

policy *express*

We've all heard the statistic "47 million Americans do not have health insurance" as an underlying argument for massive health care reform. But did you know that 57 percent of the 47 million uninsured have annual incomes above \$50,000? Or that two-thirds of the 47 million are between the ages of 18 and 34? Are younger Americans being sold another Social Security scheme?

Who Should Pay for Health Care?

About the Author

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Health care reform has emerged as a top issue in the states and in the 2008 presidential election. The public debate about health care reform is often complex and confusing, riddled with misinformation, myths, and ideological agendas.

It is important to note that the health care reform debate is *not* about access to medical treatment when one needs it, since access is already guaranteed to all by federal law.¹ Rather, the debate centers around who will pay the costs of medical care and by what arrangement. While most Americans agree that everyone should have access to affordable health insurance coverage, they disagree strongly on how to make that happen.

At their core, all health care reform proposals can be categorized into two traditional, competing visions: one focuses on *government, mandates and taxes*. The other focuses on *markets, consumer free will and innovation*. The first promotes *universal coverage*; the second promotes *universal choice*.

Governments, Mandates, and Taxes

Today, the *government vision* is in ascendance, and it has two defined camps. One camp, comprised of traditional proponents on the Center-Left, sees government mandates on individuals and employers as a solution to the coverage-cost problem. This camp advocates forcing everyone to purchase health insurance or face penalties and fines. The Massachusetts Plan, for example, relies on government coercion to achieve *universal coverage*, while doing nothing to make insurance coverage more affordable for either individuals or employers.

The second camp, which consists of proponents on the far Left, advocates a Canadian-style single-payer, or government, system. Dubbed "Medicare for All" by Senator Edward Kennedy (D-MA), the actual model is Medicaid—a comprehensive welfare-style program for low-income people that is administered by states and funded jointly by state and federal taxpayers. One example is Senator Hillary Clinton's (D-NY) "American Health

¹The Emergency Medical Treatment and Active Labor Act (EMTALA), a federal law enacted in 1986, requires hospital emergency departments to treat emergency conditions regardless of patient ability to pay.

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Choices Plan,” which relies on government mandates, taxes, subsidies, controls on insurance companies, and expanded welfare health care programs. Senator Clinton’s plan is estimated to initially cost taxpayers \$110 billion per year.

The government already controls 51 percent of the U.S. health care economy through various government programs such as Medicare, Medicaid, State Children’s Health Insurance Program (SCHIP), and veteran services as well as federal, state, and local government employee plans. *Government vision* proponents want to place the remaining 49 percent under government control as well.

Supporters use five myths to advance the *government vision* approach:

Myth 1: 47 million Americans do not have health insurance.

This estimate is from the U.S. Census Bureau. What most people don’t know, however, is that the Census Bureau counts as “uninsured” anyone who is without health insurance during any part of the previous year, including those who change jobs and may be temporarily uninsured during a brief break between employer plans.

Of the 47 million,

- 27 million Americans have annual incomes over \$50,000 (10 million of these have an annual income over \$75,000)—they can afford health insurance, but choose not to purchase it;

- 14 million are eligible for government welfare coverage through Medicaid or SCHIP, but they have not signed up; and
- Two-thirds—over 31 million—are between the ages of 18 and 34.

Overall, only about eight million Americans—less than three percent of the U.S. population—are chronically uninsured for two years or more.

Government vision proponents insist that the uninsured represents a “hidden tax”—that is, those with health insurance pay a hidden tax to subsidize the care of those without health insurance. In reality, the “uninsured” add only about one percent in hidden costs to the price of the insured’s insurance plan. A far greater hidden tax is caused by government Medicare and Medicaid programs’ low reimbursement rates that add as much as 10 percent in hidden costs, or subsidies, to those paying for health insurance.

Myth 2: Universal health coverage can be achieved by an ‘individual mandate’

Advocates believe that by legally requiring all Americans to buy health insurance, the uninsured problem will disappear. Experience with government mandates for car insurance proves otherwise. California, for example, requires all drivers to purchase car insurance, yet 25 percent of the state’s drivers are still not insured.

Health Care Rationing

Imagine that you paid a set annual fee to get all your meat and fish at one market, and there was no limit on what you could take for your use. The easiest way for the grocer to keep costs in line with annual fees and discourage waste, abuse, or overuse would be to ration availability, that is, to offer more hamburger and fish sticks and fewer steaks and lobster. This same form of rationing is often used in government single-payer health care systems by limiting the number of costly medical procedures available and forcing patients to get on a waiting list for them.

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As noted earlier, most of America's uninsured are healthy young adults who rarely need expensive medical care, and many have consciously chosen not to purchase expensive health insurance plans that could cost them \$400 or more in monthly premiums.

The high cost of monthly premiums is partly due to government regulations requiring insurance companies to charge everyone the same rate (called *guaranteed issue* and *community rating*). The unintended consequence is that young people end up paying far more in premiums than they should in order to subsidize older or less healthy people.

