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How the Federal Government Is Causing Our Nation's Health Care Crisis

A common assumption behind most health care reform proposals is that the private sector is causing our national health care crisis. Republicans and Democrats alike persist in seeing the problems as originating outside of Washington.

"State governments are powerless to solve a crisis created in Washington."

Acting on this assumption, President Bush and other national leaders are encouraging state governments to experiment with health care reform — to find out what does and does not work. Most states are responding by considering a wide variety of reform proposals.

Are their efforts futile? Probably. In fundamental ways, the federal government rather than the private sector is responsible for our health policy crisis, and state governments can make few improvements as long as unwise federal policies remain in place. The following is a brief review.

Federal Spending Has Caused Spiraling Health Care Costs

Prior to 1960, health care spending as a percent of gross national product (GNP) increased very slowly in the United States. That changed with the enactment of the Medicare and Medicaid programs in 1965. As these two programs expanded, health care spending in the United States soared:

- Between 1940 and 1960, health care spending rose modestly, from 4 percent of GNP to 5.2 percent.[1]

- Since 1960, the percent of gross domestic product (GDP) spent on health care has almost tripled, reaching an estimated 13.4 percent in 1992.[2]

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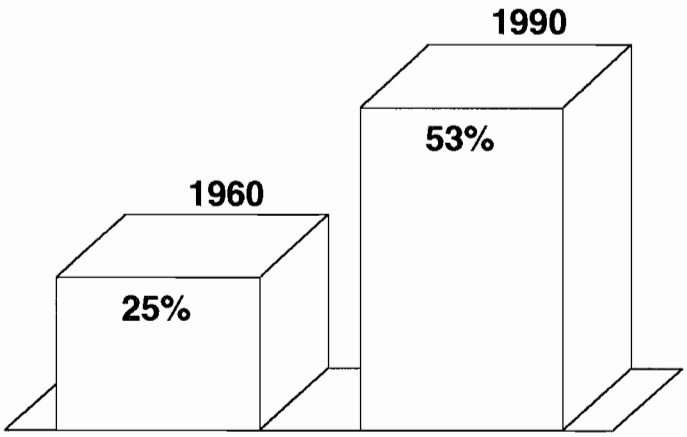
The Government's Role. Many people who look to government to solve our health policy problems are unaware of how large a role the government already plays. When federal tax subsidies for health insurance are combined with direct spending, government at all levels (federal, state and local) spends more than half of all health care dollars. Moreover, spending on Medicare and Medicaid has skyrocketed from 5.9 percent of total health care spending in 1967, the first full year of Medicare and Medicaid expenditures, to 28 percent of total health care spending in 1990.[3] Overall:[4]

- Direct government spending has increased from 24 percent of all health care spending in 1960 to 42 percent in 1990.
- When tax subsidies for health insurance are included, the government's share of health care spending has increased from 25 percent in 1960 to 53 percent today. [See Figure I.]

"Government now spends more than half of all health care dollars."

FIGURE I

Government Spending as a Share of All Health Care Spending[1]



[1]Includes tax subsidies for health insurance.

Source: NCPA/Fiscal Associates health care model.

Health Care Inflation. Many view Medicare and Medicaid as necessary programs, providing services to people who would not otherwise be able to afford them. If that were true, expansion of the two programs might be justified. In fact, increased government spending has mainly increased prices rather than services.

- According to the Health Care Financing Administration (HCFA), which administers Medicare, every extra dollar spent on health care buys 65 cents in increased prices and only 35 cents in real services.[5]

- According to the NCPA/Fiscal Associates health care model, every extra dollar spent on health care buys 57 cents in increased prices and only 43 cents in real services.[6]

"Every extra dollar spent on health care buys 65 cents in increased prices and only 35 cents in real services."

Prospects for the Future. Largely because of federal policies, health care spending over the last decade increased almost twice as fast as GNP. If that trend continues, sometime in the next century we will be spending 100 percent of GNP on health care. The federal government is doing nothing to alter this course. Even as the federal government attempts to limit what it pays doctors and hospitals, it continues to expand benefits — ensuring that utilization will continue to rise, with an increasing share of the cost shifted to the private sector.

Federal Tax Law Prevents Private Sector Cost Control

A primary reason why health care spending is out of control is that most of the time when we enter the medical marketplace as patients we are spending someone else's money rather than our own. Economic studies — as well as common sense — confirm that we are less likely to be prudent, careful shoppers if someone else is paying the bill.

The Extent of Third-Party Payment of Medical Bills. Although polls show that most people fear they will not be able to pay their medical bills from their own resources, the reality is that few of us will ever have to. On the average:[7]

- Every time we spend a dollar in a hospital, we pay only 5 cents out-of-pocket, and 95 cents is paid by a third party (employer, insurance company or the government).

- Every time we spend a dollar on physicians' fees, we pay less than 19 cents out-of-pocket.

