An Agenda for Solving America's Health Care Crisis

Task Force Report
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Contact:

John C. Goodman

The National Center for Policy Analysis
12655 N. Central Expy., Suite 720
Dallas, Texas 75243
(214) 386-6272

HEALTH CARE TASK FORCE

Lee Benham
Professor of Economics
Center for the Study of
American Business
St. Louis, MO

William J. Dennis
Senior Research Fellow
The National Federation of
Independent Business Foundation
Washington, DC

Peter J. Ferrara
Associate Professor of Law
George Mason University School of Law
Senior Fellow
Cato Institute
Washington, DC

John C. Goodman
President
National Center for Policy Analysis
Dallas, TX

Jesse S. Hixson
Director
Department of Public Policy Studies
Center for Health Policy Research
American Medical Association
Chicago, IL

Cotton Lindsay
J. Wilson Newman
Professor of Managerial Economics
Department of Economics
Clemson University
Clemson, SC

William Mellor
President
Pacific Research Institute for
Public Policy
San Francisco, CA

Tom Miller
Senior Policy Analyst
Competitive Enterprise Institute
Washington, DC

Thomas Moore
Senior Fellow
Hoover Institution
Stanford University
Stanford, CA

Gerald Musgrave
President
Economics America, Inc.
Ann Arbor, MI

Aldona Robbins
Vice President
Fiscal Associates, Inc.
Arlington, VA

Gary Robbins
President
Fiscal Associates, Inc.
Arlington, VA

Robert M. Sade
Professor of Surgery
Division of Cardio-Thoracic Surgery
Medical University of South Carolina
Charleston, SC

Norman Ture
President
Institute for Research on the
Economics of Taxation
Washington, DC

Michael Walker
Executive Director
The Fraser Institute
Vancouver, BC
Canada

Carolyn Weaver
Resident Scholar and Director
Social Security and Pension Project
American Enterprise Institute
Washington, DC

John Andrews
President
Independence Institute
Golden, CO

Charles Baker
Director
Pioneer Institute
Boston, MA

Sam Brunelli
Executive Director
American Legislative Exchange Council
Washington, DC

John Carlson
President
Washington Institute for Policy Studies
Bellevue, WA

James W. Carr
Executive Director
American Studies Institute
Searcy, AR

A. Lawrence Chickering
Executive Editor
Institute for Contemporary Studies
San Francisco, CA

Robert Cooke
President
Institute for Business Ethics
Chicago, IL

John W. Cooper
Executive Director
The James Madison Institute for
Public Policy Studies
Tallahassee, FL

Lloyd C. Daugherty
President
South Foundation
Knoxville, TN

Porter Davis
Executive Director
Southwest Policy Institute
Oklahoma City, OK

Harold Eberle
Executive Vice President
South Carolina Policy Council
Education Foundation
Columbia, SC

Don E. Eberly
President
Commonwealth Foundation for
Public Policy Alternatives
Harrisburg, PA

Mark J. Greenfield
Executive Director
Heartland Wisconsin
Milwaukee, WI

Jacques Krasny
Director
and Managing Principal
Bogart, Delafield, Ferrier
Morristown, NJ

Andre V. Murchison
President
The New England Center for
Political Studies and Research, Inc.
Springfield, MA

Lawrence Reed
President
The Mackinac Center
Midland, MI

Simon Rottenberg
Professor of Economics
Economics Department
University of Massachusetts at Amherst
Amherst, MA

Michael Sanera
Executive Director
The Barry Goldwater Institute for
Public Policy Research
Flagstaff AZ

Richard Sherlock
Assistant Director
Institute of Political Economy
Utah State University
Logan, UT

Fritz S. Steiger
President
Texas Public Policy Foundation
San Antonio, TX

Richard Sweetser
Executive Director
Yankee Institute for Public Policy
Studies
Norwalk, CT

Michael Warder
Executive Vice President
The Rockford Institute
Rockford, IL

David Theroux
President
The Independent Institute
Oakland, CA

Bob Williams
President
Evergreen Freedom Foundation
Olympia, WA 98507

Walter Williams
John M. Olin
Distinguished Professor of Economics
Department of Economics
George Mason University
Fairfax, VA

Not all task force members agreed with every recommendation. In some cases, the authors have made other recommendations in other publications. The consensus was that the proposals made here would be a vast improvement over the current system, however. Task force members served as individuals, not as representatives of institutions.

Summary of Proposals

The American health care system has been shaped and molded by unwise government policies. Most of the problems of our health care system — including the rising costs and the increasing number of uninsured people — are direct results of those policies. Solving America's health care crisis requires a new policy agenda — one designed to assure that we can purchase high-quality health care for a reasonable price.

To Encourage Uninsured Individuals to Purchase Health Insurance: Employees of large companies usually have health insurance exempt from costly state regulations and encouraged by generous provisions of the federal tax law. Individuals who purchase health insurance on their own, however, receive no tax encouragement and face premiums inflated by costly regulations. Public policy should be neutral with respect to the way in which health insurance is purchased. We recommend the following:

- Allow insurers to sell no-frills, catastrophic health insurance not subject to state mandated benefits, premium taxes, risk pool assessments and other costly regulations.
- Allow individuals a tax credit for a portion of their health insurance premiums, so that individuals receive the same tax advantages available to employer-provided health insurance.
- Make tax credits refundable for low-income families.

To Encourage Health Insurance for Employees: Because of federal employee benefits law, health benefits are individualized, but the costs are collectivized — a situation in which encourages waste and discourages cost control. Small employers are further victimized by costly state regulations and federal laws which force them to create one-size-fits-all health insurance plans for their employees. These policies are encouraging large employers to limit coverage for employee dependents and encouraging small employers to drop health insurance benefits altogether. We recommend the following:

- Allow insurers to sell no-frills, catastrophic group insurance, not subject to costly state government regulations and taxes.
- Make health insurance benefits part of the gross wage of employees and allow tax credits for premiums on individual tax returns, so that employees (rather than employers) bear the cost of waste and reap the benefits of prudence.
- Allow each employee to choose a health insurance policy tailored to individual and family needs.

To Eliminate Waste and Control Rising Health Cares Costs: The tax law contains generous encouragement for wasteful, first-dollar health insurance coverage under employer health care plans. There is no tax encouragement for individual self-insurance, allowing people can pay small medical bills with their own funds. Waste also occurs because most hospitals refuse to do for individual patients what they often do for government and large insurers — quote a single package price prior to admission. Patients cannot be prudent buyers in the hospital marketplace if they cannot compare prices. Medical costs are also rising because of an inefficient tort system. We recommend the following:

- Limit favorable tax treatment for health insurance to catastrophic policies.

- Allow each employee to choose between wages and health insurance coverage, so that employees who choose less expensive coverage will have more take-home pay.

- Create tax credits for deposits to individual Medisave accounts, from which people would use their own money to pay small medical expenses.

- Require hospitals which accept government funds to negotiate a preadmission package price with patients.

- Allow patients to avoid the costly effects of the tort system through voluntary contract.

To Encourage Saving for Postretirement Health Care: Although the tax law encourages virtually unlimited employer-provided health insurance coverage for current medical expenses, it provides little encouragement for employers and no encouragement for individuals to save for postretirement medical needs. In both the public and private sectors, we are following a chain-letter approach to funding health care expenses for the elderly — an approach that will create an unbearable burden for future generations of workers. We recommend the following:

- Create tax incentives for individuals and employers to save for postretirement medical expenses.

- Allow tax credits for individual or employer contributions to Medical IRA accounts, designed to supplement and eventually replace coverage under Medicare.

To Limit Waste in Medicare and Encourage Catastrophic Health Insurance for the Elderly: Medicare pays too many small medical bills for the elderly while leaving them exposed to large, catastrophic medical expenses. Yet all attempts to resolve the problem through a one-size-fits-all health care plan have failed. We recommend the following:

- Allow private insurers to repackage Medicare benefits and create diverse policies tailored to the different needs of Medicare beneficiaries.

- Give the elderly tax incentives to self-insure through Medisave accounts for small medical bills rather than rely on wasteful, third-party insurance coverage.

To Avoid Health Care Rationing in the Medicare and Medicaid Programs: Medicare (for the elderly) and Medicaid (for the poor) are becoming price-fixing schemes, administered by large, impersonal bureaucracies. Rather than empower patients in the medical marketplace, these programs increasingly limit access to medical care by regulating the terms and conditions under which medical services can be delivered. We recommend the following:

- Medicaid patients should have the right to draw on an account, negotiate prices and add their own money if necessary, in order to purchase certain types of medical services — particularly prenatal care.

- For those categories of illness where it is apparent that Medicare is paying much less than the market price for reasonable care, Medicare patients should have the right to negotiate prices and supplement Medicare's payment with their own money or with private health insurance funds.

America's Health Care Crisis

America's health care system is in crisis. That is the conclusion of virtually every commentator on American medicine, regardless of political persuasion. Ask any doctor, any patient, any business executive or politician. Indeed, virtually everyone who has even remote contact with the health care system will readily agree that it is in need of serious reform.

The crisis is not new. It has been emerging for at least two decades. Over that period there have been numerous recommendations for reform. Yet we are no closer to a national consensus on how to solve our health care problems today than we were 20 years ago.

One reason why there is no national consensus on a solution is that most people do not agree on what the problem is. What we believe to be the nature of the health care crisis often depends almost entirely on where we stand in relation to the health care system.

Why People Do Not Agree on the Nature of the Crisis

"The nation has found no solutions because we cannot agree on what the problem is."

For employers and many public officials, the crisis is one of costs. America, they remind us, is spending $550 billion a year on health care — more than $2,000 per year for every man woman and child in the country. Health care spending is approaching 12 percent of our gross national product, higher than in any other country.

Yet for every cry of alarm over rising health care spending, there are at least two or three other cries of alarm over our failure to spend even more money on health care. Thirty-seven million Americans, we are told, lack health insurance. Among those who have health insurance, too often the policies fail to cover needed services, such as mental health care or treatment for alcohol and drug abuse. There also is a seemingly endless list of health care needs going unmet: prenatal care for the young, nursing home care for the old, and organ transplants for the young and old. Indeed, the most popular measures before Congress and the state legislatures are proposals not to lower health care spending but to forcibly extend the reach of private and public health insurance to more people and for more services.

The conflict of perspectives does not end there. Wherever we look in the health care system, we find almost diametrically opposed views on the nature of our problems. To most doctors, the main problem is increased bureaucratic interference from government, insurers, employers and even

hospital administrators — interference which raises costs and sometimes lowers the quality of care patients receive. But to almost all third-party (insurance) payers and to many hospital administrators, the problem is that doctors have too much freedom — especially too much freedom to increase costs.

