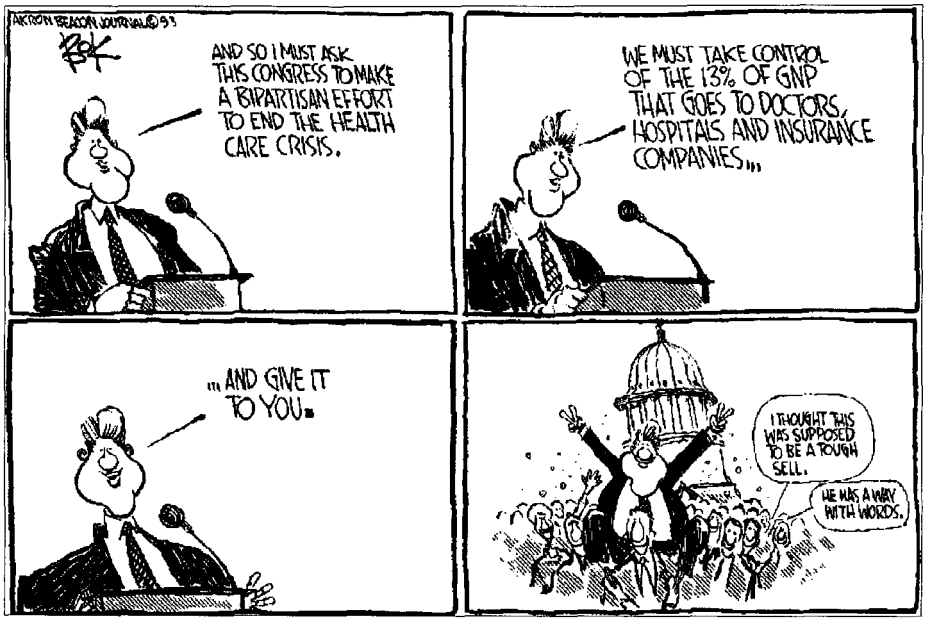
Reality Check

By David R. Henderson

The work of mainstream economists makes the case against ClintonCare.



THERE ARE WELL OVER 500 HEALTH economists in the United States. And believe it or not, they have reached a consensus on certain underlying facts about health care. These facts are largely being ignored in the health-care debate because the Clintons and other advocates of draconian regulation cannot acknowledge them and at the same time plausibly argue for more government.

Opponents of further controls have a powerful ally in the mainstream health economists whose work implicitly or explicitly makes the case against government intervention in health care. Here are the most important facts that these economists agree on.

Fact One: Health-care spending is growing faster that gross domestic product almost everywhere.

We often hear that health-care spending is consuming a growing share of GDP in the United States, but this country is hardly unique in that respect. Take the so-called G-7 countries: Canada, France, Germany, Italy, Japan, the United Kingdom, and the United States. In all but Germany, health-care spending consumed a higher percentage of GDP in 1990 than in 1980. The United States led the way, with the share of GDP consumed by health care rising from 9.2 percent to 12.1 percent, a whopping 32-percent increase.

But guess which country was a fairly close second, with its health-care spending rising from 7.4 percent of GDP to 9.3 percent, an increase of 26 percent. Hint One: Proponents of socialized medicine—pardon me, "single-payer health care"—often hold it up as a model. Hint Two: I was born there and left for "the States" when I was 21. Hint Three: This country is directly north of us. Hint 4: Take off, hoser. That's right. Canada, which has "solved" the problem of access to health care by giving it away and which supposedly has kept spending down, has had to contend with massive cost increases.

The Clintons don't want you to know this because, despite the evidence from other countries, they plan to use the police power of the federal government to freeze private real per-capita spending on health care in 1999 and later years. Yet in all of the G-7 countries, including Germany, and in every other Western European country except Ireland, real per-capita spending on health care grew substantially between 1980 and 1990. Indeed, in all but a few, it grew by more than 1.5 percent a year, meaning a compound growth of over 15 percent for the decade. The Clintons would use so-called global budgets to make sure that private spending grew by no more than the consumer price index and the growth in population. And what if an area of the country hit its budget cap for 1999 by, say, October? Tough.

FACT TWO: GOVERNMENT SPENDING ON health care has risen much more than private spending.

We often hear that it doesn't matter whether you look at government spending or private spending on health care because both have risen rapidly in the last few decades. Actually, it does matter. Spending by government on its two main health-care programs, Medicare and Medicaid, has risen much more rapidly than private spending. In 1970 federal, state, and local governments spent $12.3 billion on Medicare and Medicaid combined. By 1991 this was up to $216.7 billion, an inflation-adjusted increase of 427 percent. By contrast, private spending on health care rose from $42.5 billion in 1970 to $377 billion in 1991, an inflation-adjusted increase of 165 percent. To be sure, this is a substantial increase, but it's less than half the increase in Medicare and Medicaid spending.

