

7 Health Care One More Time

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People on all sides of the political spectrum agree that the crazy-quilt of the American health-care system needs major revamping. The analysis typically revolves around three interrelated axes: access, cost, and quality.

On access, the dominant concern is the forty-six million individuals who do not have health insurance, plus those who may lose their coverage if the current recession deepens. That figure is, however, subject to important refinements: about ten million of those who are uninsured have had to opt out of the market because of high prices; about twelve million are eligible for government programs in which they have not enrolled; about 4.1 million children are now eligible for inclusion in the expanded State Children's Health Insurance Program (SCHIP); and another ten million are illegal immigrants. The remaining fourteen million represent less than 5 percent of the overall population. Any comprehensive health-care plan must at a minimum address each of these groups.

On cost, health care now gobbles up an ever larger fraction of gross domestic product (GDP). Three numbers capture the overall picture. First, total health-care expenditures reached \$2.4 trillion in 2007, almost 17 percent of GDP, or about \$7,900 per person. The projections are for more of the same. One estimate has 17.6 percent of GDP going for health care in the year 2009 (see <http://homecare>

mag.com/news/health-care-spending-exceed-gdp-growth-20090224). Another estimate finds that \$4.3 trillion, or 20 percent of GDP, will be spent on health care as of 2017 (see www.nchc.org/facts/cost.shtml). Poorer countries have lower costs, broader health-care coverage, and longer life expectancies. What, if anything, would allow us to spend health-care dollars more efficiently than we do today?

On quality, at its best American health-care is as good as or better than any other throughout the world. But U.S. quality standards are far from uniform, and the uneasy sense is that the insistent cost pressures on the system will erode health-care quality in ways hard to identify and harder to correct. How should we cut this Gordian knot?

The first hundred days of the Obama term have yielded only hints as to its eventual approach because the going is necessarily slow. Health-care reform is more complex than labor market reform, which has generated a huge hubbub involving the (mis-named) Employee Free Choice Act, legislation that is only two pages long. No one can pack health-care reform into that small a nutshell. In addition, the Obama team lost momentum when former Senate majority leader Tom Daschle, a consummate insider, was forced to withdraw his nomination for secretary of health and human services, paving the way for former Kansas governor Kathleen Sebelius, who is not. As the Obama administration works feverishly to extend insurance coverage without upsetting established institutions, it is critical that we take stock of the full range of reform possibilities, including roads not taken. This chapter first examines the philosophical foundation behind the modern claims of the right to health care before turning to the two major policy initiatives that are now under consideration: the first is a single-payer health-care system based on the Canadian model; the second, more eclectic effort hopes to build on existing public and private programs to extend basic coverage. I support neither of these efforts. The simplest and most cogent objection is that they are too costly, as no government can successfully devise rules to constrain

demand while seeking to drive to zero the health care costs of recipients. Accordingly, in the last section I present an alternative approach that stresses deregulation, which, by reining in health care, expands access to health-care services for those now excluded from the system.

A RIGHT TO HEALTH CARE

The Obama administration has begun with the premise articulated in the Democratic National Platform for 2008: “Every American man, woman, and child be guaranteed affordable, comprehensive health care.” Such a program is a far cry from the now disfavored market-based system that gives all individuals the right, not to a claim against the state but to purchase whatever mix of goods and services they can from willing vendors. That market system does not impose any direct costs on the government and generates powerful pressures to reduce costs. But market solutions must meet serious problems of their own. Information about health care is hard to assemble and interpret. Huge payments for emergency treatments call for insurance companies, which have problems of their own in dealing with moral hazard and adverse selection issues. Insured people often exhibit riskier behavior than do those who are uninsured. People who are likely to become sick flock to insurance companies. But even in a competitive market, many people lack money to pay for basic treatment that everyone regards as appropriate. Unless supplemented by charitable contributions, voluntary markets could leave some people out in the cold.

Such objections explain the enormous political pressures to create positive rights to health care, understood here as direct claims against the government to either supply or fund health-care services. The hard question is whether that approach is more imperfect than the market alternatives that might be strengthened in its stead.

Unfortunately, the fixation on health care ignores a key insight: health outcomes depend not only on health care but also on all personal activities that enhance or detract from the quality of our lives. Give younger people high disposable incomes, and they will drive cars with better tires, eat better food, and live in nicer places, all of which reduce the likelihood that they will need medical care. Easing general taxation burdens saves the lives of people who now die before reaching the emergency room by allowing them to purchase on their own similar goods and services that prolong and make it possible to enjoy life while they are still healthy. For all the huge expenditures on Medicare, since its inception in 1965, life expectancy past the age of sixty-five has only gone up a few years. So beware of all those true stories of people who lack desperately needed medical care; such testimonials don't explain the background conditions that make their illnesses so acute.