- For the health care system as a whole, we pay only 24 cents out-of-pocket every time we consume a dollar's worth of services.

Moreover, the explosion in health care spending over the past three decades parallels the rapid expansion of third-party payment of medical bills. The patient's share of the bill has declined from 52 percent in 1965 to 23 percent today.[8]

The Wastefulness of Third-Party Insurance. There is substantial evidence that a great deal of waste in our health care system is caused by people who have too much insurance. For example, Rand Corporation studies imply that if every family in America had a $2,500 deductible,[9] personal health care spending would drop as much as one-fourth [10] with no adverse effects on health.[11]

Market prices for health insurance also provide powerful evidence of the wastefulness of low deductibles.[12]

- If a family in a city with average health care costs increases its deductible from $250 to $1,000, its premium savings will be $1,315 — almost twice the amount of the increase in the deductible.[13]

- If the family increases its deductible from $250 to $2,500, it will save $1,749 on premiums — roughly the amount of coverage the family would forego, considering the effects of the deductibles and copayment.[14]

"Families can potentially save a lot of money by choosing higher deductibles."

High-deductible health insurance is often a good buy for three reasons. First, when people have low-deductible insurance, or first-dollar coverage, some will abuse the system and consume services they do not really need. That causes premiums to rise for all policyholders. On the other hand, with high-deductible insurance, routine services are paid for out-of-pocket and do not affect premiums. Second, when people pay a large share of the bill with their own resources, they are more careful shoppers — avoiding unnecessary services and seeking low prices for the services they do consume. Third, using third parties to pay small medical bills often leads to wasteful administrative expenses. For example, a physician's fee of $25 can easily become $50 in total costs after an insurer monitors and processes the claim — thus doubling the cost of medical care.[15]

Tax Subsidies for Third-Party Insurance. In most insurance markets, insurers pay only in the case of risky events — events not under the control of policyholders. Moreover, high deductibles are common. Health insurance is different. Insurers often pay routine expenses (for checkups, diagnostic tests, etc.) unrelated to risky events, and low deductibles are common. There is nothing normal or natural about the way the health insurance market functions. It is the result of perverse incentives created by the tax law.

Under current law, every dollar of health insurance premiums paid by an employer escapes, say, a 28 percent income tax, a 15.3 percent Social Security (FICA) tax and a 4, 5 or 6 percent state and local income tax, depending on where the employee lives. The government is effectively paying half the premiums — a generous subsidy that encourages employees to overinsure.

Because of federal tax policy, employees tend to prefer health insurance to taxable wages, even when the insurance is wasteful. [See Figure II.] For example, if an employer attempted to give a higher paid employee $1.97 in wages, the employee would take home only $1.00 after taxes. As a result:[16]

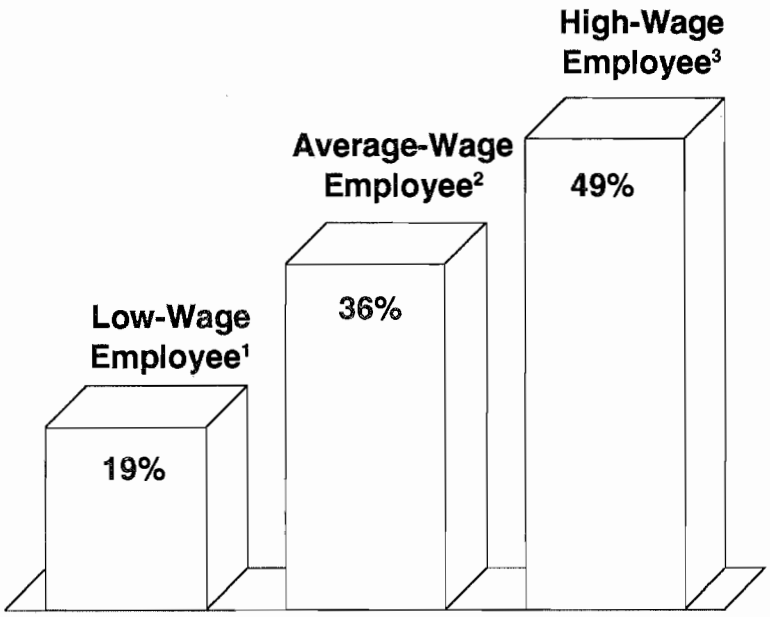
- For a highly paid employee, $1.97 spent on health insurance need only be worth $1.01 to be preferable to $1.97 of gross wages.
- Thus, 96 cents of $1.97 (or 49 percent of the premium) can represent pure waste and still leave health insurance preferable to wages for the employee.

"Federal tax law encourages wasteful first-dollar coverage for all medical services."

Penalties for Individual Self-Insurance. Most individuals and families would be much better off if they had the opportunity to choose high deductibles and place the premium savings in a bank account — to use for small medical bills. Yet, while the federal government generously subsidizes third-party insurance, it discourages self-insurance by heavily taxing funds that individuals put aside for medical expenses.