Almost every patient who sees a hospital bill believes the hospital is overcharging. Almost all employers and insurance companies share that view. But almost all hospital administrators believe their hospitals are unfairly underpaid for the services performed and they worry about what services they will have to cut if they cannot increase hospital revenues. Many physicians have a similar view.

How The Medical Marketplace Differs From Other Markets

It is not unusual for the participants in a market to have different perspectives and different frustrations. In a normal market, however, major problems are solved by individual initiative on the part of consumers and producers pursuing their own self-interest. Consumers circumvent waste, inefficiency and resulting high prices by searching for bargains offered by efficient suppliers. Producers search for less costly ways of meeting consumer needs. Pursuit of self-interest by one person usually helps solve problems by creating benefits for others. Pursuit of self-interest by consumers rewards the most efficient producers, and pursuit of self-interest by producers rewards consumers.

"Normal market processes have been replaced by bureaucratic institutions."

In the health care sector, however, normal market processes have been replaced by bureaucratic institutions. Normal market incentives have been replaced by bureaucratic rule-making. As a result, the scope for individual initiative is greatly restricted and all too often people can pursue their own interests only by creating costs for others. The following are some examples:

- Whereas in a normal market consumers spend their own money, in the medical marketplace consumers are usually spending someone else's money. Less than 10 cents out of every dollar of hospital income and only 28 cents out of each dollar of physicians' fees is paid by patients using their own funds.

- Whereas in a normal market producers continuously search for ways to reduce costs, often when physicians and hospitals increase costs they also increase their incomes. Success depends less on service to patients and more on meeting the requirements of third-party (government and private insurance) reimbursement formulas.

- Whereas in other insurance markets individuals are often confronted with a diversity of products, the vast majority of people who have health insurance are covered under an employer or government plan. These plans usually give people very few options. An individual usually cannot purchase a less expensive plan with a different type of coverage without considerable personal sacrifice.

- Whereas in a normal market innovation and technological change are viewed as good for consumers, in the medical marketplace third-party payers are increasingly hostile to new technology and are discouraging its development.

- Whereas in a normal market producers advertise price discounts and quality differences, in the hospital marketplace most patients cannot find out what the cost will be prior to admission and cannot read the hospital bill upon discharge. Patients rarely can obtain information about the quality of physicians or hospitals — even when quality problems are well-known within the medical community.

The result is a marketplace in which the pursuit of self-interest often does not solve problems, but instead creates them. When consumers consume they drive up insurance premium costs for other consumers. The primary ways in which physicians and hospitals increase their incomes also lead to increasing insurance premiums. Rarely can individuals act to change things without operating through large bureaucracies, and when bureaucracies attempt solutions their "success" usually creates new problems and new costs for other bureaucracies.

"In the medical marketplace, consumers are usually spending someone else's money."

How the Crisis Evolved

The medical marketplace today is not a competitive market in which resources are allocated based on mutually beneficial exchanges between patients and physicians. It is instead a regulated, bureaucratized, institutionalized market, replete with perverse incentives for all who participate in it.

If the medical marketplace had developed the way other markets for goods and services developed, and if health insurance resembled insurance in other fields, the vast majority of the problems we are discussing would never have emerged. Our health care system is not the result of free choices exercised by consumers and producers in a competitive market, however. The

American system of health care finance has been shaped and molded by unwise government policies.

The United States is not alone. In almost all Western industrial democracies, health care systems shaped by government policies have evolved through three stages.

The Cost-Plus System of Health Care Finance (Stage I). From the end of World War II through the mid-1980s, Americans paid for hospital care principally through a "cost-plus system" of health care finance. Cost-plus reimbursement worked like this: If Blue Cross patients accounted for 25 percent of a hospital's patient days, Blue Cross reimbursed the hospital for 25 percent of its total costs. If Medicare patients accounted for 30 percent of the hospital's patient days, then Medicare paid the hospital 30 percent of its total costs. Other insurers reimbursed in much the same way.[1]

"In a cost-plus system, the pressures to increase spending are inexorable."

In the cost-plus system, health insurance literally served the function of insuring that hospitals had enough income to cover their costs. In this role, health insurers were acting as agents not for their policyholders, but for the suppliers of medical services. Since the only way the suppliers could increase their incomes was to increase costs, the cost-plus system of health care finance invariably led to rising health care costs.

A cost-plus system could never exist if patients were spending their own money in a competitive marketplace. Therefore, the prerequisite for cost-plus medicine was a market in which the supply side was dominated by non-profit institutions with limited ability to compete, and the demand side was dominated by large, third-party bureaucracies which were more responsive to the needs of sellers of medical services than to the needs of the people they insured. By the 1970s, these institutions were well in place.[2]

In a cost-plus system, the pressures to increase spending on health care are inexorable. Patients have no reason to show restraint, since the funds they spend belong not to them but to third-party institutions. When they enter the medical marketplace they are spending someone else's money, not their own money.

Physicians often believed that the "pure" practice of medicine could be free from the constraints of money. In prescribing tests and other medical treatments, physicians not only did not think about costs, they had no idea what those costs were. Guided by the sole consideration of patient health, physicians naturally were inclined to do anything and everything that *might* help the patient — restrained only by the ethical injunction to do no harm.

The system in its pure cost-plus phase rewards scientists, inventors and R & D personnel. The message of the medical marketplace is, "Invent it; show us it will improve health; and we will buy it, regardless of the cost." In no other market for any other type of technology does anything remotely similar take place.

The role of the hospital in such a world is to provide an environment in which cost-plus medicine can be practiced. A suitable environment is one in which all of the latest technology is available, preferably within easy reach and on demand. In such a world, hospital administrators do not manage doctors. To the contrary, they serve the physicians' interest in practicing medicine with as little interference as possible in the physicians' activities.

"The message is: Invent it; show us it will improve health; and we will buy it, regardless of the cost."

Such a hospital environment would be inconceivable were it not for a system that reimburses hospitals based on their costs. The role of third-party payers in the system, therefore, is to pay whatever bills are submitted with few questions asked. Cost increases are passed along to policyholders in the form of higher health insurance premiums.

The Cost-Plus System in its Cost-Control Phase (Stage II). Because there is a limit to how much any society will pay for health care, the cost-plus system is ultimately forced to limit the decisions of the suppliers of medical care in arbitrary ways. These limitations take the form of rules and restrictions written by impersonal bureaucracies, far removed from the doctor/patient relationships they seek to regulate. The extreme form of this approach is national health insurance (or socialized medicine), in which decisions concerning the allocation of health care resources are as far removed from patients as they can possibly be.

During the 1980s, the U.S. health care system evolved from a pure cost-plus system (Stage I) into a cost-plus system in its cost-control phase (Stage II). In this stage, there are many different third-party paying institutions, some public and some private. Each is engaged in a bureaucratic struggle — not merely to resist the cost-plus push of the medical care providers, but also to reduce its share of the total cost. Each separate third-party institution is free to initiate its own cost control strategy in random and uncoordinated ways. But since the basic structure of cost-plus finance has not been changed (that is, no real market has been created), Stage II only *secondarily* is about holding down total spending. *Primarily*, Stage II is the stage in which there is bureaucratic warfare over shifting costs.[3]

The central focus of third-party paying institutions is to eliminate what they perceive as "waste." Yet bureaucratic institutions (operating principally through reimbursement strategies chosen by people remote from actual patients and doctors) usually cannot eliminate waste without causing harm to patients. Third-party payers may seek to eliminate waste by controlling price, or quantity, or both. In the very act of trying to control prices, however, third-party institutions invariably focus on a normal price for a normal service, thus ignoring patients and institutional settings which are not normal. In the very act of trying to control quantity (e.g., by eliminating "unnecessary" surgery or "unnecessary" hospital admissions) third-party institutions again invariably set standards for what is normal — thus ignoring the unanticipated, abnormal circumstances in which medical care is often delivered.

On the supply side of the medical marketplace, institutions have great resources and considerable experience at resisting change. So in the face of a cost-control measure initiated by one institutional buyer, the suppliers attempt to shift costs to another institutional buyer, without changing their fundamental behavior. We expect the suppliers to be sufficiently adept at this so that, over the long haul, costs are not really controlled in Stage II. At best, the rate of increase is slowed at various intervals. Each new wave of buyer restrictions has an initial impact. But after suppliers adjust to the new restrictions, costs rise again. Precisely for this reason, a system in Stage II evolves into Stage III. It is in this final stage that institutional buyers acquire the ultimate weapon in the cost-control battle — the power of government.

"Bureaucratic institutions usually cannot eliminate waste without causing harm to patients."

Evolution to National Health Insurance (Stage III). In the final phase of the cost-plus system's evolution, the third-party payers directly or indirectly control the entire system. That is, third-party institutions begin to determine what technology can be used, what constitutes ethical behavior in the practice of medicine, what illnesses can be treated and how they are to be treated. Ultimately, these institutions determine who lives and who dies.

In most countries with national health insurance schemes, many of the perverse incentives that were present in Stage I are still in place. The appetite to spend is held in check, or misdirected, by rules and regulations enforced either directly by government or by insurance company proxies for government. In this stage, government not only controls the total amount of spending on health care, it also actively intervenes in the allocation of health care dollars. Stage III is pure special interest warfare, fought out in the political arena. Stage III takes all of the struggles present in Stage II, and elevates them to the realm of politics.[4]

How the Health Care System Affects Patients

In Stage I in the evolution of a cost-plus system, the quality of medicine delivered may be very high. This is because medical care is administered in an environment in which cost is no object, and physicians are trained to do everything possible to alleviate any and all illnesses, whether real or imagined.

Once the cost-plus system enters a cost-control phase, however, the quality of patient care can deteriorate rapidly. This is because, in the cost-control phase, competing institutions begin a monumental struggle over resources. In this environment, the patient is no longer seen as a consumer or buyer of medical care. Indeed, individual patients become largely unimportant except insofar as their formal consent is needed in order to legitimize a continuation of bureaucratic warfare over vast sums of money.

"Health insurance has become prepayment for the consumption of medical care."

The Role of Insurance. Outside of the health care sector, there are well-developed markets for insurance for a wide variety of unforeseen, risky events: life insurance (for an unforeseen death), auto liability insurance (for an unforeseen automobile accident), fire and casualty insurance (for unforeseen damage to property), disability insurance (for unforeseen physical injuries). Indeed, there is hardly any risk that is not in principle insurable. Lloyd's of London will even insure against the failure of a communications satellite to achieve orbit.

All of these markets have certain common characteristics.[5] The amount to be reimbursed is based on a risky event. Once the event has occurred and the damage has been assessed, the insurer writes a check to the policyholder for the agreed-upon amount. Policyholders are free to do whatever they prefer with the money they receive.