By missing such broader themes, the Obama team is likely to champion counterproductive and costly measures that will put a health-care system already in distress on the critical list. At every step we must all remember that rights are easy to announce but difficult to fund. Because it is never clear in principle just who should pick up the tab, governments struggle to tap new sources of revenue, not to improve market institutions. The Obama administration, deaf to market arguments, worries exclusively about how best to implement the positive right to health care. The two major possibilities—single-payer and building on existing programs—both have serious pitfalls.

SINGLE-PAYER SYSTEMS

In 1993, the Clinton administration spearheaded an abortive campaign for a single-payer health-care system patterned on the Canadian model, which guarantees all its citizens affordable health care regardless of their ability to pay. Its commitment to centralized

financing, however, does *not* mean that the government runs the system. Instead, the Canadian national government distributes funds to the provinces, which in turn enter into various service and fee arrangements with health-care providers. A strong budgetary thumb, however, has created extended queues for services, with some of the excess demand being supplied in the United States, and postponed investments in modern medical equipment. In recent years, the cost increases have paralleled those in the United States, albeit from a lower initial base. It is an open question as to whether to count the Canadian system as a success. Yet even if the Canadian system were flawless in design, it is doubtful that it could be transferred in its entirety into the very different political arrangements and cultural expectations in the United States. Our hodgepodge arrangements cannot be easily rationalized.

In evaluating the above prospects we should take heed of why the Clinton plan failed. That mammoth proposal was defeated, at least in part, because it left unclear whether ordinary individuals could purchase additional health-care insurance outside the nationalized plan. Such private options are allowed in England but have been fiercely resisted in Canada, where they are seen as the source and symbol of an unacceptable two-tier system of health-care entitlements. Such egalitarian sentiments in the United States were not—and are not—as intense. The uncertainties over extra coverage created a large backlash against the Clinton plan. Many Americans believe strongly in *minimum* health-care entitlements but oppose any system that imposes *maximum* health-care limits.

The doubters have a point. It is easy to attack the rich for spending their money on frivolities; it is also easy to attack them for spending their money on necessities. Together, the two prohibitions point to a system of perfect income equality, which, no matter how disguised, stifles initiative, hard work, and innovation. In the long run, that self-destructive constraint reduces the labor of our most productive citizens, which in turn erodes the wealth base needed

for any redistributive program. Any Obama health-care plan will have to make peace with at least some inequalities; maximum limits on the private purchase of health care are out.

The second difficulty with an American single-payer system is that of scale. What might work for twenty-five million people in Canada is not likely to work for the more than three hundred million people in the United States. No one could figure out how to divide the nation into operational subdivisions in the Clinton years, and no one can do it today. For example, separating cities and suburbs into different units would have enormous ramifications for the cost and quality of care that people would receive under alternative configurations of the health-care system.

The third difficulty with any single-payer plan is captured in its name. Single-payer creates another state monopoly that carries with it the same baggage as all other monopolies. Price competition would come to a halt, as would innovations in new services; funding for basic research in health care could easily decline. Patients would be either restricted in or denied their choice of hospitals, physicians, and ancillary services. To be sure, any sensible single-payer plan would try to mitigate such problems, but how?

The root problem here is that a single-payer monopoly does not try to maximize its profits—at which point it would cut down on services. Instead, it tries to give away the services at as low a cost as possible. But it has no idea which mechanism to substitute for price in rationing services. King Canute could not stop the tides; a lumbering government agency cannot hold payments down for patients and prop wages up for hospitals, physicians, and other health-care providers. Medicare has never been able to achieve those dual goals, and a broader plan will face even greater pressures. Ideally, we would supply medical care to all individuals until the marginal cost of additional services exceeds their marginal benefits. But no one has any idea of how to implement such a regime. Supplying health care at zero or low cost stimulates demand even for those who must bear the costs and risks of treatment. Under conditions of scarcity,

some people who need care must do without it, but who? The blunt truth is that administrative guidelines are made to be evaded; only a price system can cut back on demand, especially when some of the cases crying out for treatment come from people who cannot pay for it. So if the Obama administration chooses to abandon single-payer health care, what should it put in its place?