FIGURE II

How Much Waste Can Be Present and Still Leave Health Insurance as Valuable as Wages?



[1]Employee faces a 15 percent FICA tax and a 4 percent state and local income tax.

[2]Employee faces a 15 percent FICA tax, a 15 percent federal income tax and a 6 percent state and local income tax.

[3]Employee faces a 15 percent FICA tax, a 28 percent federal income tax and a 6 percent state and local income tax.

One exception to this general rule is that federal tax law permits employees to make pretax deposits to Flexible Spending Accounts (FSAs) from which to pay for medical expenses not covered by employer-provided health insurance.[17] These accounts are governed by a use-it-or-lose-it rule, however. Within a certain time period, usually a year, employees must spend all funds in the account or forfeit them. FSAs, then, are designed to encourage spending, not restraint.

"Federal tax law penalizes people who save to pay their own small medical bills."

The federal government could make major progress in eliminating the distortions in federal tax law by giving just as much tax incentive to individual self-insurance as it now gives to third-party insurance. [See sidebar on Medical Savings Accounts.] Without this change, there is little reason to think health care costs can be controlled without government-imposed health care rationing.

Federal Policies Prevent the Public Sector from Controlling Health Costs

Just as the federal government encourages first-dollar private health insurance coverage, it has implemented first-dollar coverage in the Medicaid and Medicare programs. It also has adopted other policies that impede cost control.

First-Dollar Coverage in Government Health Care Programs. The elderly are the wealthiest group in our society. They have more aftertax income than the nonelderly and own 40 percent of the nation's capital stock.[18] Despite that, the Medicare program pays many first-dollar expenses that most Medicare patients could pay with their own resources. [See the discussion below.] Such a policy encourages overconsumption by Medicare patients who see few reasons to compare the value of an additional test or physician visit with the other uses of the same money. The Medicaid program also restricts the ability to charge patients for low-cost items.[19]

Federal Mandates. City and county health officials almost everywhere can point to rules and regulations that prevent them from spending health care dollars wisely. Many of these regulations are imposed by the federal government. For example, almost one-fourth of all Medicaid spending is for nursing home care. Yet federal regulations impose tight restrictions on the type of facility that can be used as a nursing home and prohibit less costly, equally effective alternatives.[20]

To Control Health Care Costs: Medical Savings Accounts

No one is better suited to make decisions concerning the trade-off between money and health care expenditures than informed patients, acting on the advice of their physicians. People differ greatly in their attitudes toward risk and in the value they place on health versus other uses of money.

A system using Medical Savings Accounts would give patients control of health care spending. Individuals or their employers would be allowed to make tax-free deposits each year to Medical Savings Accounts. The accounts would be similar to Individual Retirement Accounts (IRAs) but would be used to fund health care expenditures over a person's lifetime.

People would pay their own medical bills, using funds from the accounts. They could buy high-deductible health insurance policies for protection against catastrophic expenses. Money for deposits to the accounts could come from the premium savings associated with higher deductibles. In a city with average health care costs, a family can save about $1,315 annually by choosing a policy with a $1,000 deductible rather than a $250 deductible. The savings would be less for group policies, but still substantial.

Medical Savings Accounts would be allowed to grow tax-free, with withdrawals permitted only for legitimate medical expenses. They would be the private property of the account holder and become part of an individual's estate at the time of death. If created by an employer, they would be personal and portable for the employee. Eventually they could pay for postretirement health care or become part of an individual's retirement fund.

The biggest obstacle is the U. S. tax code, which subsidizes health insurance premiums paid by an employer but taxes dollars destined for medical savings. Under current tax policy, if an employer buys a high-deductible policy and tries to pass the savings on in the form of higher wages, or to place the money directly into a savings account, up to half of the amount go to taxes. Current law encourages low-deductible health insurance, with insurers paying small medical bills that would be much less expensive if paid out-of-pocket.

If everybody had catastrophic health insurance for large medical bills and Medical Savings Accounts for small bills, the administrative costs of the U. S. health care system would be reduced an estimated $33 billion. More prudent buying of health care by patients could reduce spending by another $207 billion.

Medical Savings Accounts could also solve Medicare and Medicaid problems. Persons on Medicaid might have a government-provided account to draw on. The elderly could choose higher Medicare deductibles and make deposits to their own Medical Savings Accounts.

If most medical expenses were paid by people using their own Medical Savings Account funds, patients would have a financial self-interest in eliminating waste and reducing costs in the medical marketplace, and they would acquire greater control over how their health care dollars were spent. Third-party payers would interfere far less in the doctor-patient relationship. And health insurance companies could specialize in what they do best: managing risks for rare, expensive, catastrophic medical events.

Source: John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs With Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992.

