



Confronting Healthcare Costs

By Jonathan J. Miltimore

The escalating cost of healthcare in the United States is a phenomenon of historic proportions. In 1962, the U.S. spent 5.2 percent of its Gross Domestic Product (GDP) on healthcare. In 2004, this figure rose to 16 percent — a total of \$1.9 trillion or six times the total cost of the Iraq war as of September 2006. By 2015 an estimated 20 percent of GDP will be spent on healthcare — roughly twice as much as nations such as Germany, France, Canada, and Switzerland. In 2005, the annual cost of the average family insurance policy topped \$10,000, while the average price for a routine hip replacement averages \$50,000.¹

It should be noted that the fact that the U.S. spends a higher percentage of its GDP on healthcare than its neighbors is not, in itself, necessarily a bad thing. The primary reason the U.S. spends a high percentage of GDP on healthcare is because it provides greater *access*. As health expert John Goodman has pointed out, “Countries with national health insurance limit healthcare spending by limiting supply.” This method is what Goodman describes as “rationing by waiting.”²

These nations impose fixed hospital budgets and eliminate premium equipment and drugs. Patient waiting-time to see a physician is significantly longer, while one-on-one time with that physician is much shorter. Consider this:

Delays in Britain for colon cancer treatment are so long that 20 percent of the cases considered curable at time of diagnosis are incurable by the time of treatment. During one 12-month period in Ontario, Canada, 71 patients died waiting for coronary bypass surgery while 121 patients were removed...because they had become too sick to undergo surgery with a reasonable chance of survival.³

I recently visited a state-run Department of Motor Vehicles. After receiving a number, I waited in line for two hours and forty-five minutes. When my number was called, I was assisted and out the door in three minutes. This is an example of rationing by waiting. The bureaucracy dictates the supply, not the consumer.

That Americans demand quick and easy access to first-rate medical facilities (and are willing to pay for it) explains part of the equation. The U.S. is, in fact, an aging nation, and it is quite plausible that this is characteristic of highly affluent free societies. The fact remains, however, that not only is America spending a growing percentage of its GDP on healthcare, but the cost of that care is ballooning as well.

The healthcare system itself, of course, relies on an arrangement that partly isolates consumers from market forces: “A” (patient) receives a service from “B” (Doctor) who charges “C” (insurer). Because “A” will bear little or no cost of the service, there is little or no reason to decline or conserve the service. On the other hand, “B” has every reason to offer services.

Though one can see such a system has its snags, there is probably no more practical or efficient pay method for administering healthcare than risk pooling. Government regulations, however, have exacerbated the system by further removing consumers from normal market forces.

In 1945, Congress passed the McCarran-Ferguson Act, which established that state governments (not the federal) would possess the authority to tax and regulate insurance. In theory, this sounds logical. In practice, it creates a regulatory nightmare and discourages competition. Because it is almost impossible for insurers to accommodate and adapt to 50 different sets of regulations, and because licensing fees tend to be extremely high for insurers licensed in another state, insurance markets tend to be uniform and dominated by a single provider. In Iowa — like New Jersey and Kansas — Blue Cross Blue Shield has cornered 60 percent of the health insurance market. In Kentucky, Blue Cross holds 90 percent of the market.⁴

Wait, you say, this system sounds conspicuously like a monopoly. Right you are, but McCarran-Ferguson exempts insurers from most anti-trust laws as they are subject to state regulation. Unfortunately, though monopolies regulated by the state are technically legal, they are still bad for consumers.

A Publication of: **Public Interest Institute at Iowa Wesleyan College**

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Isolated from interstate competition, states pass myriads of unnecessary expensive mandates. In many states, men are forced to purchase plans that cover contraception, and women buy plans that cover hair-replacement. That they will not use the service is inconsequential; they are paying for the coverage.

