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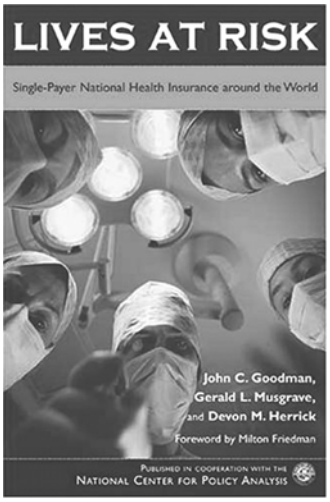
Health Insurance Decisions

by Peter T. Ittig, University of Massachusetts, Boston

Lives at Risk: Single-Payer National Health Insurance Around the World
by John Goodman, Gerald Musgrave & Devon Herrick

Rowman & Littlefield Publishers, 2004, $22.95, 263 pages



In an economy dominated by services, the largest of the service industries in the U.S. is health care, now comprising about 15 percent of Gross Domestic Product (GDP) and rising. Many books have been written about the peculiar economic structure of this industry in the U.S. A recent book by John Goodman, Gerald Musgrave, and Devon Herrick explores the peculiar resource allocation consequences of the national health insurance schemes used in *other* countries, including the U.K. and Canada. In *Lives at Risk: Single-Payer National Health Insurance Around the World*, the authors draw from these foreign experiences to make suggestions for changes in health insurance in the U.S. Milton Friedman (Nobel laureate) wrote the foreword for "this important book," concluding that, "Their findings will surprise many and deserve wide attention." Goodman is an economist with a Ph.D. from Columbia University who runs the National Center for Policy Analysis (http://www.ncpa.org).

Most western countries have adopted a national health insurance scheme of some sort. The U.S. is a notable exception. Resource allocation in a national health scheme is generally handled through a political process that generates global budgets, price controls, and limits on service capacities. The U.S. has made quite different choices than most other western countries about health insurance and has not yet abandoned competitive models and private health insurance. A relatively unique and quite interesting aspect of the Goodman book is the argument that national health schemes *inevitably* produce profoundly inefficient results and long waiting times due to imperatives that arise when resource allocation decisions are transferred from market mechanisms to political mechanisms. In making this argument the authors draw on "Public Choice Theory," which is related to ideas in the classic book *The Calculus of Consent: Logical Foundations of Constitutional Democracy*, by James Buchanan and Gordon Tullock (originally published in 1962, but still in print as a paperback from the University of Michigan Press for $22.95). *The Calculus of Consent* is not really about calculus, but it does describe the logical consequences of making decisions by a majority vote in a democratically elected legislature. "Public Choice Theory" is essentially a mixture of decision sciences, economics and political science. A somewhat related set of ideas can be found in another classic book *The Logic of Collective Action: Public Goods and the Theory of Groups*, by Mancur Olson (originally

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published in1968, but still in print as a paperback from the Harvard University Press for $20.95). Your education is not complete until you read these books on the fundamental forces driving public policy decisions in a democracy!

Some of the most interesting aspects of the Goodman book are the discussions of the logical consequences of the incentives of various arrangements for paying for health services. The authors are very hard on national health insurance schemes and describe as "twenty myths" various popular arguments for implementing a national health insurance program. Many of the problems associated with national health schemes are well known, particularly the common complaints of inadequate service capacity for both specialized services and specialized equipment, as well as the rationing of services through waiting time. The authors describe these difficulties by citing reputable statistical sources and through numerous anecdotes. For example, Goodman reports that in Britain, 20 percent of colon cancer cases originally diagnosed as curable are *incurable by the time of treatment* and that "rationing by waiting is pervasive, putting patients at risk and keeping them in pain." Goodman cites a study showing that about 36 percent of people in Britain must wait more than five months for non-emergency surgery, about 27 percent of Canadians must wait this long, but only 5 percent of Americans must wait this long! Goodman quotes a Canadian government report stating that, "Waiting is widely associated with publicly funded health care systems; it indicates the absence of costly excess capacity." Goodman argues that problems of this sort are *inevitable* with a national health scheme.

