Making Markets Work: Five Steps To A Better Health Care System

Five policy reforms to harness the power of markets.

by John F. Cogan, R. Glenn Hubbard, and Daniel P. Kessler

ABSTRACT: Although the U.S. health care system has made remarkable advancements, it is costly and wasteful, and it leaves many people without appropriate care. The challenge for public policy is to enable consumers and taxpayers to obtain good value for their health care dollars. Achieving this objective stands the greatest chance of success if health care markets function well. To make markets work, we recommend changes in five areas of public policy: tax reform, insurance reform, improved provision of information, enhanced competition, and malpractice reform. Our policy reforms will improve the productivity of the health care system, make insurance more affordable, reduce rates of uninsurance, and increase tax fairness and progressivity.

WHAT SHOULD BE THE FOCUS of U.S. health reform? Policymakers, like Americans as a whole, are divided about whether the solution lies in private markets or increasing direct government involvement. Supporters of private markets point out that competition and choice provide consumer satisfaction and keep costs down in most markets; health care should be no different. Supporters of public intervention argue that market failures and distributional concerns give government a direct role in health care.

In our view, any plan for health system reform must begin by taking advantage of the power of markets. Neither market-based reform nor government intervention is a cure-all. Neither will eliminate wasteful health care cost growth or uninsurance. But the power of markets to allocate resources efficiently—power evident in every other sector of the economy—is part of the solution.

Unfortunately, a handful of U.S. public policies prevent markets for health services from accomplishing this objective. In two areas—tax policy and health in-

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surance regulation—government policy has actively hindered the operation of markets. In three other areas—the provision of health care information, the enforcement of antitrust laws, and medical malpractice rules—government policy has failed to adequately promote the proper functioning of markets. In doing so, it has contributed to the spread of wasteful (inefficient) medical practice, rising health care costs, and rising rates of uninsurance. Although making markets work is not a silver bullet, it is a necessary first step.

Tax Policy

Current tax policy allows people to deduct the costs of employer-sponsored health insurance but generally requires out-of-pocket medical spending to come from after-tax income. This tax bias creates an incentive for employers to offer, and workers to choose, health plans that allow workers to purchase as much medical care through insurance as they can. In practice, this has been achieved through insurance that covers a broad array of health services with minimal deductibles and low copayments, instead of catastrophic coverage.

The tax preference for employer health insurance is substantial. For the typical U.S. worker, the combination of federal income and payroll tax rates raises the total marginal tax rate on wage income to approximately 30 percent and thereby reduces the effective cost of purchasing medical care through insurance, rather than out of pocket, by 30 percent. In states with high state and local income taxes, and for people with high family incomes, the effective cost reduction is even larger.

The tax preference has had a powerful impact on the way medical care is purchased in the United States; approximately 85 percent is purchased through insurance. According to unpublished data for 2003 from Anthem, a large health insurer, the average annual deductible of health insurance policies purchased by individuals ($1,250) is four times greater than that of policies purchased by large firms ($250). Although many factors could affect the magnitude of this difference, the tax preference for employer-sponsored insurance is clearly important.

Low-deductible, low-copayment insurance has led to today's U.S. health care market in which a lack of cost-consciousness and an abundance of wasteful medical practices are the norm. According to the RAND Health Insurance Experiment, an increase in a health plan's annual deductibles from $200 to $500 reduces the total amount a person spends on health care through both insurance and out-of-pocket payments by nearly 5 percent.[1] More recent estimates of the effect of deductibles and copayments on health spending are even larger.[2] The fact that these changes occur without any appreciable impact on most people's measurable health outcomes implies that the extra care attributable to expansive insurance does not provide good value for money.[3] We propose three changes in the tax code to correct this bias.

■ **Full deductibility.** All Americans should be entitled to deduct health insurance and out-of-pocket health care expenses as long as they purchase insurance.

