

Healthy, Wealthy, and Wise: Five Steps to a Better Health Care System

John F. Cogan, R. Glenn Hubbard, and Daniel P. Kessler
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Two stumbling blocks typically thwart good health policy. The first is the pervasive belief that the focus of health policy should be ensuring that all individuals have health coverage. The second is the tendency of many who understand the importance of markets to argue that for markets to work, government must grow.

Healthy, Wealthy, and Wise is a new book by the distinguished economists John Cogan, Glenn Hubbard, and Daniel Kessler. Cogan and Kessler are professors at Stanford University. Hubbard is dean of the Graduate School of Business at Columbia University and a former head of the president's Council of Economic Advisers. Their book deftly clears the first stumbling block, but is regrettably tripped up by the second.

The desire to "expand coverage" is deeply ingrained in the psyche of most health policy wonks, and for good reason. Though the United States is supposedly a bastion of free-market health care, we pay a larger share of our medical bills (86 percent) through third parties (governments, employers, and insurers) than 17 other OECD nations. That includes Canada, where the government is supposed to pay for everything.

When most health expenditures are financed by someone other than the patient, it seems logical and compassionate to extend "coverage" to those who do not have it. And there are plenty who don't. Depending on the meaning of "uninsured," there are 21 million, 45 million, or even more uninsured Americans.

However, expanding coverage does not reduce the cost of health care. For that you need markets, which reduce costs at the same time they improve quality. Health coverage shifts costs from the patient to workers or to taxpayers. If patients are too heavily insured, the market's ability to reduce costs can actually be defeated, making health care less affordable.

In a world of so much quackery, Cogan, Hubbard, and Kessler examine the health care sector and deliver a precise diagnosis. “The problem,” they write, “is not that market forces cannot work in health care. Rather, public policies have prevented health care markets from functioning properly” (p. 25). The chief culprits are the tax code’s distortion of health care prices, overregulation of health insurance, a lack of information on health care quality, a lack of competition among hospitals, and malpractice liability rules that encourage waste and error. (In a bow to the zeitgeist, the authors estimate that their proposals would reduce the number of uninsured by as many as 20 million. That is not the object of their recommendations, but rather a side benefit that might accrue from sound public policies.)

To address those root causes, the authors propose five incremental reforms designed “to make markets work.” Here the book stumbles. Rather than try to rein in a federal government that has sown so much mischief, the authors offer four reforms that would increase federal power over health care markets and a fifth whose effect on federal power would be mixed.

The latter is a proposal to reduce the price distortions created by the federal tax code. Those distortions tend to encourage paying for health care through employer-sponsored insurance (ESI) rather than directly or through individually purchased insurance. Among other things, this makes patients less price-sensitive, and weakens the market’s most important check on excessive costs and poor quality: the cost-conscious consumer.

Cogan, Hubbard, and Kessler advocate reducing these harmful distortions by (1) providing income-tax deductibility to out-of-pocket expenditures (contingent on the purchase of health insurance) and all health insurance premiums, (2) capping contributions to tax-free health savings accounts (HSAs) and allowing HSAs to be combined with any type of insurance, and (3) creating federal cash payments (deemed “refundable tax credits”) to help low-income families afford health insurance.

Out-of-pocket expenditures and individually purchased health premiums currently must be purchased with after-tax dollars. That makes those items relatively expensive compared with ESI, which may be purchased with pretax dollars. Extending income-tax deductibility to those items would somewhat reduce this artificial price distortion.

It is unclear, though, whether that change would have much impact other than to increase utilization. Lowering the price of health care relative to the price of hot dogs will increase consumption of health care relative to hot dogs. However, the authors argue that reducing the price of paying for health care out-of-pocket relative to paying for it through ESI would constrain health care consumption overall by encouraging less comprehensive health coverage. They project that this effect would overwhelm the health care vs. hot dogs effect, resulting in a net reduction in health expenditures.

That is plausible when consumers control all the dollars involved.

Unfortunately, employers control most of the dollars spent on health insurance, which complicates workers' ability to adjust to the new incentives. Only about one-quarter of workers have the kind of health benefits (cafeteria plans) that allow them to reap the savings from choosing a less expensive plan. And one-third of workers are only offered one plan to begin with.

Whether deductibility reduces utilization, then, will depend on whether *employers* respond to incentives directed at *workers*. Will employers pare back health benefits and cash-out employees? Over the long term, perhaps. But in the short term, the utilization-increasing effect likely would dominate, with troubling implications for the price and quality of care.