An Indirect Result of Federal Policies: The Lack of a Competitive Medical Marketplace

The medical marketplace — particularly the hospital marketplace — shows none of the normal signs of a competitive market. In most places, patients cannot find out the cost of even routine procedures before they enter a hospital. At the time of discharge, they are confronted with lengthy, line-item bills that are virtually impossible to read or understand. Small wonder that there is so much waste in our health care system! The people who make the purchasing decisions cannot discover the price before they buy and, afterward, cannot understand what they were charged.

"Patients cannot find out the price before entering a hospital, and cannot read the bill at the time of discharge."

The major reason why the market is not competitive is that it is dominated by large, bureaucratic institutions. Because 95 percent of hospital revenues come from third-party payers, prices charged to patients are not market-driven prices. Instead, they are artificial prices — designed to maximize revenue against third-party reimbursement formulas. The federal government has encouraged an institutionalized, bureaucratized market by subsidizing third-party payment. Yet the evidence suggests that the market would be radically different if patients were spending their own funds.

Hospital Prices. Patients who try to find out about hospital prices before they are admitted face a depressing surprise. A hospital can have as many as 12,000 different line-item prices. For patients doing comparison shopping among the 50 hospitals in the Chicago area, for example, there are as many as 600,000 prices to compare. To make matters worse, different hospitals use different accounting systems. As a result, the definition of a service as well as the price of the service may differ from hospital to hospital.

Although hospital administrators do not have to give patients advance notice of their total bill, Illinois hospitals are required to tell the state government what they charge. The following total charges for outpatient services were reported by Chicago hospitals in 1988:[21]

- The charge for a mammogram varied from $13 to $127 — a difference of almost 10 to one.
- The charge for a CT scan varied from $59 to $635 — a difference of more than 10 to one.
- Tonsillectomy charges ranged from $125 to $3,365 — a 27 to 1 difference.
- Cataract removal charges varied from $125 to $4,279 — a 34 to 1 difference.

If patients knew about these differences, they could significantly reduce their medical bills. Unfortunately, most do not.

Why Empowering Patients Makes a Difference. In a few areas of the medical marketplace, most of the generalizations made above are no longer true. For example, cosmetic surgery is not covered by any private or public health insurance policy. Yet in every major city, it is a thriving industry. Patients pay with their own money, and they are almost always given a fixed price in advance — covering all medical services and all hospital charges. Patients also have choices about quality (e.g., surgery can be performed in a physician's office or, for a higher price, on an outpatient basis in a hospital). Overall, patients probably have more information about the price and quality of cosmetic surgery than about any other type of surgery.

Cosmetic surgery is not an isolated case. Because of the trend toward higher deductibles, parents today can expect to pay a large portion of the bill for well baby delivery. In response, Humana and other hospital chains are beginning to advertise package prices (from $1,000 to $1,200) in many cities. And, in England, private hospitals frequently offer package prices for routine surgery to patients who pay with their own funds.

"Federal policy has discouraged a competitive hospital marketplace."

The Role of Federal Policy. The hospital marketplace today is the result of a long, complex evolution. The federal government did not create a noncompetitive market. But it did subsidize and sustain it. Historically, state governments were openly hostile to proprietary (for-profit) hospitals and adopted policies that encouraged nonprofits — which were never intended to operate as businesses. The federal government supported this evolution by making construction grants to nonprofit hospitals, but not to for-profits, and by allowing tax deductible contributions to nonprofits, but not to their for-profit rivals.[22]

The historical practice of reimbursing hospitals based on costs rather than market prices was clearly favored by the American Medical Association and Blue Cross-Blue Shield, as well as by the hospitals themselves. The federal government extended this system by adopting cost-plus reimbursement in the Medicare and Medicaid programs.[23]

Today, competitive pressures are mounting in every sector of the medical marketplace. Federal tax policy is retarding this development by continuing to subsidize the only institution that can prevent a competitive market from emerging: third-party payment of every medical bill.[24]

Federal Tax Law Contributes to the Rising Number of People without Health Insurance