That is, people already covered by an employer plan may deduct out-of-pocket expenses and employee contributions. Self-employed people with insurance may deduct out-of-pocket expenses. Those who lack coverage may deduct premiums and out-of-pocket expenses if they purchase coverage. (In all cases, the deduction is "above the line"—available even to taxpayers not itemizing income tax deductions.)[4] This levels the playing field among those who are buying health care directly, buying insurance on their own, and buying insurance through their employer.

Allowing out-of-pocket health care spending to be tax-deductible would have two opposing effects on health care spending. First, the policy would lower the overall price of health care relative to other goods and services and thereby increase health care spending. Second, the policy would raise the price of purchasing health care through insurance relative to out-of-pocket. The second effect would induce people to shift to health plans with higher deductibles and coinsurance rates, which, in turn, would lower health care spending.

Although we are not the first to make this observation, our key result is that the first effect is greater in magnitude than the second under virtually any reasonable set of assumptions.[5] In our recent monograph, "Healthy, Wealthy, and Wise: Five Steps to a Better Health Care System," we calculated that full deductibility would reduce wasteful private health spending by 6.2 percent, or $43 billion, in 2004.[6]

This result is important for two reasons. First, it implies that full deductibility is an effective policy to address rising health care cost growth and its close relative, uninsurance. Second, it has important implications for the policy's impact on the federal budget. The tax-free resources no longer used for health care consumption would be channeled to other, taxable, economic activities. The resulting increase in tax revenues would offset a sizable amount of the revenue loss from making out-of-pocket health care expenditures tax-deductible.

This approximately 6 percent savings in private health spending could be achieved with modest increases in cost sharing. For example, in our monograph we showed that if this reduction were achieved entirely through a rise in coinsurance rates, the typical coinsurance rate would rise from 25 percent to 35 percent. This implies a major shift in how medical care would be purchased, away from insurance and toward out-of-pocket spending. We calculated that out-of-pocket spending would increase from about $149 billion (in 2004 dollars) to $216 billion, while private insurance spending would fall from about $500 billion (in 2004 dollars) to $390 billion.

Full deductibility would have several additional beneficial effects. Because the tax change would allow the deductibility of out-of-pocket health care expenses only with the purchase of insurance, the proposed policy also would create a powerful tax incentive to purchase insurance. Under current law, a typical uninsured person receives no tax benefit from purchasing insurance. Under our proposal, a person who purchased a health plan with a $2,000 premium and also paid $1,000 out of pocket would be able to deduct the premium and out-of-pocket costs. For a

person in the 15 percent tax bracket, the tax deduction would be worth $450—23 percent of the cost of insurance.

Although deductibility would mitigate the bias against individual insurance (because both employer-sponsored and individual insurance could be acquired with pretax dollars), it still would retain major incentives for the purchase of insurance and for the purchase of employer-sponsored insurance. Because the tax change would allow the deduction of the cost of individual insurance from the income tax base but not from the payroll tax base, the proposed policy would retain a tax incentive for the purchase of employer-sponsored insurance. Spending on insurance purchased through an employer would, as under current law, still be excludable from both the income and the payroll tax bases. For this reason, deductibility would be unlikely to increase the number of uninsured people by inducing employers to stop offering insurance to their employees.

Finally, the tax change would increase the fairness of the federal income tax system. Under current law, people whose employer declines to offer insurance are penalized because they must purchase insurance with after-tax income. Tax deductibility would replace a myriad of special health care tax deductions—such as Section 125 flexible spending accounts and Section 105 health reimbursement arrangements—with a single deduction equally applicable to all.

