Opinion

Healthcare reform

JAMES C. CAPRETTA

American Enterprise Institute, Washington, DC, USA

Catholic social teaching provides the essential framework for thinking clearly about societal problems, but it cannot be applied like a recipe in a cookbook. It is the responsibility of informed citizens to take what Catholic social teaching offers and use their own knowledge and reason to advance concrete approaches for addressing complex issues of public policy.

Lay Summary: In health care, full governmental control would lead to a decline in the quality of services provided to all patients. It is possible to build a market-driven system of universal insurance enrollment that provides full protection to the lowest income households while also providing space for private initiative and innovation.

INTRODUCTION

Catholic social teaching provides the essential framework for thinking clearly about societal problems, but it cannot be applied like a recipe in a cookbook. It is the responsibility of informed citizens to take what Catholic social teaching offers and use their own knowledge and reason to advance concrete approaches for addressing complex issues of public policy.

In health care, Catholic social teaching does not provide a single “right answer” for how the United States should organize enrollment in health insurance and the delivery of medical services. Reasonable people, including well-formed Catholics, can come to different conclusions about important aspects of how to make the provision of medical services just and effective, not just for today’s citizens but also for future generations of Americans.

What is clear, however, is that Catholic social teaching requires a system of health-care provision that is just for those with the least resources. It is unacceptable to have a system that provides high quality services to those with the economic means to pay for those services while providing restricted access, or even no access, to needed medical care for those with less means. In practical terms, this means that all Americans, and especially those with low incomes, should be enrolled in some kind of health insurance because that is the normal means by which patients have access to needed care.

Suggesting that insurance enrollment is important does not mean that insurance always guarantees access to quality medical services. It does not. But given the high expense of treating difficult conditions and diseases, such as the many different forms of cancer, it is obvious that insurance

coverage will be critical to ensuring that a patient has access to needed services.

THE CRITICAL QUESTION: WHO DECIDES?

While it is clear that Catholic social teaching would not condone healthcare arrangements that leave millions of lower income people with inadequate access to health care, this does not necessarily mean that health care must be provided and controlled entirely by the central government, although that is the predominant form of provision today in the developed world. Indeed, the doctrine of subsidiarity would suggest that, *if possible*, it would be better to have healthcare decisions made closer to the point at which the services are actually delivered to patients, to prevent a distant central government from establishing rules and protocols that are inattentive to the individualized needs of those patients.

Is there a realistic alternative to centralized decision making by the government in health care? Is it even possible to organize healthcare arrangements so that decisions are made in a more decentralized fashion, or is centralization in a government authority inevitable and in fact wise?

Analysts of healthcare policy in the U.S. tend to answer these questions differently based on their views of the advisability of using market forces to allocate healthcare resources. This is why the divide in healthcare policy is often summarized as pitting those who support a market-based approach against those favoring a dominant governmental role.

Although health care is a unique segment of the economy in many ways, it is not immune to the laws of supply and demand, nor exempt from the reality of limited resources, much as we might wish otherwise. This is not universally understood.

Some advocates for government-run health care imply that the government can and should be responsible for making sure every possible treatment is available for every possible patient, without regard to cost. This is, of course, unrealistic. Resources are limited, even for health care. The question is, who makes the decisions about the allocation of those scarce resources? Put another way, who decides when a medical service is valuable and worthwhile, and when it is not?

In most sectors of the economy, the consumer makes those decisions with their purchasing choices. What they buy is what they find valuable, and, by definition, what they forgo is not worth the price that is required.

Many prominent economists, otherwise disposed to the value of market forces, argue that health care is different from other goods and services for a number of reasons, most especially because of the imbalance in information and expertise. It is argued that patients do not have the knowledge to be able to question the judgment of their physicians, who are trained and take an oath to look out for the interests of their patients. Thus, unlike most markets, the consumers are not often in a good position to say no to treatments that their physicians recommend.