In the market for health insurance, however, things are very different. Often, there does not need to be any risky event in order to trigger insurance payments (e.g., coverage for preexisting illnesses). Once it is determined that a health insurer owes something, the amount to be paid is not a predetermined sum but is determined by the *consumption* decisions of the policyholder (e.g., the choice to have surgery in a hospital rather than as an outpatient, or the choice to undergo a battery of tests). Payment is made not to the policyholder but to medical providers, based on the consumption decisions that are made.[6]

These differences make a major impact on the way that the health insurance market functions. In fact, in many respects health insurance is not insurance at all. It is instead *prepayment for the consumption of medical care.*

Because health insurance is the primary vehicle by which people consume medical services, in a very real sense it is the insurer, not the patient, who is the customer of medical providers. Thus, people insured by Blue Cross are not the principal buyers of the medical care they receive. Blue Cross is. Similarly, Medicare beneficiaries are not the principal buyers of their medical care. Medicare is.

"The real customer in the medical marketplace is the third-party payer, not the patient."

The result is a medical marketplace in which the principal role of the patient is to give *consent* to medical procedures. Once patient consent has been secured, the real forces in the medical marketplace emerge: third-party payers buy, and medical providers sell.

The Relationship Between Buyer and Seller. In a normal marketplace, buyers and sellers haggle over price, quantity, quality and other terms, and reach mutually beneficial agreements. An exchange is not consummated unless it benefits both parties. The preferences of others who are not parties to the exchange are rarely considered.

In the medical marketplace, however, rules imposed by third-party institutions are increasingly shaping the practice of medicine. When Medicare patients interact with the health care system, *what* procedures are performed — and *whether* a procedure is performed — is increasingly determined more by Medicare's rules than by patient preferences or the physician's experience and judgement. Although this phenomenon is more true of government health care programs (Medicare and Medicaid), private insurers and large self-insured companies are increasingly copying the methods of government.

The Role of Information. One of the strangest features of the medical marketplace is how little information patients have — even on matters of life and death. Most patients who enter a hospital do not know (and cannot find out) what they will be charged for the procedures that are going to be performed. At the time of discharge, patients are frequently confronted with lengthy line item bills which they cannot read or understand. They have no idea why they were charged what they were charged and no way of checking to see that it was reasonable. Although many patients assume that their health insurer will check the bill and look out for their interests, third-party insurers frequently cut their own deals with hospitals and leave patients to fend for themselves.

"Third-party payers are increasingly dictating the quality of health care."

If patients have little knowledge about prices in the medical marketplace, they know even less about quality. In the market for any professional service, consumers often have difficulty making judgments about the quality

of services being rendered. In the medical marketplace, these problems are worse. Although patients frequently assume that third-party institutions are their agents, these institutions frequently sacrifice the patient's interest in pursuit of their own interest. For example, third-party payers often put pressure on medical providers to lower the quality of care in order to control costs.

Thus, patients receiving a pacemaker implant frequently are not told — and may never learn — that a better, higher-quality pacemaker was available but not used. Patients receiving drugs in a hospital frequently are not told — and may never learn — that more effective (and more expensive) drugs were available but not administered. In general, medical equipment manufacturers, pharmaceutical manufacturers and other suppliers (who have a great deal of information about quality) do not communicate this information to patients because patients are not viewed as the principal buyers. Instead, the principal customers are hospitals, physicians and third-party institutions.

"Patients may never learn that higher quality care was available but not administered."

Patients frequently do not have information about quality for yet another reason. In an effort to suppress competition among the providers, associations of physicians and hospitals have gone to great lengths to make it difficult (if not impossible) for patients to get information about quality. The obligation not to make quality comparisons became a matter of professional ethics. In the past, adherence to these ethical codes was backed by the force of state law. As a result, in most communities patients cannot even discover the mortality rate for surgery and for specific surgeons at public hospitals funded by the patients' own tax dollars.

An Exception: Cosmetic Surgery. In one area of the medical marketplace, most of the generalizations made above are no longer true: cosmetic surgery. In general, 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 quality in the field of cosmetic surgery than in any other area of surgical practice.[7]

"The market for cosmetic surgery is different because patients pay with their own money."

Vision of an Ideal Health Care System

Before we recommend solutions to America's health care problems, we need a clear idea of where we want to go. That is, we need a vision of an ideal medical marketplace in order to plan the necessary steps to get us there.

In general, the vision of the health care system we accept determines what we think is possible, and even desirable. Our vision of how the health care system can and should function determines what we see as problems, how we analyze those problems and how we propose to go about solving them.

One vision, the cost-plus vision, has dominated thinking about health care since the end of World War II. In this vision, the primary relationships are between bureaucracies rather than between patients and physicians. People who accept this vision will inevitably attempt to solve health care problems through bureaucratic rule-making, or by changing the ways bureaucracies relate to each other.

"In the ideal market, the pursuit of self-interest by individuals solves social problems."

We propose a different vision — a vision of an ideal health care system. The secret of the American success story is that for most of our history, in most sectors of our economy, we have created an institutional environment in which the pursuit of individual self-interest promotes the well-being of all of us. That is not true in the health care sector. But it can be. The market for medical care will never resemble the market for corn or wheat. Yet there is no reason why health care problems cannot be solved through market-based institutions. In such a system, decisions would be made by individuals rather than large institutions. Supply and demand and competitive forces would allocate resources. But the destiny of our health care system would be determined by consumer preference and individual choice.

By "ideal," we do not mean a visionary world in which there are no problems. The ideal medical marketplace is simply a market which works at least as well as most other markets in which we buy and sell.[8]

Principles that Would Govern an Ideal Health Care System. If our objective is to create a medical marketplace which solves problems at least as well as markets for other goods and services, we can identify five principles that would govern an ideal health care system. These principles serve as goals. In the very act of reaching these goals, we would be simultaneously solving America's health care problems.

"Solving the crisis means transferring power from large bureaucracies to individual people."

- Solving America's health care problems requires transferring power from large institutions and impersonal bureaucracies to individual people.

- Solving America's health care problems requires restoring the buyer/seller relationship to patients and medical suppliers, so that patients (rather than third-party insurers) become the principal buyers of health care.

- Solving America's health care problems requires creating institutions in which patients (as much as possible) spend their own money, rather than someone else's money, when they purchase health care.

- Solving America's health care problems requires removing health care (as much as possible) from the political arena, in which well-organized special interests can cause great harm to the rest of us.

- Solving America's health care problems requires subjecting the health care sector to the rigors of the competitive markets, and creating market-based institutions in which individuals reap the full benefits of their good decisions and bear the full cost of their bad ones.

How an Ideal Health Care System Would Function. In a health care system based on principles listed above, there would be a radical change in the roles of patients, physicians, hospitals, insurance companies, employers and even government.

"In the ideal system, patients — not third-parties — would become the principal buyers of medical care."

- In an ideal health care system, patients rather than third-party payers would become the principal buyers of health care, comparing options, comparing prices and making decisions.

- In an ideal health care system, physicians would no longer serve as the principal agent of third-party payers. Physicians instead would serve as the principal agent of patients, helping them make informed choices.

- In an ideal health care system, hospitals would no longer serve as the principal agent of either physicians or third-party payers. Instead, hospitals would become competitors in the business of health care delivery and would compete for patients by improving quality and lowering price.

- In an ideal health care system, health insurance companies would no longer be buyers of health care. Instead, insurers would specialize in the business of insurance, reimbursing policyholders in the case of unforeseen and risky adverse health events.

- In an ideal health care system, employers would not be buyers of health care and would no longer make decisions for employees concerning the content of employee health insurance policies.

Instead, employers would be agents for individual employees, helping them to make informed choices in the health insurance marketplace and to monitor the performance of competing insurers.

- In an ideal health care system, government (in its role as an insurer of last resort) would no longer serve as a buyer of health care. Instead, the role of government would be to provide a source of funds for health insurance premiums for indigent policyholders.

- In an ideal health care system, government (in its policymaking role) would facilitate the goals of the system on the demand side by encouraging private savings for small medical bills, private health insurance for large medical bills and life-long savings for medical needs during retirement. On the supply side, government would encourage free and open competition in the markets for physicians services, hospital services and private health insurance.

"Physicians would become the principal agents of patients, rather than agents of third-party payers."

Moving Toward the Ideal: An Agenda for Change

We cannot move from the current health care system to an ideal system overnight. We can move in the right direction, however, by adopting policies designed to solve immediate problems in ways that also help us attain the long-run goal. This agenda is designed to address five immediate problems:

1) The current system of paying for health care is contributing to rising health care costs.

2) Too many Americans are choosing not to purchase catastrophic health insurance for themselves and their families.

3) Too many Americans who have health insurance have been effectively denied the opportunity to choose a less costly type of insurance policy or a policy which is better suited to individual and family needs.

4) Too many Americans are failing to save for health care expenses they are almost certain to incur during the years of their retirement.

5) There is increasing danger that we are moving toward a system of health care rationing under which individuals are denied the opportunity to purchase more (or better) health care without suffering costly penalties.

These five problems primarily are caused by unwise policies adopted by the federal government and by state governments. This agenda is designed to create new incentives under which people will find it in their self-interest to solve these problems through individual initiative and choice. Accordingly, the provisions of this agenda would expand the range of choices open to people — giving them greater opportunity to purchase health insurance tailored to their own needs, to control how their health insurance dollars are spent, and to save for medical expenses which they will incur during the years of their retirement. Specifically, this agenda would:

"People will find it in their self-interest to solve problems through individual initiative and choice."

- Give individuals greater opportunity to purchase no-frills catastrophic insurance for a reasonable price.
- Give individuals greater opportunity to choose among competing health insurance plans and to select the type of coverage best suited for individual and family needs.
- Give individuals the opportunity to choose between group health insurance (provided by an employer) and individual or family policies — without income tax penalties.
- Give individuals the opportunity to choose between self-insurance and third-party insurance for small medical bills — without income tax penalties.
- Give individuals the opportunity to choose health insurance plans with effective cost-control techniques and to realize the financial benefits from these choices — without income tax penalties.
- Give individuals the opportunity to build a reserve of savings for future medical expenses, thus allowing them to rely less on third-party insurance and to reduce their annual health insurance premiums.
- Give individuals greater opportunity to compare prices in the hospital marketplace and realize the financial benefits of prudent buying practices.
- Give people covered by Medicare and Medicaid opportunities to avoid the harmful effects of health care rationing.
- Give all participants in the medical marketplace an opportunity to avoid the costly effects of the tort system through voluntary contract and exchange.

1. Equity in Taxation

Problem: Health insurance provided by an employer is excluded from the taxable wages of the employees, but insurance premiums paid by individuals are not tax deductible. This means that some people realize generous tax advantages from the purchase of health insurance, while others do not.

Solution: All Americans should receive the same tax treatment with respect to health insurance, regardless of employment and regardless of who purchases the health insurance policy — an individual, employer or self-employed person.