Of course, the competitive mechanisms driving resource allocation decisions in U.S. health care have major flaws as well. Goodman explores some of those flaws from an economic perspective and offers some suggestions that are intended to strengthen the forces of competition on the demand side of the economic equation. You may or may not agree with those suggestions, but the ideas are thought-provoking and some are being widely considered. One of the unique issues in health services is the prevalence of insurance that covers routine services as well as non-routine treatments and hospitalization. Due to the prevalence of this form of "insurance," the immediate price of health services to the consumer is typically near zero at the point of contact, even for routine office visits. This arrangement is quite different from the role of insurance in other sectors of the economy, where insurance is typically used only to provide financial protection against relatively catastrophic events that are infrequent but may be financially devastating. Goodman describes the customary use of insurance as the "casualty" model. Insurance organizations in health care typically take on a much larger role as an intermediary and often serve as a "managed care organization" or a "health maintenance organization" (HMO), rather than the more passive role of insurance firms in insuring lives and property. An HMO fully merges the roles of health care provider and insurance intermediary, thereby imposing some internal discipline on service costs and quality. Competition in the U.S. is focused on the opportunity afforded to employers and employees to choose between competing health plans and the power of these intermediaries to negotiate favorable prices from providers. The health plans compete in the benefits they offer and the insurance premiums they charge. Posted prices for individual services play a very minor role in this competition since consumers typically do not know or care about the prices for the health services that they use. Hospitals often do not particularly care about posted prices *either*, since very few patients pay them! Rather, hospitals are concerned with the reimbursement rates that are negotiated with the "third party payers." Posted prices in a hospital may be *two to four times* the reimbursement rates negotiated by the third party payers! Many economists have been fascinated by these peculiar industry characteristics and the weak role of prices in resource allocation.

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Patients without health insurance in the U.S. may be billed by hospitals at posted prices, but those bills are often not paid. This is the "uncompensated care" problem, a major issue for many hospitals. Goodman reports that about 15 percent of Americans do not have health insurance. However, due to various legal restrictions, hospitals in the U.S. have great difficulty denying health services to patients who cannot or will not pay for them. Goodman cites a study by the Urban Institute that found that U.S. spending on free health care for the uninsured is about $850 per uninsured person per year, or about $34.5 billion. The Commonwealth of Massachusetts alone reports spending over $1 billion per year on medical care for the uninsured through its "uncompensated care pool." Goodman reports that hospital emergency rooms have become sources of primary care for the uninsured since "federal law requires emergency rooms to take all comers, regardless of ability to pay." He refers to the uninsured as the "free rider problem." These individuals may "choose not to pay insurance premiums . . . confident that the community as a whole will provide them with care." Goodman provides government data on the income distribution of the uninsured showing that most are not poor. Massachusetts is currently considering legislation to deal with this issue by requiring that all employees purchase health insurance! Currently, some individuals who are offered health insurance at work turn it down, and some employers don't offer it. It is argued that those who have in-

surance end up paying for those who don't. One Massachusetts proposal includes a requirement that any company with more than 10 employees would either have to provide health insurance or pay a 5 to 7 percent payroll tax. Currently, only Hawaii makes health care an employer responsibility.

