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APPLYING THE "DO NO HARM" PRINCIPLE TO HEALTH POLICY

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INTRODUCTION

"First, do no harm." This principle is well known to physicians as part of the Hippocratic Oath. No similar oath is taken by politicians, of course. But suppose they did. Suppose that, before they pass any new health legislation, our political representatives were required to reexamine existing laws and make sure that government is not the cause of the very problems it attempts to solve. What would our health care system look like?

Health economists at the National Center for Policy Analysis set out to answer that question recently. They began by identifying five major choices people make and isolating five ways in which public policies interfere with those choices—perversely encouraging people to make socially undesirable decisions. They then sought to determine what our health care system would look like if government policy were at least neutral.[1] What follows is a summary of that analysis, along with some rather surprising conclusions.

I. CHOICE NUMBER 1: TO INSURE OR NOT TO INSURE

Why do we care whether other people have health insurance?[2] 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

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[1] If people must choose between a socially desirable alternative and an undesirable one, government policy is "neutral" if it gives equal encouragement to both alternatives. Under a set of neutral policies, government is not solving any problems; on the other hand, it is also not creating any problems.

[2] This section is partly based on John C. Goodman, *Solving the Problem of the Uninsured*, 15 THORACIC SURGERY CLINICS 503, 503-12 (2005).

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.[3] How do government policies affect our incentives with respect to this choice?

A. Subsidies for Private Health Insurance

Most people who purchase private insurance take advantage of federal, state, and local tax subsidies that total about $188.5 billion each year nationwide.[4] How much subsidy is available to an individual, however, depends upon how the insurance is purchased, as well as the family's tax bracket. If an employee works for an employer who provides health insurance (an untaxed fringe benefit) as an alternative to higher taxable wages, the employer's premium payments avoid federal, state, and local income taxes as well as payroll (FICA) taxes. For a middle-income family facing a 25% federal income tax rate, a 15.3% Federal Insurance Contributions Act (FICA) tax and a 5% state income tax rate, the subsidy is 45.3%—with government paying almost half the cost of the insurance.[5]

To see the financial implications of these subsidies, consider a health insurance plan that costs $6,000 a year. To enable the employer to pay such a sum, the employee has to produce at least $6,000 worth of goods and services. However, without a subsidy, a worker in the 45.3% tax bracket would have to earn almost $11,000 (at the margin) to be able to pay the taxes and buy insurance with the remainder.[6]

Generous tax subsidies undoubtedly encourage people who would otherwise be uninsured to obtain employer-provided insurance. There are two problems, however, with the way these subsidies are structured. First, the largest subsidies are given to people who need them least. Second, the subsidies generally are not available to most of the uninsured.

First, under the current system, families who obtain insurance through an employer obtain a tax subsidy worth about $1,482, on the average.[7] Not

[3] By "social safety net," we mean all federal, state, and local government programs (other than Medicaid and the State Children's Health Insurance Program) that subsidize indigent health care, in addition to private-sector charitable funding, including uncompensated physician services.

[4] John Sheils & Randall Haught, *The Cost of Tax-Exempt Health Benefits in 2004*, 23 HEALTH AFFAIRS 106, 106 (Web Exclusive Supp. 1 Feb. 2004).

[5] Employer premium payments automatically escape federal taxes for any qualified health plan. The employee's share of the premium can be paid tax free by using Section 125 plans. *Id.* State and local tax law almost always piggybacks on the federal system, exempting whatever federal tax law exempts.

[6] Although most of the uninsured have below-average incomes, a considerable number are above the average. About one-third of the uninsured have family incomes in excess of $50,000 and more than half of those earn $75,000 or more. *See* CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004, at 18 (2005), *available at* http://www.census.gov/prod/2005pubs/p60-229.pdf.

[7] Sheils & Haught, *supra* note 4, at 109.

everyone, however, gets the average tax subsidy. Households earning more than $100,000 per year receive an average subsidy of $2,780. By contrast, those earning between $20,000 and $30,000 receive only $725. One reason is that those earning higher incomes are in higher tax brackets. For example, a family in the 40% tax bracket gets a subsidy of 40 cents for every dollar spent on health insurance. By contrast, a family in the 15% bracket (paying only the FICA payroll tax) gets a subsidy of only 15 cents on the dollar.