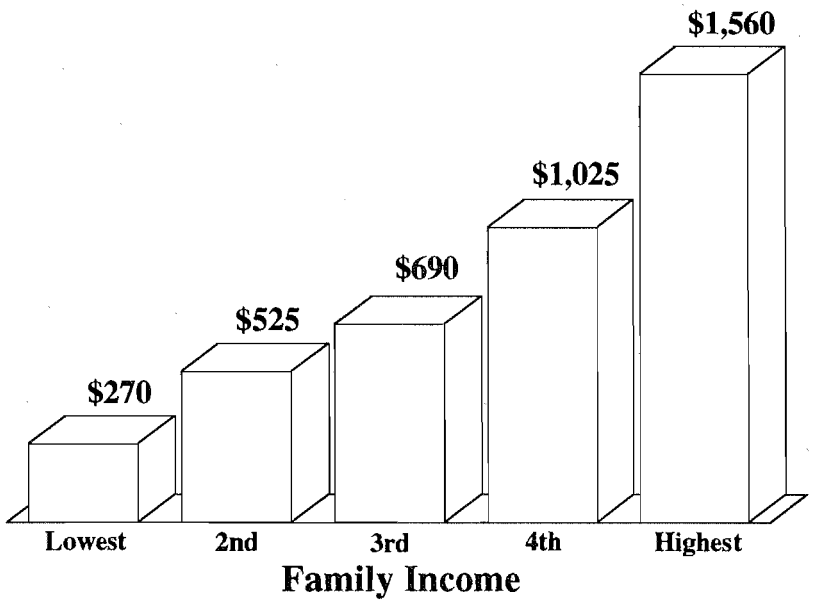
Each year the federal government "spends" about $60 billion in tax subsidies for health insurance. Ostensibly, this is done to encourage private health insurance coverage. However, this policy probably does more harm than good for three reasons. First, the largest subsidies go to those who need them least — people who probably would purchase health insurance without any tax encouragement. Second, the tax law penalizes people who purchase their own health insurance — encouraging them to postpone becoming insured until they can do so through an employer. Finally, the tax law encourages a system under which people who are insured through an employer can lose their coverage — and become uninsurable —after they get sick.

Subsidizing the Rich. The current system favors high-income over low-income families in two ways. First, the ability to exclude employer-provided health insurance from taxable wages is more valuable to employees in higher tax brackets. Second, by restricting this tax subsidy to employer-provided insurance, the law favors people who work for larger firms. The result is a highly regressive tax subsidy. As Figure III shows:

"High-income families get six times as much help from government as low-income families."

FIGURE III

Average Benefit for a Family From Tax Subsidies for Health Insurance



*Subsidies include reduced Social Security (FICA) and income taxes.

Source: C. Eugene Steuerle, "Finance-Based Reform: The Search for Adaptable Health Policy," paper presented at an American Enterprise Institute conference, American Health Policy, Washington, DC, October 3 - 4, 1991.

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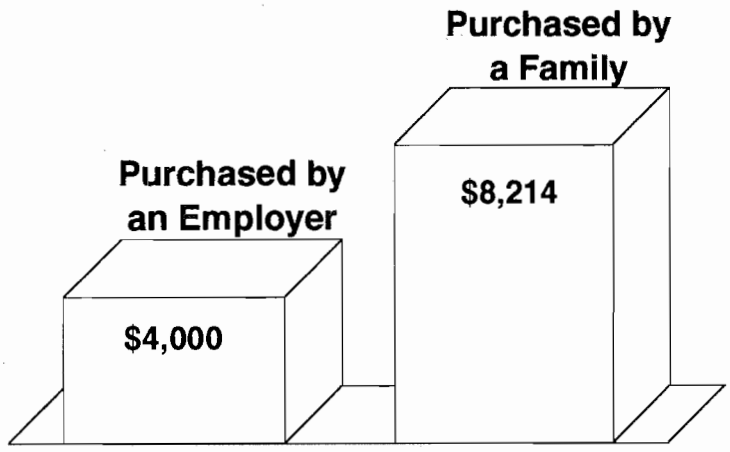
- Families in the bottom fifth of the income distribution get an average benefit of $270 a year from federal tax subsidies for health insurance.
- By contrast, families in the highest fifth of the income distribution get an average annual benefit of $1,560.
- Thus the tax law benefits high-income families six times more than it benefits low-income families.

Penalizing the Nonrich. Under the current system, well-paid employees at General Motors have one of the most lavish health insurance plans in the world — with Uncle Sam footing as much as half of the bill. At the same time, the self-employed, the unemployed and employees of small companies that do not provide health insurance are discriminated against.[25] They must pay taxes first and buy health insurance with what's left over. As Figure IV shows, this makes the effective price of health insurance twice as high as the price for people who have employer-provided insurance. Small wonder that almost 90 percent of the population under 65 years of age with health insurance is insured through an employer.[26] A fairer policy would be to give just as much tax encouragement to those who purchase their own health insurance as to employer-provided insurance and base the size of the subsidy on family need. [See sidebar on "A Pay-or-Play Plan That Works."]

"The effective cost of health insurance is twice as high for people who buy their own policy."

FIGURE IV

Effective Cost of a $4,000 Health Insurance Policy[1]



[1] Figures show the amount of additional pre-tax income that must be earned in order to purchase the policy. The family is assumed to have adjusted gross income of $35,000 and to face a 28 percent federal income tax rate, a 15.3 percent Social Security (FICA) tax rate and an 8 percent combined state and local income tax rate.

Source: Gary and Aldona Robbins, Fiscal Associates. For a detailed explanation of the tax differences, see Health Care Solutions for America, "Federal Tax Policy and the Uninsured," Washington, DC, January 1992.