As we show in our recent monograph, deductibility would also increase the progressivity of the tax system. Although marginal tax rates are higher for higher-income people, the fact that lower-income people have higher (currently taxable) out-of-pocket spending more than compensates for this effect. Using data from the 2002 Medical Expenditure Panel Survey (MEPS), we found that the tax reductions for low-income households are three to five times as large, on a percentage basis, as those for high-income households. For example, households earning less than $20,000 per year can expect a 5.7 percent reduction in their average tax rate, whereas households earning $20,000–$30,000 per year can expect an 8.3 percent reduction. This reduction would come about because our policy would allow health expenses to be deducted "above the line." By comparison, households earning $70,000–$100,000 per year can expect only a 1.8 percent reduction in their average tax rate, and households earning more than $100,000, a 1 percent reduction.

As a health care policy matter, we would prefer to revoke the tax preference for insurance altogether. Several studies conclude that such a policy would lead the effective coinsurance rate to rise substantially.[7] According to one, such a change would lead to average employer-group health insurance premiums that were only about 55 percent as high as they would be if the tax preference were not in effect.[8] However, this policy is highly unlikely to succeed for political reasons. Only President Ronald Reagan expressed a willingness to consider repealing the health insurance tax exclusion. In 1983 he proposed to cap the amount of employer-sponsored insurance that could be excluded from taxation. His proposal was soundly rejected by Congress. A similar proposal was considered and rejected during the

1985 tax reform debate. Since then, no president has proposed to modify the exclusion for employer-sponsored health insurance. And recent tax and health policy changes—such as HSAs—move further in the direction of deductibility. Today, when Americans are registering unprecedented concerns about the high cost of health care, a policy that would raise this cost would likely face insurmountable legislative hurdles.

■ **Universal health savings accounts.** The tax code could also be changed to make it easier for individuals and families to save for expenses not covered by higher-deductible insurance. Medical savings accounts and recently enacted HSAs permit tax-free contributions for people who are purchasing high-deductible health insurance plans. We propose making all individuals eligible for HSAs conditional on the purchase of insurance that covers at least catastrophic expenditures. As with current HSAs, balances may be spent on the health care of a relative, and balances not spent on health care could be carried forward tax-free. Funds withdrawn for non–health care purposes would be subject to income tax. Recipients of health care tax credits (described below) could deposit funds in an HSA if they wished.

To expand the availability of HSAs, we propose three major changes. First, under current law, an employer-sponsored family health insurance plan must have a deductible of at least $2,000 to qualify its purchaser for the HSA ($1,000 for an individual plan). We should eliminate the minimum deductible requirement. Second, the amount a household can deposit in an HSA is now limited to the amount of the health insurance plan deductible, up to $5,150 ($2,600 for an individual plan). We propose setting a $2,000 limit ($1,000 for individuals) on the amount that can be deposited in an HSA, independent of the deductible.[9] Third, under current law, funds from an HSA cannot be used to purchase insurance. Under our proposal, funds from an HSA could be used for any qualified health care expense.

The purpose of these proposed changes is to make the HSA law less prescriptive and thereby encourage greater use of HSAs. We are concerned that the high-deductible requirement under current law might serve as a barrier to the widespread use of HSAs. Under our proposal, people would be free to choose the deductible level, make trade-offs between deductible and coinsurance amounts, and purchase insurance on their own rather than through an employer, all without tax penalty. Consistent with our policy of full deductibility, we believe that public policy should, whenever possible, allow individual preferences rather than government mandates to determine people's health insurance arrangements.

■ **Tax credits for low-income peple.** A third policy we support is designed to improve the health care "safety net" for very-low-income households. Although our proposal to make out-of-pocket medical expenses tax-deductible offers important benefits for many low- and middle-income working families, it does not help families that pay few or no income taxes.

To address this inequity, we should offer low-income households financial assistance to purchase health services. Specifically, we propose a refundable tax

credit that would subsidize 25 percent of household health care expenses up to a maximum credit of $500 for an individual or $1,000 for a family. Eligible expenses would include payments for insurance and out-of-pocket expenses. Thus, the refundable credit would be available to buy insurance through an employer or on one's own, or to pay for out-of-pocket expenses (conditional on having insurance).