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These numbers indicate that the explosion of costs in Medicare and Medicaid is mainly an explosion of government costs. Which makes you wonder why Bill Clinton is not laughed out of court when he says that one main reason he wants the government to control one-seventh of the economy is to keep costs down. Incidentally, the Clintons are aware that Medicare and Medicaid spending are growing faster than private health-care spending. That's probably why their plan has looser limits on Medicare and Medicaid spending than on private spending.

Fact Three: We're getting a better product for our health-care spending.

As Northwestern University health economist Burton A. Weisbrod recently wrote, "Fifty years ago, physicians were little more than diagnosticians..." All they could do was identify an illness and predict the likely outcome. Now they can actually *do* something. Weisbrod cities many effective medical procedures: kidney dialysis, organ transplants, polio vaccines, arthroscopic surgical techniques, CAT scans, magnetic resonance imaging, and in-vitro fertilization. These techniques have undoubtedly reduced deaths and made life easier. There's still a serious question whether they are worth their high cost. But the only reason that question arises is that those who benefit don't typically pay for the bill. Which brings us to the next fact.

Fact Four: The amount of any good people consume is higher if they're spending other people's money than if they're spending their own.

This is not a controversial proposition in economics. It's one of the few principles that economists are really sure of. It applies to food, housing, and, yes, health care. But just to make sure it applied to health care, the U.S. government paid the Rand Corporation to do a five-year, $80-million experiment, beginning in 1974. For a few years, thousands of families in the experiment were given one of four health-insurance plans. The main difference between the plans was the co-payment rate—the percentage of health expenses paid by the family—which was 0, 25, 50, or 95 percent. Under all the plans, if a family's out-of-pocket expenses reached $1,000, the insurance paid for all additional expenses.

The Rand experiment's main finding was that people do consume more health care if they're spending other people's money. The higher a family's co-payment rate, the less often members of that family went to a doctor and the less often they incurred medical expenses generally. The researchers concluded that a catastrophic insurance plan—a plan in which patients pay a high deductible and then the insurance pays all costs in excess of the deductible—would reduce expenditures by about 31 percent relative to a plan in which people paid nothing out of pocket. If you doubt that, ask yourself how likely you are to have a doctor examine your scratchy throat when the insurance company covers $40 of his $50 fee, leaving you with a bill for $10. Now ask yourself how likely you are to see the doctor if you have to pay the whole $50.

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Because almost all insured people, whether covered by their employers or by Medicare and Medicaid, pay close to zero out of pocket, we can straightforwardly apply the Rand results to most Americans. Updating the experiment's $1,000 deductible to 1994 dollars gives a deductible of about $2,000 today. If everyone in the United States switched to such a deductible, estimates Harvard health economist Joseph Newhouse, our health-care spending would fall by about 30 percent. Instead of spending over 14 percent of our GDP on medical care, as we do now, we would spend only about 10 percent.

In short, we could get the waste out of the health-care system simply by buying health insurance with high deductibles. And we could get the share of GDP spent on health care to a level way below the one Clinton says he wants to achieve. Clinton doesn't want you to know that high deductibles would solve the problem because his plan makes any deductible higher than $400 per family illegal.

Fact Five: Employers provide low-deductible medical insurance for their employees—with deductibles that often amount to only $200 or $250 per year, after which the insurance pays 80 percent to 100 percent of costs—because the tax law gives them an artificial incentive to do so.

This fact was driven home by my former boss at Ronald Reagan's Council of Economic Advisers, Martin Feldstein. Feldstein, a Harvard professor and a leading health economist in the late 1960s and early '70s, was one of the first to point out that, because employers' contributions to their employees' health insurance are not taxable as employee income, employers have an incentive to load up their employees with health insurance. Consider an employer and employee trying to choose between an extra dollar in taxable wages and an extra dollar of health insurance. If the dollar is in wages, the employer must spend an extra 7.65 cents in Social Security and Medicare taxes. So the real cost to the employer is $1.0765. And the employee gets not $1.00 but $1.00 minus 7.65 cents for the employee's portion of Social Security and Medicare taxes, mi-

nus 28 cents if the employee's federal marginal tax rate is 28 percent, minus 4 cents if the employee's state marginal tax rate is 4 percent. Net take-home pay on $1.00: 60.35 cents.

But if instead the employer pays the dollar in higher premiums for a more generous health-insurance program, the government takes nothing. As long as the employee values the extra dollar in health insurance at more than about 60 cents, he or she is better off taking it in that form. That is one main reason that employers have paid for insurance policies with low deductibles. The employee is better off charging a $50 doctor's bill to the insurance company, even if the insurer spends $20 to process it, and having the employer pay the extra $70 in a higher premium. The alternative, having the employer pay an extra $70 in cash, yields the employee only about $42.

