

# Health Insurance and Health Care Spending

Martin Feldstein\*

I am delighted to participate in this session in honor of Amy Finkelstein. Amy is an outstanding contributor to the field of public economics and, as many of you know, she has dominated the study of health insurance and its impact on health care and health care costs. I applaud her for that and for seeing the links between those issues and the public economics questions of fiscal deficits and tax costs.

These issues are ones that I began studying many years ago. So I am delighted to see how Amy has carried the subject forward in her own work.

I want to focus my remarks today on three subjects: the first is the importance of patient preferences in the design of insurance; the second is the current excess amount of health spending; , and the third is the rapid rise in health spending relative to GDP.

## Patient Preferences

Preferences matter in the consumption of health care. Not everyone faced with the same income, the same access to health care, and the same medical advice would make the same choices. Even individuals who are fully informed about the consequences of different treatments will choose differently because of different attitudes about risk and about pain. That's why doctors often insist that patients understand the options and make choices themselves.

As economists we know that preferences are generally important. One of the virtues of a well-developed market is that it caters to a variety of preferences. But when it comes to health care, we often forget the importance of preferences and treat health care as a technical issue to be resolved by a cost benefit analysis that ignores differences in

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\* Professor of Economics, Harvard University. These remarks were prepared for a session at the 2013 American Economic Association meeting to honor Amy Finkelstein as winner of the John Bates Clark medal, January 5, 2013.

patients' preferences. I'll confess that I made that mistake in the first papers that I published in this field.

Economists often rationalize this technical approach on the notion that everyone wants better health and therefore preferences are irrelevant. But while everyone does want better health, people differ in what they are willing to do to achieve that outcome. This is not just about money but also about lifestyle.

Everyone recognizes that smoking, obesity, and a sedentary life increase the risk of premature death. And yet many continue to smoke, to overeat, and to avoid exercise. These lifestyle choices need not be irrational or the result of addiction. Preferences differ and preferences matter.

The same is true about spending for health care. Two individuals with the same incomes can choose to spend different amounts on drugs or tests or second opinions. Some individuals, when faced with a variety of different insurance policies will choose one with low copayments, knowing that that policy has a higher premium and that it will also lead them to consume more care.

I think that we as economists should emphasize the importance of diverse preferences and should incorporate that insight in the design of health care systems.

This issue arises clearly in discussions of Medicare. There is widespread agreement that the growth of government spending on Medicare must be slowed. According to the Congressional Budget Office the cost of Medicare and other government health programs will rise from 5.5 percent of GDP now to 11 percent in 2035 and about 20 percent by 2087. That reflects the increased number of individuals eligible for Medicare, the demographic shift to older and more costly beneficiaries, and, most important, changing medical technology.

Two quite different approaches have been proposed to slow the growth of Medicare costs. The Obama administration has said that if the future productivity gains do not limit Medicare costs enough, the Independent Payment Advisory Board created by the Affordable Care Act would limit

the cost of Medicare services. Although no specifics have been provided, this looks like delivering a less expensive common set of benefits, perhaps by reducing payments to providers. There would be nothing to reflect differences in individual preferences. It is not clear, to me at least, whether future Medicare beneficiaries would be able to purchase uncovered benefits by paying out of pocket or with the help of supplementary private insurance.

The other approach to limiting the Medicare costs is the bi-partisan proposal to provide seniors with “premium support payments” that could be used to enroll in Medicare or to pay for private insurance plans that would have to provide at least as much coverage as Medicare. The dollar value of the premium support payments would rise over time, would differ by patient age, and would reflect cost differences among individuals.

The premium support approach provides opportunities to reflect patient preferences. Private policies with the same cost could offer different combinations of benefits. Individuals could also supplement their premium support payments to purchase more comprehensive policies.

Although the recent Presidential election may have temporarily settled the financing of Medicare, rising program costs and a future need to turn to the Payment Advisory Board may reopen program design and bring back the issue of preferences and choice.

### Excessive Health Spending

This brings me to my second subject: the widespread concern that health care spending is excessive and should be reduced.

Everyone agrees that it is wrong to waste resources on care that is not at all effective. The real issue is about how much to spend on care that is effective. For other goods and services, we leave that decision to the market. If consumers are willing to pay for something, economists accept that the expenditure produces enough value to the consumer to warrant the cost.

But insurance makes health care different from other kinds of consumer spending. Health insurance lowers the cost to the patient at the time of care and that increases demand for health services. A rational patient, guided by his or her physician, should want to purchase health care until the health value of the marginal unit of care is just equal to the cost of that care net of insurance. That leads to an excess consumption of care.

Some economists urge physicians to consider the full cost of care when making decisions and not just the patient's cost of care net of insurance. But that produces a tension between the physician's role as agent of the patient – doing what is in the best interest of the individual patient – and the physician's role in controlling overall cost. If patients are to trust their doctors and the health care system as a whole, they must believe that their personal doctor is acting in their best interest and not withholding care that the patient can afford with the help of insurance.