The growth of health insurance in the U.S. is largely a 20th century phenomenon that parallels the growth of U.S. income taxes. In fact, the income tax has probably been a major driving force behind the expansion of health insurance as an employee benefit, an issue of some concern to Goodman. The reason for the relationship is that the cost of health insurance as an employee benefit is exempt from income taxes and payroll taxes. Goodman argues that this represents a large "tax subsidy" that distorts resource allocation decisions. You need to add your federal tax bracket, your state tax bracket, and the 15.3 percent employee and employer share of Social Security taxes to see that this "tax subsidy" or exclusion may be valued at about half of the cost of health insurance for many workers. This provides a large incentive for workers to purchase all health services through an employee health insurance mechanism. It should not be a surprise that employees and their unions prefer generous amounts of this "insurance" and that they prefer low deductible and co-pay provisions. Goodman argues that, *"As a result of federal tax policies, most employees are overinsured . . . too much insurance encourages people to be wasteful health care consumers. It also adds to administrative costs."* Most Americans (about 75 percent) obtain health insurance through employee plans. Many others (about 10 percent) are covered by government health insurance programs instituted in the 1960s to cover the poor (Medicaid) and the elderly (Medicare), leaving about 15 percent uninsured.

While Goodman suggests that the "tax subsidy" of employee health insurance may result in excessive spending on health services, he does not explore the size of the excess. He also argues that the countries with national health schemes "have been no more successful than the United States in controlling costs." This is a somewhat contradictory argument. In order to make this case, the chapter on costs discusses growth rates of spending for various countries *but neglects to show the base amounts*, a common bad behavior in statistical comparisons that is quite misleading in this instance. For comparison purposes, Table 1 shows health expenditures as a percentage of GDP for the U.K., Canada, and the U.S. since 1960. This data is from the U.S. National Center for Health Statistics (NCHS) publication *Health United States 2004* (http://www.cdc.gov/nchs/). Goodman objects that *"different countries use different methods to report costs."* However, the trends over time *are* meaningful. Note that in 1960 and in 1970, the GDP percentages for the U.S. and Canada were very close. In the mid-1960s, both Canada and the U.S. started major government health insurance programs, Medicare/Medicaid in the U.S. and a national health insurance program in Canada. After an initial bulge in expenditures in both the U.S. and in Canada, the Canadian system of national health insurance appears to have resisted upward pressures on spending to a *much* greater extent. Britain implemented a National Health Service much earlier, in 1948, and appears to have contained costs more effectively.

Table 1 actually understates the extent of spending on health care in the U.S., since the U.S. has a much higher income per capita than either Canada or the U.K. In U.S. dollars, health care spending per person for these countries in 2001 was: U.K. $1,992, Canada $2,792, U.S. $5,021 (also from NCHS). Thus, in 2001, U.S. health care spending per person was about 80 percent higher than in Canada and 2.5 times higher than in the U.K. Goodman argues that some of the difference is attributable to the preference of richer countries for higher amounts of health care, though this is not entirely consistent with the ranking of the income statistics for these countries. Particularly, Canada has the lowest income per capita in this table, but spends much more on health care than the U.K. The most recent data on income per capita from the World Bank are (2004, in U.S. dollars): Canada $28,390, U.K. $33,940, U.S. $41,400 (http://www.worldbank.org/).

If you agree that the "tax subsidy" of employee health insurance results in "excessive" spending on health insurance and on health services, then a logical question concerns what, if anything, to do about it. Some economists have favored removing the income tax exclusion for employee health insurance altogether! This change would subject employees to income taxes and payroll taxes on their salary *plus* the cost of employee health insurance. The immediate effect of such a change would be a substantial tax increase on employees. Martin Feldstein, a prominent economist, advocated proposals related to this idea, prompting my critique in a book review some years ago in the *Journal of Consumer Affairs* (vol. 16, n. 1, p. 177-181, 1982). Feldstein's proposals were intended to force the replacement of conventional employee health insurance with "Major Risk Insurance," carrying high deductible provisions, so that "the vast majority of payments for physician and hospital services would not be covered by insurance." The U.S.

Country	1960	1970	1980	1990	2000	2001
U.K.	3.9	4.5	5.6	6.0	7.3	7.6
Canada	5.4	7.0	7.1	9.0	9.2	9.7
U.S.	5.1	7.0	8.8	12.0	13.3	14.1

Table 1. Health expenditures as percentage of GDP—Selected years.

Congress never removed the tax exclusion of employee health benefits and seems unlikely to do so.