This sets up the related problem of third-party payment for health services. Most patients have insurance and therefore do not pay for a large portion of their expensive medical bills. If a physician recommends a treatment, and a patient with insurance is in no position to question the value of that recommendation for their health or to say no based on financial incentives, then that exposes the insurance plan to paying for all costs that a physician and a patient agree might be helpful. There is much experience indicating that this approach is a recipe for rapidly rising costs.

So, someone or some organization has to be in a position to decide which medical services are worthy of being purchased for patients, and which are not. Many countries have concluded that only the government can make those determinations fairly on behalf their citizens. The United States has adopted a series of laws over the years that have slowly moved more decision-making authority to the federal government. It cannot yet be said that the U.S. has a fully government-run system, but the trend is clear. In time, the U.S. is likely to fully embrace government-run health care.

Placing all decision-making with the central government is not without its own problems, of course. There is great variation around the world in the quality of medical services provided by government-controlled systems, but a common problem is a severe lack of capital investment and the imposition of price controls to artificially lower the cost of care. When prices are held below what would occur in a less regulated marketplace, supply is always and everywhere restricted, which is why patients in many countries often must wait many weeks or months for certain services.

Health systems run by central governments are also less flexible and open to innovation. If the U.S. were to adopt fully a government-run model, that would likely discourage companies from making the expensive investments needed to develop and test the next generation of drugs and other products that might help patients.

The big concern, then, with government-run health systems is that they lower the quality of care provided to everyone, including the poor.

It is also false to claim that health care is immune to market discipline. It is well documented that consumers will use fewer health services when they, rather than a third party, are paying the bill. That is human nature.

Moreover, the healthcare system in the United States is immense, and much of the spending that occurs is for discretionary medical services, where some judgment is necessary. Further, patients can greatly influence the setting in which they get care, based on the price they must pay to obtain the services. In other words, there is still plenty of room for consumers to make rational judgments on the use of health services, even if there are some very expensive occasions when the patient will have to trust the judgments of others, especially their doctors.

A MARKET-BASED PLAN WITH UNIVERSAL INSURANCE ENROLLMENT

A market-based approach to allocating resources to, and within, the health sector is possible, but it requires redesigning the roles of the government, the citizen, and those providing insurance and medical services in the private sector.

The government must play a crucial role in ensuring that those with low and modest incomes have access to insurance and care that is comparable to what is available to those with higher incomes. This will generally involve providing subsidization for enrollment in health insurance. Consumers must take on more responsibility in making decisions about how to allocate the resources available to them—some of which will come from the government—to the insurance plans they purchase, and the providers of medical services whom they see when they need patient care.

For their part, insurers, hospitals, physicians, and others providers of medical services should be asked to compete to provide patients with the highest quality care at the lowest possible price. That is how a marketplace needs to work.

Of course, the U.S. already has many laws on the books governing how citizens get their health care. It is not possible, or desirable, to sweep that all away and start from scratch. Rather, it is best to work from what exists, and move it steadily in the direction of a more functioning marketplace that also protects the poor and low-income households.

The following are the most important steps necessary to move toward a market-based approach to health care that also provides universal enrollment in health insurance.

- (1) *Retention of Employer-Sponsored Care.* The tax treatment of healthcare benefits has encouraged widespread enrollment in employer-sponsored health benefit plans. For working age Americans and their families, this is far and away the preferred avenue for securing coverage, in large part because employer-paid premiums are not subject to either income or payroll taxes.

Job-based insurance plans should largely be left alone. There is no reason to disrupt them unnecessarily. But the current federal tax treatment encourages expensive insurance because there is no upper limit on the tax break. To bring more cost-discipline to employer plans, federal tax law should be amended to put an upper limit on the amount of employer-paid premiums that will be exempt from taxation. The limit could be set a high level so that only the most expensive plans would be forced to make adjustments.