Not surprisingly, addition of a low-income tax credit makes our proposed tax policy even more progressive. Based on our analysis of MEPS data, addition of the credit does not affect the percentage reduction in tax burden for upper-income groups, who would be ineligible for the credit. In contrast, households earning less than $20,000 per year could expect a 110 percent reduction in their average tax rate; those earning $20,000–$30,000 per year, a 41 percent reduction.

Health Insurance Regulation

The second area in need of policy reform is the regulation of markets for health insurance. Under the McCarran-Ferguson Act of 1944, states have primary responsibility for regulating health insurance markets since the 1940s. Each state specifies the rules by which its insurance market operates, including the financial requirements insurers must meet to sell policies in the state, the services that a health insurance plan must cover, the prices that insurers can charge, the individuals or groups that must be offered coverage, and the method by which insurance companies must conduct their business operations. As with the tax preference, the unintended consequences of inefficient insurance regulation drive up costs and increase uninsurance.

We propose two major changes to insurance regulation: the creation of a federal market for health insurance; and provision of a subsidy for the insurance costs of the low-income, chronically ill.

■ **Create a federal insurance market.** One particular form of state insurance regulation—benefit mandates—has expanded dramatically over the past forty years. In 1965 there were fewer than a dozen such mandates throughout the fifty states and the District of Columbia; by 2003 the number had risen to more than 1,800.[10] Benefit mandates now require coverage of off-label drug use (thirty-seven states), acupuncture (eleven states), and chiropractic (forty-seven states).[11] According to the Congressional Budget Office (CBO), states' benefit mandates have raised the cost of a typical insurance plan 5–15 percent.[12] According to one study, about one-quarter of those who lack coverage are uninsured because of the cost of state mandates alone.[13]

We propose that insurance companies that meet certain federal standards be permitted to offer plans nationwide, free from costly state mandates, rules, and regulations. With this change, insurance would become available to individuals and small groups on the same terms and conditions as those now available to employees of many large corporations, which, by self-insuring, are exempt from state insurance regulations and instead operate under the federal insurance law provi-

sions of the Employee Retirement and Income Security Act (ERISA).

Given that approximately half of the privately insured U.S. population is already covered by plans that operate under federal regulations, this reform would not lead to radical or unpredictable changes in consumer protection. Federally certified health insurance products would be required to meet all federal regulations that now govern the provision of health insurance for large employers; there would be no rollback of existing protections. Insurance companies that now offer federally certified products would be required to meet financial structure and solvency requirements. In addition, states could continue to supervise day-to-day market conduct, such as claims handling and consumer complaints. Finally, insurance companies that now offer federally certified products would no longer be exempt from antitrust liability under the McCarran-Ferguson Act, which would expand the federal government's ability to police anticompetitive behavior.

This change would bring several benefits. Most importantly, it would foster a more competitive, efficient nongroup health insurance market that would enable people to obtain a greater variety of lower-cost health insurance alternatives. The lower cost would induce more people to buy insurance and thereby increase the size of risk pools—which would further strengthen markets for insurance. In addition, a federal market would increase the portability of health insurance by making it easier for people to keep their insurance when they move across state lines.

■ **Subsidize insurance for the chronically ill.** Providing affordable health insurance for chronically ill people who have predictably high medical expenses year after year and who lack sufficient resources to finance them is one of health policy's most vexing problems. Competitive markets for insurance, which provide good protection for unforeseen major medical expenses, do not work well for persistently high-cost patients.

States have responded to this problem in two ways, both of which have been unsatisfactory. High-risk pools, in theory, allow those who have been denied coverage or charged a high premium because of their health status to obtain subsidized insurance through the high-risk pool. According to a recent study, although twenty-eight states operated high-risk pools in 1999, they covered a total of only 105,000 people.[14] This study concluded that the small size of pool enrollment was the result of several factors, including high costs; limited benefits; limited outreach to prospective members; and, in some cases, explicitly capped enrollment.