Premium costs are also undermining the Massachusetts “individual mandate.” Although the state offered substantial premium subsidies for low-income residents, officials had to exempt 20 percent of the state's residents from the “individual mandate” because the insurance rates were still too expensive for many to pay. The Massachusetts Plan may be unaffordable to state taxpayers as well: only 63,000 of the 600,000 uninsured have become insured through the non-subsidized Commonwealth Choice Plan (many decided to pay the fine rather than the premiums), and the plan is already \$150 million in debt.

Myth 3: Expensive prescription drugs contribute to rising health care costs.

The real price of prescription drugs is actually decreasing. In 2007, inflation rose more than four percent, while drug prices increased only one percent. And drug spending is but a small slice of total health-care spending—less than 11 cents of every health care dollar goes to prescription drugs.

Moreover, prescription drugs actually reduce health-care costs in the long run as newer drugs often obviate the need for expensive surgeries and long hospital stays. According to a recent

paper published by the National Bureau of Economic Research, each dollar spent on pharmaceutical drugs through Medicare saves the program \$2.06.

Myth 4: Drug importation is the solution.

The Congressional Budget Office estimates that foreign drug importation would save Americans only one percent at most over the next decade. There are serious long-term consequences to foreign drug importation, however.

Cheaper prescription drugs in Europe and Canada are possible because those governments negotiate bulk-rate prices with U.S. drug manufacturers and impose price controls as a condition of importation. What is not widely understood is that U.S. drug manufacturers can only afford to sell pills at cut-rate, controlled prices in Europe and Canada because Americans pay full market price for them. In short, Americans are subsidizing the prescription drugs Europeans and Canadians use.

If American policymakers allow foreign-sold drugs to re-enter the U.S. market, they'll in effect import price controls, too. Price controls create practical problems such as shortages resulting from limited negotiated-price supplies, and they also deny pharmaceutical companies the return on investment necessary to plunge into the next round of research and development (R&D) for new cures.

Since most experimental drugs fail in clinical trials, the average cost to bring a new drug successfully and safely to consumers is about \$1.3 billion. Since Europe and Canada do very little drug R&D, they absorb few of these costs. Investors in the U.S. are willing to make such a risky investment because the rewards of developing a cure for Non-Hodgkins Lymphoma, AIDS, or diabetes, for example, are considerable. If the profit motive for U.S. R&D vanishes,

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venture capital would dry up and the miracle cures from America's drug and biotech industries that the world relies on would vanish as well.

Myth 5: State-run health care systems in Canada and Europe are better and cheaper than ours.

People who make this claim usually note that life expectancy is higher in Canada and Europe. But life expectancy is an inadequate measure since it is influenced by variables beyond the control of a nation's health care system—variables such as genetics, diet, infant mortality rates, exercise, smoking, pollution, and even marital status.

A better, more direct measure of a quality health care system is the relationship between medical treatment and health outcomes. A 2007 study published in the British medical journal, *Lancet Oncology*, suggests America is much better at treating cancer than Europe or Canada. Researchers found Americans have a better survival rate five years after diagnosis for 13 of the 16 most prominent cancers. An American man, for example, has nearly a 20 percent better chance of living for five years after being diagnosed with prostate cancer than his European or Canadian counterpart.

Experience From the Canadian Single-Payer Health Care System

Americans are told that Canada spends only nine percent of its gross domestic product (GDP) on health care, while the U.S. spends 16 percent. The Canadian government's single-payer system is more efficient, say U.S. health care critics, and less expensive.

Yet I lived under the Canadian system, and I saw first-hand how Canada keeps costs under control. First, it has long waiting lists for care. Canadians pay \$5,000 per year for their health care system through hidden taxes, but they aren't guaranteed access to a doctor when they need one. About 250 doctors leave the Canadian system each year. At any given time, ten percent of Canadians are waiting to get an appointment with a primary care doctor because there is a shortage of them, and the wait for treatment by a specialist after seeing a primary care doctor is 18.3 weeks (about four months) on average.

Second, Canada spends less on new medical technology and equipment. Canada ranks 13th among the 22 industrialized nations, for example, in the number of Magnetic Resonance Imaging (MRI) machines available. Canadian hospitals often don't have the

Employer vs. Personal Insurance

Employer-based health insurance was instituted during the World War II era for large industrial employers when job mobility and wage increases were infrequent. It uses pre-tax (or tax free) dollars to purchase large-pool health insurance plans at better prices, but insurance coverage is not portable, i.e., it doesn't follow the worker to his next job.

Today, most U.S. workers are highly mobile and employed by small, service-oriented companies that do not have access to better-priced large-pool corporate plans. Consequently, many U.S. workers are left uninsured or under-insured.

A health care tax deduction of \$7,500 for individuals and \$15,000 for families would allow Americans to purchase personal insurance, treat all U.S. workers equitably, and make health insurance portable and more affordable.

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newer, high-tech diagnostic machines that Americans take for granted, and their doctors aren’t routinely trained to use them.