This policy would in no way harm the poor or low-income households, most of whom are not enrolled in expensive job-based coverage.

- (2) *Tax Credits for Americans without Access to Employer Coverage.* A primary problem in U.S. health care has been the inability of Americans without

employer coverage to access stable insurance coverage. The solution is to provide to these households a refundable, age-adjusted tax credit that is set roughly equal to the average tax break for an employer plan. These tax credits could be used to purchase any health insurance plan approved for sale in a state. These should be sufficiently generous to ensure that anyone receiving them can afford the health care that they need but not necessarily all the comprehensive care that they might want.

To qualify for the tax credit, individuals would need to purchase qualified health insurance, defined as plans providing an out-of-pocket limit on consumer spending for necessary medical services.

- (3) *Providing "Continuous Coverage Protection."* A third key element of a market-based reform plan is continuous coverage protection for persons with preexisting conditions. Current federal law, enacted in the Affordable Care Act, prohibits insurers from taking into account health status when charging premiums or establishing coverage. This rule protects sicker patients but also discourages the healthy from enrolling in coverage (they can wait until they are sick and still pay the same premiums).

The ACA has attempted to counteract the incentive to delay insurance enrollment with the requirement that all Americans have health insurance or pay a tax penalty (the so-called "individual mandate"). The mandate is among the most unpopular provisions of the ACA.

The alternative is to reward continuous enrollment in insurance rather than punishing individuals for the lack of coverage. To do this, the federal government must provide a targeted regulatory response that

allows people with preexisting conditions who have stayed insured to have access to coverage wherever they seek it. That means insurers could not charge more, or provide more restrictive coverage, to consumers with a history of high health expenses so long as the consumers have had minimal breaks in their insurance enrollment.

This new protection would apply nationwide, and would provide strong incentives for all Americans to enroll and keep their insurance coverage.

(4) *A State Option for Default Insurance.*

Even with a widely available tax credit for insurance, some portion of the population would likely still go uninsured. It is possible, however, to boost insurance coverage among the hard-to-reach population without coercion.

The best approach is to provide default insurance. States would be responsible for designating several insurance plans as default options to which persons who are eligible for a refundable tax credit would be assigned (on a random basis) if they failed to sign up for coverage on their own.

The key to making this concept work is that the premiums for default insurance would need to be set to the value of the tax credit so that persons who were assigned to such plans would not be charged any additional premium. And to keep the premiums equal to the credits, the insurance plans must be given the authority to set up their upfront deductibles accordingly so that the cost of the coverage does not exceed the federal credit.

This approach would of course mean that persons assigned to default plans would likely get catastrophic insurance coverage, with a larger-than-normal deductible. Nonetheless, they would have

insurance to protect them against high medical expenses, which is the primary need and benefit of health coverage. Most importantly, those assigned to a default plan would retain the continuous coverage designation and thus be protected against getting risk rated later based on their health status.

The insurance plans offered for default coverage could also be made available to persons eligible for the tax credit who want to sign up for a plan that involves no additional premium from them. These plans may turn out to be among the most attractive options in the marketplace.

Default insurance, in combination with a federal tax credit for persons without access to employer coverage, would ensure that a market-based reform plans would be, for all intents and purposes, a plan for universal enrollment in health insurance. Every American household would either be in an employer plan or get the refundable credit, and those who, for whatever reason, failed to use their credit to buy coverage would be placed into an insurance plan providing catastrophic insurance protection. Thus, there would be no reason for anyone in the United States to have a significant break in their insurance protection.

(5) *Health Savings Accounts.* A very important element of market-based reform is the promotion of enrollment in health savings accounts (HSAs). HSAs allow consumers to save for their medical expenses in tax-preferred accounts. Often, employers make contributions to these accounts in combination with providing their workers with high-deductible insurance. Consumers with HSAs have a strong incentive to be judicious in their use of medical care because they can build their accounts and increase

their wealth if they stay healthy and use few services.

