Editorial

The Ownership Society and Health: 2006 AcademyHealth's Chair's Address

Thomas Rice

During his acceptance speech at the 2004 Republican National Convention, President Bush called upon America to “build an ownership society,” where “more people will own their health plans and have confidence of owning a piece of their retirement” (<http://www.whitehouse.gov/news/releases/2004/09/20040902-2.html>). These views are amplified on the White House's website, which contains a Fact Sheet about “America's Ownership Society,” (<http://www.whitehouse.gov/news/releases/2004/08/20040809-9.html>) with two examples in the area of health care: health savings accounts (HSAs) and the new Medicare prescription drug benefit.

There is much to be said for an ownership society. We live in a country in which the concept of ownership is central to attaining much of what people desire. Even most on “the political left” would agree that if individuals do not have the ability to own and retain much of their wealth, there is little incentive to produce and diminished incentives to achieve. Most modern societies that have attempted to collectivize resources and decision making have proven that such an approach is neither politically nor economically sustainable, and can be maintained only by relying on force.

Moreover, the notions of ownership and responsibility go hand in hand. If you own a home or a car, you are more likely to take good care of it. Larry Summers, in a quotation attributed to him all over the Internet (that he very well may have said) summed this notion up nicely: “In the history of the world, no one has ever washed a rented car.”

Economists sometimes go a step further, arguing that if people have to pay even a token amount of their health care, they will feel some “ownership” for it and will forgo services that do themselves little good but are costly to society. Many experts claim that one factor in “excess” use of health care comes when the price is artificially low or “free” for the consumer—a view subscribed to by 63 percent of health economists, in one survey (Feldman and

Morrisey 1990). In today's parlance, consumers, we are told in a rather distasteful metaphor, need to have some "skin in the game"—as though people undergoing surgery and other medical procedures don't quite literally already put their "skin" on the line.

So I would agree that we need a good measure of ownership in our society, but want to examine whether this neatly applies to health care, or if, alternatively, such an analogy might contain some serious problematic elements. To explore this, let's think about *what* is being owned. The White House website mentions two things: an account, as in the case of HSAs; and an insurance policy, as in the case of the Medicare drug benefit.

Beginning with HSAs . . . owners enjoy benefits and bear responsibilities as well. On the benefit side, there are substantial tax advantages: those opening HSAs can deduct contributions, enjoy tax-free earnings on investments, and have tax-free withdrawals for qualified medical expenses. They can even will these accounts to their heirs.

In essence, when you join an HSA you are in two risk pools. One risk pool includes just you—that's your individual account. The other includes people who, in some ways, are like you: those who choose HSAs and therefore purchase high-deductible, catastrophic health insurance coverage. This raises a fundamental issue: if your good health benefits others, and vice versa, what mechanisms will we have left to support each other's health, as we embrace the individual ownership of health accounts? Moreover, do we really want people to "think twice" about receiving preventive and primary care? This is not intended to be a rhetorical question, but I do know how my colleagues in Public Health would answer it.

Let's instead ask, "Who are these people who can earmark money into such accounts and who are willing to purchase policies with very high deductibles?"

- First, they are likely to be those with higher incomes, who benefit more both because they have higher marginal tax rates and because they have more surplus income that is not required for immediate consumption.
- And second, they are likely to be those who are in better health and are not scared away by the high deductibles.

That tells us with whom they will no longer have to share a risk pool: those who have lower incomes and are in poorer health. So—the tendency will be that the healthy and wealthy will not be subsidizing those with lower incomes—and the sick. As a result, those people who need cross-subsidization the most, will not get it. Instead, they will pay more out of pocket or through higher private insurance premiums, or public programs will pay more in direct subsidies.

Curiously, many economists would view this phenomenon as consistent with their notion of a perfectly functioning insurance market. The argument goes like this: health insurance should be priced appropriately for each individual. If you are more predisposed to having an expensive illness, you should pay more in premiums; those who are less likely to use costly services should pay less. There is an underlying logic to this. Most people, whether sick or healthy, are risk-averse, and risk-averse people want fairly priced insurance. If a healthy, risk-averse person has to subsidize an unhealthy person, he or she will be less likely to purchase coverage. This makes the person less well off, and, by extension, does the same to society. Only if everyone pays premiums based on their own predilection to use services can private insurance markets operate perfectly. The counterargument, of course, is that people don't choose to have expensive illnesses the same way they choose to purchase expensive cars, and moreover, there are key genetic, social, and environmental forces at play—most illnesses are not a person's own fault.

The question that we, as a society must ask, is this: should we encourage a system of ownership where the healthy and wealthy do not subsidize the poorer and sicker? Many of us would object to this notion, particularly because poverty and sickness are hardly randomly distributed in the population; rather, they are strongly correlated with socioeconomic status, and oftentimes, the former causes the latter.

