior citizens had very little role, if any, in designing Medicare coverage and payment systems. It is no surprise that Medicare restricts consumer choice.
4. Because the government should be neutral on where insurance is purchased and how health care is paid for, the tax credit should cover insurance (whether employer provided or individually purchased), contributions to an MSA, and out-of-pocket health care expenses. The credit could be used to pay for any health care providers or services currently allowed by the Internal Revenue Service.

All told, the universal tax credit for health insurance is an efficient and fair way to help Americans gain greater control over their health care choices. If one does not like the choice of providers and treatments covered by his employer-sponsored health insurance plan, then he is free to buy

another plan without paying higher taxes. That is especially important for the 48 percent of American workers who are offered only one health plan. The universal tax credit should be considered a viable policy option for covering the uninsured while restoring health freedom for all individuals.

Managed Care

There is no doubt that there is rising dissatisfaction with managed care. That is particularly true because, with our employment-based insurance system, Americans increasingly find themselves with little control over their insurance plans. In fact, 48 percent of U.S. workers report that their employers offer only one health care plan. Those plans often are health maintenance organizations (HMOs) or other types of managed care plans that limit the available number of physicians and treatments.

The result has been moves in Congress to regulate managed care, mandating the benefits that plans must offer and allowing individuals to sue plans if they are denied reimbursement for care. However, increased regulation is the wrong way to deal with the problems of managed care.

Health insurance mandates do not offer something for nothing. Mandating additional benefits drives up the cost of health care, increases the number of uninsured, and lowers wages. In their seminal work, *Patient Power*, John Goodman and Gerald Musgrave cite numerous examples of how mandates affect the price of health insurance. For example, they note that when visits to psychologists were mandated, health insurance premiums increased 10.4 percent. And also, when routine dental care was mandated, the average premium for health insurance increased by 23.8 percent. The increased price of health insurance, in turn, leads to a greater number of uninsured. That is because when individuals are forced to choose between an expensive, comprehensive health plan or no coverage, many healthy, young workers opt out of the health insurance market altogether. Of course, some workers have no choice—they simply cannot afford to purchase health insurance at current prices.

Mandated health benefits also reduce wages. Jonathan Gruber, professor of economics at the Massachusetts Institute of Technology, examined the effects of mandates for maternity care. He found that wages decreased by 5.4 percent for 20- to 40-year-old married women in states that passed mandates for maternity coverage. Not only did the maternity mandates lower women's wages, but the mandates also prevented individuals from buying a cheaper, less comprehensive health insurance policy.

Congress should, therefore, avoid any new regulation of the health insurance or managed care industries. Instead, Congress should expand MSAs and enact a universal tax credit for health insurance to give Americans control over the insurance marketplace.

Medicare

People who have not enjoyed the recent debates over Medicare should consider this: The fun has just begun. Until Medicare is fixed, this issue will only grow bigger and bigger.

Medicare has a fundamental structural problem. It makes grand promises but does not have revenue sources anywhere near sufficient to finance them. The government's own projections show that over the long run the program's current revenue sources will finance only about a third of expenditures.

Medicare Part A, the Hospital Insurance program, is financed by a flat payroll tax of 2.9 percent on wages. The latest projections by the trustees show that, under intermediate assumptions, paying all benefits to today's young workers in retirement will require a Medicare payroll tax rate of almost 9 percent. Medicare Part B, the Supplementary Medical Insurance program, pays doctors' bills and other health care charges. Monthly premiums paid by the elderly finance only about a third (31.5 percent) of the costs of this program. Taxpayers finance the rest out of general revenues.

By the time today's young workers retire, keeping the premiums at about one-third of Part B expenditures would require increasing premiums about four times relative to the income of the elderly today, again under intermediate projections. That means current premiums of almost $50 per person and $100 per couple per month would be increased to the equivalent of almost $200 per person and $400 per couple per month. Meanwhile, the Medicare Part B deficit financed by general revenues would alone be more than $309 billion per year.

And those projections may well be overoptimistic. They assume, for example, that the rate of increase in life expectancy over the next 75 years will be substantially less than over the last 50 years, while current and prospective advances in modern medical technology seem to suggest the opposite. Longer life expectancies, of course, would mean higher Medicare expenditures because retirees would be collecting benefits longer. The projections also assume that real wages will be growing twice as fast over the next 75 years as they have over the past 25 years. But if real wages

continue to grow at the slower pace, the payroll tax will generate less revenue than expected.

Congress must be honest with the American public. The current system is unsustainable and fundamental reform is necessary. It is a betrayal of congressional responsibility to allow this issue to become a partisan football or to allow fear of the seniors' vote to forestall needed changes.

In the short term, Congress can expand the Medicare reforms passed as part of the 1996 budget agreement, allowing seniors the freedom to opt out of the traditional Medicare program and purchase health insurance from the private sector. In particular, Congress should remove the cap on the number of seniors eligible to participate in MSAs.

Over the long run, however, Medicare must be transformed into a fully privatized system. Congress should allow young workers to divert their 2.9 percent Medicare payroll tax to purchase individual private insurance that would ''kick in'' at age 65. An early study by Professor Thomas Saving of Texas A&M University indicates that such a policy could be purchased by most young workers for far less than the current payroll tax. Of course, as with Social Security privatization, there are important transition questions about how to continue paying current beneficiaries. There are other issues that remain unresolved, but this idea clearly deserves further consideration.

Private-sector reform is the only hope for solving the otherwise intractable Medicare financing crisis. Such reform would again shift more power and control to the people, allowing them to gain greater control over their Medicare funds and use them to buy the health coverage and services that best suit their needs and preferences.

Conclusion

The nation's major health care problems must be quickly addressed by taking an approach that is the opposite of the one tried by the Clinton administration in 1993 and 1994. Instead of shifting ultimate control over the health care of workers and their families to the government and third-party insurance bureaucrats, Congress must fully restore control to workers and their families.

Suggested Reading

Blevins, Sue A. ''Restoring Health Freedom: The Case for a Universal Tax Credit for Health Insurance.'' Cato Institute Policy Analysis no. 290, December 12, 1997.

Ferrara, Peter. ''The Next Steps for Medicare Reform.'' Cato Institute Policy Analysis no. 305, April 29, 1998.

Goodman, John, and Gerald Musgrave. *Patient Power: Solving America's Health Care Crisis*. Washington: Cato Institute, 1992.
Saving, Thomas. ''Medicare Reform: In Search of a Permanent Solution.'' Private Enterprise Research Center, Texas A&M University, November 15, 1996.
Scandlen, Greg. ''Medical Savings Accounts: Obstacles to Their Growth and Ways to Improve Them.'' National Center for Policy Analysis Policy Report no. 216, July 1998.
Tanner, Michael. ''Medical Savings Accounts: Answering the Critics.'' Cato Institute Policy Analysis no. 228, May 25, 1995.

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