Third, care is rationed. In Canada’s single-payer system, government officials—not the patient and doctor—decide whether a particular treatment or surgery is warranted or allowed, and those decisions may be based on the system’s best interests rather than the patient’s.

Faced with critical care needs, Canadians often turn to the free-market U.S. health care system for timely medical treatment and they pay for it with their own money.

Markets, Consumer Free Will, and Innovation

The free-market sector of the U.S. health care system consistently produces the most advanced and safest medical care in the world—as evidenced by the steady stream of foreigners, including Canadians and Europeans, who come to the U.S. for treatment each year. America’s market-based, consumer-directed health care approach places decisions in the hands of the patients and their doctors and ensures that the patients’ interests and well-being are paramount.

Market vision reforms build on this sector’s unparalleled success and extend it, through universal consumer choice, to uninsured and under-insured Americans.

Since the majority of America’s uninsured are young people between the ages of 18 and 34, the most logical way to attract them into the insurance market is to lower premiums and enable them to buy the type of insurance plan that fits their individual needs. This can be done as follows:

- *Change the tax code to allow health care tax deductions.* Health care tax

deductions of \$7,500 for individuals and \$15,000 for families will give all Americans the same tax benefits as those with employer-based insurance. It will also make health insurance “portable,” i.e., coverage will not be interrupted when an individual changes jobs.

- *Create vouchers for the working poor and chronically uninsured.* Vouchers will enable workers whose income is too small to pay premiums and too great for welfare to purchase insurance through a large state insurance pool.
- *Allow individuals to buy insurance across state lines.* State borders act as regulatory walls, denying Americans access to health insurance plans by insurers in other states. Eliminating these walls will allow individuals to “shop” among a more robust market of insurance companies and plans (much as we shop for cell phone service and car insurance).
- *Reduce costly government mandates and regulations, and eliminate “guaranteed issue” and “community rating” regulations.* Health care is arguably the most heavily regulated industry in the U.S. In 2007, 1,901 mandates and regulations governed the content of health insurance plans (up from 1,843 in 2006). Example: Massachusetts requires all insurance plans to cover in-vitro fertilization, a highly specialized, expensive medical procedure (\$15–\$20,000 per treatment) that few need. This change will allow insurance companies to offer a range of plans—from basic/lower cost to comprehensive/higher cost—to meet a variety of individual needs and preferences and make insurance more affordable.
- *Allow health care providers to offer affordable care at convenient*

locations. More than 700 new retail health care clinics are now available at Wal-Mart, Target, and Walk-In Centers, and their numbers are expected to grow to 3,000 in the next five years. These clinics offer routine care at a substantially lower cost than hospital emergency departments, which are increasingly used for routine care by low-income individuals with Medicaid. Retail clinics also have “price transparency,” i.e., a patient knows in advance how much a throat culture or a flu shot will cost.

- *Implement tort reform.* Medical malpractice insurance, which costs physicians as much as \$240,000 per year in specialties such as obstetrics, is driving up medical treatment costs and driving physicians out of specialties. Tort reform will significantly reduce these hidden costs and prevent a shortage of medical specialists.

Conclusion

Young Americans have the most to gain or lose by the outcome of the health care reform debate. The similarity between government ‘universal coverage’ health care reforms and the Social Security system, which forces the young to subsidize the old, can not be ignored.

Practically, government-mandated universal coverage is an ineffective solution to the uninsured problem, and it will likely lead to a Canadian-style government single-payer system down the road. It is ironic that as Canadians in Quebec win their Supreme Court’s blessing to move toward a free-market health care system, Americans are being told to abandon theirs.

To paraphrase P. J. O’Rourke, *if you think health care is expensive now, just wait until it is free.* Only by expanding the free-market, consumer-directed health care system can Americans of all ages hope to continue finding new cures and improve access, effectiveness, and affordability in health care. ■

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Resources:

- “Special Report: The Uninsured: A Hidden Burden on Texas Employers and Communities,” Apr 2005, Carole Keeton Strayhorn, Texas Comptroller <http://www.window.state.tx.us/specialrpt/uninsured05>
- “Access to Health Insurance for the Uninsured,” Texas Health Institute, Dec 1, 2006, http://www.healthpolicyinstitute.org/healthpolicy/uninsd_12_01_06_forum_brief.pdf
- Jonathan Oberlander, “Health Reform Interrupted: The Unraveling of the Oregon Health Plan,” *Health Affairs*, Dec 19, 2006 <http://www.nonprofitthehealthcare.org/documentView.asp?docID=676>
- Massachusetts premium and enrollment data [http://www.mass.gov/?pageID=hichomepage&L=1&L\)=Home&sid=Qhlc](http://www.mass.gov/?pageID=hichomepage&L=1&L)=Home&sid=Qhlc)
- Massachusetts-Style Coverage Expansion: What would it cost in California?, California HealthCare Foundation, Apr 2006 <http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=120742>
- Peter J. Cunningham, “What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities?,” *Health Affairs*, Jul 18, 2006 <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.w324v1>