The second problem is that people who do not obtain insurance through an employer get very little tax relief if they purchase insurance on their own. Individuals paying out of pocket for health care can deduct costs in excess of 7.5% of adjusted gross income.[8] For instance, a family with $50,000 in income would not be able to deduct the first $3,750 in health insurance premiums.[9] The threshold for a $100,000 a year family is twice that amount.

B. Subsidies for the Uninsured

Consider now the alternative: free care, obtained through a local social safety net. What does government do to encourage this choice? Although no one knows the exact number, public and private spending on free care is considerable. For expository purposes, I will assume that the United States spends $1,500 per full-time uninsured person per year, or about $6,000 for a family of four.[10]

Interestingly, $6,000 is a sum adequate to purchase private health insurance for a family in many cities. Therefore, one way to look at the choice

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[8] An exception is made for the self-employed, who get 100% relief from federal income taxes by virtue of a tax deduction, but no relief from the payroll tax.

[9] U.S DEP'T OF TREASURY, INTERNAL REVENUE SERV., TAX TOPIC 502: MEDICAL AND DENTAL EXPENSES, *available at* http://www.irs.gov/taxtopics/tc502.html (last visited Sept. 23, 2006).

[10] A Kaiser Commission on Medicaid and the Uninsured report estimates spending on uncompensated care was $41 billion in 2004. Of this, $30 billion was on individuals uninsured for an entire year. In 2004, the United States Census Bureau listed 46 million people as uninsured. A newer report by the National Center for Health Statistics finds in 2005 only 29 million had been uninsured for more than a year at the time of interview. The Congressional Budget Office (CBO), based on analysis of the Survey of Income and Program Participation, puts the number of uninsured between 21 million and 31 million people. Therefore, annual charity care spending on the full-time uninsured ranged from $965 per year to a high of $1,424 per year in 2004. Adjusting for inflation, charity care spending in 2006 would range from $1,049 to $1,548. *See* JACK HADLEY & JOHN HOLAHAN, THE KAISER COMM'N ON MEDICAID & THE UNINSURED, THE COST OF CARE FOR THE UNINSURED: WHAT DO WE SPEND, WHO PAYS, AND WHAT WOULD FULL COVERAGE ADD TO MEDICAL SPENDING? 12 (2004), *available at* http://www.kff.org/uninsured/upload/The-Cost-of-Care-for-the-Uninsured-What-Do-We-Spend-Who-Pays-and-What-Would-Full-Coverage-Add-to-Medical-Spending.pdf; DENAVAS-WALT ET AL., *supra* note 6, at 17; ROBIN A. COHEN & MICHAEL E. MARTINEZ, NAT'L CTR. FOR HEALTH STATISTICS, HEALTH INSURANCE COVERAGE: ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, 2005 (June 2006), *available at* www.cdc.gov/nchs/data/nhis/earlyrelease/insur200606.pdf; *The Uninsured and Rising Health Insurance Premiums: Testimony Before the House Subcomm. on Health, Comm. on Ways and Means*, 108th Cong. (Mar. 9, 2004) (statement of Douglas Holtz-Eakin, Director, Congressional Budget Office), *available at* http://www.cbo.gov/ftpdocs/51xx/doc5152/03-09-HealthInsurance.pdf.

families face is that they can rely on $6,000 in free care (on the average) or can purchase a $6,000 private insurance policy with after-tax income.

The problem with the current system of spending subsidies is that they encourage millions of people to be uninsured. Why pay for expensive private health insurance when free care provided through public programs is de facto insurance? Yet, society should not be indifferent about this decision. For one thing, the choice to rely on safety net care is a choice to be a "free rider" at the taxpayers' expense. For another thing, the two types of care are not equivalent. The privately insured patient has more choices of physicians and hospital facilities.

Further, safety net care is generally much less efficient. For instance, uninsured patients often use emergency rooms to provide care that is more economically provided in a free-standing clinic. As a result, per dollar spent, the privately insured patient typically gets more care and better care. For that reason alone, it is in society's interest not to encourage people to be in the public sector rather than the private sector.

C. 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.]

The uniform subsidy should reflect the value society places on having one more person insured. What is that value? An empirically verifiable number is at hand, so long as we are willing to accept the political system as dispositive. It is 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 $1,500 per year on free care for the uninsured, on the average, we should be willing to offer $1,500 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.]