The need for insurance to limit the financial risks of health care means that there will be too much consumption of health services. We should recognize and accept the second best nature of health spending decisions that inevitably results from insurance.

It is important however not to distort the demand for insured care by excessive amounts of insurance. The choice of insurance should balance the gain from risk reduction against the waste from excessive consumption of care. Unfortunately, the current US tax system leads to excessive health insurance because it excludes employer payments for health insurance from employees' taxable incomes.

That exclusion now reduces Federal tax revenue by more than \$250 billion a year. The low co-payments in private insurance that results from this tax subsidy are then copied in the design of Medicare and Medicaid, increasing the cost of that care.

If it were politically possible to eliminate completely the tax exclusion of employer paid health insurance, the Federal debt would be at least \$3 trillion less a decade from now, reducing the debt to GDP ratio by 15 percentage points.

Unfortunately that is not going to happen. But to the extent possible, the goal of health care policy should be to eliminate health care that does no good at all and to reform the insurance system in a way that balances risk reduction and the distortion of the demand for care. If that can be done, the resulting level of spending should be accepted as a second best optimum.

### The Rapid Rise in Future Health Care Spending

That brings me to my final issue: the rapid rise in future health care spending. Experts forecast that health spending will take an increasingly large share of GDP and argue that that should be prevented. I disagree.

As incomes rise, there is no reason why a nation should not devote a larger share of its GDP to health care. The key lesson for economists to explain to the general public is that we can devote a larger share of our future GDP to health care and still have a very substantial rise in income available to spend on other things public and private.

It is important, however, to distinguish between the growth of overall health care spending and the growth of health care spending that is financed through the tax system.

Consider the tax financed health care. The Congressional Budget Office projects that the cost to the government of Medicare and other health care programs will rise from 5.5 percent of GDP now to 20 percent of GDP by 2087 at the end of the 75 year CBO forecast period.

How bad would it be if this were allowed to happen? That depends on how much other income will remain to spend on everything else. So let's look at that arithmetic.

The CBO assumes real GDP per capita will grow at 1.3 percent a year from now until 2087, substantially lower than the 2.3 percent rate over the past 75 years. That implies real per capita GDP will rise by some 163 percent over the next 75 years. If government health spending that now absorbs 5.5 percent of GDP is allowed to rise to 20 percent of GDP in 2084, the remaining GDP that is not absorbed by those federal health programs goes from 94.5 percent of GDP now to 80 percent of GDP in

2087. But with real per capita GDP equal to 263 percent of today's value, the 80 percent available for everything else would be equal to 210 percent of today's per capita GDP. That means that the income available for everything else would still be more than double today's real per capita income.

The real problem created by the projected growth of Medicare and related spending is that it is financed by taxes. If we continue to finance these programs by taxes alone, the rise in the share of GDP devoted to government health programs from 5.5 percent now to 20 percent in 2087 would require raising the tax share of GDP by nearly 15 percentage points. Since federal taxes have averaged less than 20 percent of GDP for a long time, this 15 percentage point rise would require a 75 percent increase in tax revenue. That would have very serious adverse effects on the overall economy, slowing the rate of real growth and lowering the general standard of living.

The right strategy is therefore to allow spending on Medicare and other health programs to rise but not to finance all of that increase with taxes. That is what the recent Bowles-Simpson Commission proposed when they called for limiting the rate of growth of tax-financed health spending to one percent more than the rate of growth of GDP. Over 75 years, that would increase the tax share of GDP by five percentage points, an amount that might be offset by other tax reforms.

A natural corollary to limiting the growth of the tax financed portion of Medicare (and of Medicaid benefits for seniors) is to encourage individuals to accumulate funds during their working years to supplement the government programs.

The analysis is similar if we turn from government health programs to total national spending on health care. That total is now about 15 percent of GDP, implying that health spending other than the government programs is about 10 percent of GDP. Health spending on the non-aged can be expected to grow more slowly than spending on the aged. So if Medicare and Medicaid go from 5.5 percent of GDP to 20 percent, the remaining health spending might go from 10 percent of GDP to 25 percent of GDP. That would bring total health care spending by 2087 to 45 percent of GDP.

While that 45 percent share might seem a cause of concern, is it really? It would imply that the real GDP per capita available for everything but health would rise from 85 percent of the current real GDP per capita to 55 percent of the projected future real GDP. Since that projected future per capita GDP is 2.63 times current GDP, the future amount for everything else would still be 145 percent of today's GDP or 170 percent of the amount that is currently available for all non-health spending.

That is an enormous rise in incomes to spend on all other things, both private and public.

The implication of all this is clear. Physicians should seek to eliminate spending that produces no positive results. Health insurance should not be subsidized or pushed beyond the point that balances risk reduction and demand distortion. But given those two things, the remaining level and growth of health care spending should not be reduced because they do not represent a problem for our future standard of living.

These are important issues for the economics profession and for the general public.

I am very pleased that Amy and others who are working on these issues will help to shape the public policy debate that links health care, insurance, and public finance.

Thank you – and congratulations again to Amy.