Contributing to the Number of Uninsurable People. The U.S. health care system has been shaped and molded by the tax law. The kind of health insurance most of us have is determined by what the tax law subsidizes. This has led to an employer-based system under which people lose their health insurance when they leave a firm.[27]

Almost all economists believe that fringe benefits are a substitute for wages. Thus fringe benefits are "paid for" by workers in the form of lower take-home pay. Yet despite the fact that employees pay for their own health insurance, they have no ownership rights. Employers can cut back on coverage, even after an employee gets sick.[28] And when employees with a preexisting illness leave, they may find it impossible to get insurance elsewhere. A much fairer system would be one under which no tax subsidy is made available for employer-provided health insurance unless the policy is personal and portable.

Federal Employee Benefits Law Encourages Lack of Health Insurance

"State mandates have priced as many as one out of every four uninsured people out of the market for health insurance."

One area in which state governments have contributed to the number of uninsured people is through mandated health insurance benefit laws. Clearly the result of special interest pressures, these laws raise the price of health insurance and force millions of families out of the market. Such laws might be successfully resisted if the largest employers were leading the struggle. But the federal government lets the biggest firms off the hook, leaving small companies and individuals to fend for themselves.

State-Mandated Health Insurance Laws. Mandated health insurance benefit laws tell insurers what services and providers they must cover if they issue policies within a state. Such laws cover health conditions ranging from mental illness to alcoholism and drug abuse. They cover services ranging from acupuncture to in vitro fertilization. They cover everything from the serious to the trivial: heart transplants in Georgia, liver transplants in Illinois, hairpieces in Minnesota, marriage counseling in California, pastoral counseling in Vermont and sperm bank deposits in Massachusetts.[29]

Currently, there are 240 health-related occupations. Lobbyists representing these groups descend on state legislatures each year to demand still more special-interest legislation. Their efforts are having an effect. By one estimate:[30]

- As many as one out of every four people who lack health insurance have been priced out of the market by the cost-increasing effects of state-mandated benefits.
- Thus state regulations are directly responsible for as many as 9 million people being uninsured.

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Exemptions for Large Companies. A reasonable federal policy might be to exempt individuals, families and small businesses from state-mandated benefits regulations. Large companies, it might be argued, are sufficiently resourceful to fight their own political battles. Ironically, federal policy does the opposite. It allows large companies that self-insure to escape from mandated benefits — and from state premium taxes, contributions to risk pools and other cost-increasing regulations.[31] Federal policy leaves those who are most vulnerable to fight their own political battles. The best policy would be to override state mandates and exempt everyone.

To Insure the Uninsured: A Pay-or-Play Plan That Works

The problem with the existing system is not that the uninsured are getting a free ride at everyone else's expense. Instead, there are two other problems. First, the tax subsidy for health insurance is arbitrary and unfair. The system is regressive, with most of the benefits going to higher income families, and it arbitrarily excludes people who purchase health insurance on their own. Second, under the current system most of the additional taxes paid by the uninsured go to Washington rather than to the local hospitals that provide the free care.

A solution is to offer everyone a tax subsidy for the purchase of health insurance, with higher subsidies for lower income families. For individual purchases of health insurance, a tax credit could be entered on individual income tax returns. The cost of employer-provided insurance could be included in the gross wages of employees and tax credits also entered on their tax returns. At the bottom end of the scale, there should be refundable tax credits — with government directly subsidizing a portion of the health insurance premium.

Even faced with a generous subsidy, some people will opt to be uninsured. If they do so, they should pay higher taxes. These additional taxes should be pooled and returned to the local hospitals that administer uncompensated care to people who have exhausted their own financial resources.

Under this proposal, no one would be required to purchase health insurance. Those who chose not to do so would be forced to rely on charity care if they could not pay their medical bills. Existing laws generally require hospitals to provide emergency care to patients, regardless of ability to pay. With the new source of funds proposed here, we could liberalize access to health care for indigent patients. But "free" care is unlikely to be perceived as being as desirable as "purchased" care and may involve considerable health care rationing.

Thus, people would have incentives to purchase health insurance — to protect their own assets, to acquire the quality of health care they want and to be free to exercise choice in the medical marketplace.

Source: John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Crisis* (Washington, DC: Cato Institute), forthcoming

Federal Tax Policies Undermine the Social Safety Net

A common fallacy is that people who lack health insurance are getting a free ride at the expense of the rest of us. When the uninsured get sick, it is argued, they usually get health care. And when they can't pay their medical bills, the rest of us pay them through cost shifting or higher taxes.

"Uninsured people pay more taxes — but the money goes to Washington, not to county hospitals."

What this argument overlooks is that the uninsured pay higher taxes precisely *because* they do not get the tax subsidies enjoyed by others. In fact, based on the average tax subsidy given to those with employer-provided health insurance, the uninsured pay about $6 billion to $7 billion in extra taxes each year. Since this is roughly equal to the unpaid hospital bills of uninsured patients, it is by no means clear that the uninsured as a group are getting a free ride.

The problem is that the extra taxes go to Washington while the free hospital care is delivered in local communities. A reasonable reform would be to require the federal government to return the extra taxes to the hospitals that deliver free care. [See sidebar on "A Pay-or-Play Plan That Works."]