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

FIGURE 1A. Federal Government Subsidy

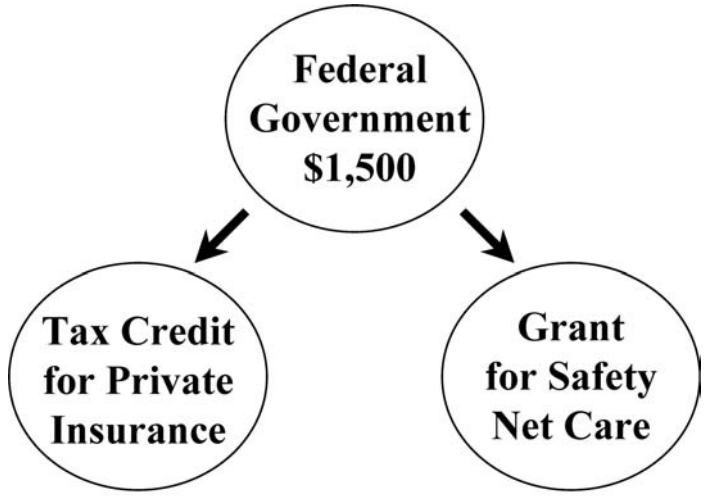


FIGURE 1B. The Marginal Effect of Choosing to Be Uninsured

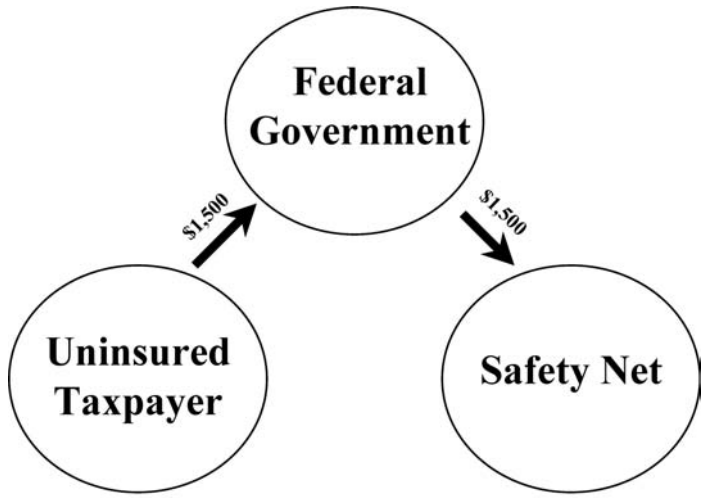
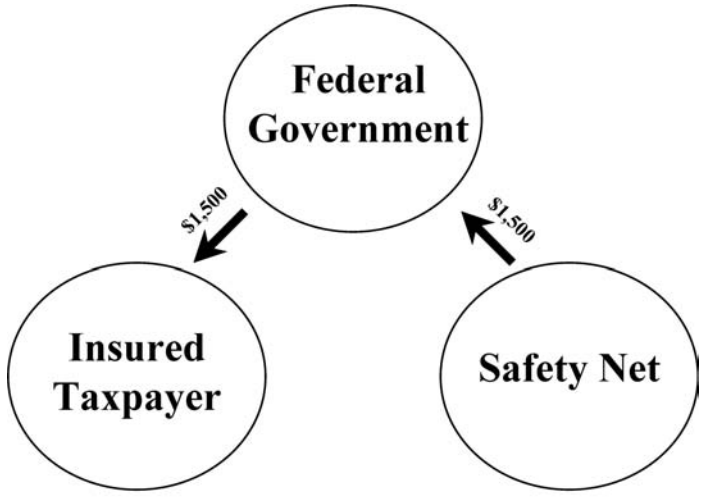


FIGURE 1C. The Marginal Effect of Choosing to Be Insured



County chose to obtain private insurance, relying on a refundable $1,500 federal income tax credit to pay the premiums. As a result, Dallas County no longer would need to spend $1,500 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.]

D. 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 $1,500 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 $1,500 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.[11]

In a private insurance market, insurers will not agree to insure someone for $1,500 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

[11] 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.

E. The Costs of Reform

A common misconception is that health insurance reform costs money. For example, if health insurance for 40 million uninsured people costs $1,500 a person, some conclude that the government would need to spend an additional $60 billion a year to get the job done. What this conclusion overlooks is that we are already spending $60 billion or more on free care for the uninsured, and if all 40 million uninsured suddenly became insured they would—in that act—free up the $60 billion from the social safety net.

