Goodman Institute
Turning Ideas Into Policy

Public policy should not encourage people to be uninsured.

John C. Goodman, Ph.D.
President and CEO
Goodman Institute

A Workable Safety Net

Why do we care whether other people have health insurance? One reason we care is that uninsured people may incur medical bills they cannot pay from their own resources. When that happens, the cost is often borne by other people, either through shifting costs to insured (paying) patients or through free-care programs subsidized by taxpayers. The choice to insure or remain uninsured often means, as a practical matter, the choice to insure or implicitly rely on the social safety net.

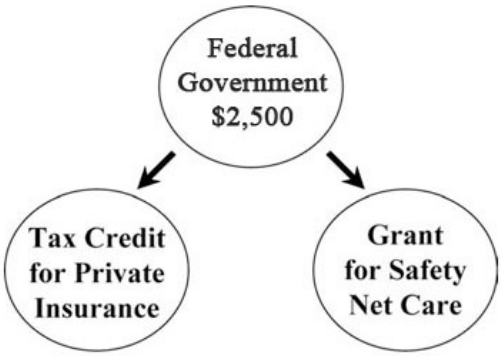
How should government policy affect this choice? If we take a "do-no-harm" approach, at a minimum we want to make sure we are not encouraging people to be uninsured.

In what follows, I will first present the classical approach to this problem as outlined in *Characteristics of an ideal Health Care System* and in *Applying the "Do No Harm" Approach to Health Policy*. Then I will explain how the Session/Cassidy bill modifies this approach.

Achieving Neutrality.

Suppose the government offered every individual a uniform, fixed-dollar subsidy. If the individual obtained private insurance, the subsidy would be realized in the form of lower taxes by way of a tax credit. The credit would be refundable, so that it would be available even to those with no tax liability. If the individual chose to be uninsured, the subsidy would be sent to a safety net agency in the community where the person lives. [See Figure 1A.]

FIGURE 1A. Federal Government Subsidy

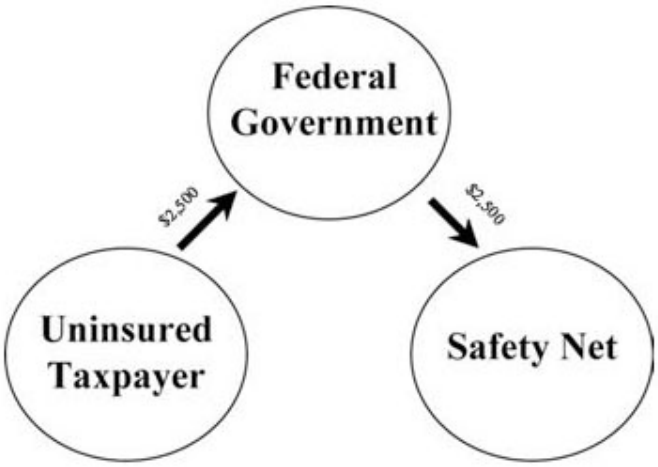


The uniform subsidy should reflect the value society places on having one more person insured. What is that value? It should be at least as much as the amount we expect to spend (from public and private sources) on free care for that person when he or she is uninsured. For example, if society is spending $2,500 per year on free care for the uninsured, on the average, we should be willing to offer $2,500 to everyone who obtains private insurance. Failure to subsidize private insurance

as generously as we subsidize free care encourages people to choose the latter over the former.

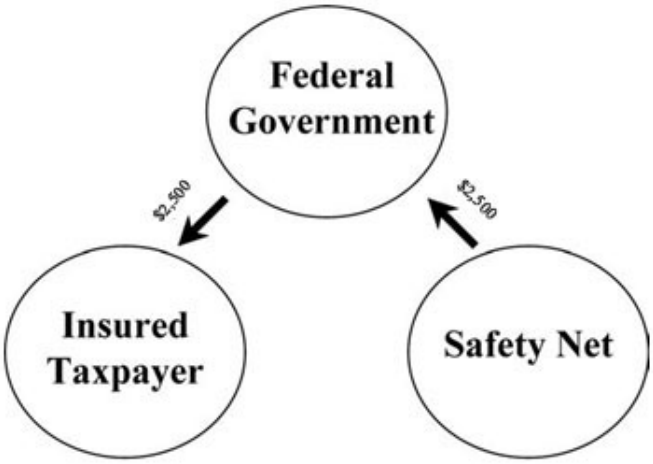
One way to think of such an arrangement is to see it as a system under which the uninsured as a group pay for their own free care. That is, in the very act of turning down a tax credit (by choosing not to insure), uninsured individuals would pay extra taxes equal to the average amount of free care given annually to the uninsured. [See Figure 1B.]