EXPAND FROM THE EXISTING BASE

Plan B calls for extending the reach of health care by building on public and private programs now in place, with the first prong of the strategy expanding eligibility to existing programs, as witnessed the rapid passage of SCHIP in the opening weeks of the Obama administration. In its initial incarnation SCHIP covered about seven million children not poor enough to participate in Medicaid but not fortunate enough to have private insurance. The program's expanded access will substantially benefit the children who receive the care, but its long-term consequences could undermine its short-term gains. Early evidence suggests that the number of employers now offering health insurance to children has dwindled from 69 to 60 percent, and we could easily see such a cycle repeated, with the expansion of SCHIP leading to a further contraction of the voluntary market, followed by additional expansions of eligibility in SCHIP.

Most SCHIP supporters prefer to think of the program as a down payment on universal health care. But at this point, the worries over a single-payer plan loom large. Its early detection programs may reduce the heavy costs of health care down the road, but its implicit heavy subsidies could also lead to a vast increase in the demand for less-essential services that become affordable only at subsidized prices. The unresolved long-term question is whether this program is sustainable in the long run, which Medicare is not,

as evident in the grim annual reports prepared by Medicare trustees.

Similar observations apply to Medicare Part D, a new entitlement program introduced by the Bush administration in 2006 that deals with prescription drugs. Its subsidy for prescriptions is incorporated into a system that encourages health benefit plans to compete actively for customers, which has happily lowered the cost below the original projections. CMS (an imperfect acronym for the Center of Medicare & Medicaid Services) had originally estimated the costs of Medicare Part D at \$634 billion, but estimates from 2008 dropped that figure to \$395 billion. The Obama administration may seek to inject the United States into the market as a monoposony buyer of drugs to lower their costs further. Yet that approach appears to be doubly uninformed: it is always a mistake to tinker with any government program that works, and any effort to drive prices lower is likely to have a negative effect on research and development.

Unfortunately, this prospect is far from remote; drug companies are already reeling from a broad array of regulations and restrictions, including tough terms of sale in foreign markets dominated by local governments; increased expense and duration of clinical trials under stringent FDA rules; more uncertain patent protection, including protection against reimportation at low prices; expanded liability under state tort law; mandated sales to state Medicaid programs at low prices; the constant specter of general price controls; and increased restrictions on sales techniques in both the consumer and the physician market. No recent regulatory change in the pharmaceutical space has been of help to private firms that supply patented drugs. In this area, as in so many others, the risk of government overreach is real. The president may have lifted the legal restrictions on stem-cell research, but the landscape remains precarious for research in this area.

Private employer and insurance benefit programs. The Obama administration is also likely to build on the employer-based private

health plans now in place for most Americans, with his mantra being that “if you like your current health plan, keep it.” The point of this message is to underscore the differences between Clinton in 1993 and Obama in 2009. The Obama health-care plan does not impose uniform standards of health care on all individuals; nor does it force everyone to do business with a government monopolist. Instead it goes to great length to preserve choice to the extent feasible. In addition, it calls for offering a range of options to those who are unsatisfied with the current system, including coverage “similar to what members of Congress enjoy.”

The coercive portion of the Obama health-care plan, however, lies in its treatment of those employers who do not currently supply health insurance to their employees. A new “pay or play” regime will require such firms to pay taxes into the public coffers or provide health insurance to their workers. The program also requires that health insurance be purchased at some minimum figure—\$6,000 or upward for a family—that could not be offset by wage reductions for those workers who earn close to the minimum wage, with the likely result being increased unemployment. The pressure on insurance plans is further tightened by mandates prohibiting insurance companies from charging higher prices to those with pre-existing conditions.

In tandem, those multiple restrictions could easily gut the private building blocks on which the Obama program for national health care rests. Private health insurance is not a fixed fact of nature. Health plans regularly alter their cost and coverage in response to pressures on both supply and demand. Even if the federal government did not put its thumb on the scale, the shifts in law, population, and technology would continue to reconfigure those plans in the future as they have done in the past. New mandates, applied at the employer or the insurer level, could easily force insurers to contract or fold. An Obama requirement that restricts employers and insurers from discriminating against persons with preexisting conditions could further eviscerate employer-based insurance.

Traditional insurance in voluntary markets was not a form of “social insurance” intended to both pool risk and redistribute wealth from one person to another. Rather, traditional insurance companies set rates to bleed out cross-subsidies across the insured by matching premiums with anticipated risks. The gains to all players come from smoothing the risk over time, not from getting someone else to pay for their losses. Any requirement that firms not discriminate in accordance with perceived risk requires that healthy persons overpay on a prospective basis so that sick people can underpay. Healthy individuals will leave such plans, unless coerced to remain. The Democratic National Platform calls for firms to compete on service, “not on their ability to avoid or overcharge people who are or may get sick.” But sound competition works on all margins. The ablest firm cannot survive if its operations cannot cover its anticipated losses. One response is for insurers to package their coverage to discourage high-risk patients whom they can only serve at a loss. But if such devices are forbidden, the ablest firms can be driven into bankruptcy precisely because they are attractive to the sickest patients. Yet it is unlikely that any federal action would, or could, design an assigned-risk pool (like those for high-risk drivers) that would help insurers avoid insolvency. Left unchecked, employers will drop health-care insurance as insurance companies flee the field.