At nearly two trillion dollars a year,[12] 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.[13] But it need not add to budgetary outlays.

II. CHOICE NUMBER 2: PUBLIC OR PRIVATE COVERAGE

Many poor and near-poor families have a choice of public or private insurance. Because of their low income, they can either qualify for Medicaid or State Children's Health Insurance Program (SCHIP) enrollment or obtain private insurance (typically through an employer). Clearly, we should not be indifferent about this choice. Private insurance means people are paying their own way. Further, as noted, private insurance often means better health care.

How does government policy affect this choice? Unfortunately, public policy overwhelmingly encourages people to drop private insurance and enroll in public programs instead. As noted, tax subsidies for private insurance are quite meager for those with near-poverty incomes (basically consisting of the avoidance of the 15.3% FICA tax), whereas public programs are free. Further,

[12] This is an estimate for 2005. *See* Stephen Heffler et al., *U.S. Health Spending Projections for 2004-2014*, 24 HEALTH AFFAIRS 74, 75 (Web Exclusive Supp. 1 Feb. 2005).

[13] *See* C. EUGENE STEUERLE, URBAN INST., CHILD CREDITS: OPPORTUNITY AT THE DOOR (1997), *available at* http://www.urban.org/publications/1000111.html (last visited Sept. 23, 2006).

except for a few pilot programs underway,[14] states do not allow Medicaid enrollees to use their Medicaid dollars to buy into an employer plan or purchase private insurance directly.

A. Consequences of Perverse Incentives

Many observers assume Medicaid insures people who otherwise would not have access to private insurance.[15] However, Medicaid induces some people to turn down or drop private coverage to take advantage of free health insurance offered by the state. As a result of such crowding out, the cost of expanding public insurance programs has been high relative to the gain. For example, if for each new enrollee in a public program at least one person loses private insurance, there will be no net reduction in the number of uninsured, despite the higher taxpayer burden. If for every two new enrollees in the public program one person loses private insurance, the net cost to the taxpayers for each newly insured person doubles.[16]

Economists David Cutler and Jonathan Gruber found that Medicaid expansions in the early 1990s were substantially offset by reductions in private coverage.[17] For every additional dollar spent on Medicaid, private-sector health care spending was reduced by 50 cents to 75 cents, on the average.[18] Thus taxpayers incurred a considerable burden, but at least half, and perhaps as much as three-fourths, of the expenditures replaced private-sector spending rather than buying more or better medical services.

A similar principle applies to the SCHIP. Take a low-income working family covered by an employer-sponsored health plan. The employer might have covered some or all of the cost of insurance premiums for the employee and family with pretax dollars. However, paying wages is more attractive to

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[14] Kentucky is one of the states that will use federal Medicaid funds to purchase private coverage if it is more economical. South Carolina and Florida also have pilot projects. *See* National Council of State Legislators, *available at* http://www.ncsl.org/programs/health/1115waivers.htm (last visited Sept. 23, 2006).

[15] For instance, it was widely assumed that the 1996 welfare reforms, which limited the eligibility of immigrants for Medicaid, would increase the uninsured rate of that population. Instead, the immigrant uninsured rate fell slightly as more immigrants purchased private insurance. *See* George Borjas, *Welfare Reform, Labor Supply, and Health Insurance in the Immigrant Population*, 22 J. HEALTH ECON. 933, 936 (2003).

[16] However, the loss of private insurance is likely to cause a small, offsetting increase in government revenues as employers substitute taxable wages for previously untaxed health benefits.

[17] David M. Cutler & Jonathan Gruber, *Does Public Insurance Crowd Out Private Insurance?*, 111 Q.J. ECON. 391, 394-95 (1996); *see also* TANYA T. ALTERAS, ROBERT WOOD JOHNSON FOUNDATION, UNDERSTANDING THE DYNAMICS OF "CROWD-OUT": DEFINING PUBLIC/PRIVATE COVERAGE SUBSTITUTION FOR POLICY AND RESEARCH 14-15 (2001), *available at* www.hcfo.net/pdf/crowdout.pdf; RAND HEALTH, STATE EFFORTS TO INSURE THE UNINSURED: AN UNFINISHED STORY 3-4 (2005), *available at* www.rand.org/pubs/research_briefs/RB4558-1/RAND_RB4558-1.pdf.

