Forbes

Myths of the "Free Rider" Health Care Problem

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Figure 1Image by Getty Images via @daylife

Both the policy justification, and part of the Constitutional justification, for including the individual mandate in Obamacare is that the individual mandate will eliminate "free-riding," in which the uninsured take advantage of free emergency-room care at taxpayer expense. This, from Judge Vinson's ruling:

The defendants contend that there are three unique elements of the health care market which, when viewed cumulatively and in combination, belie the claim that the uninsured are inactive. First, as living and breathing human beings who are always susceptible to sudden and unpredictable illness and injury, no one can "opt out" of the health care market. Second, if and when health services are sought, hospitals are required by law to provide care, regardless of inability to pay. And third, if the costs incurred cannot be paid (which they frequently cannot, given the high cost of medical care), they are passed along (cost-shifted) to third parties, which has economic implications for everyone. Congress found that the uninsured received approximately $43 billion in "uncompensated care" in 2008 alone. These three things, according to the defendants and various health care industry experts and scholars on whom they rely, are "replicated in no other market" and defeat the argument that uninsured individuals are inactive.

The contention that the individual mandate is necessary, because it solves the "free-rider" problem, is worthy of further examination: because it suffers from numerous conceptual and factual flaws.

1. In the first place, "free-riding" is an artifact of clumsy government policy

People talk about "free-riding," or uncompensated care, as if it were a law of physics, like gravity: a fundamental problem that has no other solution than forcing everyone to buy health insurance. But it's not. In fact, "free-riding" is a direct result of a clumsy, unfunded mandate

passed by Congress in 1986, called the Emergency Medical Treatment and Active Labor Act, or EMTALA.

EMTALA requires that hospitals provide emergency care to anyone who needs it, regardless of citizenship, legal status (i.e. illegal immigrants), or ability to pay. Technically speaking, EMTALA only requires this of hospitals that accept Medicare and Medicaid insurance. But since Medicare and Medicaid represent more than half of all health expenditures in the United States, very few hospitals are equipped to function without government funding, and therefore, nearly every hospital in the United States is covered by EMTALA.

EMTALA is, indeed, the central factor in the "free-rider" phenomenon. The government forces hospitals to care for these individuals, without financially compensating hospitals for the cost of doing so. It is one of the largest and most coercive unfunded mandates in the United States.

Personally, I think it's a good thing that we as a country ensure that everyone, regardless of ability to pay, has access to emergency health care. (We might even call it universal health care.) As I wrote last year,

There are some instances in which we should obviously consider more than economics: Certainly no wealthy nation should allow a destitute woman who has been hit by a car to die in the street. Likewise, in a pressing emergency, catastrophic care should be provided to those who need it, and the costs can be sorted out later…A more organized program to cover these expenses — provided that the distinction between emergency, chronic, and routine care were reasonably well defined — would be a step forward, and would also clarify the boundaries of the free market in health insurance.

Even leaving comprehensive health reform aside, there are many, many alternatives to caring for these individuals that don't involve an individual mandate. The government could cut other spending or raise taxes in order to fully reimburse hospitals for EMTALA care. The government could require hospitals to check for Medicaid, Medicare, and S-CHIP eligibility, and then fully fund care for the remainder of the uninsured. You could repeal EMTALA and replace it with a PPACA-like expanded Medicaid program. None of these adjustments are optimal, but none of them impose a Constitutionally problematic individual mandate.

(In an ideal world, we would replace both EMTALA and government-controlled Medicaid with cash payments or premium support for the indigent to purchase their own catastrophic coverage in the private market.)

2. PPACA's individual mandate overshoots the free-riding problem

The problem of uncompensated care is one of uncompensated care in the emergency room (and any other care arising from an admission to the ER). But Obamacare's individual mandate doesn't allow people to buy inexpensive insurance focused on emergency care: instead, it forces people to buy comprehensive insurance packages with a generous list of basic benefits, benefits far exceeding those required to address the issue of uncompensated emergency room care.

You're not going to the emergency room to get a mammogram. Hence, a significant portion of the individual mandate—the portion that requires people to buy insurance exceeding ER care—has nothing to do with the policy problem of uncompensated care.