Federal Spending Programs Undermine the Social Safety Net

This year the federal government will spend about $215 billion on health care. How much of this spending actually goes to low-income families who need help? Surprisingly little. Only one out of every four dollars spent by the federal government goes to a poor family that qualifies for benefits under a means-tested program. The vast bulk of federal spending goes to middle- and upper-middle-income families, even though the taxes used to pay for these benefits often come from low-income workers.

As noted above, high-income families get six times as much benefit as low-income families from the $60 billion a year in tax subsidies for health insurance. The $130 billion the federal government spends each year on Medicare is not much more defensible.

- The lowest income workers pay 2.9 percent of their income each year to support Medicare.
- Yet the primary beneficiaries of Medicare — the elderly — have higher aftertax incomes and considerably more assets than the nonelderly.[32]

For the most part, federal health dollars go for the benefit of the non-poor. In the process, they force up prices for the poor.

Federal Policies Undermine Postretirement Health Care Security

"Federal policy encourages current health care spending but discourages saving for future medical bills."

About one-third of all workers work for an employer who provides postretirement health care benefits, covering items not paid for by Medicare.[33] Yet because of federal tax law, many of these workers will never collect a dime in benefits. The federal government's Medicare program makes things worse by covering many items the elderly could easily pay for themselves, while leaving them exposed for catastrophic medical bills. Such policies place the burden of catastrophic coverage on individual families and state and local governments.

Employer-Provided Health Insurance. Although federal tax law allows unlimited spending for current health care needs — and excludes all of it from employee income — it severely limits the ability of the private sector to save for postretirement health care.[34] As a result, most employers have not put aside funds to pay for future promises:[35]

- According to one estimate, unfunded liabilities of employers for postretirement health care now total $332 billion.
- This is equal to about 30 percent of the net worth of large companies.

Not only does federal tax law discourage employers from saving, but it also discourages individuals. The tax system generously subsidizes current health care spending, but the government taxes savings and provides no deduction for long-term care insurance.

Medicare. The federal government pays for many small medical bills for Medicare patients. For example:[36]

- Following a deductible of $100, Medicare pays 80 percent of all remaining physicians' fees.
- Medicare pays all expenses for the first 20 days in a nursing home.
- Following a deductible of $652, a Medicare patient faces no additional costs for a hospital stay of up to 60 days.

Unfortunately, Medicare leaves the elderly exposed for the most expensive bills — paying nothing after the 100th day in a nursing home and the 150th day in a hospital. Moreover, because Medicare offers too much first-dollar coverage and too little catastrophic coverage, state and local governments often must pick up the tab when catastrophic illnesses occur.

Medigap Insurance. The bias toward front-end coverage also extends to federal laws governing private insurance to pay for expenses not paid by Medicare. Under current federal law, these policies are required to pay for small-dollar items, but are left free to skimp on catastrophic coverage.[37]

Conclusion

"To solve our health care crisis, we much change the federal policies that created it."

Most of our health policy problems — from rising costs to an increasing number of uninsured people — have been created by unwise federal policies. Because of this fact, state governments are very limited in what they can do. Ultimately, if we are to solve the nation's health care crisis, we must reform the federal policies that created it.

John C. Goodman

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NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Footnotes

[1] Health One, *The Trauma of Transformation in the 1990s* (Minneapolis: Health One Corporation, 1989), p.11.

[2] Estimate of the Health Care Financing Administration, Office of the Actuary, Fall 1991.

[3] Calculated from data in the National Health Accounts/Health Care Financing Administration.

[4] Source: NCPA/Fiscal Associates Medical Model Project.

[5] Gary Robbins, "Insurance as the Source of Medical Inflation," paper presented to the Cato conference, "The Regulation of Medical Care," Washington, DC, April 30, 1992.

[6] Source: NCPA/Fiscal Associates Medical Model Project.

[7] John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs With Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992.

[8] Ibid.

[9] The Rand Corporation, in a study conducted from 1974 to 1982, found that people who had access to free care spent about 50 percent more than those who had to pay 95 percent of the bills out-of-pocket up to a maximum of $1,000. A $1,000 deductible over that period would be equivalent to a deductible between $1,380 and $2,482 today. See Robert Brook et al., *The Effect of Coinsurance on the Health of Adults* (Santa Monica, CA: Rand, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American Economic Review,* June 1987. For a survey of economic studies of the demand for medical care, see Paul Feldstein, *Healthcare Economics* (New York: Wiley, 1988).

[10] This estimate assumes a $33 billion decrease in administrative costs and a $147 billion decrease in direct expenses. Total health care costs for 1991 are estimated at $707 billion. See the analysis in Goodman and Musgrave, "Controlling Health Care Costs With Medical Savings Accounts."