[18] Cutler and Gruber found that most of the reduction came from workers deciding to drop private coverage (particularly for dependents) rather than because their employers stopped insurance coverage. Cutler & Gruber, *supra* note 17, at 395.

actual and potential employees if coverage is provided by the state. Thus, SCHIP offers some employees the opportunity to increase wages and reduce their health insurance costs.

Overall, the number of poor children without health insurance fell from 19% in 1997 to 11% in 2003. During this period, enrollment of low-income children in public programs increased from 29% to 49%.[19] At the same time, private insurance coverage fell from 47% to 35%, although there was little change in the percentage of privately insured children in households at higher income levels. It appears that the crowd-out of private insurance because of the expansion of public programs was 0.6, meaning that every percentage point increase in public coverage resulted in a reduction of about 0.6 percentage points in private coverage among low-income children.[20]

B. Adopting a Policy of Neutrality

The solution here is very similar to the solution to the previous problem. If government is spending $1,500 a year per person enrolled in Medicaid, it ought to be willing to spend an identical sum on private insurance instead. [See Figure 2.] On paper, Medicaid coverage often looks more generous than private insurance—covering almost all physicians, facilities, and procedures at no out-of-pocket cost to the patient, at least in principle. In practice, many physicians refuse to see Medicaid patients and, because of the low rates of reimbursement, there is often rationing by waiting. As a result, a policy that is financially neutral would be one that encourages private insurance.

III. CHOICE NUMBER 3: INDIVIDUAL OR GROUP INSURANCE

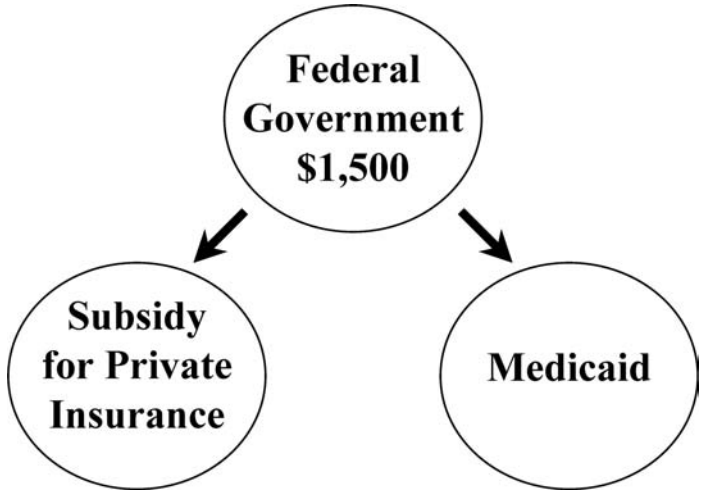
The pros and cons of individual versus group insurance have been the subject of many discussions and debates. Employers, it is argued, are in a unique position to pool groups of people. Also, there are economies of scale in group purchase. On the other hand, employer-provided insurance is not portable. People who change jobs often must also change physicians, thus losing continuity of care. Plus, there is no guarantee that insurance at the new job will provide the same coverage for the same conditions as the original insurance.

Individual insurance has the virtue of portability. People can take their coverage with them as they move from job to job. Further, in the individual market, people have a better opportunity to purchase insurance tailored to

[19] *See generally* PETER J. CUNNINGHAM & MICHAEL H. PARK, CTR. FOR STUDYING HEALTH SYSTEM CHANGE, RECENT TRENDS IN CHILDREN'S HEALTH INSURANCE: NO GAINS FOR LOW-INCOME CHILDREN (Issue Brief No. 29, 2000), *available at* http://www. hschange.com/CONTENT/42/42.pdf.

[20] NCPA calculations were based on HSC Community Tracking Surveys, 1997 to 2003, Center for Studying Health System Change (HSC).

FIGURE 2. A Level Playing Field for Private and Public Insurance



individual and family needs. On the downside, individual insurance has higher administrative costs[21] and subjects enrollees to individual underwriting. But why not let employers buy individual insurance for their employees the way they currently buy group insurance?[22]

This is not the appropriate place to sort out the advantages and disadvantages of the two types of insurance. Presumably, the market could do that sorting out much better than academics. Unfortunately, the playing field is not level.