Consider race. Compared to whites, African Americans have about 2.5 higher infant death rates and 25 percent higher death rates overall and for heart disease and cancer specifically; their death rates for homicide are more than five times higher (National Center for Health Statistics 2005).

Now consider education. Infant mortality rate of children of women who did not graduate from high school is more than 50 percent higher than those who attended at least some college. More dramatically, the death rate for people age 25–64 is almost three times as high for non-high school graduates than for people who attended at least a year of college (National Center for Health Statistics 2005).

You might say, “but people of all races or any education level can establish HSAs.” That's technically true, but we already saw that it is more

advantageous to wealthy people, and other data show that median family income for white families is 58 percent higher than for African Americans (U.S. Census Mini Historical Statistics 2006). As for education, median household income for those with some college is almost three times higher than those who didn't graduate from high school (U.S. Census Bureau 2006).

The implication is that as we let wealthier and healthier people pull themselves out of the joint risk pool, others will suffer—and those “others” are disproportionately nonwhite and poorly educated.

Interestingly, one provision of the 2006 Deficit Reduction Act allows up to 10 states to create Health Opportunity Accounts—essentially, HSAs for Medicaid. Needless to say, we need to closely examine these demonstration project results as they will provide one of the first examples of what may become a trend: applying the concepts of consumer-driven health care to public insurance programs.

I want to move on to the *responsibilities*. If these accounts are discretionary, as are HSAs, then one would hope that people would open them only if they felt competent to handle the responsibility. But in the area of health insurance, we seem to be putting responsibilities on people—particularly seniors—that they cannot avoid. I would contend that we have stacked the deck against them.

Recall that the second example of applying the ownership society to health is the new Medicare drug benefit. What does it take to be a successful owner? One prerequisite is having a good understanding of your own personal future needs, and how different types of insurance coverage will best provide personal security.

In a recent paper, Yaniv Hanoch and I illustrate the maze that seniors find themselves in now; it is replicated in Figure 1 (Hanoch and Rice 2006). As illustrated, decision making is quite complicated because seniors must make a variety of upstream [future] decisions, such as whether or not to buy a Medigap policy for nondrug expenses and whether and which drugs they will use in the upcoming year. The reality is actually much more Kafkaesque than shown in this graphic, in two ways. First, drug benefits are not so nearly standardized as portrayed here, i.e., we list only two types, basic and extended. In reality, making apples to apples comparisons between plans is quite difficult. Second, we only list up to three companies (A, B, and C) for each option. In Los Angeles County, where I live, seniors must choose among 85 plans offering prescription drugs (Hanoch and Rice 2006). In contrast, the great majority of younger people need to choose among at most four or fewer health insurance plans offered by their employer. Unlike Medicare, where no one helps the

Figure 1: Health Insurance Decisions Facing the Elderly

Source: Hanoch and Rice (2006). Reprinted with permission from the Milbank Memorial Fund.

senior winnow down the choices, employee benefit managers make the initial “cut” among plans to offer and are more likely to provide clear incentives and advice on remaining choices for their employees.

You would think education would help people to make wise choices, and it probably does. But education alone isn’t sufficient when the choices are as difficult as they are in health care. Even in the area of retirement savings—an arguably more tractable problem because it’s much easier to compare outcomes among alternative choices—the well educated are befuddled. The *Los Angeles Times* reported that a number of Nobel Laureates in economics have been making bad retirement investment choices. For example, Harry Markowitz, the father of modern portfolio theory, failed to diversify his retirement investment portfolio, in complete negation of his own theory (Gosselin 2005).

A career’s worth of research by our conference Chair, Judy Hibbard, and her colleagues have shown that consumers generally, and Medicare beneficiaries in particular, do not have nearly enough understanding of health plans to make good choices (Hibbard et al. 1998). Of particular concern, again, are those who are being asked to participate in this ownership society but are disadvantaged. Proponents claim that by making poor people part of the ownership society, they can serve their own interests better (Boaz 2006). In fact, the drug benefit could work to their advantage. The Centers for Medicare & Medicaid Services estimate that, on average, beneficiaries receiving the low-income subsidies would spend just \$170 out-of-pocket in 2006—compared with \$1,122 for those not receiving it (70 FR 4468, January 28, 2005). With the low-income subsidies, you pay no premiums, deductible, and minimal copays; without them, you face the donut hole. The most recent numbers, published in May 2006—several months after low-income beneficiaries could have started taking advantage of these benefits—showed that only about one-third of eligible near-poor had signed up Kaiser Family Foundation 2006, in spite of a massive publicity campaign that cost an average of \$250 per enrollee (Connolly 2006)¹. In an ownership society, who’s to blame and suffer the consequences is clear: it’s those who didn’t sign up.