FIGURE 1B. The Marginal Effect of Choosing to be Uninsured



How can we fund the subsidies for those who choose to move from being uninsured to insured? We can do it by reversing the process. At the margin, the subsidy should be funded by the reduction in expected free care that person would have consumed if uninsured. For example, suppose everyone in Dallas County chose to obtain private insurance, relying on a refundable $2,500 federal income tax credit to pay the premiums. As a result, Dallas County no longer would need to spend $2,500 per person on the uninsured. Thus, all of the money that previously funded safety net medical care could be used to fund the private insurance premiums. [See Figure 1C.]

FIGURE 1C. The Marginal Effect of Choosing to Be Insured



Implementing Reform.

To implement the program, all the federal government needs to know is how many people live in each community. In principle, it will be offering each of them an annual $2,500 tax credit. Some will claim the full credit. Some will claim a partial credit (because they will only be insured for part of a year). Others will claim no credit. What the government pledges to each community will be $2,500 times the number of people. The portion of this sum that is not claimed on tax returns should be available as block grants to be spent on indigent health care at the federal level.

In a private insurance market, insurers will not agree to insure someone for $2,500 if the expected cost of care is, for example, $5,000. If the safety net agency expects a $5,000 savings as a result of transferring a patient to a private insurer, however, the agency should be willing to pay up to $5,000.

How would the federal government manage to reduce safety net spending when uninsured people elected to obtain private insurance? Because much of the safety net expenditure

already consists of federal funds, the federal government could use its share to fund private insurance tax credits instead. For the remainder, the federal government could reduce block grants to states for Medicaid and other programs to subsidize the private insurance premium. The additional, higher subsidy could be incorporated into the tax credit or added as a supplement to the tax credit.

The Distribution of Safety Net Dollars.

Unlike the current system, under which virtually all Medicare and Medicaid dollars for the uninsured and the underinsured go to hospitals, communities should be free to find innovative and less expensive ways of delivering health care. In general, a hospital is typically the most expensive place to do that. Also, safety net money for outpatient care need not go to highly regulated community health centers. Communities should be free to take advantage of walk-in clinics, telemedicine and other innovative and less expensive options.

The Costs of Reform.

A common misconception is that health insurance reform costs money. For example, if health insurance for 30 million uninsured people costs $2,500 a person, some conclude that the government would need to spend an additional $75 billion a year to get the job done. What this conclusion overlooks is that we are already spending a great deal of money on free care for the uninsured, and if all 30 million uninsured suddenly became insured they would—in that act—free up all of that money from the social safety net.

At more than three trillion dollars a year, there is no reason to believe our health care system is spending too little money. To the contrary, attempting to insure the uninsured by spending more money would have the perverse effect of contributing to health care inflation. Getting all the incentives right may involve shifting around a lot of money, such as reducing subsidies that are currently too large and increasing subsidies that are too small. It may also mean making some portion of people's tax liability contingent on proof of insurance. But it need not add to budgetary outlays.

The Sessions/Cassidy modifications to this analysis.

Although the bill is based on the thinking described above, analysts point out that safety net care is not automatically free care for anyone who walks into a hospital or a doctor's office. Patients are generally expected to pay their medical bills. Only when the patients cannot pay, does the facility draw on safety net money. Perhaps partly for that reason, the uninsured obtain about half as much health care as the insured and they tend to pay only about half of the cost of their care. (By some estimates, they pay only one fifth of the cost of their care.)

In light of these considerations, The Session/Cassidy bill refunds only one-fourth of unclaimed tax credits to the local communities where the uninsured live.

Goodman Institute
FOR PUBLIC POLICY RESEARCH

6335 W Northwest Hwy - #2111 • Dallas, TX 75225 • email: info@goodmaninstitute.org • +1 214 302.0406