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Weidenbaum Center Forum
Medicaid Financing: Challenges for Missouri and the Nation

Discussant: Free Market versus Public Provision of Health Care

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Thank you very much for inviting me and for giving me the opportunity to talk. I will not be defending view one or view two, but see myself somewhere in the region of view three but maybe slightly somewhere else because I think view three certainly has room for very many views. My comments will not be directly addressed to Len Nichol's PowerPoint slides which he partly based on the problems he identified in his paper. I want to talk about these problems to the extent that they are problems.

In my view, the current American system certainly has very many strong features – predominant role of private insurers, the important role of private hospitals, private HMOs, and private physicians. Certainly the fact that they compete against each other for health-care dollars and patients, that is certainly something you want to preserve in our future health-care system. But given this, I would like to talk about some of the problems that Len mentioned that were noted sometimes in his presentation.

One issue that is often mentioned and was also talked about this morning is, "Is there a problem because the cost of health-care is rising?" From the economist prospective, rising costs by themselves do not necessarily mean that there is a problem. Even if the cost of essential products like health-care, national defense, or food rises that does not necessarily mean we have a problem in our world. What you want to understand is where the cost increase comes from in health care. There are many reasons. On the supply side, quality is certainly much higher than it used to be. This is one

factor that drives up the price. On the other end there is also the demand side, and demand has also been increasing.

Why? Because people live longer and as they live longer they require more health care and more medical services to maintain their quality of life. Also, we have many more options than we had before. You can think about it in terms of quality increasing relative to the price. Lots of the spending in health care is discretionary. For example, treatment for mild emotional or cognitive problems, mild depression, treatments to enhance mobility, or cosmetic surgery, all of those things are discretionary expenditures where there have been a lot of improvements over time. Clearly, demand to take advantage of those extra procedures is going to increase. That's going to increase the cost.

The mere fact that people spend a lot on health care does not mean that there is necessarily a large problem. It is also not necessarily a problem if they decide to spend less on food and housing and more on health care. That is an individual free and legitimate choice. It may even be a sign of affluence that we are able to afford that much spending on health care. Finally as a last comment on this issue, as an economist I'm not saying we've spent too much, that we've spent \$2 trillion on health care and that's too much. The right question that an economist would say, "Can we spend the \$2 trillion more efficiently?" That was something exactly that Len addressed.

Is the quality of health services poor? That is another theme that has been going around. It seems we get a lot of value out of the health-care dollars we spend. Although spending certainly has increased over time, benefits have increased as well. For example, in a paper in the 2006 *Journal of Political Economy* by Kevin Murphy and Robert Topel and they estimate that the value of life expectancy in the United States in the last 30 years, 1970 to the year 2000 to be specific, is worth \$95 trillion. So even if you subtract the \$35 trillion we've been spending on health care over the same period, we still have a net benefit of \$60 trillion. This certainly doesn't mean that no improvement in

efficiency can be gained, but it also means that the situation perhaps is not quite as dire as sometimes portrayed.

How about other countries? We just talked about it. Other countries seem to favor less spending and they seem to do even better in terms of mortality all the same. What does this mean? It could, of course, mean that other countries are more efficient in their health-care delivery system than the United States. But other nations often also ration, as for example, Great Britain. They are less generous in providing quality of life improvements such as perhaps hip replacement or breast reconstruction after breast cancer. Much of health-care is more than just extending life. It's about improving life quality and based on that metric the United States seems to be doing fairly well. Clearly those quality of life improvements do not show up in mortality comparisons. Mortality is just one aspect of health outcomes.

One also has to be careful making these cross-national comparisons because individuals change their behavior in response to medical progress. The better a nation's health-care system is the riskier the behavior. Going back to something we talked about this morning, if someone knows the diabetes treatment is excellent in the United States maybe they will decide to eat another cheeseburger and so thereby increasing their risk of obesity and likelihood they will have to be treated down the line. This changed behavior in response to medical progress is going to offset some of the effectiveness of the medical progress. There are certainly lots of studies documenting this upsetting behavior.

Finally, it's worth saying again that the indicator of the high-quality care in the United States is that the United States is the leader in the world in terms of medical research. People from across the world come to the United States for advanced medical treatments of serious diseases and illnesses. Clearly this indicates there is a high quality at the high end, at least there is no problem at the high end.