Discussion: Federal tax law has an enormous impact on the employee benefit plans of employers precisely because marginal tax rates are so high. Even a moderate wage-earner in the U.S. economy gets to keep less than 70 cents out of each additional dollar earned. The federal income tax rate for this worker is 15 percent and the combined (employer plus employee) Social Security tax rate is 15.3 percent. Thus, federal taxes take 30.3 cents out of each additional dollar of wages. If this employee faces a 6 percent state and local income tax, the marginal tax rate is 36.3 percent, leaving the employee with less than two-thirds of a dollar of wages in the form of take-home pay.

"The tax advantage for health insurance ranges from $1,200 per year for an auto worker to zero for people who purchase their own health insurance."

As Table 1 shows, workers in the 28 percent federal income tax bracket face a marginal tax rate of 43.3 percent — leaving them with less than 57 cents in take-home pay out of each additional dollar of earnings. If state and local income taxes apply, the situation is much worse. Indeed, millions of American workers take home less than 50 cents of each dollar of earnings.

TABLE 1

After-Tax Value of a Dollar of Money Wages

Federal Tax Category	No State and Local Income Tax	State and Local Income Tax
FICA Tax Only	**85¢**	**81¢**[1]
FICA Tax Plus 15 percent Income Tax	**70¢**	**64¢**[2]
FICA Tax Plus 28 percent Income Tax	**57¢**	**51¢**[2]

[1]State and local income tax rate equals 4 percent.

[2]State and local income tax rate equals 6 percent.

These high tax rates give employers and employees strong incentives to replace wages with nontaxable health insurance benefits. These incentives make the purchase of health insurance very attractive, even if it would not otherwise have been purchased. The total tax deduction for employer-provided health insurance is about $48.5 billion per year — roughly $485 for every American family. Yet most of the 37 million individuals who do not have health insurance (including about 17.5 million employees),[9] and about 10 percent of insured individuals who purchase health insurance on their own, have no opportunity to receive a tax subsidy. As a result some employees of large companies have lavish health insurance plans (all tax deductible) while other Americans have no tax-subsidized health insurance. In general:

"All Americans should receive the same tax encouragement to purchase health insurance, regardless of who buys the policy."

- The value of the right to exclude health insurance coverage from taxable wages ranges from about $1,200 per year in reduced taxes for an auto worker to about $300 for a worker in retail trade.[10]

- Self-employed individuals are allowed to deduct only 25 percent of their health insurance premiums, and even this right has an uncertain future.[11]

- Unemployed people and employees of firms which do not provide health insurance receive no tax subsidy for the health insurance they purchase.

Not surprisingly, people respond to these incentives. The more generous the tax subsidy, the more likely people are to have health insurance.[12] Those most likely to be uninsured are people who receive no tax subsidy.

Equity in taxation requires that all Americans receive the same tax encouragement to purchase health insurance, regardless of employment. Accordingly, the self-employed, the unemployed and employees who purchase health insurance on their own should be entitled to a tax deduction or tax credit that is just as generous as the tax treatment they would have received if their policies had been provided by an employer.

2. Equal Tax Advantages for Families with Unequal Incomes

Problem: Under the current system, the ability to exclude employer-provided health insurance from taxable income is more valuable to people in higher tax brackets.

TABLE 2

Value of a Dollar of Employer-Provided Health Insurance

(Relative to Taxable Wages)

Federal Tax Category	No State and Local Income Tax	State and Local Income Tax
FICA Tax Only	$1.18	$1.24[1]
FICA Tax Plus 15 percent Income Tax	1.44	1.56[2]
FICA Tax Plus 28 percent Income Tax	1.76	1.97[2]

Note: Table shows the amount of taxable wages that are equivalent to a dollar spent on an employee benefit.

[1]State and local income tax rate equals 4 percent.

[2]State and local income tax rate equals 6 percent.

Solution: If it is socially desirable to encourage families to purchase health insurance for large medical bills through the income tax system, then all families should receive the same encouragement, regardless of income level.

Discussion: Since the value of the tax subsidy rises with income, it is hardly surprising that the lower a family's income, the less likely the family is to have health insurance. About 92 percent of all people who lack health insurance have an annual income less than $25,000.[13] Table 2 shows the value of employer-provided health insurance relative to the payment of a dollar of wages. As the table shows:[14]

"The tax advantage for health insurance rises as the worker's income rises."

- For a low-income worker who is paying no income tax, federal tax law makes a dollar of health insurance benefits equivalent to $1.18 in wages.

- For a worker who is in the 28 percent bracket and paying the Social Security (FICA) tax, however, a dollar of health insurance benefits is equivalent to $1.76 in wages.

If an employer gave the higher-paid worker $1.76 in wages, the worker's take-home pay would only be $1.00 after taxes are paid. On the other hand, if the $1.76 is spent on health insurance premiums, the worker gets the full value of the benefit.

"Low-income families should receive as much or more tax encouragement as high-income families."

In order to give all people the same economic incentives to purchase health insurance, premiums paid by employers should be included in the gross wages of their employees, and all taxpayers should receive a tax credit equal to a percent (say, 30 percent) of the premium.[15] This would make the tax subsidy for health insurance the same for all taxpayers, regardless of income and regardless of whether the policies are purchased individually or by employers. For individuals who pay no federal income tax, the tax credit could be made refundable. This proposal would also have other advantages discussed below.

3. Ending Tax Subsidies for Wasteful Health Insurance

Problem: Under the current system, the ability to exclude health insurance from taxable income is unlimited, encouraging some employees to "purchase" too much insurance.

Solution: The ability to exclude payments for health insurance from taxable income (or the opportunity to receive a tax credit for premiums) should be limited to a premium sufficient to allow the purchase of a no-frills, catastrophic health insurance policy. Individuals who pay higher premiums for additional coverage should do so without tax subsidy.

"Auto workers receive $3,055 of tax subsidized insurance each year, while other workers receive no tax subsidy."

Discussion: As noted above, the tax subsidies for health insurance are quite large. For a higher-paid employee (facing a 6 percent state and local income tax rate), $1.97 of wages is equivalent to $1.00 of health insurance. This encourages employees to prefer overly generous (and wasteful) health insurance coverage — coverage that they would not buy out-of-pocket without tax subsidies. For a highly-paid employee, $1.97 spent on health insurance need only be worth $1.01 to be preferable to $1.97 of wages. If paid in wages the employee will be left with just $1.00 of take-home pay. Moreover, since higher-paid workers tend to dictate the contents of employee benefits plans, their choices tend to be imposed on all other workers.

The tax law encourages over-insurance in yet another way. One of the strange features of the tax code is that a physician's fee paid by an employer (or an employer's insurance carrier) is paid with pretax dollars, whereas fees paid out-of-pocket by employees must be paid with after-tax dollars. As a result, the tax law encourages (subsidizes) 100 percent health insurance coverage (with no deductibles and no copayments) for all medical expenses. Unfortunately, insurance for small medical bills is the most wasteful type of health insurance. For one thing, it usually costs an insurance company more

than $50 to administer and monitor a claim for a $50 physician's fee, effectively doubling the cost of health care. For another thing, people are far less prudent in purchasing health care if the bills are paid by someone else.[16]

"The tax law should encourage only catastrophic, no-frills coverage."

Under the current system, tax deductible health insurance expenditures range from a high of $3,055 under the generous health care plans provided by the automobile manufacturers to as little as $793 — the average for workers in retail trade. Although this system may appear to benefit large companies with highly-paid employees, in many cases these companies are trapped in benefit plans that are eating into company profits and raising production costs. The current system not only encourages and subsidizes rising health care costs, it is causing harm to the very industries and companies which are subsidized the most.

To correct this abuse, it should be national policy to encourage individuals to purchase health insurance for catastrophic medical expenses and to save to pay small medical expenses with their own funds. Accordingly, the tax credit for health insurance should be limited to a premium amount sufficient to purchase a policy, say, with a $1,000 deductible and a 20 percent copayment up to an additional $1,000.[17] At the same time, people should be encouraged to save for small medical expenses in the manner described below.

4. Creating Individual Self-Insurance for Small Medical Bills

"The current system encourages first dollar coverage for third-party insurance, but penalizes self-insurance."

Problem: Because employees (through their employers) are able to purchase health insurance with pretax dollars, but individuals are not allowed to self-insure (personal savings) for small medical expenses with pretax dollars, too often people buy low-deductible health insurance, using insurers to pay for small medical bills that would be less expensive if paid out -of-pocket.

Solution: Individuals should be able to make annual deposits to individual Medisave accounts and to use these funds for medical expenses without tax penalty.

Discussion: The easiest way to hold down premium increases is to choose health insurance policies with high deductibles. Table 3 presents the marginal cost (premium increase per additional dollar of coverage) of buying down the deductible on a representative individual health insurance policy for a middle-aged male. As the table shows:[18]

- Lowering the deductible from $750 to $500 costs 55 cents in additional premium for each additional dollar of insurance coverage.

- Lowering the deductible from $500 to $250 costs 62 cents in additional premium for each additional dollar of insurance coverage.

While lower-deductible policies may occasionally be a good buy from the point of view of an isolated individual, they cannot possibly be a good buy for policyholders as a group. As noted above, hiring an insurance company to pay small medical bills can double the costs of the medical service. As a result, low-deductible policyholders as a group are paying far more in premiums than they will "collect" in medical benefits. Table 3 also shows an even more bizarre phenomenon:[19]

"Low-deductible health insurance is almost always a waste of money."

- Lowering the deductible from $250 to $100 costs $2.14 for each additional dollar of insurance coverage.

- Policyholders who choose this option are paying $1.14 more than any possible benefit they could derive from each additional dollar of coverage.

Low-deductible insurance policies, then, are not simply wasteful. In some cases policyholders pay more than any possible value that could be gained from the extra coverage. Yet the current tax law encourages such

TABLE 3

Cost of a Lower-Deductible Health Insurance Policy

(Male, Age 40)[1]

Lowering the Deductible[2]			Additional Premium	Cost of Each $1 of Additional Coverage
$1,000	→	$750	$ 97.49	0.49¢
$ 750	→	$500	$109.93	0.55¢
$ 500	→	$250	$124.56	0.62¢
$ 250	→	$100	$256.82	$2.14

[1]Assumes the policyholder lives in a city with average health care costs.

[2]Policy has a 20 percent copayment up to a maximum of $1,000.

[3]Because the policy has a 20 percent copayment, additional coverage is 80 percent of the difference between the two deductibles.

Source: Golden Rule Insurance Company.

policies and discourages high-deductible policies. On a $1,000-deductible policy, for example, the first $1,000 must be paid out-of-pocket with after-tax dollars. If that $1,000 were paid by employer-provided insurance, the premium could be paid with pretax dollars, thus benefiting from a tax subsidy.