3. The individual mandate only somewhat reduces uncompensated care, at massive taxpayer cost

In Massachusetts, the uncompensated care pool did shrink after the installation of Romneycare: but only by two-fifths. Uncompensated care in the Bay State was $661 million in the pool's 2007 fiscal year, $409 million in PFY 2008, and $414 million in PFY 2009. That's not terrible, but underwhelming compared to what Massachusetts residents were promised, especially considering Romneycare's staggering cost: remember that the mandate comes with large subsidies so that lower-income individuals aren't forced to buy something they can't afford. (The percentage of uninsured went from 5.7% in 2007 to 2.7% in 2009.)

Whether you support or oppose PPACA, the fact is, it doesn't cover everyone. If you go by the Congressional Budget Office's numbers, which are flawed in many ways, the uninsured population will shrink under PPACA from 50 million in 2010 to 23 million in 2019. Therefore, under Obamacare, there will continue to be a sizable population of uninsured individuals, including much of the illegal immigrant population, which isn't eligible for PPACA's benefits but will still gain access to uncompensated care via EMTALA.

Why is spending large gobs of taxpayer money to only partially address a problem costing less gobs of taxpayer money called an improvement?

4. Uncompensated care is a small problem, relative to undercompensated care

Because Medicaid dramatically underpays physicians for treating Medicaid patients—under 60 percent of what private insurance pays—very few physicians actually admit Medicaid patients into their practices. As a result, many Medicaid beneficiaries are forced to go to the ER to seek basic medical care. And Medicaid underpays hospitals just as it underpays doctors. Indeed, on average, hospitals lose money on *every Medicaid patient they treat*, receiving 88 Medicaid cents for every dollar of health costs.

So hospitals are losing money, not because of uncompensated care due to EMTALA, but rather because of *under-compensated care* due to Medicaid and also Medicare. While uncompensated care may indeed account for tens of billions of dollars per year, under-compensated care accounts for *hundreds of billions of dollars per year*, a number that Obamacare will increase. The true "free-rider" isn't the uninsured. It's the government.

5. Mandates reduce access to emergency care for the most vulnerable

As John Goodman of the National Center for Policy Analysis has often pointed out, in Massachusetts, where an individual mandate was instituted in 2006, emergency room traffic is higher than ever before. Indeed, between 2005 and 2007, Massachusetts ER visits *rose by 7 percent*, and the state's costs of caring for ER patients rose 17 percent between 2007 and 2009.

The uninsured don't even account for their fair share of health expenditures. A Kaiser Family Foundation study found that, while the uninsured made up 15 percent of KFF's surveyed population, the uninsured accounted for only 14 percent of total ER visits, and only 12 percent of aggregate ER expenditures.

By contrast, Medicaid beneficiaries accounted for 9 percent of the population, but 15 percent of visits and 9 percent of expenses. (For those with private insurance, the stats were 60%, 47%, and 54% respectively; for Medicare beneficiaries, 14%, 20%, and 22%.)

Why does this happen?

It's pretty simple: if your health care is paid for, you are more likely to see the doctor more, and consume more tests and procedures, than if you are uninsured. Hence, people with insurance consume, on average, twice as much health care as do the uninsured.

This problem leads to more ER crowding, poorer access to emergency care for the truly vulnerable, and more losses for hospitals. Hospitals can't make more money on patients if they are turning those patients away due to capacity constraints. (Remember that the biggest part of how PPACA covers the uninsured is by expanding Medicaid.)

The bottom line

The free-rider problem was caused by clumsy government policy. The solution to the problem, therefore, isn't to add more clumsy government policy on top: it is to fix the original policy. PPACA's individual mandate is not needed to address the free-rider problem. Furthermore, aspects of the individual mandate have *nothing to do* with the free-rider problem.

For all that, the individual mandate is only capable of partially relieving the free-rider problem, and simultaneously creates entirely new problems of increased spending, ER overcrowding and limited ER access for the truly needy.

Let that sink in for a second: the Constitutional justification of the individual mandate—that it is necessary to relieve the problem of uncompensated care—is an unproven, if not disproven, hypothesis.

Constitutional law is supposed to be about the Constitution, not health care policy. But PPACA's advocates are arguing that the constitutionally dubious mandate is required to address a pressing public policy problem. Unfortunately, that isn't true. Here's hoping that someone raises these points when *Florida v. HHS* gets heard in the Eleventh Circuit Court of Appeals.