State-mandated premium risk bands and underwriting restrictions seek to extend coverage by limiting the range of premiums and the characteristics on which they can be based. However, a study of regulation of the small-group market found that such stringent regulations decreased the rate of coverage among workers and increased premiums for small employers.[15] Further, most of the increase was passed on to workers through higher employee contributions—ironically worsening the problem of uninsurance in an effort to ameliorate it.[15]

We propose a subsidy to help people with predictably, persistently high health

costs to purchase insurance in the new nationwide market. A public-private partnership between the federal government and insurance companies would administer the subsidy. To be eligible for the subsidy, chronically ill people would be required to have been covered by insurance in the past and have insufficient resources to pay for their own coverage.

This subsidy would preserve coverage for the chronically ill at a lower cost than, and without the unintended consequences and market distortions created by, its alternatives. One alternative, for example, seeks to socialize the costs of all high-cost patients. Such socialization helps the chronically ill but also subsidizes the catastrophically ill—those with unexpectedly high costs that will not persist, such as costs for people injured in auto accidents. Private insurance markets, however, work well at financing the care of the catastrophically ill; adverse selection arises only when a patient's (high) expenditures are predictable in advance.

Information, Competition, And Malpractice

We also propose reforms in three additional areas: better provision of information to providers and consumers; an explicit public goal to control anticompetitive behavior by doctors, hospitals, and insurers; and reforms to the medical malpractice system to reduce wasteful treatment and medical errors. In each of these areas, research has indicated that major opportunities exist to improve medical productivity. In the interest of space, we leave discussion of these reforms to our recent monograph.

Conclusion

The U.S. health care system—the envy of the world in innovation—faces major criticisms about cost, accessibility, and quality of care. Although these criticisms are not without foundation, a more productive approach is to ask whether consumers of health care—and taxpayers in public financing—are obtaining the highest value for the resources devoted to health care. In our view, achieving this objective stands the greatest chance of success if health care markets function well. Yet markets cannot flourish without the appropriate institutional support for consumer incentives and choice, provider accountability, and competition. These needed features are held back largely by the unintended consequences of U.S. public policies in five areas. Any serious reform of the U.S. health care system must begin by changing these policies.

■ **Estimated impact of our proposals.** In our recent monograph we estimated the consequences of our reforms for health care spending, for the number of uninsured people, and for the federal budget. We determined that full deductibility, the tax credit for low-income people, the creation of a federal insurance market, and caps on noneconomic damages in medical malpractice cases would reduce health spending by 9 percent, or $61 billion in 2005. These same policies, along with the subsidy for the chronically ill, would also reduce the number of uninsured people by

six to twenty million; the large range reflects the considerable uncertainty about how responsive the uninsured would be to the price of coverage. Our reforms would cost the federal budget approximately $9 billion per year. By the standards of most comprehensive reform proposals, however, this cost would be small—and the "bang for the buck" that it would give, in terms of reduced wasteful spending and expansion of insurance coverage per dollar of public expenditure, would be large.

■ **Criticisms of our proposals.** Thoughtful observers have voiced three types of criticisms—philosophical, economic, and administrative—of these reforms.[16] Although some of these concerns have merit, they are, in our opinion, outweighed by the reforms' likely benefits.

Philosophical objections. For different reasons, analysts from across the political spectrum have philosophical objections to an above-the-line deduction for health expenses. According to one view, deductibility should be replaced with a tax credit for all taxpayers, not just for those with no tax liability. The obvious merit of this alternative would be to create appropriate incentives to consume health care on the margin by making everyone responsible for all of their health costs in excess of the credit. However, unless the credit were extremely generous, replacing deductibility with a credit would increase the tax burden of the majority of taxpayers. For this reason, it is just as politically infeasible as eliminating deductibility. In addition, fixed credits necessarily create inequities by giving a smaller proportional subsidy to older, sicker, and higher-risk people than they do to younger and healthier people, which further limits their political viability.