To eliminate the perverse incentives in the current system, we should allow individuals to make deposits, say, of $300 per year to individual Medisave accounts. These accounts would serve as self-insurance for small medical bills and would be an alternative to the wasteful practice of using third-party insurers for this purpose. Medisave accounts would be the private property of the account holder and become part of an individual's estate at the time of death. Contributions to Medisave accounts should receive the same tax encouragement as payments for conventional health insurance.[20]

"The tax law should encourage self-insurance as much as it encourages third-party insurance."

This proposal is designed to change incentives and, therefore, change the way in which we pay for medical care. It is not designed to change the total tax benefit people now receive For example, the average insured worker in the U.S. economy has a deductible of about $250.[21] If that deductible were raised to $1,000, the premium saving would be about $300 — an amount that would be deposited to a Medisave account. For the average worker, then, there would be no change in the amount reserved for health care benefits or in the total tax subsidy. Yet the change would encourage prudence, eliminate waste and give employees greater control over how their health care dollars are spent.

Creating individual and family Medisave accounts would represent a major departure from the current system of paying for health care. These accounts would have immediate advantages which would become even more important over time.[22]

"Medisave accounts would be personal and portable and funds would accumulate tax free."

1. Medisave accounts would give individuals direct control over their health care dollars — freeing them from wasteful consumption decisions by other policyholders and from the arbitrary, bureaucratic constraints imposed by third-party insurers.

2. When people spent money from their Medisave accounts, they would be spending their own money, not someone else's money — giving people excellent incentives to become prudent buyers in the medical marketplace.

3. The funds in Medisave accounts would grow over time, allowing people to choose higher-deductible policies — thus relying less on

third-party insurers and acquiring more control over how their health care dollars are spent.

4. Since Medisave accounts would last over an individual's entire life, they would allow people to engage in lifetime planning — recognizing that health (and medical expenses) are related to choices people make throughout their lives.

"When people purchase medical care from their Medisave accounts, they will be spending their own money, not someone else's money."

5. Medisave accounts would eventually become an important source of funds from which to purchase health insurance or make direct payments for medical expenses not covered by Medicare during retirement.

5. Creating Freedom of Choice in Health Insurance

Problem: Mandated health insurance benefits imposed by state governments as well as other state regulations are increasing the price of health insurance and pricing as many as one out of every four uninsured people out of the market for health insurance.

Solution: Individuals should have the freedom to buy no-frills health insurance, tailored to individual and family needs.

Discussion: The number of Americans without health insurance has increased by 25 percent since 1980 and now totals as many as 37 million people.[23] A major reason why so many people lack health insurance is that state regulations are increasing the costs of insurance and pricing millions of people out of the market for insurance.[24] In recent years there has been an explosion of state laws requiring health insurance policies to cover specific diseases and specific health care services. These laws are called mandated health insurance benefit laws.

"One out of every four people without health insurance has been priced out of the market by costly regulations."

- In 1970, there were only 30 mandated health insurance benefits in the United States.

- Today there are at least 800 mandated benefits, including legislation passed by every state in the union.

Mandated health insurance benefits cover ailments ranging from AIDS to alcoholism and drug abuse, and services ranging from acupuncture to *in vitro* fertilization. Mandated benefits cover everything from the life-prolonging procedures to purely cosmetic devices: heart transplants in Georgia, liver transplants in Illinois, hairpieces in Minnesota, marriage counseling in Cali-

fornia and pastoral counseling in Vermont. These laws reflect the fact that special-interest groups now represent virtually every disease and disability and virtually every health care service. Currently:

"State governments are mandating coverage for services ranging from acupuncture to in vitro fertilization."

- Thirty-seven states require health insurance coverage for the services of chiropractors, three states mandate coverage for acupuncture and two states require coverage for naturopaths (who specialize in prescribing herbs).
- At least 13 states limit the ability of insurers to avoid covering people who have AIDS or a high risk of getting AIDS.
- Laws in 40 states mandate coverage for alcoholism, 20 states mandate coverage for drug addiction, and 30 states require coverage for mental illness.
- Five states even mandate coverage for *in vitro* fertilization.

Collectively, these mandates have added considerably to the cost of health insurance, and they prevent people from buying no-frills insurance at a reasonable price. As Table 4 shows, mandated coverage for substance abuse is very costly — increasing premium prices by 6 to 8 percent. Mandated coverage for outpatient mental health care is even more expensive — increasing premium prices by 10 to 13 percent. Psychiatric hospital care apparently has little effect on premium prices for the primary insured person. But if dependents are covered, premium prices can rise by as much as 21 percent.

"Everyone should have the right to buy a no-frills policy."

These price increases are having an effect. As many as one out of every four uninsured people lacks health insurance because state regulations have increased the price of insurance.[25] This means that as many as 9.3 million people lack health insurance because of current government policies. Employees of the federal government, Medicare enrollees and employees of self-insured companies are exempt from these costly regulations under federal law. Often, state governments exempt Medicaid patients and state employees. The full burden, therefore, falls on employees of small business, the self-employed and the unemployed — the groups which are increasingly uninsured.

Freedom of choice in health insurance means being able to buy a health insurance policy tailored to individual and family needs. This freedom is rapidly vanishing from the health insurance marketplace. Accordingly, insurers should be permitted under federal law to sell federally qualified health insurance both to individuals and to groups. This insurance would be free

from state mandated benefits, state premium taxes and mandatory contributions to state risk pools.

"Under state mandates people must pay more for a package of benefits they may not want or need."

TABLE 4

Effects on Insurance Premiums of Specific Health Insurance Benefits

Feature	Change in Individual Premium	Change in Dependent's Premium
Home Health Care	**+ 0.1 %***	**- 5.0 %***
Extended Care	**- 0.4 %***	**- 5.1 %***
Substance Abuse Treatment	**+ 7.9 %**	**+ 6.2 %**
Psychiatric Hospital Care	**- 1.7 %***	**+ 20.8 %**
Psychologists Visits	**+ 10.4 %**	**+ 12.6 %**
Routine Dental Care	**+ 23.8 %**	**+ 11.8 %**

* = not statistically significant

Source: Gail A. Jensen (University of Illinois at Chicago) and Michael A. Morrisey (University of Alabama at Birmingham), "The Premium Consequences of Group Health Insurance Provisions," September, 1988, mimeograph.

6. Giving Employers and Employees New Options For Cost Containment and Individual Freedom of Choice

Problem: Under current employee benefits law, employers have few opportunities to institute sound cost-containment practices without substantial income tax penalties, and employees have few opportunities to purchase less costly health insurance or policies tailored to individual and family needs.

"Health insurance benefits should be personal and portable."

Solution: Health insurance benefits should be personal and portable, with each employee free to choose an individual policy which would remain with the employee in case of a job change. Health insurance benefits should be included in the gross wages of employees who would be entitled to tax credits for premiums on their personal tax returns — so that employees reap the direct benefits of prudent choices and bear the direct costs of wasteful choices.

"Current law prevents employers and their employees from finding sensible solutions."

Discussion: Suppose a small firm is considering purchasing an individual health insurance policy for each employee in order to take advantage of the favorable treatment of health insurance under the tax law. As Table 5 shows, this firm will immediately confront four problems. The first problem is that the cost of the policy will vary depending on the age of the employee. (A 60-year-old male, for example, is about three times more expensive to insure than a 25-year-old male.) The obvious solution is to pay the premiums for the policies and reduce each worker's salary by the premium amount. The second problem is that not all employees may want health insurance (e.g., some may be covered by another policy). The obvious solution is to give health insurance only to those employees who want it, reducing the salary of each by the amount of the premium. The third problem is that some employees may have preexisting illnesses, and the insurer may want to insert exclusions and riders into their policies. The obvious solution is to get each employee the best possible deal. The fourth problem is that employees may have different preferences about the content of their policies. Some may want to trade off a higher deductible for a lower premium. Others may want coverage for different types of illnesses and medical services (e.g., infertility coverage). The obvious answer is to let each employee choose a policy best suited to the employee's needs and preferences.

TABLE 5

Solving Health Insurance Problems For Employers and Employees

Problem	Solution
Employees have different pref–erences about health insurance coverage (deductibles, types of services covered, etc.)	**Allow each employee to choose a policy best suited to individual and family needs.**
Costs differ by age, sex, type of job and other employee characteristics.	**Reduce each employee's gross salary by the amount of that employee's premium.**
Not all employees want or need employer-provided coverage.	**Give health insurance only to employees who want it.**
Some employees have pre-existing illnesses.	**Negotiate the best coverage possible for each individual employee.**

NOTE: Each of these solutions requires changes in the tax law and in employee benefits law in order to avoid costly tax penalties.

Despite the fact that these solutions seem obvious and despite the fact that every single employee may gain from them, they are generally forbidden under federal law. In general, the tax law forbids employees from choosing between wages and health insurance and insists that all employees be offered the *same* coverage on the *same* terms.

The result is that the employer must turn to a more expensive group policy with a package of benefits that no single employee may want. To make matters worse, the employer is forced to adopt a health care plan in which *benefits are individualized,* but *costs are collectivized.* Although large employers have a few more options, they too are forced into a system which has two devastating defects.

"Employees should be able to choose between wages and health insurance benefits."

First, under the current system there is no direct relationship between health insurance premium costs and individual employee wages. In many cases employees do not know what the premiums are. In those cases where they are made aware (e.g., when employees are asked to pay part of the premium), each employee is charged the same premium — regardless of age, sex, place of work, type of work or any other factor that affects real premium costs. The upshot is that the individual employee sees no relationship between the cost of employer-provided health insurance and personal take-home pay. Small wonder that employees of large companies demand lavish health care benefits.

Second, there is no relationship between wasteful, imprudent health care purchases and salary under conventional employer health plans. Under most policies, it is as though the employee has a company credit card to take to the hospital equivalent of a shopping mall. The employee will find many interesting things to buy, all chargeable to the employer. Under this system, employees have no personal incentives to be careful, prudent buyers of health care.

"Employees should be able to choose a plan tailored to individual and family needs."

In the face of constraints imposed by federal policy, employers are trying to hold down health care costs by taking actions that have very negative social consequences. Unable to adopt a sensible approach to employee health insurance, many large firms are asking employees to pay (with after-tax dollars) a larger share of the premium. Often employers will pay most of the premium for the employee, but ask employees to pay a much larger share for their dependents.[26] These practices result in some employees' opting not to buy into an employer's group health insurance plan. More frequently, employees choose coverage for themselves but drop coverage for their dependents.

Indeed, three million people who lack health insurance are dependents of employees who are themselves insured.[27]

"As employers try to control costs under the current system, they cause more people to be uninsured."

Because employee benefits law prevents smaller firms from adopting a sensible approach to employee health insurance, many are responding to rising health insurance premiums by canceling their group policy altogether. Often, employers will give bonuses or raises in an attempt to pass on to employees the gain from eliminating the health insurance benefit. Employees are then encouraged to purchase individual health insurance policies (with after-tax dollars) on their own. Many, of course, do not.