[11] The Rand study found no significant differences in the health status of people who had high and low deductibles. The one exception was vision care, which is not surprising — since eyeglasses are often viewed as a marginal health care expenditure. See Joseph Newhouse et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine*, Vol. 305, No. 25, December 17, 1981, pp. 1501-7; and Robert Brook et al., "Does Free Care Improve Adults' Health?", *New England Journal of Medicine*, Vol. 309, No. 23, December 8, 1983, pp. 1426-34.

[12] Source: Golden Rule Insurance Company. Figures are for two adults and two children in a city with average health care costs.

[13] For deductibles less than $2,500, policyholders face a 20 percent copayment up to $1,000. Thus, the foregone coverage is 80 percent x ($1,000 - $250) = $600. The savings from a higher deductible are even greater considering that more than one family member can incur expenses. Under the low-deductible policy, the deductible is $250 per person, with a $500 maximum for the entire family. Under the high-deductible policies, the deductible indicated is for the entire family.

[14] The foregone coverage is 80 percent x ($2,500 - $250) = $1,800.

[15] See the discussion in Goodman and Musgrave, "Controlling Health Care Costs With Medical Savings Accounts."

[16] The value of the benefit equals 1/(1-t), where t is the marginal federal income tax rate plus the combined employer-employee Social Security payroll tax rate. For a worker in the 15 percent bracket, t = 0.15 + 0.153. For a worker in the 28 percent bracket, t = 0.28 + 0.153.

[17] See Alain Enthoven, "Health Tax Policy Mismatch," *Health Affairs,* Winter 1985, pp. 5-13.

[18] Aldona Robbins and Gary Robbins, "Taxing the Savings of Elderly Americans," National Center for Policy Analysis, NCPA Policy Report No. 141, September 1989.

[19] See the discussion in Lucy Johns and Gerald S. Adler, "Evaluation of Recent Changes in Medicaid," *Health Affairs,* Spring 1989, p. 179.

[20] Federal regulations relating to nursing homes are in National Fire Protection Agency (NFPA) *101 Life Safety Codes*, 1985 edition.

[21] Illinois Health Care Cost Containment Council, *A Report of Selected Prices at Illinois Hospitals: Outpatient Services,* August 1989.

[22] For a historical analysis of how these changes were brought about, see John C. Goodman, *Regulation of Medical Care: Is the Price Too High?* (Washington, DC: Cato Institute, 1980). A different perspective, one more sympathetic to the suppression of market incentives, is contained in Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

[23] See John C. Goodman and Gerald L. Musgrave, "The Changing Market for Health Insurance: Opting Out of the Cost-Plus System," National Center for Policy Analysis, NCPA Policy Report No. 118, September 1985.

[24] See John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute), forthcoming.

[25] Unemployed people and employees of firms that do not provide health insurance receive no tax subsidy for the health insurance they purchase. Self-employed individuals are allowed to deduct 25 percent of their health insurance premiums, but this right has an uncertain future. The deduction must be periodically renewed by Congress and is not a permanent feature of the tax code.

[26] About 89 percent of nonelderly Americans who have health insurance acquired it through an employer. See Employee Benefit Research Institute, "A Profile of the Nonelderly Population Without Health Insurance," *EBRI Issue Brief,* No. 66, May 1987, Table 2, p. 3.

[27] Under the provisions of Consolidated Budget Reconciliation Act (COBRA), employees are entitled to continue coverage for a limited period of time after they leave an employer.

[28] In a recent and highly publicized case, H & H Music Company of Houston, TX, reduced its lifetime benefit limit from $1 million to $5,000 after learning that one of its employees had tested positive for the AIDS virus. The employee sued the company but lost the suit because the employer was self-insured and therefore not subject to federal regulations. The case is currently before the Supreme Court. See Terry Giesel, "Self-Insurers Can Limit AIDS Benefits: Court," *Business Insurance,* August 6, 1990, pp. 1, 27-28.

[29] See John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 134, November 1988.

[30] Ibid.

[31] The exemption is created by the provisions of the Employee Retirement Income Security Act (ERISA), 1974.

[32] Aldona Robbins and Gary Robbins, "Taxing the Savings of Elderly Americans," National Center for Policy Analysis, NCPA Policy Report No. 141, September 1989.

[33] Jonathan C. Dopkeen, "Post Retirement Health Benefits," in *The Sourcebook on Retirement Health Care Benefits*, Robert D. Paul, ed. (Greenvale, NY: Panel Publishers, 1988), p. 566.

[34] See John C. Goodman and Gerald L. Musgrave, "Health Care After Retirement: Who Will Pay the Cost?", National Center for Policy Analysis, NCPA Policy Report No. 139, July 1989.

[35] Mark J. Warshawsky, "Retiree Health Benefits: Promises Uncertain," *The American Enterprise*, July/August, 1991, Figure 2, p. 63.

[36] Source: Health Care Financing Administration. Dollar amounts are for 1991.

[37] See Goodman and Musgrave, "Health Care After Retirement: Who Will Pay the Cost?"