According to another view, health expenses should be fully deductible, but only below the line, on the grounds that above-the-line deductibility is a "slippery slope" that would invite proposals to make charitable contributions, mortgage interest, and other deductions above the line as well. This point is well taken. However, the policy rationale for above-the-line deductibility of health expenses is to reduce the distortion from the existing exclusion for as many people as possible. A policy rationale of extending deductibility of charitable contributions or mortgage interest would magnify an existing distortion.

Economic objections. There are two main potential economic criticisms of our proposals. The first is that they would lead to the splintering of risk pools and increased adverse selection. Although this is correct, it is also true that our proposals would make markets for health insurance more competitive. Thus, there is a trade-off between the welfare gains from competition and the losses from adverse selection. In our view, a tilt toward more competition would be socially constructive, especially given that our policies contain several elements designed to reduce the opportunities and incentives for adverse selection.

First, because our proposed tax change would only allow the deduction of the cost of individual insurance from the income tax base but not from the payroll tax base, we would retain an important tax incentive for the purchase of employer-sponsored insurance; any shift toward individual insurance would therefore be

limited and gradual. Second, by making individual and small-group insurance more affordable, our policies would induce healthier people to buy insurance who previously found it in their interest to go uncovered. Third, by directly subsidizing predictably, persistently high-cost people (and preserving states' right to regulate market conduct), our policies would greatly reduce insurers' incentives to select clients on the basis of risk.

Moreover, even if the after-tax prices of individual and employer-sponsored insurance were equalized, there is no evidence that the splintering of risk pools would be a serious problem. Similarly, there is no evidence that employers would drop health insurance to any great degree. In the absence of any tax preference, employers would cease to offer insurance only if enough workers gained from buying insurance in the individual market instead. Research by Mark Pauly and colleagues shows that this is unlikely: Under plausible assumptions, the average benefit to an employee of opting out of his or her employer-based insurance plan (in the absence of any tax preference) would be approximately equal to the average cost, in terms of the increased administrative expenses that the employee would face in the individual versus the group market.[17]

The second economic criticism of our proposal is that the savings we calculate depend upon unrealistic estimates of the elasticity of the responsiveness of health spending to copayment rates. Calculations of the overall impact of our policies on spending are not sensitive to the magnitude of the response of health spending to its effective price. Even if people's behavioral response is half as great as we assume it would be, the total effect of our package on health spending would be 9.4 percent—greater than our estimate of 8.9 percent. As we showed in our monograph, the composition of savings would shift from being primarily attributable to deductibility to being attributable in about equal measure to deductibility, insurance market reform, and malpractice reform, but the bottom-line total would be roughly the same. Even if one were to consider only the expenditure savings resulting from our proposed tax changes, assuming a much lower behavioral response would only reduce the magnitude of the benefits of our proposal, not eliminate them.

Administrative objections. Finally, our proposals might be criticized on the basis of their administrative costs. In our view, the incremental administrative costs of our proposals would be small relative to their substantive benefits. The Internal Revenue Service (IRS) already administers several refundable tax credits, including the Earned Income Tax Credit and the Trade Adjustment Assistance Health Coverage Tax Credit. The IRS also administers a highly complex set of health insurance and health expense deductions, including employer-paid insurance, self-employed insurance, employer-provided cafeteria plans, and MSAs; if anything, full deductibility would simplify its task. We agree that the definition and determination of eligibility for the subsidy for the chronically ill would be a complicated and contentious issue. However, the administrative cost of this system must

be weighed against the administrative and efficiency costs of states' high-risk pools, which empirical evidence suggests are far greater.

The time to implement these reforms is now. Failure to do so will exacerbate the problems of wasteful cost growth and uninsurance. It will increase the pressure for more government intervention that will inevitably have adverse consequences for innovation and flexibility. With this stark choice, health care is likely to be the center stage of domestic policy debates during the next decade.

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NOTES

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