The existing rules for HSAs should be modified to allow all Americans to make annual contributions to them. Moreover, HSAs should be fully integrated into the government's big insurance programs—Medicare and Medicaid. The government could provide high-deductible insurance to the enrollees in these programs, and then deposit the rest of the entitlement benefit into their HSAs to pay for services before the deductible is met.

- (6) *Medicaid*. The Medicaid program should be integrated with the new refundable tax credits. Program beneficiaries would get the credit plus additional assistance from Medicaid. They would then be allowed to enroll in state-approved plans for insurance, and to enroll in job-based insurance plans if those are available to them. This reform would help move millions of Medicaid enrollees who get restricted access to care today into more mainstream networks of providers of medical services.

An additional problem in Medicaid is the split financial responsibility for the program. The federal government pays for about 60 percent of all state Medicaid spending, with no upper limit on total cost. The federal government points to its financial stake in the program as a rationale for imposing an extensive web of rules on the states. At the same time, states find it easier to maximize federal Medicaid funding rather than implement difficult measures to improve the cost-effectiveness of the program.

Reform of Medicaid should change how the federal government pays for its share of the program's total cost. The federal government should make fixed, per capita payments to the states based on historical

spending patterns for the program's population groups. States would be given much more authority to manage the program without federal interference.

States would be allowed to implement major changes in Medicaid support for the disabled and elderly without the need of prior federal approval. This would allow implementation of changes giving beneficiaries, and their caregivers, more control over what services they procure, and from whom.

- (7) *Medicare*. Medicare is pivotal to an effective reform of U.S. health care because of the program's dominant regulatory role. Medicare's rules for paying hospitals, physicians, and other providers of services heavily influence how care is delivered to all patients, not just Medicare enrollees.

Most fundamentally, the program needs to be reformed into a consumer choice model. Beneficiaries should receive a uniform subsidy to purchase insurance from competing plans, including the traditional, government-run option. The subsidy amount would be based on bids from the competing plans. Beneficiaries choosing more expensive plans would pay any extra premium themselves. This reform would give seniors an incentive to select lower-cost and higher-value plans and would give plan providers an incentive to deliver high quality care in the most cost-effective manner possible.

CONCLUSION

Catholic social teaching calls us to consider complex social realities in light of enduring truths. There is no utopia on Earth, and no perfect way to organize the provision of medical services to patients. There are only imperfect solutions, some

of which might be somewhat better than others.

In general, there is ample evidence that markets are the most effective means of allocating scarce resources in most circumstances. Consumer preferences ensure that funds are spent on their most valuable uses, and providers of services have the incentive to seek ever better ways of satisfying consumer needs at affordable prices.

Government monopolies can deliver services in many sectors, but, over time, there is a tendency toward lack of innovation and improvement. For example, in education, there are plenty of fine public schools around the country, but there are also abundant examples of poor schools which have proven to be particularly difficult to reform.

Policymakers in the United States must ask themselves whether handing over total control of health care to the federal government could be done without a long-term decline in the quality of the services provided to patients.

The alternative is to move more in the direction of a marketplace, with consumers and patients empowered to make more of the decisions for themselves. That can be

done with reforms in a number areas, and it can be done in a way that also ensures all Americans are enrolled in health insurance, and thus able to get needed medical services, especially for high-expense situations.

Moving in this direction will not be easy. Existing laws are in place, and the federal government has accrued substantial power in recent years that it will not give up easily.

The United States has not decided to fully embrace a government-run system. If it had done so, it would be hard to change course (as can be seen in the experience of other countries). As things stand today, there is still time to make adjustments and move in a different direction. It is therefore very much worth the effort to think carefully about what kind of system will serve the American people—including those with low incomes—the best, not just this year or next, but for decades to come.

BIOGRAPHICAL NOTE

James C. Capretta, is the Milton Friedman Fellow at the American Enterprise Institute.