Let me address one other issue, which is “Does the United States become less competitive because of the employer-based health insurance?” In my view it is difficult to imagine that this is the case. Even though employers are legally responsible to pay the health-insurance premium, the workers end up having the burden because they receive lower wages as we also just heard and saw in the graph. This is because the health-insurance premiums are just a part of the cost of labor and therefore the employers are willing to pay a lower wage. We hear some firms complaining that they can’t compete any more because they have to pay high health-insurance premiums.

For example, the Detroit car manufacturers are among those too, but there are also foreign firms in the United States that manufacture cars, like Toyota. They also pay health-insurance premiums and they don’t have any problem at all. The problem with the Detroit car manufacturer is rooted in something else, not rooted in health-insurance premiums.

Is there a problem that many workers are uninsured? We may have humanitarian concerns with the well being of others that may lead us to believe everybody should be insured, but besides those concerns, is there a reason, does it matter that many of those who are young and healthy do not have health insurance. Besides our humanitarian concerns, is there a reason for concern? One argument that is often advanced why we want everybody insured is people are saying the insured are paying higher health-insurance premiums because of the uninsured that essentially pay for the treatment of the uninsured. This is because, again it was briefly mentioned, that all persons must be accepted for treatment in the emergency rooms. Perhaps there are some people out there who decide not to become insured because they know they are going to be treated in the emergency room. That is sort of the most common argument where uninsured impose costs on to the insured. But clearly the incentive to go to the emergency room is really not very strong. Often it doesn’t provide the proper care or exactly the most effective care nor is it the most pleasant care. Actually there was a study in the *Annals of Emergency Medicine* in 2004 by a Dr. Weber. She interviewed

about 50,000 emergency room patients and found that emergency rooms are not used disproportionately by the uninsured. So it seems like the uninsured are not the most frequent visitors to emergency rooms after all.

Why is it so? Well the uninsured often are mainly the young and healthy and they often have little reason to go to the emergency room. The fact that millions of people do not have health insurance is not necessarily a social problem. The cost imposed on the insured is not that large, in my view, even though there are some other studies we can talk about during the discussion. Those who can afford but forego health insurance often young and healthy and for poor individuals Medicaid is paying the bills. Again, there is something economists call free riders, those people who are not insured but basically for whom the insured are paying. To some extent this so-called free riding even occurs for insured people. Premiums typically do not increase when the health condition deteriorates. So there is also some free riding within the insured going on. I'm just not sure how important this really is.

Which brings me to how can we improve the present system. Under the present system, employed workers are getting tax benefits when the employers make contributions to the health-insurance plans. The tax benefits occur because the workers do not have to report the contributions as part of their taxable income. What is the problem with this system? Since there is no limit on how much can be deducted, often very expensive policies are chosen, very extensive coverage, and these are just chosen because workers don't have to pay the full cost. Again this turns out to be of cost depressing to workers wages.

One issue that needs to be addressed is to level this tax playing field between those with individual health insurance and those people with employer insurance. One way to do this is, of course, to reduce or eliminate the tax exemption for employer-based health insurance, but if the goal is to get more people insured, an alternative way of leveling the playing field is to subsidize those who

obtained their insurance not through the employer, but as an individual. We're going to subsidize them to a limit, just by having a cap. That would make sense just to discourage the use of more elaborate insurance plans, which often add not very much to healthiness but often are just purchased because they are artificially cheaper. This subsidy proposal certainly would reduce the cost of obtaining insurance by a lot for the 47 million who are currently not insured and it levels the playing field. In this proposed system, the employer-based plan would still be important. Now it's on a level playing field with the individual plans and it's important because it will compete with the individual plans. So now group employer-based plans will continue to be important because they compete with the individual plans.

This brings me now to the last point. Besides leveling the playing field, it would make sense to have some mandatory catastrophic health insurance, not regular health insurance but catastrophic health insurance. It's insurance against catastrophic events. Again, what's the rationale for this? Again leaving humanitarian concerns for now aside and looking at it from the economic perspective, the rationale for it is the risk that some people are trying to – using again the term “free ride” on the insured. Mandatory health insurance should therefore just be limited to long-term illnesses that would drain individuals or families' resources. These events are rare and therefore the premiums would tend to be low and the poor individuals actually do not need extra subsidy because they are already covered through Medicaid. In making some coverage compulsory for all and leveling the playing field and then subsidizing only the coverage of the poor families seems the right way to go.

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