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

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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

mean higher costs for some Americans? Yes, but those higher costs would be offset by the larger credits under the Heritage proposal. Would the government lose tax revenue because the larger credits for more expensive plan? No, because although more revenue would be lost on more expensive plans, the revenue loss on low-cost plans for healthy Americans would be much lower.

2) Mandate all households to obtain adequate insurance.

Many states now require passengers in automobiles to wear seatbelts for their own protection. Many others require anybody driving a car to have liability insurance. But neither the federal government nor any state requires all households to protect themselves from the potentially catastrophic costs of a serious accident or illness. Under the Heritage plan, there would be such a requirement.

This mandate is based on two important principles. First, that health care protection is a responsibility of individuals, not businesses. Thus to the extent that anybody should be required to provide coverage to a family, the household mandate assumes that it is the family that carries the first responsibility. Second, it assumes that there is an implicit contract between households and society, based on the notion that health insurance is not like other forms of insurance protection. If a young man wrecks his Porsche and has not had the foresight to obtain insurance, we may commiserate but society feels no obligation to repair his car. But health care is different. If a man is struck down by a heart attack in the street, Americans will care for him whether or not he has insurance. If we find that he has spent his money on other things rather than insurance, we may be angry but we will not deny him services – even if that means more prudent citizens end up paying the tab.

A mandate on individuals recognizes this implicit contract. Society does feel a moral obligation to insure that its citizens do not suffer from the unavailability of health care. But on the other hand, each household has the obligation, to the extent it is able, to avoid placing demands on society by protecting itself.

3) Provide help to those who cannot afford protection.

A mandate on households certainly would force those with adequate means to obtain insurance protection, which would end the problem of middle-class "free riders" on society's sense of obligation. But of course there are many lower-income households who could not reasonably afford to meet that obligation and yet are not eligible for current direct assistance programs such as Medicaid.

Tax Credits. To an extent, the problems of affordability among these families would be dealt with through the system of tax credits outlined above. The Heritage plan also sees these tax credits as refundable – that is, a check would be sent to the family if the total credit exceeded the tax liability. In this way, families would receive direct assistance through the tax code to enable them to fulfill the obligation to obtain insurance.

Nevertheless, there are certain families for whom even this assistance is not sufficient. Families with a very long history of health problems, for instance, may find insurance prohibitively expensive, even with generous tax benefits. In these cases, the Heritage plan envisions an expansion of subsidized risk pools operated through the states. Many states have these plans, in which high-risk individuals are pooled together, and then insurers are invited to compete to cover the pool with rates subsidized by the government.

Using subsidized risk pools allows high-risk individuals to be subsidized by taxpayers in general. An alternative strategy – mandating insurance coverage without regard to risk – is attractive to some analysts, but it has the defect of pushing up rates for all insured individuals. Thus the cost of protecting the high-risk group is shouldered equally by all insured families. This is far more regressive than using the general tax code to cover these individuals.

Medicaid Reform. Help for those who cannot afford insurance under the proposal also would be provided by reforms in the Medicaid system. Specifically, the Heritage plan envisions the decoupling of Medicaid from welfare eligibility under AFDC or SSI. Under the plan, a new index of eligibility would be developed to link Medicaid coverage to poverty instead of welfare. This is an important distinction, because many poor families struggling to keep off welfare currently risk enormous and uncovered medical bills because they are not eligible, or do not seek, to go on to the welfare rolls. In addition, there are many families who go on to welfare, with its attendant costs to government, specifically to obtain the Medicaid coverage. Thus changing the eligibility criteria in the way proposed would not necessarily lead to a significant increase in Medicaid costs, even though it would make the program more attuned to the needs of the poor.

To keep Medicaid costs under control, the Heritage plan suggests steps to encourage greater flexibility and creativity within state Medicaid programs. Specifically, the plan would encourage states to manage their health care delivery systems more creatively. States were given incentives to move in this direction during the Reagan Administration. Under the Heritage plan, the federal government would give greater latitude to states to enroll the poor in prepaid medical plans and to institute more experimental management procedures. The aim of such reforms not only is to stimulate the creative juices of the states, but also to make Medicaid more like a genuine insurance program. Medicaid has tended to operate only as a reimbursement system. It does not, in general, build in management techniques and incentives to encourage cost-effective decisions before treatment takes place – it just picks up the tab.

4) Reform programs for the elderly.

The recent political battle over catastrophic health care for the elderly illustrates the current shortcomings of the Medicare system. Neither is the program a true insurance system nor is it a system that channels aid to those who really need it. In addition, its structure discourages cost consciousness once the deductibles have been met.