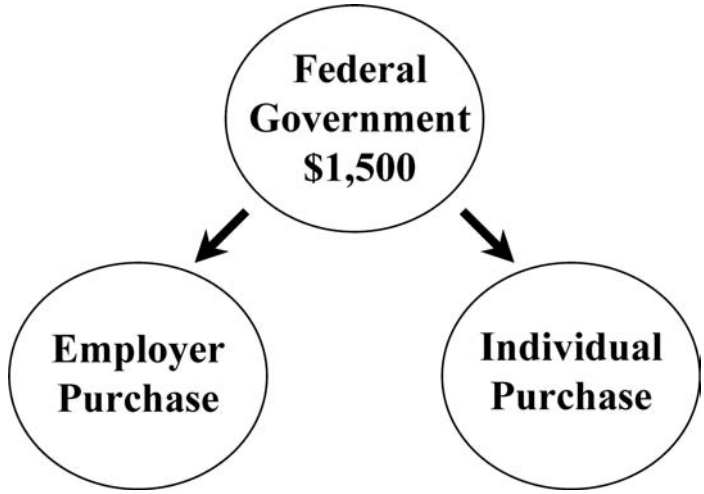
A. The Bias Toward Group Insurance

As noted, current tax law grants very generous subsidies to employer purchase of health insurance. Yet, those same subsidies are denied to individuals who purchase their own insurance. In almost everyone's estimation, this is the accidental result of years of tax policy rather than a methodical approach to health policy. Perhaps unintentionally, the tax-writing committees of Congress have shaped and molded our health insurance system.

[21] The administrative costs for individual insurance are not as high as commonly supposed, when the length of the insurance relationship is considered. Whereas group insurance is typically renegotiated every year, individuals tend to retain their coverage for several years, spreading out the administrative cost of the initial sale over time.

[22] John C. Goodman, *Employer-Sponsored, Personal and Portable Health Insurance*, 25 HEALTH AFFAIRS, 1, 556 (2006).

FIGURE 3. A Level Playing Field for All Insurance Purchases



B. Achieving Neutral Policy

In the case of individual versus group insurance, neutral policy is easy to envision and implement. A neutral government would give the same tax subsidy to every form of insurance. [See Figure 3.] Accordingly, individual and group coverage would compete on a level playing field. In such a world, employers would not offer insurance at all unless they had a comparative advantage in doing so in their competition for labor. Undoubtedly, many large companies do have an advantage. They can do for their employees things the employees cannot do for themselves. Many small firms, however, have no such advantage and probably would be better off paying higher wages instead of paying for health insurance.

IV. CHOICE NUMBER 4: THIRD-PARTY INSURANCE OR INDIVIDUAL SELF-INSURANCE

In every insurance field, people must decide how much risk to transfer to an insurer and how much to retain. Often, the decision focuses on the size of the deductible. There are, though, other ways to divide up responsibilities for risks. In general, risk is transferred to an insurer in return for third-party insurance. When risk is retained, the individual is said to self-insure. In a competitive market, individuals would decide how much risk to transfer to third parties based on their own attitude toward risk and insurance premiums. Unfortunately, government policies intervene.

A. The Bias Toward Third-Party Insurance

As noted, every dollar an employer pays in health insurance premiums avoids income and payroll taxes. For a middle-income employee, this generous tax subsidy means government is effectively paying for almost half the cost of the health insurance. On the other hand, government will tax away almost half of every dollar the employer puts into a savings account for the employee to pay medical expenses directly. The result is a tax law that lavishly subsidizes third-party insurance and severely penalizes individual self-insurance. This encourages people to use third-party bureaucracies to pay every medical bill, even though it often makes more sense for patients to manage discretionary expenses themselves.[23]

B. New Opportunities to Self-Insure

In recent years, a number of formal vehicles have become available to make it easier for individuals to self-insure for medical expenses. These include tax-free Medical Savings Accounts (MSAs), Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs).[24] Also, about half the states now have cash and counseling programs for the Medicaid disabled population. These are pilot programs that allow enrollees to manage their health care dollars.