The remaining tax-based proposals are also a mixed bag. The authors would allow HSAs to be paired with any type of health insurance, which is the strongest proposal in the book. The existing requirement that HSA holders purchase only catastrophic coverage is a major reason why HSAs are unattractive to many consumers. However, the authors would also cap tax-free HSA contributions, increasing taxes on HSA holders who fully fund their accounts today.

Finally, the authors propose a subsidy to help low-income families purchase health insurance. Though labeled a "tax credit," it is not so much a creature of the tax system as a new spending program. Low-income families (individuals) would receive vouchers equal to 25 percent of their health care expenses, up to \$1,000 (\$500). The subsidy would phase out as income increases, creating disincentives to work and save. Medicaid already provides assistance to low-income Americans, and such a proposal could be crafted in that context. The authors do not explain why a new program is necessary.

In contrast, the remaining proposals are straightforward increases in federal power over the health care sector.

First, the authors propose to have the federal government regulate even more of the health insurance market than it does today. They argue that overregulation by states has dampened competition and that federal regulation, which presently is lighter, would enhance competition. The authors dismiss concerns that federal regulation would likely become as onerous as state regulation—and much tougher to dislodge—despite Congress's manifest willingness to overregulate in this area.

The authors also give short shrift to a reform endorsed by President Bush that would put permanent downward pressure on unwanted regulatory costs by allowing individuals and employers the freedom to purchase insurance from out-of-state carriers, regulated by the carrier's home state. A similar regulatory model already exists in corporate chartering, and could be applied to health insurance either wholesale by Congress or by each state on its own. The authors note that this reform would be difficult to achieve. The right thing usually is.

Second, the authors advocate imposing federal malpractice liability rules on states. Their preferred rules would reduce wasteful "defensive

medicine” (via caps on noneconomic damages) and reduce medical errors (by limiting the discoverability of data on medical errors collected for quality improvement purposes). These reforms may have merit, but the authors do not discuss why they should be enacted at the federal level rather than by the states.

Any such discussion would first have to overcome a constitutional obstacle: the U.S. Constitution does not grant Congress the power to impose substantive tort rules on state courts. Moreover, federal rules are unnecessary. States have shown an increasing willingness to experiment with tort reform. The authors even acknowledge as much. One-size-fits-all rules imposed by Washington would prevent states from learning from each other’s experiments and competing to offer efficient malpractice rules.

Third, the authors seek to increase competition in the hospital sector (undoubtedly a positive, as Kessler’s previous research has shown) by beefing up federal antitrust regulation of hospital mergers. Antitrust enforcement can sometimes block welfare-reducing consolidation. But the authors do not discuss the counterargument: that antitrust can also block efficiency-enhancing consolidation (often at the behest of inefficient competitors). As economist Barbara Ryan has demonstrated, most hospital regulation decreases competition. That suggests pro-competition reformers might look to deregulation as a way to promote competition. Unfortunately, the authors do not discuss why more regulation would be preferable.

Finally, the authors propose additional federal funding for report cards that measure the quality of health care providers. By all accounts, consumers have insufficient information about the quality (and cost) of medical care. However, that is most likely a result of the fact that consumers have little incentive to demand cost-effective care. Information on health care quality is unlikely to appear without a demand for it. That argues for making consumers more price-sensitive.

Indeed, the private sector has begun furnishing price and quality information at the same time HSAs and similar innovations have made patients more price-sensitive. Instructively, Forrester’s Research rated a number of private-sector report cards as more user-friendly than existing government report cards. While there may be public goods aspects to this information problem, it would make sense first to see what the private sector can do by itself once we get the market incentives right.

The authors note that their proposals are meant to be incremental and politically feasible steps to improve the functioning of health care markets—not wholesale changes, nor even their first choices for reform. For example, they flatly admit that revoking the tax exclusion for ESI would be preferable to the tax changes they propose. However, their proposals would generally increase federal power over the health care sector, and it seems odd to think that health care markets have been functioning so poorly because the federal government has not been involved deeply enough.

Cogan, Hubbard, and Kessler are not primarily health economists. Nonetheless, if forced to choose a triumvirate to wield all-encompassing power over health care, the trio would make my short list. I am fairly confident that given their druthers, they would deliver—more precisely, they would enable markets to deliver—astounding improvements in quality and affordability, probably by day three. By the weekend, they would be fielding calls from foreign heads of state.

But without the benefit of all-encompassing power, they (along with the rest of us) have to confront political feasibility. And they certainly have forwarded a politically feasible package of reforms.

The trouble with focusing solely on what is politically feasible—rather than trying to expand what is politically feasible—is that most of the available options involve expanding government power.

There's always a constituency for that.

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