The situation will only get worse as Congress and the states pile on new mandates. For example, the recent bailout legislation included the Paul Wellstone Mental Health and Addiction Equity Act of 2008, which requires that every element of coverage supplied for physical ailments be carried over to these illnesses, which private insurance carriers often exclude from coverage for good economic reasons. Addiction is in part a willful condition that could become more common precisely because insurance coverage for it is now available. Moreover, the high costs for a small fraction of the workforce will drive up rates for everyone else. Mental health hazards are difficult to detect and monitor, and the base rates for insurance

must reflect those differences. Because these risks are more acute in some patient populations than in others, some employer plans may well perish owing to cost; other plans will adjust rates to make them less desirable than before. The illusion that any insurance coverage will remain constant when all else is in flux is a form of naiveté that will hasten the destruction of the voluntary market on the path to national health care.

The cost pressures of the Obama proposals have now hit home. In March 2009, Obama indicated that he might let (a Democratic) Congress back off from his State of the Union pledge not to alter the current tax rule that allows employers to deduct their premiums on employee health care from gross income without requiring the employees to take the fair market value of the plan into taxable income. This proposal will bleed much of the current subsidy out of health care, which is welcome as a matter of first principle. But the proposal also undercuts any effort to make current private health plans the linchpin of a new national health-care system. The added tax revenues will not be used to reduce overall tax rates but will help fund the costs of insuring uninsured or underinsured people. Ordinary taxpayers will experience declines in their disposable income that will in turn reduce their demand for health-care coverage. Without corrective action, the present system will unravel.

The pressures will only intensify if the Obama administration keeps its pledge to provide ordinary people with additional health-care options “similar to those that Members of Congress enjoy.” That statement rests on a deep misunderstanding of insurance underwriting. It is always possible to offer the same *formal* coverage to ordinary people that Congress now provides for itself. But the composition of the two risk pools is so radically different that they cannot be funded at anything close to the same cost. It costs a lot more to service a random draw of the population than it does members of Congress under identical policies. Indeed, the economy

will rapidly deteriorate if the sickest people are allowed to buy policies whose costs cannot be covered by existing revenue sources.

How then to fund these new ambitions? Largely by mirrors it seems. The Obama health plan seeks to cover the costs by bleeding key inefficiencies into the provision of health care. But it can't deliver. The Obama administration envisions "state-of-the-art health information technology systems, privacy-protected medical records, reimbursement incentives," and independent review boards to make sure the people get the right drugs at the right time. All this is said to yield an annual savings of \$2,500 per family, which, with a 100 million families, clocks out at \$250 billion per year. That huge number, if realized, still buys us only a two-year respite in health-care cost increases. But the savings are unlikely to materialize at all. Electronic records don't come cheap for single institutions, many of which have already foundered at the task. New technology requires expensive up-front costs, which are complicated by the need to transition away from older systems onto newer ones. State and private hospitals have already started off in different directions, hampering efforts at unification. The effort to bring millions of new individuals into a single integrated system, often with sketchy data, will be mammoth. The mundane business of data entry introduces errors into the records that are hard to undo, even if the system is continuously updated. Perhaps a program like this will pay for itself in a decade, but it can't offer a short-term fix for today's budget flows.

Similarly, the effort to improve reimbursement schemes has been a Medicare mantra since the early Reagan years. But each new government protocol is quickly neutralized when hospitals switch billing strategies in response to the government initiative. The costs of the Obama plan are real. Its savings are largely mythical. There is no balanced budget in this nation's future. There is only the relentless movement to a single-payer plan from which there will likely be an opt-out provision allowing some well-to-do individuals to get decent health care.

AN ALTERNATIVE REFORM PROPOSAL

This glum assessment of the Obama approach to health care begins with the premise that it is easier to enact entitlements than it is to pay for them. What is needed is a fresh approach that does not seek new sources of revenue to pay for unlimited access without compromising quality. Rather the appropriate line of attack addresses cost directly, using better control of costs to ease the pressure on access. The principle here is simple: lower costs will bring into the marketplace individuals who cannot afford health-care coverage under the current system. Unfortunately, the Obama approach does not mention one specific regulatory program *now in place* that it will repeal or slim down. Nor was one market-oriented individual or organization invited to participate in the Obama health-care summit held in March 2009 (see <http://spectator.org/archives/2009/03/11/ostracized-by-obama/print>). But many regulations cry out for reconsideration.