All of these are steps in the right direction, but the restrictions on these accounts are too onerous. For example, employees cannot even have an HSA unless the employer has a qualified plan and the restrictions in such plans prevent many sensible arrangements. Moreover, unlike the Medicaid programs, employers are not allowed to put different amounts in the accounts of the chronically ill to coincide with the severity of their illness. Also, the law requires the same across-the-board deductible for inpatient and outpatient expenses, as if patient discretion were equally appropriate in all cases.[25]

C. Achieving Neutrality

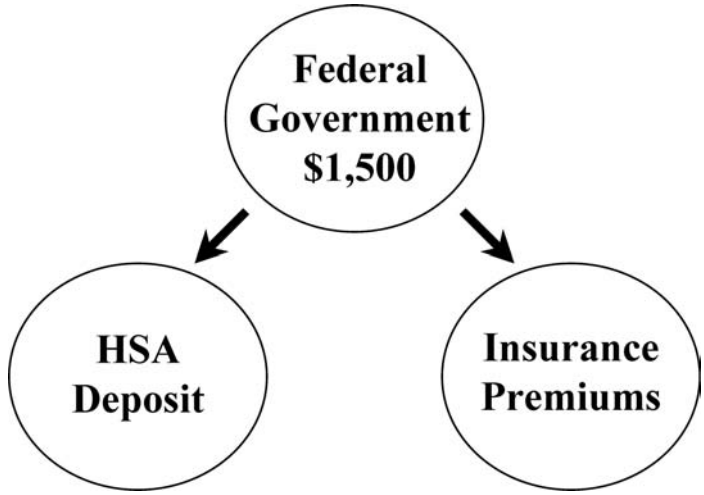
A neutral policy is one that treats third-party insurance and individual self-insurance the same. For example, if government offers a $1,500 tax credit,

[23] JOHN C. GOODMAN, NAT'L CTR. FOR POL'Y ANALYSIS, HEALTH SAVINGS ACCOUNTS WILL REVOLUTIONIZE AMERICAN HEALTH CARE, BRIEF ANALYSIS NO. 464 (2004), *available at* http://www.ncpa.org/pub/ba/ba464/HSAs.pdf.

[24] *See* MICHAEL F. CANNON, NAT'L CTR. FOR POL'Y ANALYSIS, THREE AVENUES TO PATIENT POWER, BRIEF ANALYSIS NO. 430 (2003), *available at* http://www.ncpa.org/pub/ba/ba430/ba430.pdf.

[25] JOHN C. GOODMAN, NAT'L CTR. FOR POL'Y ANALYSIS, MAKING HSAS BETTER, BRIEF ANALYSIS NO. 518 (2005), *available at* http://www.ncpa.org/pub/ba/ba518/ba518.pdf.

FIGURE 4. A Level Playing Field for All Types of Insurance



that credit should apply to dollars used to pay premiums as well as deposits to HSA accounts.[26] [See Figure 4.]

V. CHOICE NUMBER 5: DECISIONS IN THE MARKET FOR RISK

In 1980, Census Bureau statistics showed that less than 1% of the population had been denied health insurance because of a health condition.[27] Moreover, this was a period of time when there were few legislative remedies. Even so, this 1% was a politically vocal group and, in many cases, they evoked understandable sympathy. However, rather than deal with this group directly (for instance, by creating risk pools or offering direct subsidies), politicians through the years have imposed unwise restrictions on the other 99% of the people.

A. Destroying the Market for Risk

A proliferation of state laws has made it increasingly easy for people to obtain insurance after they get sick. Guaranteed issue regulations (requiring

[26] More precisely, true neutrality requires that the MSA deposits be made with after-tax dollars and withdrawals for any purpose be tax-free. *See* John Goodman & Mark Pauly, *Tax Credits for Health Insurance and Medical Savings Accounts*, 14 HEALTH AFFAIRS 126, 135 (1995).

[27] KAREN BEAUREGARD, PERSONS DENIED PRIVATE HEALTH INSURANCE DUE TO POOR HEALTH, PUB. NO. 92-0016 (Agency for Healthcare Research and Quality, Dec. 1991).

insurers to take all applicants, regardless of health status) and community rating regulations (requiring insurers to charge the same premium to all enrollees, regardless of health status) are a free rider's heaven. They encourage everyone to remain uninsured while healthy, confident they will always be able to obtain insurance once they get sick. Moreover, as healthy people respond to these incentives by electing to be uninsured, the premiums that must be charged to cover costs for those who remain in insurance pools rises. These higher premiums, in turn, encourage even more healthy people to drop their coverage.