There is an alternative: give the benefit to everyone; don’t make them sign up for it. That’s what we’ve done with Medicare Part A, and effectively, with Part B as well. This approach would help solve three problems: getting the benefit in the hands of those who need it; ensuring that everyone is part of the risk pool, so that the sick do not have to pay more; and removing the vexing choices that seniors now face.

A similar proposal comes from this year’s Distinguished Investigator Awardee, Karen Davis, and co-authors Marilyn Moon, Barbara Cooper, and

Cathy Schoen (Davis et al. 2005). They suggest that Medicare offer as an option what they call “Medicare Extra.” This proposal would solve some of these same problems by providing a single product that combines the benefits included in basic Medicare, Medigap, and the new prescription drug benefit.

But this is not the direction in which we are heading. I want to end with a quotation, from Robert Evans, Morris Barer, and Greg Stoddart, because it reiterates who would be disadvantaged by the policies I’ve been discussing—in the context of patient cost sharing—a co-requisite of many “ownership society” proposals and policies in health.

[P]eople pay taxes in rough proportion to their incomes, and use health care in rough proportion to their health status or need for care. The relationships are not exact, but in general sicker people use more health care, and richer people pay more taxes. . . . Whether one is a gainer or loser, then, depends upon where one is located in the distribution of both income . . . and health . . . In general, a shift to more user fee financing redistributes net income . . . from lower to higher income people, and from sicker to healthier people. The wealthy and healthy gain, the poor and sick lose (Evans, Barer, and Stoddart 1993).

In closing, let me reiterate a point made at the beginning: very good things happen when people feel ownership of a resource. Indeed, ownership is, and always has been, an integral part of the American dream. I have tried to show, however, that applying this doctrine to health care policy raises a number of fundamental concerns—ones that surely merit a most serious national debate.

ACKNOWLEDGMENTS

I would like to thank several people who provided comments on a draft of this speech: Gerard Anderson, Katherine Desmond, Susan Ettner, Jon Gabel, Richard Kronick, Tricia Neuman, Mark Peterson, and Sara Rosenbaum. It should not be inferred that any of these people endorse the views expressed, and all errors are my own.

NOTE

1. The exact percentage is difficult to discern. 1.7 million beneficiaries were receiving the subsidies, and 3.2 million were not. There were another 1.0 million who were estimated to have other drug coverage (oftentimes, they were eligible for V.A. benefits although they might not be using them). If one does not include the latter

group, the percentage of eligible persons enrolled was 1.7/4.9 million, or 35%. If one includes the latter group, it was 1.7/5.9 million, or 29%.

REFERENCES

- Boaz, D. 2006. "Defining an Ownership Society," [accessed August 13]. Available at http://www.cato.org/special/ownership_society/boaz.html
- Connolly, C. 2006. "Millions Not Joining Medicare Drug Plan." *Washington Post* February 21, p. A-1.
- Davis, K., M. Moon, B. Cooper, and C. Schoen. 2005. "Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries." *Health Affairs*: W5-442–W5-454, Web Exclusive, October 4.
- Evans, R. G., M. L. Barer, and G. L. Stoddart. 1993. *The Truth about User Fees*, In *Policy Option*. Montreal, QC: Institute for Research on Public Policy, 4pp.
- Feldman, R., and M. A. Morrissey. 1990. "Health Economics: A Report on the Field." *Journal of Health Politics, Policy and Law* 15 (3): 627–46.
- Gosselin, P. G. 2005. "Experts Are at Loss on Investing." *Los Angeles Times*, May 11
- Hanoch, Y., and T. Rice. 2006. "Can Limiting Choice Increase Social Welfare?: The Elderly and Health Insurance." *Milbank Quarterly* 84 (1): 37–73.
- Hibbard, J. H., J. J. Jewett, S. Engelmann, and M. Tusler. 1998. "Can Medicare Beneficiaries Make Informed Choices?" *Health Affairs* 17 (6): 181–93.
- National Center for Health Statistics. 2005. *Health, United States*. Hyattsville, MD: National Center for Health Statistics.
- Kaiser Family Foundation. 2006. "Medicare: Low-Income Assistance under the Medicare Drug Benefit," Fact Sheet [accessed August 13, 2006]. Available at <http://www.kff.org/medicare/upload/7327.pdf>
- U.S. Census Mini Historical Statistics. 2006. [accessed August 13]. Available at <http://www.census.gov/statab/hist/HS-25.pdf>
- U.S. Census Bureau. 2006. "Statistical Abstract of the United States, 2006, Table 675" [accessed August 13]. Available at <http://www.census.gov/prod/2005pubs/06statab/income.pdf>
- White House, President's Remarks at the 2004 Republican National Convention [accessed August 13, 2006]. Available at <http://www.whitehouse.gov/news/releases/2004/09/20040902-2.html>
- White House, Fact Sheet: "America's Ownership Society: Expanding Opportunities" [accessed August 13, 2006]. Available at <http://www.whitehouse.gov/news/releases/2004/08/20040809-9.html>