The first such step would turn its back on government mandates for private coverages such as the recent Wellstone Act. The philosophy behind mandates rests on the strong conviction that any denial of coverage for a particular condition signals a market failure that requires government intervention. The correct way to read all mandates, however, is as implicit taxes that undo considered market judgments that certain coverages cost more than they are worth. There is no reason to impose a mandate if a private employer or insurer already offers coverage. No insurance company has an incentive to turn down any line of business from which it can turn a profit. But it has every incentive to turn down a line of business that will cost consumers (and their informed intermediaries) more for coverage than they are willing to pay.

When government mandates certain coverages, it does more than create an administrative headache; it in effect imposes a loss on employees, employers, and insurers who have chosen not to include the specified coverage, dangers that go unnoticed when

absorbed without a reduction in coverage. Thus, assume that for some workers the mandate costs \$50 per month more than it is worth but that their implicit gain (often called consumer surplus) from the underlying insurance contract is \$100 per month. Those workers will keep the policy and absorb the loss. But now reverse the numbers: suppose that the new mandate imposes a net loss of \$100 per month for a policy that previously generated only a \$50 per month surplus and that the coverage will be dropped, adding to the ranks of the uninsured. The combined impact of multiple mandates only exacerbates the overall situation. In short, we can have extensive coverage for a few people or modest coverage for many. We cannot have extensive coverage for many individuals. Strong mandates increase the ranks of the uninsured.

The issue of mandates is only one instance whereby a disregard of sound contracting principles imposes taxes that reduce overall coverage. The simmering malpractice crisis is best understood as a judicial mandate for extensive tort damages that costs consumers more than it is worth, resulting in higher insurance premiums and withdrawal of medical services when costs become prohibitive. Unfortunately, the Obama approach refuses to treat high malpractice premiums as a sign of distress. Rather, it regards them as an open invitation for price controls on medical malpractice insurers that will drive them from the market, thereby exacerbating the underlying problem of health-care delivery.

The list goes on. One of the most intrusive and costly systems of health regulation is HIPAA, or the Health Insurance Portability and Accountability Act, which President Clinton signed into law in 1996 and which has been a chronic administrative headache ever since. Before HIPAA, the reported instances of troublesome invasions of privacy and misuse of data, especially in psychiatric cases, were negligible. Those cases that did occur were met with stern administrative or judicial sanctions. HIPAA was meant to be primarily directed at the transference of insurance coverage between jobs, which turned out to be a less serious problem than expected. But

its baroque privacy regulations create endless nightmares on the ground and will vastly complicate any effort to set up a comprehensive electronic network. Repealing this bill would most likely save significantly more than the \$25 billion that the total system would cost.

Another promising area for reform is state restrictions on licensing for both out-of-state physicians and insurance companies. Let us assume that licensing is necessary to preserve a minimum level of medical and health-care services. In that case, adopt a simple rule saying that anyone who has practiced for five years in his or her home state has a license to practice anywhere, without undergoing a third-degree investigation with anticompetitive motives. More important, allow the free entry of businesses into the health-care market, including Wal-Mart, Target, or any new player. Why use emergency rooms as the provider of last resort? Well-run private systems can pick up the slack at a fraction of the cost, in part by substituting sophisticated systems and protocols for individual physician judgments, which are often unreliable in practice. The same approach should work for hospital care, where competition is now hobbled by the need for certificates of need. Open up entry and local monopolies will lose their dominance. Similarly a relaxation on the sale of insurance across state lines would increase competition. Note that all these proposals loosen regulatory chains: none of them require new budget appropriation, and all open up new sources of taxable revenues. Ultimately their combined effect should reduce the pressures on government funding of health care. Lower costs would then increase the private utilization of health care.

CONCLUSION

Reforming health care will not take place if all government does is tweak current political solutions. Instead, it is imperative to ransack the statute books, state and federal, to weed out all the counterproductive regimes that stifle competition and raise cost. Unless this is

done, the drift toward a single-payer system will be inexorable, for the defects of bad regulation will be treated as conclusive evidence of the inherent defects of unregulated markets. Yet the proper approach can slow down, and perhaps stop, the endless cycle of government taxes and transfer payments to facilitate broader access and higher levels of affordable care. Obama's bromides will not cut the Gordian knot.