Understanding these incentives, most economists have concluded that more regulation is not necessary to get people out of low-deductible plans. All the government would have to do is end the favorable tax treatment of health insurance. There are two ways to do this. One is for Congress to declare that henceforth employers' contributions to their employees' health insurance are taxable income. The other way is to make a certain amount of compensation—say, $3,000 per employee each year—tax-free income which the employee can use to buy health insurance or put in a medical savings account similar to an individual retirement account.

So is there a health-care crisis? There are actually two. The first, if we had truth in political advertising, would be labeled "Made in Washington." The second is about to be made in Washington. ®

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Banking on Markets

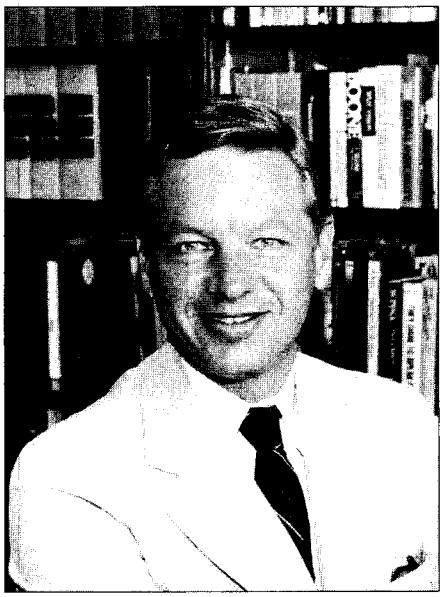
By Cornelius Chapman

After the S&L crisis, deposit insurance gets new scrutiny.

THE FINAL BILL FOR THE S&L CRISIS is being tallied up, and like the bar tab for a drunken night on the town, it is simultaneously sobering and stomach-churning: at least $200 billion in government funds to pay depositors' claims against the Federal Deposit Insurance Corporation and the now-defunct Federal Savings and Loan Insurance Corporation. And on top of that already staggering figure are less obvious costs—such as additional interest payments on the national debt, an overbuilt real-estate market financed by high-risk loans, and losses of personal net worth for people who bought homes shortly before the bubble burst—that will continue to act as a drag on the national economy for some time to come.

Now that the biggest banking crisis since the Great Depression is over, the question in some people's minds is how to reform the system of federal deposit insurance that grew out of the first major banking debacle of this century and was a contributing cause of the second. "The excesses of the 1980s would not have happened without the federal deposit insurance system," says University of Chicago law professor Geoffrey Miller. Federal deposit insurance, he argues, encourages the very behavior—risky lending—that it insures against, just as federal flood insurance encourages people to live in areas that are prone to flooding.

When depositors have recourse to "free" government insurance, they have no incentive to monitor the prudence of their financial institutions, because they cannot lose their money. And if banks are certain that the government will pay off depositors in the event of a failure, lenders have less reason to avoid high-risk ventures (with potentially higher investment returns). In effect, both depositors and bankers are playing an investment game with other people's—the taxpayers'—money.



Rep. Thomas Petri's bill would effectively privatize both deposit insurance and bank regulation.

THE FISCAL IRRESPONSIBILITY INHERENT in federal deposit insurance prompted Rep. Thomas Petri (R-Wis.) to introduce the Deposit Insurance Reform, Regulatory Modernization, and Taxpayer Protection Act (H.R. 3570) late last year. The bill, which has five co-sponsors, would do away with the FDIC's insurance functions, replacing them instead with "cross-guarantee" contracts by which other banks, insurance companies, pension funds, and anyone else who could satisfy certain tests of financial strength would back bank deposits.

Petri's bill would effectively privatize both deposit insurance and bank regulation, since the federal government's role would be reduced to making certain that a cross-guarantee contract was in place for every bank. Syndicates of private guarantors would decide on the safety and soundness requirements to be imposed on each bank whose deposits they guaranteed, and they would price their services according to the varying levels of risk they chose to undertake. Individual banks could choose from a variety of insurance policies based on price and flexibility. Petri argues that would reduce the possibility of future "credit crunches," since no single insurer would be in a position to dictate what risks were acceptable for all banks across the entire country. But since private investors, unlike the federal government, do not have an effectively limitless supply of money, they have a vested interest in regulating the banks they back.

To avoid disrupting markets during the transition from public to private insurance, the plan would not go into effect until either banks with at least $500 billion in total assets signed on or the expiration of an 18-month period following the passage of the bill, whichever came first. The bill is currently being considered by subcommittees of the Ways and Means, Judiciary, and Banking committees.

"Mispriced federal deposit insurance contributed to a series of asset deflations that caused bank insolvency losses not seen since the Great Depression," says Petri. Until recently, the FDIC failed to use risk-based insurance premiums, argues Petri, enabling banks that were active lenders to "boom" sectors of the economy such as oil and real estate to attract deposits long after warning signs of coming "busts" would have otherwise scared off depositors. Even after the S&L wake-up call, the FDIC has been slow to implement a congressional mandate to do what any non-governmental primary insurer does as a matter of course: privately reinsure its liability to spread its risk.

A market-driven insurance system