One of the great ironies of employee benefits law is that, although it was designed to encourage the purchase of health insurance, its more perverse provisions are increasing the number of people without health insurance. Because employers cannot individualize health insurance benefits, many are turning to other practices that are increasing the number of uninsured people.

To remedy these problems we recommend that: (1) health insurance benefits be made personal and portable; (2) health insurance premiums be included in the gross wage of employees with tax credits for those premiums allowed on individual tax returns; (3) individual employees be given the opportunity to choose between lower wages and more health insurance coverage (and vice versa); and (4) individual employees be given freedom of choice among all health insurance policies sold in the market place. These recommendations would have several advantages:[28]

"There should be a direct link between salary and health insurance benefits."

1. Rising health care costs would no longer be a problem for employers — health insurance premiums would be a direct substitute for wages.

2. Employees would have opportunities to choose lower-cost policies and higher take-home pay.

3. Employees would have the opportunity to select policies tailored to their individual and family needs.

4. Employees would be able to retain the tax advantages of the current system, but avoid the waste inherent in a system in which benefits are collectivized.

5. Employees would be able to continue coverage at actuarially fair prices if they quit work or switched jobs.

When there is a direct link between salary and health insurance premiums, employees will be more prudent about the policy they choose. For example, those who want policies with no deductibles and all the bells and whistles will pay the full premium cost in the form of a salary reduction. Faced with this choice, employees are more likely to choose high-deductible, no-frills catastrophic coverage.

7. Freedom of Information in the Hospital Marketplace

Problem: In most cities, patients cannot find out the cost of even routine procedures before entering a hospital and, at the time of discharge, they are often confronted with bills that are literally unreadable. Because they lack access to the information necessary to make price-conscious decisions, individual patients are unable to play an effective role in containing costs in the hospital marketplace.

Solution: All hospitals that receive Medicare funds should be required to negotiate preadmission prices with all patients.

Discussion: In most cities in the United States, patients cannot find out a hospital's total charge for a procedure prior to treatment. At the time of discharge, they learn there is not one price, but hundreds of line item prices for everything from a single Tylenol capsule to the hospital's admission kit. After only a few days in the hospital, a typical bill can stretch 30 feet in length.

"90 percent of the items on a hospital bill are in principal unintelligible."

If restaurants priced their services the way hospitals do, at the end of an evening meal customers would be charged for each time they used the salt shaker, took a pat of butter and had their water glass refilled. There would, however, be this difference: at least they could read the restaurant's bill.

About 90 percent of the items listed on a hospital bill are in principle unreadable. In only a handful of cases can the patient *both* recognize what service was rendered *and* form a judgment about whether the charge is reasonable. For example, a $30 charge for a Tylenol capsule is common but clearly outrageous, as is a $45 charge for an admissions kit, similar to the free kits airlines give passengers on international flights. In other cases, the patients might recognize the service but have no idea whether they are being overcharged.

What's a "reasonable" price for an x-ray, a complete blood count or a urinalysis? The patient who tries to find out is in for another surprise. Prices

for items such as these can vary as much as five to one among hospitals within walking distance of each other, and in most cases the prices charged bear no relationship to the real cost of providing the services.

"Hospital patients cannot find out the price before they buy, and cannot understand the charges afterwards."

Patients who try to find out about prices prior to admission face another surprise. A single 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, there are as many as 600,000 prices to compare. To make matters worse, different hospitals frequently use different accounting systems. As a result, the definition of a service may differ from hospital to hospital in addition to the differences in the price of the service.

Although hospital administrators do not have to give patients advance notice of their total bill, hospitals in Illinois are required to tell the state government. The following are some examples of total charges for outpatient services reported by Chicago hospitals in 1988:[29]

- 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).

"Among hospitals, there are large variations in the cost of different procedures."

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

Hospital prices today are an unfortunate remnant of the system of cost-plus hospital finance. Since 90 percent of hospital revenue came from insurers who reimbursed on the basis of costs, a hospital's line item prices were relevant only for a small fraction of the hospital's income — the 10 percent paid out-of-pocket by patients. Hospital line item prices were used in some of the more complicated cost-plus reimbursement formulas, however. This gave hospitals an incentive to artificially raise or lower prices in order to manipulate their reimbursement from third-party payers.

In a short period of time, hospital prices became artifacts rather than real prices determined by the forces of supply and demand. Why don't hospi-

tal line item prices reflect true hospital costs? Because hospital prices haven't served that purpose for decades.

We cannot possibly control spiraling health care costs in this country unless patients can make prudent buying decisions. That cannot happen unless patients are confronted with a total package price prior to admission to hospitals. Accordingly, any hospital that receives Medicare money should be required to quote preadmission prices — either per procedure or per diem — to all patients. This is a requirement to quote prices, not an attempt to create price controls. Hospitals would remain free to charge any price to any patient.

8. Encouraging Savings for Postretirement Medical Expenses

"Medical IRAs are needed to supplement and eventually replace Medicare."

Problem: Because federal health care programs for the elderly operate on a pay-as-you-go basis, and because federal tax law encourages employer-provided postretirement health insurance to operate on the same basis, there is very little saving — public or private — to prefund health care expenses that are virtually certain to occur during people's retirement years.

Solution: Individuals and their employers should be given tax incentives to make deposits to Medical IRA accounts designed to supplement and eventually replace coverage under Medicare.

Discussion: One of the most frightening social problems we will face as we move into the next century is the problem of paying retirement pensions and medical expenses for the elderly. Since both Social Security and Medicare are pay-as-you-go programs in which there is no current saving to meet future obligations, tomorrow's obligations will have to be met mainly by taxes on tomorrow's workers. The bill will be high. According to reasonable projections:[30]

- By the year 2000, total health care expenses for the elderly will equal 14.3 percent of workers' payroll, and health care plus Social Security will equal 21 percent.

- By the year 2050, total health care spending for the elderly will equal 46 percent of payroll, and health care plus Social Security will equal 69.2 percent.

Currently the elderly pay about one-third of their own health care expenses. If we can continue that practice, the future burden for workers will be lower, but still quite high:[31]

- If the elderly continue to pay one-third of their health care costs, the combined burden of elderly health care and Social Security will be 17.7 percent of payroll by the year 2000.

- That burden will reach 54.5 percent of payroll by the year 2050.

"The burden of Social Security and health care for the elderly will exceed 50 percent of payroll by the middle of the next century."

In the year 2050, retirees on the average will be older than they are today, however, and as retirees age they tend to have fewer assets and less income from assets. Thus, in the future it will be increasingly difficult for the elderly to pay one-third of their health care costs. Clearly the need is to create a system in which the elderly can pay much more than one-third — relieving future workers of an almost impossible burden. But in order for that to happen, there must be increased saving by today's workers to meet postretirement medical needs.

Although the federal government subsidizes spending on current medical needs to the tune of $45.8 billion, individuals have no opportunity to engage in tax-subsidized savings for postretirement medical needs.[32] Corporations are also greatly constrained in their ability to set aside funds today for the postretirement health care expenses of their employees. As a result, the federal government is encouraging employers to adopt the same pay-as-you-go approach that characterizes Medicare and other government health care programs for the elderly. Although one-third of all employees work for companies that provide postretirement health care benefits, currently:

"Like the federal programs, employers operate on a pay-as-you-go basis, with little savings for future health care obligations."

- Unfunded liabilities for postretirement health care for U.S. employers are as high as $2 trillion.[33]

- If Fortune 500 companies were required to account for postretirement health care benefits the way they now account for pensions, their annual net income would be reduced by 30 to 60 percent.[34]

To address this problem, individuals and employers must be encouraged to save and invest today for future health care expenses. One method is through deposits to Medisave accounts which will grow tax free and provide funds for medical expenses (including nursing home care and long-term care insurance) not now covered by Medicare. More is needed, however.

Individuals and their employers should be given additional tax incentives to save today for postretirement health care needs. In addition, individuals and their employers should be given tax incentives to contribute to Medical IRA (MIRA) accounts. Funds deposited to MIRAs would substitute for future

claims against Medicare.[35] By making annual contributions over time, people would rely more on private savings to support their postretirement medical needs, and less on Medicare. Eventually, we would move to a postretirement health care system in which each generation pays its own way and in which postretirement health care dollars become the private property of the elderly, out of reach of politicians and special interest bureaucracies.[36]

Creating tax incentives for deposits to MIRA accounts would, of course, reduce federal revenue and increase the federal deficit. However, the evidence shows that each dollar contributed to ordinary IRA accounts is mainly a dollar of new savings. If the same were true of contributions to MIRA accounts, then for every dollar of lost federal revenue there would be more than a dollar of new savings. This means that new savings will be more than enough to finance any increase in the federal deficit.

9. Creating Catastrophic Health Insurance Coverage for the Elderly

Problem: The Medicare program pays too many small medical bills which the elderly could easily afford to pay out-of-pocket, but it leaves Medicare beneficiaries exposed to the risk of a catastrophic medical event — such as Alzheimer's disease, requiring an expensive nursing home stay.

"Medicare pays too many small bills, while leaving the elderly exposed for catastrophic nursing home expenses."

Solution: Private insurers should be given the opportunity to repackage Medicare benefits and compete for customers based on the package of benefits they offer.

A major reason why Congress was unable to solve the problem of catastrophic coverage for the elderly was the fact that Medicare is a one-size-fits-all insurance policy designed for a very diverse group of people. Since the elderly who have few assets would be on Medicaid anyway, if faced with a catastrophic health care bill these people are far more interested in coverage for small medical bills. The elderly who have substantial assets are capable of paying several thousand dollars of small medical bills each year, but need catastrophic coverage in case a large medical bill threatens to take all their assets.

Private health insurers should have the opportunity to repackage Medicare benefits by offering private policies as an alternative to Medicare. The only required benefit would be catastrophic hospital insurance. If an elderly person chooses a private insurer, the insurer would receive 95 percent of the actuarially fair value of Medicare insurance. For example, a private

"Private insurers should be able to repackage Medicare benefits in private policies."

insurer might offer Medicare beneficiaries a policy with a $2,000 hospital deductible, a $2,000 physician deductible and a combined deductible of $3,000. In return for these higher deductibles, the insurer might offer immediate nursing home coverage for Alzheimer's disease and an expanding nursing home benefit for other illnesses, depending on the number of years of coverage.[37]

Under this proposal, private insurers would have the option of reimbursing hospitals under Medicare's fixed DRG rates. But they would also have the option of finding less expensive ways to deliver medical care .

10. Avoiding Health Care Rationing Under Medicaid and Medicare

Problem: Medicare and Medicaid are price-fixing schemes in which the level of reimbursement is often too low to assure high-quality health care. The result increasingly is implicit and sometimes explicit health care rationing.