Goodman offers a related proposal. Rather than killing the tax exclusion for employee health benefits, he proposes to *extend* the tax exclusion to Health Savings Accounts (HSA's) that could be used to pay for routine health care expenses in conjunction with a high deductible (catastrophic) health insurance plan. He believes that this would cause health insurance to *evolve* toward a "casualty" model and would induce a greater degree of price sensitivity and price competition in health care. Health Savings Accounts are somewhat similar to the tax favored "Flexible Spending Accounts" (FSA's) that are currently offered by many employers, but without the annual "use it or lose it" requirement of FSA's that limits their popularity. The U.S. Congress actually passed legislation in 2003 that authorized HSA's! Employer and employee contributions to HSA's are tax exempt and balances may be rolled over from year to year. HSA's may be supplemented with health insurance, ***but*** the law requires that any health insurance used with an HSA ***must have a large deductible*** amount. Particularly, the law requires a deductible of at least $1,000 per person or $2,000 per family. The combination of a Health Savings Account and a supplemental high deductible health insurance policy creates a health plan that is similar to the older proposals of Feldstein (and others) to replace conventional employee health insurance with "Major Risk Insurance." High deductible health insurance has *not* proven to be popular with employees thus far, but Goodman's proposals have some significant support. In the debate over required coverage in Massachusetts, Republican Governor Romney (a presidential aspirant) has proposed covering many of the residents who lack insurance with high deductible plans, in order to hold down costs. High deductible plans, sometimes called "consumer-driven" health plans, have considerable appeal to employers who have experienced years of rapid growth in premiums for conventional health insurance. A recent survey of large national employers by Fidelity Investments reported that 45 percent intend to offer such high deductible plans (*Boston Globe*, 11-7-2005). If you live in the U.S., you will probably hear more about high deductible health plans in the future.

Regardless of your views on health care and health insurance, you will find this book to be interesting. The pressure to do something about health insurance will probably grow as health care spending in the U.S. grows to absorb a larger and larger share of national income and as the pressure to do *something* about the uninsured population continues to grow.

Related Web Sites

National Center for Policy Analysis: **http://www.ncpa.org**

US National Center for Health Statistics (NCHS) publication *Health United States 2004:* **http://www.cdc.gov/nchs/**

World Bank: **http://www.worldbank.org/** ■

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BOARD OF DIRECTORS REPORT

President Thomas E. Callarman (Arizona State University) chaired the Board of Directors meeting that was held on Saturday, November 19, 2005, at the San Francisco Marriott Hotel. The following is a report of the actions taken by the Board and matters brought to its attention. The Executive Committee also met on Friday, November 18. Its recommendations to the Board are included in the items reported below.

1. The minutes of the April 23, 2005, meeting of the Board of Directors were approved.
2. The audit report for FY 2004-2005 was reviewed and accepted.
3. The auditor's management letter was reviewed and accepted.
4. The financial statement for the period ended June 30, 2005, was reviewed and approved.
5. The financial statement for the period ended October 31, 2005, was reviewed and approved.
6. FY 2005-06 Midwest, Northeast, Southeast, Southwest and Western regional budgets were reviewed and accepted.
7. The proposed changes to the APDSI Constitution and Bylaws were approved.
8. Review of creating a Corporate Officer position on the Board of Directors was deferred.
9. Review of approval of an endorsement by the Institute of the MSIS 2006 Model Curriculum and Guidelines for Graduate Degree Programs in Information Systems was deferred.
10. The following reports and information items were reviewed and accepted:
    a) 2004-2005 Southeast DSI State of the Region report
    b) 2004-05 Midwest DSI State of the Region report
    c) Review of approved change to the Institute's Bylaw 5
    d) Schedules and locations of the 2006 Executive Committee and Board of Directors meetings
    e) Board representation at the 2006 Annual Regional Meetings
    f) Slate of nominees for the 2006 election of officers ■