Controls commonly referred to as “guaranteed issue” and “community rating” are mandates that particularly hamper the health insurance market. Both of these regulations raise overall premiums by denying insurers the ability to account for the risk of the insured. “Guaranteed issue” achieves this by compelling the insurer to offer coverage to any applicant regardless of their medical condition. “Community rating” denies insurers the prerogative of adjusting premiums based on risk.⁵

These controls create a vicious cycle. The young and healthy pay disproportionately high premiums for services. Eventually, many of these individuals opt out or are priced out of the market. This further increases premiums, as the insured pool consists of a higher percentage of unhealthy and high-risk individuals. This in turn drives more of the young and healthy from the market, as insurance becomes even more expensive for those who are less likely to need the coverage and tend not to be able to afford astronomically high premiums.

Fortunately, Iowa has, for the most part, avoided the worst mandates. Consequently, the Hawkeye state is noted for its low healthcare premiums and low rate of uninsured (9.5 percent). Thus, the average plan for a 25-year old male in Iowa runs \$1,692, compared to \$4,032 in Massachusetts or \$5,880 in New Jersey.⁶

Though there is no silver bullet to the healthcare dilemma, the first step to recovery is to bring *some* market forces back into the equation. Most obviously, this means busting the state-regulated monopolies in the industry. The Health Care Choice Act (H.R. 2355 and S.1015)⁷ would do just this. Sponsored by South Carolina Senator Jim DeMint [R] and Arizona Rep. John Shadegg [R], the Act would allow buyers to bypass certain state mandates to purchase coverage across state lines.

Insurance purchasers could simply go onto the internet and select from hundreds of different plans, selecting one according to individual need and means. Under the DeMint-Shadegg Act, if one does not want a plan that covers acupuncture, drug rehabilitation, podiatry, and hairpieces, one does not have to pay for it. By allowing consumers to select from plans offered across the 50 states, the healthcare industry would be made competitive again overnight.

The American healthcare system needs a facelift, but socialized healthcare in the form of government rationing is not the answer. (After my latest trip to the DMV, I am more convinced of this than ever.) Fortunately, we have options, beginning with the Healthcare Choice Act.

(Endnotes)

¹ “Facts on Healthcare Costs,” National Coalition on Healthcare, <<http://www.nchc.org/facts/cost.shtml>> (28 August, 2006); Kathleen Dracup and Christopher Bryan-Brown, “The United States Healthcare Crisis: using our bold voices to effect change,” *American Journal of Critical Care*, July 2003, <http://www.findarticles.com/p/articles/mi_m0NUB/is_4_12/ai_105556270/pg_2> (August 29, 2006); Julie Appleby, “Average Family Health Policy Nears \$11,000,” *USA Today*, September 9, 2003; Gina Kolata, “Making Healthcare the Engine that Drives the Economy,” *The New York Times*, 22 August, 2006.

² John C. Goodman, “Healthcare in a Free Society: Rebutting the Myths of National Health Insurance”, Cato Institute, *Policy Analysis No. 532*, January 27, 2005, p. 3.

³ *Ibid.*

⁴ Devon M. Herrick, “How to Create a Competitive Insurance Market,” National Center for Policy Analysis, Brief Analysis No. 558, June 15, 2006.

⁵ *Ibid.*

⁶ Laura Keith, “Low Mandates = Healthy Iowa,” *INSTITUTE BRIEF*, Vol. 11, No 35, Public Interest Institute, Mt. Pleasant, IA, December, 2004; “America’s Health: State Health Rankings,” United Health Foundation, 2005, <<http://www.unitedhealthfoundation.org/shr2005/states/Iowa.html>> (October 25, 2006).

⁷ Robert, E. Moffit, “The Healthcare Choice Act: Eliminating Barriers to Personal Freedom and Market Competition,” Web memo #1164, The Heritage Foundation, July 17, 2006, <<http://www.heritage.org/Research/HealthCare/wm1164.cfm>> (October 23, 2006).

Jonathan J. Miltimore is a Research Analyst with Public Interest Institute.

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