Solution: For selected illnesses and conditions, Medicare and Medicaid patients should have the right to circumvent the normal reimbursement rules in ways that empower the patients and make them full participants in the medical marketplace.

"Medicare and Medicaid are price fixing schemes which invariably lead to health care rationing."

Discussion: In virtually every state in the nation, the people who matter least in the construction of health care programs for the poor are *poor people*. Far from empowering the indigent and giving them buying power in the medical marketplace, the health care poverty industry consists of relationships between large bureaucracies in which poor patients are an excuse for the transfers of large sums of money.

The Medicaid program in many states pays about half as much as other insurers for comparable services. This practice by itself is not bad. It means that Medicaid patients may have to wait until a hospital bed is available in order to obtain elective surgery. In return for waiting, they receive medical care for free. What is bad is that Medicaid patients have no input whatever into the terms of the discount or the conditions under which they receive surgery, and they have increasingly fewer options in the market for any medical service. The reason is that Medicaid patients are not the principal clients of the medical community; the Medicaid bureaucracy is. The type of medical service Medicaid patients receive is often dictated by the amount the Medicaid bureaucracy will pay. Patients are forbidden to add to this amount in order to purchase higher-quality service.

Nationwide, "good" doctors increasingly will not see Medicaid patients, especially for prenatal care. Doctors who do see them all too often practice "revolving door medicine" in which the objective is to service patients as quickly as possible and promptly submit reimbursement forms to Medicaid. To make matters worse, state laws generally prohibit nurse practitioners and physicians' assistants (including people who gave medical care to our soldiers in the field during the Vietnam War) from providing primary care services to low-income patients. The result has been a general deterioration in the quality of care Medicaid patients receive. In some places, outright rationing schemes have been installed — schemes constructed by the health care bureaucracy, not by the patients themselves.

As an initial step toward empowering patients and dismantling the Medicaid bureaucracy, we should identify areas in which the normal reimbursement rules should be suspended. Pregnant women on Medicaid, for example, should have an account to draw on for prenatal care. They should be able to add personal funds to the funds in this account, negotiate prices and pay any amount they choose in order to purchase prenatal care from any physician in the medical marketplace.

"Patients are forbidden to pay more in order to receive a higher quality of care."

A similar problem is occurring under Medicare. Medicare's DRG system for reimbursing hospitals is not structured so that government is simply one more buyer in a competitive market. Instead, the DRG system is a price-fixing scheme in which the government is attempting to create an artificial market. DRG reimbursement prices do much more than limit the amount that government will pay. Medicare literally fixes the price of services rendered, independent of conditions of supply and demand. For example, hospitals are forbidden to charge more than the DRG price, even if patients are willing to pay more. Hospitals also are forbidden to lower their prices by giving rebates to patients who use their services. Moreover, current plans are to move to a single, national rate of reimbursement, ignoring differences in local conditions. This is comparable to attempting to establish one uniform room rate for all the nation's hotels.

The attempt to establish an artificial market creates perverse incentives for providers, which leads to adverse health effects for patients and may even increase health care costs. At the most basic level, two mistakes can occur in any price-fixing scheme. Either the price can be set too high, or the price can be set too low. In the former case, the system encourages too many medical procedures, as was the case under pure cost-plus reimbursement. In the latter case, the system encourages too few.

Although the DRG system pays one fixed price for treatment of a specific condition, the actual cost to hospitals of delivering medical care can vary enormously, depending on the patient. Within a single DRG category in 1984, the cost of care ranged from a low of $5,500 to a high of $200,000. In "heart failure and shock," the DRG with the highest volume of cases, two-thirds of the patients that year cost hospitals less than $4,000, whereas 7 percent of the patients cost hospitals more than $100,000.[38]

"When the government underpays, the service may not be delivered."

In principle, the DRG price covers the average cost of treatment for hospitals which treat a wide variety of patients. But it is unlikely that any particular hospital will have an "average" case load. Clearly, survival in the hospital marketplace in this system means trying to attract below-average-cost patients and trying to avoid above-average-cost patients.

Who are the high-cost patients? The high-cost patients are the sickest patients, and more often than not these patients come from low-income families and are nonwhite. For example, black and Hispanic patients have a greater severity of illness, a longer length of hospital stay and greater hospital costs than white patients, on the average.[39]

Among elderly patients, the "young" elderly are usually much less expensive to treat than the "old" elderly. For example, a study of orthopedic surgical patients found that the average cost of treatment rises considerably with the age of the patient, even though the DRG price is the same for all of

"Fixed prices discriminate against high-cost patients — who are frequently minority patients and older patients."

TABLE 6

Diagnostic Costs for Medicare Patients by Race

Race	Cost Per Patient[2]
White	**$656**
Hispanic	**$753**
Black	**$809**

[1]Based on admissions to Long Island Jewish Medical Center during 1985-1987.

[2]Adjusted for DRG Weight Index.

Source: Eric Muñoz, Eugenio Barrios, Houston Johnson, Jonathan Goldstein, Morton Slater and Leslie Wise, "Race, DRGs, and the Consumption of Hospital Resources," Health Affairs, Spring 1989 p. 187.

them. Among patients over the age of 75, hospitals on the average lose from $3,000 to $5,000 per patient for orthopedic surgery.[40]

"Patients should have the right to add their own funds to the government's payment in order to become full participants in the medical marketplace."

There is increasing evidence that hospitals are responding to the financial initiatives created by the DRG system. Thus hospitals give care readily and quickly to the "profitable" Medicare patients while they give care slowly and reluctantly (and often at a lower level of quality) to the "unprofitable" Medicare patients. This is especially true in the area of medical technology.

Once Medicare identified the DRG categories and the DRG prices, a reimbursement system was put in place. Medical technology, however, is rapidly changing, with new inventions and innovations coming on the market every day. Any technological advance which is cost-reducing causes no problem. By using the technology, hospitals can make a bigger profit. If the new technology causes treatment costs to rise, however, the incentives are entirely different. Unless Medicare raises the DRG price to cover the increased costs, the hospital will not be able to afford to use it or, if the technology is used, it may be restricted to lower-cost patients. Administrative changes in Medicare's DRG prices are made slowly, however, and may not be made at all. As a result, a great many technological innovations are being rationed to Medicare patients.

Even when Medicare recognizes that an expensive technological device should be used, it will often combine patients who need the device with patients who do not in the same DRG category and pay an average DRG price. Hospitals that have an above-average number of patients who need the device will be unable to provide it to all their patients. For example, in 1984, there were 21 DRG categories that combined patients in this way. In 18 of the 21 categories, the DRG payment was well below the average hospital cost of providing the device. In more than half the cases, Medicare patients did not receive the device.[41]

"Because Medicare underpays, most patients with hearing loss cannot get a cochlear implant — one of the most promising innovations in years."

An example of the rationing of medical technology is hearing implants.[42] Hearing loss is the most prevalent chronic disability in the United States. It affects 30 percent of people over age 65 and 50 percent of people over age 85. Fortunately, a remarkable innovation — cochlear hearing implants — with the ability to substantially improve hearing came on the market in 1978. The innovation prompted a congratulatory letter from President Reagan to the 3M Company, manufacturer of the device, and the device won fairly prompt endorsements from the American Medical Association and the American Academy of Otolaryngology — Head and Neck Surgery. Yet, more

than a decade later, most Medicare patients still cannot get a cochlear implant. In 1987, for example, Medicare reimbursed hospitals for only 69 implants.

Part of the problem is normal bureaucratic delay. But a bigger problem is the unwillingness of Medicare to pay a DRG price that covers the cost of the implant — a policy undoubtedly influenced by pressures to hold down spending. On the average, hospitals where implants are performed lose between $3,000 and $5,000 per patient. One other side effect of this policy is that three of the five companies that developed and marketed the implant in the United States have now dropped out of the market, and the 3M Company has now dropped its plans to develop a new and improved implant — one which would give elderly patients even greater hearing capabilities.

"Because Medicaid pays as little as 50 cents on one dollar, an increasing number of physicians refuse to see Medicaid patients."

The solution proposed here is only a partial step toward a more complete reform of the Medicaid and Medicare programs. The ultimate goal should be to allow the beneficiaries to negotiate all prices in a market in which the beneficiaries, rather than third-party bureaucracies, would become the principal buyers of health care. We should continue the practice of limiting the amount that taxpayers pay. But we should allow the market to determine the price and quality of health care.

11. Avoiding the Costs of the Tort System

Problem: The tort liability system is adding to the cost of health care both through the direct cost of litigation and through the costs of "defensive medicine."

Solution: Give patients the opportunity to circumvent the costs of tort law through voluntary contract and exchange.

Discussion: No one knows how much the tort liability system adds to an average medical bill. Most people think the number is quite large. Apart from measurable items (such as attorneys' fees, court costs, damage awards and settlement checks), there are thousands of unseen ways in which the tort system affects costs. Out of fear that adverse medical events will trigger a lawsuit, physicians order extra tests, perform extra procedures and use resources in other ways in the practice of defensive medicine.

"Patients should have the right to avoid the costs of the tort system through voluntary contract."

The tort system is not all bad. In a health care system in which third-party payers put enormous pressure on providers to make quality-reducing changes in the practice of medicine, the tort system may be the single most important protector of patient welfare. By contrast, consider a country such as

Britain, where the quality-reducing pressures are much greater and the rights of plaintiffs are much more restricted. When British patients sue hospitals, they are actually suing the government. Unquestionably there is far more a*ctual* malpractice in Britain than in the United States.[43]

The primary problem with the tort system is that it is another bureaucracy, replete with its own set of perverse incentives. Moreover, it is a bureaucracy that feeds off the health care sector with little consideration of the damage done to others. Juries do not even know (nor are they allowed to consider) that when they give a $5 million damage award the precedent from that decision affects every other patient, every other physician and every other hospital — not just the people who are litigating the specific case.

"The tort system is another bureaucracy, replete with its own set of perverse incentives."

To make matters worse, patients, physicians and hospitals have no opportunity to avoid the system by voluntary contract. For example, one sensible way to cut down on the litigation costs for simple negligence is to have the hospital take out a life insurance policy on a patient prior to surgery. The hospital and patient (or the patient's family) could agree that if the patient dies for any reason, the family will accept the policy's payment as full compensation, even if there was negligence. Litigation costs would be avoided, and an added advantage is that life insurance companies would become monitors of the quality of care in hospitals. Yet the current tort system does not permit such arrangements.[44]

Not only can patients and medical providers not get around the inefficiencies of the tort system by voluntary agreement, the tort system introduces into the practice of medicine a new set of perverse incentives that can be harmful to patients. Fear of tort liability is one of the principal reasons why medical providers have strong incentives to withhold and conceal information that is vitally important to patients.