Federal legislation has also made it increasingly easy to obtain insurance after one gets sick. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 had a noble intent: to guarantee that people who have been paying premiums into the private insurance system do not lose coverage simply because they change jobs. However, a side effect of pursuing this desirable goal is a provision that allows any small business to obtain insurance regardless of the health status of its employees. This means that a small mom-and-pop operation can save money by remaining uninsured until a family member gets sick. Individuals also can opt out of an employer's plan and re-enroll after they get sick. They are entitled to full coverage for a preexisting condition after an 18-month waiting period. A group health plan can apply preexisting condition exclusions for no more than 12 months, except in the case of late enrollees, to whom exclusions can apply for 18 months.

B. Consequences of Unwise Regulation

By far, the worst consequence of government regulation of the market for risk is the unintended harm done to the very people the laws intend to help. Precisely because the premium attached to high-risk individuals is much lower than their expected health care costs, insurers seek to avoid enrolling them in the first place. Precisely because payments to providers also do not reflect expected costs, they, too, have an incentive to avoid attracting the hard cases, especially among the chronically ill.

If health care markets worked the way normal markets do, health insurers and providers would vigorously compete for the business of the sick. There would literally be a market for sick people. In normal markets, entrepreneurs make profits by figuring out how to better solve other people's problems. In health care, by contrast, entrepreneurs run from other people's problems.

C. The Need for a Market for Risk

Current policy toward risk encourages all of us to remain uninsured while we are healthy. The consequences are unfortunate. People cannot make rational choices about risk if risk avoidance is not available at market prices. A neutral policy would allow risk to be freely priced in the marketplace, with government intervening to help specific individuals only in special cases.

VI. CONSEQUENCES OF A POLICY OF "DO NO HARM"

This article has had two objectives: first, to identify ways in which government policies create perverse incentives and problems that many turn to government to solve; and second, to identify what policy changes would be needed to make government a neutral player in the health care system. Under a policy of neutrality, government no longer would be a cause of the problems so many people complain about. Further, if government were removed as a source of problems, the resulting system would have some remarkably attractive features. The following is a summary.

A. A Form of Universal Coverage

Under the neutrality reforms envisioned here, government would promise every citizen a fixed sum of money. Those who choose private insurance would get a tax credit against premiums. For those who are uninsured, the sum would be used to fund a health care safety net in their locality. Further, because money follows people, there would always be a minimum amount of funding regardless of how many people are uninsured.

B. A Level Playing Field for Public and Private Insurance

Low-income families would no longer be trapped in public systems where the quality of care is frequently suspect and there is often rationing of care, especially rationing by waiting. Instead, people would be able to apply funds spent on their behalf to enroll in an employer's plan or purchase health insurance directly.

C. A Level Playing Field for Individual and Group Insurance

No longer would tax policy be biased in favor of an employer-based system in which people lose their insurance whenever they leave or change jobs. Instead, tax law would grant the same subsidy to all forms of insurance, regardless of how it is purchased. Further, employers would be able to purchase individually owned, portable insurance for their employees in the same way they purchase group insurance today.

D. A Level Playing Field for Third-Party Insurance and Individual Self-Insurance

No longer would the tax law encourage the Health Maintenance Organization form of insurance by subsidizing third-party insurance while penalizing self-insurance. Instead, all forms of insurance would compete against each other on a level playing field. The expected outcome is an evolving system under which people manage more of their own health care dollars, especially for those expenditures for which patients can exercise discretion and where it is appropriate for them to exercise discretion.

E. A Genuine Market for Risk

No longer would governments require insurers to charge prices for risk that are totally unrelated to an individual's real health costs. Instead, healthy people would be able to buy into the system at prices that reflect their lower expected costs. The insurance they buy would most likely be portable insurance, making possible a long-term relationship with their insurer and their physicians. In case of a serious illness, people would be able to transfer to other health plans at market prices (not artificially low prices) paid mainly by their current insurer. As a result, insurers would actively complete for sick people, including the chronically ill, and providers would compete to deliver that care.

CONCLUSION

The system described above would not be perfect. Far from it. It would, though, be a considerable improvement over the system we have today. The bottom line is that much good can come from undoing the harm that unwise government policies routinely cause to the nation's health care system.