Medicare. The Heritage proposal calls for major reforms of the Medicare system to use funds more effectively and to introduce greater cost consciousness. Under the proposal, the deductibles for Medicare would be increased, and part of the savings used to offset the extra costs for the less affluent elderly. In addition, there would be further encouragement for the elderly to use Medicare funds, in the form of a voucher, to obtain private insurance or HMO-type coverage instead of using Medicare as a reimbursement system. In these ways, the elderly would have more incentive to question costs, while the program would insure proper protection for those who really need it. By fostering consumer sensitivity, the reforms also would encourage the same kind of competition through Medicare as the tax reforms would accomplish for the working population.

Long-Term Nursing Costs. The Heritage plan also deals with the area of nursing home costs. While proposals have been put forward to address nursing home costs by instituting a new payroll tax, this approach would simply repeat the inflationary problems associated with all social insurance programs (such as Medicare itself). Addressing the problem of nursing home costs begins by recognizing that for most of the elderly the real concern is that they have considerable assets that risk depletion through nursing home expenditures. Thus the real problem is not the availability of funds to cover costs but the fear that an asset painstakingly built up over an entire working life will be destroyed by the cost of nursing care.

The Heritage plan seeks to provide a remedy for two groups – those already retired and those in the current working population.In the case of retirees, the plan would provide a number of avenues through which the elderly could obtain an important degree of protection for their assets while allowing other assets originally intended for one purpose to be converted to nursing home use when the original purpose was no longer necessary. Specifically, the proposal would:

♦ ♦ **Allow Americans to use their retirement funds to purchase long-term care insurance.**

Retirees (as well as workers) would be permitted to use funds in pension plans, 401 (k) plans, individual retirement accounts (IRAs), and other retirement plans to make tax-free purchases of long-term care insurance. In this way, retirees would be given tax assistance to obtain nursing home insurance.

♦ ♦ **Encourage conversion of life insurance policies into long-term care insurance policies.**

Families buy life insurance to protect themselves against the loss of earnings by the breadwinner during working years. When individuals reach retirement, however, such life insurance is less necessary since the children have left the home and other forms of income guarantees are available (such as Social Security). Thus it would make sense for many retirees to convert life insurance policies into nursing home care insurance. While some companies promote such conversions, others do not. Thus the federal government should support this notion by encouraging companies to offer such plans and perhaps even by providing tax incentives for such conversions.

♦ ♦ **Promote home equity conversion.**

Many companies already offer some variant of the home equity conversion. Under these conversions the elderly are permitted to take a lump sum or receive an annuity by selling the equity built up in their homes. Under these plans, the elderly have the right to remain in their home until the death of both spouses, at which point the company providing the financing recoups its equity from the sale of the home.

The Department of Housing and Urban Development recently launched a demonstration program to provide access to the secondary mortgage market for such financing arrangements. This demonstration program should be expanded to encourage more financial institutions to enter this field. By doing so, funds locked up in housing equity would be made available to cover nursing home expenses or premiums on nursing home insurance.

In addition, the Heritage proposal focuses on steps that could be taken to encourage working age Americans to purchase long-term care insurance. While such insurance currently is available, very few Americans purchase it. Thus the strategy of the federal government, in essence, would be to encourage households to consider nursing home care insurance to be as normal and prudent a purchase as life insurance. To stimulate the long-term care life insurance market, the federal government could:

♦ ♦ **Publicize information about long-term care insurance policies.**

One reason long-term care insurance is not widely purchased is because it is confusing to most buyers. By providing a classification system for insurance, under which certain types of coverage would be required to receive a certain classification, the federal government could provide an invaluable service to the public and make comparisons between policies easier for potential buyers. This consumer information would help stimulate the market for such insurance.

♦ ♦ **Provide tax relief for the purchase of long-term care policies.**

Currently the purchase of long-term care insurance receives no significant tax benefits, and indeed, the tax treatment of long-term care policies is far inferior to that for pension plans and medical policies. Under the Heritage proposal, a range of tax benefits would be provided to encourage working age Americans to obtain insurance when it is less expensive. For instance, IRA funds could be used to purchase long-term care insurance without incurring tax when the funds are withdrawn. Similarly, companies could be allowed to include long-term insurance in "cafeteria" plans. Current law does not allow long-term care insurance to be included in such tax-free fringe benefits. Similarly, a new IRA could be introduced specifically for the purchase of long-term care insurance.

A CONSUMER-BASED SYSTEM

All of these measures, from the basic tax treatment of health care to the encouragement of long-term care insurance, would introduce a far greater degree of consumer activism into the health care market. This strategy, combined with a requirement for basic health coverage and the focusing of government assistance to those who need it most, would change the foundations of health care in America. Rather than the current system with its built-in inflation and enormous gaps in coverage, the result would be a system providing not only coverage to all but also a powerful set of incentives for the health care industry to be as efficient and consumer sensitive as possible. In this way, America could create a national health system that combines universal health care with a degree of quality, access, and budget control that is unavailable in other national health systems around the world.

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