Most proposals to solve this problem would place arbitrary limits on the rights of plaintiffs in malpractice suits. Not all of these proposals are bad. But they share the common flaw of attempting to solve problems by bureaucratic fiat rather than by voluntary exchanges that are mutually beneficial to both patients and providers.

A more direct solution is to give patients the right to make contractual agreements in their own interests. Patients should have the same rights as buyers in other markets, including the right to waive certain tort claims in return for reductions in the cost of services or for other monetary compensation.

Conclusion

"Individuals can solve problems which can never be solved by large bureaucracies."

The proposals made in this report will not immediately solve all of America's health care problems. These proposals will empower individuals, however, and they will create market institutions through which problems eventually will be solved by individuals' pursuing their own self-interest. These proposals give individuals incentives to solve problems which can never be solved through bureaucracies, regulations or the power of government. The enactment of these proposals would constitute a national commitment to avoid the path traveled by other developed countries and follow a path which is distinctly American in character — one which relies on individual choice and the efficiency of free markets.

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]See John Goodman and Gerald 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.

[2]For a historical analyses of how these changes were brought about, see John Goodman, *Regulations 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).

[3]In 1983, Medicare adopted a prospective payment system (PPS) of reimbursing hospitals based on diagnostic-related groups (DRGs). Under the system, Medicare quit reimbursing hospitals based on costs and began paying fixed prices (determined in advance) for different procedures. At the time this change was made, many thought that the new system represented a market-based approach to health care. However, Medicare does more than limit what the federal government will pay. It also is a price-fixing scheme in which patients and providers are denied the opportunity to negotiate market prices. Moreover, prices are fixed based on average hospital costs. If the hospital marketplace were truly competitive, Medicare's DRG prices would have disastrous consequences for patients. Above-average-cost patients would not be able to get treatment. (This issue is considered at greater length below.) Because hospitals are steeped in the tradition of cost-plus medicine, however, the DRG system has had a greater impact on shifting costs to other payers than it has on changing the way medicine is practiced. During the 1980s, most private insurers (including Blue Cross) also quit reimbursing hospitals on the basis of cost. Most now pay on the basis of hospital charges. As we move into the 1990s, however, more private insurers are copying Medicare's method of payment. Many now pay a fixed price per procedure or a fixed price per diem.

[4]See "The Politics of Medicine" in John Goodman, *National Health Care in Great Britain: Lessons for the USA* (Dallas: Fisher Institute, 1980), ch. 10.

[5]An exception is insurance for tort liabilities, which has many of the defects of health insurance and leads to many of the same problems.

[6]There are a few exceptions, such as policies that indemnify patients in the form of a fixed sum of money per day spent in the hospital, a fixed sum of money for a procedure or a fixed sum of money for a diagnosis (e.g., cancer).

[7]To our knowledge, no one has studied the market for cosmetic surgery. This is unfortunate because most of what employers and insurers have unsuccessfully tried to accomplish for other types of surgery over the past decade has occurred naturally — with few problems and little fanfare — in the market for cosmetic surgery.

[8]For a more complete discussion of how an ideal health care system would function, see John Goodman and Gerald Musgrave, *Solving America's Health Care Crisis* (Washington, DC: Cato Institute), forthcoming.

[9]Employee Benefit Research Institute, "A Profile of the Nonelderly Population Without Health Insurance," *EBRI Issue Brief,* No. 66, May 1987.

[10]Aldona Robbins and Gary Robbins, "What a Canadian-style Health Care Scheme Would Cost U.S. Employers and Their Employees," National Center for Policy Analysis, NCPA Policy Report No. 145, February 1990.

[11]The deduction must be periodically renewed by Congress and is not a permanent feature of the tax code.

[12]For example, 89 percent of Americans who have health insurance acquired it through an employer. See EBRI, "A Profile of the Nonelderly Population Without Health Insurance," Table 2, p. 3.

[13]Ibid.

[14]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.

[15]See the discussion in Stuart Butler and Edmund Haislmaier, *A National Health System for America*, rev. ed., (Washington, DC: Heritage Foundation, 1989).

[16]See the discussion in Butler and Haislmaier, *A National Health System for America*, ch. 3.

[17]People would be free to purchase any insurance policy with any deductible. Insurers would be required to give their customers a form stating the amount of premium that qualifies for a tax credit under federal tax law.

[18]These calculations are based on policies sold by Golden Rule Insurance Company, the largest seller of individual and family policies in the country. Other insurance companies sell similar policies at similar prices. See John Goodman and Gerald Musgrave, "The Cost of Low-Deductible Health Insurance," National Center for Policy Analysis, forthcoming.

[19]As of 1989, Golden Rule Insurance Company no longer sells policies with a $100 deductible. People who previously had such policies, however, may renew them at the indicated prices.

[20]The concept of health savings accounts was originated by Jesse Hixson, currently a health policy economist with the American Medical Association. The idea first appeared in print in John Goodman, Peter Ferrara, Gerald Musgrave and Richard Rahn, "Solving the Problem of Medicare," National Center for Policy Analysis, NCPA Policy Report No. 109, January 1984. The idea achieved further impact through John Goodman and Richard Rahn, "Salvaging Medicare With An IRA," *Wall Street Journal,* March 20, 1984. That same year Singapore introduced a program under which all workers are required to contribute 6 percent of salary to individual Medisave accounts — a program that has been highly successful and eliminates the need for most third-party health insurance.

Footnotes (continued)

[21]See John Goodman, Aldona Robbins and Gary Robbins, "Mandating Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 136, February 1988.

[22]For a discussion of Medisave accounts in Singapore and the advantages they create, see John Goodman and Peter Ferrara, "Private Alternatives to Social Security in Other Countries," National Center for Policy Analysis, NCPA Policy Report No. 132, April 1988.

[23]This is the estimate of the Employee Benefits Research Institute. Other estimates place the number of uninsured people at about 31 million.

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

[25]*Ibid.*

[26]Kenneth H. Bacon, "Business and Labor Reach a Consensus on Need to Reduce Health Care Costs," *Wall Street Journal,* November 1, 1989.

[27]Employee Benefits Research Institute, "A Profile of the Nonelderly Population Without Health Insurance," *EBRI Issue Brief,* May 1987, No. 66, p. 7.

[28]For a discussion of these issues, see Stuart Butler and Ed Haislmaier, *A National Health System for America,* (Washington, DC: Heritage Foundation, 1989), ch. 3.

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

[30]These projections are based on assumptions used in the Social Security Administration's pessimistic projections. See Goodman and Musgrave, "Health Care after Retirement," National Center for Policy Analysis, NCPA Policy Report No. 139, June 1989. Table III, p. 6.

[31]Ibid.

[32]Jonathan C. Dopkeen, *Post-retirement Health Benefits,* Pew Memorial Trust Policy Synthesis, 2, Health Services Research, Vol. 21, No. 6, February 1987, p. 810.

[33]This is the estimate of the House Select Committee on Aging. See Employee Benefit Research Institute, *Measuring and Funding Corporate Liabilities for Retiree Health Benefits* (Washington, D.C.: EBRI, 1988), p. xv.

[34]Ibid., p. xvi.

[35]Variously called Medical IRAs, health care savings accounts, health bank IRAs and Individual Medical Accounts (IMAs), the concept of savings for post-retirement medical care has been used in proposals to supplement Medicare and to privatize or replace Medicare. It has have been endorsed by politicians reflecting a wide range of political perspectives. The original proposal to create such accounts and use them as a vehicle to privatize Medicare was made in John Goodman, Peter Ferrara, Gerald Musgrave and Richard Rahn, "Solving the Problem of Medicare" The proposal received considerable visibility based on the summary that appeared in John Goodman and Richard Rahn "Salvaging Medicare With an IRA." Subsequently, Colorado instituted a MIRA provision at the state level. Yet another version of the idea appeared in Peter J. Ferrara, "Averting the Medicare Crisis: Health IRAs," Cato Institute, Cato Policy Report No. 62, October 31, 1985. Ferrara's version of the proposal became the basis for a bill that has subsequently been introduced in several sessions of Congress, with bipartisan support among conservatives and liberals.

[36]In principle, there could be three types of deductible deposits, all made to the same account. One type of deposit is for savings for current medical expenses. A second type is for funds to supplement Medicare during retirement. A third type is to replace Medicare. Institutions which manage these accounts would keep separate balances for each of the three purposes.

[37]For a similar proposal, see Peter J. Ferrara "Health Care and the Elderly," in Butler and Haislmaier, *National Health System for America*, pp. 85-87.

[38]Nancy M. Kane and Paul D. Manoukian, "The Effect of the Medicare Prospective Payment System on the Adoption of New Technology," *New England Journal of Medicine,* Vol. 321, No. 21, November 16, 1989, p. 1379.

[39]Eric Muñoz, Eugenio Barrios, Houston Johnson, Jonathan Goldstein, Morton Slater and Leslie Wise, "Race, DRGs, and the Consumption of Hospital Resources," *Health Affairs*, Spring 1989 p. 187.

[40]Kane and Manoukian, "The Effect of the Medicare Prospective Payment System on the Adoption of New Technology," p. 1381.

[41]Ibid., p. 1379.

[42]Ibid., pp. 1378-1383.

[43]See Goodman, *National Health Care in Great Britain*, pp. 121-122.

[44]More precisely, the current system ignores contractual waivers of tort liability claims. What is needed is a legal change requiring the courts to honor certain types of contracts under which tort claims are waived in return for compensation.

THE NATIONAL CENTER FOR POLICY ANALYSIS

The National Center for Policy Analysis is a nonprofit, nonpartisan research institute, funded exclusively by private contributions. The NCPA originated the concept of the Medical IRA (which has bipartisan support in Congress) and merit pay for school districts (adopted in South Carolina and Texas). Many credit NCPA studies of the Medicare surtax as the main factor leading to the 1989 repeal of the Medicare Catastrophic Coverage Act.

NCPA forecasts show that repeal of the Social Security earnings test would cause no loss of federal revenue, that a capital gains tax cut would increase federal revenue and that the federal government gets virtually all the money back from the current child care tax credit. These forecasts are an alternative to the forecasts of the Congressional Budget Office and the Joint Committee on Taxation and are frequently used by Republicans and Democrats in Congress. The NCPA also has produced a first-of-its-kind, pro-free-enterprise health care task force report, representing the views of 40 representatives of think tanks and research institutes.

The NCPA is the source of numerous discoveries that have been reported in the national news. According to NCPA reports:

- Blacks and other minorities are severely disadvantaged under Social Security, Medicare and other age-based entitlement programs;
- Special taxes on the elderly have destroyed the value of tax-deferred savings (IRAs, employee pensions, etc.) for a large portion of young workers; and
- Man-made food additives, pesticides and airborne pollutants are much less of a health risk than carcinogens that exist naturally in our environment.

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