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Solving the Problem of the Uninsured

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The fact that millions of Americans do not have health insurance is said to be a major problem, if not the major problem, of the United States health care system. Estimates of the number who are uninsured vary widely. There are also widely different indicators of how much difference uninsurance makes. Proposed solutions range from single-payer national health insurance to individual or employer mandates to tax subsidies for the purchase of private health insurance. Even the proponents admit these proposals require large taxpayer burdens and new federal bureaucracies.

Fortunately, there is a way to deal with this problem that does not require new taxes or cumbersome (and probably unenforceable) mandates. Nor does the solution require the knowledge of how many uninsured there are at any one time or what difference uninsurance makes. The solution involves integrating the current system of tax subsidies (which encourage people to obtain private insurance) with the system of spending subsidies (which encourage people not to be insured). The purpose of the integration is to ensure that government policies are not encouraging people to be uninsured, and causing the very problem that needs to be solved.

All physicians are familiar with the do-no-harm principle in medical ethics. It is time to apply that same principle to public policy.

Nature of the problem

The latest Census Bureau report estimates that 45 million Americans are uninsured at any one time [1]. Yet, estimates using the Census Bureau's Survey of Income and Program Participation suggest that the actual number of uninsured could be half as large. For instance, a Congressional Budget Office study of the Census Bureau's Survey of Income and Program Participation estimated the actual number of uninsured may be as low as 21 million [2]. Another report finds that, even using Census Bureau methods, the 45 million number is about 25% too high, or off by 9 million people [3].

Regardless of the actual number, what is more important is how long people are uninsured. Being uninsured is like being unemployed. Most people probably experience the condition over the course of a lifetime, but in most cases it is temporary. Very few people are uninsured for a long period of time. For instance, 75% of uninsured spells are over within 12 months. Less than 10% last longer than 2 years [4].

There are dozens of studies that claim to find significant health differences between those who are insured and those who are uninsured. For instance, Marquis and Long [5,6] find that uninsured adults have about 60% as many physician visits and 70% as many inpatient hospital days as they would if they were covered by insurance. Yet, there are reasons to doubt these results. Consider the fact that there are between 10 and 14 million people who are theoretically eligible for Medicaid and SCHIP (for low-income families who do not qualify for Medicaid) but do not bother to sign up. This is almost one in every four uninsured persons in the country. Estimates of eligibility for public health care programs vary. The

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lower estimates are that around 10 million Americans are eligible but unenrolled, whereas the upper range of estimates is closer to 14 million. One study found that just over half (51.4%) of eligible, nonelderly adults were enrolled in Medicaid in 1997. Of the remaining adults who were Medicaid eligible, 21.6% had private coverage, whereas 27% were uninsured. Another study found that about 7 million uninsured children eligible for either SCHIP or Medicaid are not enrolled [7]. Of those children eligible for Medicaid or SCHIP, one third is eligible for SCHIP, whereas two thirds are eligible for Medicaid. Eight percent of uninsured, low-income children are illegal aliens and, as such, not eligible for either Medicaid or SCHIP [8,9]. Furthermore, in most places people are able to enroll in Medicaid up to 3 months after they receive medical treatment. Because these people can enroll at the drop of a hat, even after they have incurred medical expenses, are they not de facto insured even without the necessity of formal enrollment?

To see what this means on the local level, consider Parkland Hospital in Dallas, a primary source of care for the indigent and those covered by Medicaid. Uninsured patients and Medicaid patients pass through the same emergency room door; they see the same doctors; they receive the same treatments; and if required, they are admitted to hospital rooms on the same floors [10].

The only people who seem to care very much about who is insured or uninsured at Parkland are the hospital staff (presumably because that affects how they get paid). For that reason, full-time employees work their way through the emergency room waiting area to enroll all eligible patients in Medicaid (most of the time they fail). With the same goal in mind, employees also go room to room to visit those who are admitted (where their success rate is much higher).

At Children's Medical Center, next door to Parkland, a similar exercise takes place. Children on Medicaid, children on SCHIP, and uninsured children all come through the same emergency room door. Again, they all see the same doctors and receive the same treatments. Again, it is only the hospital that seems to care whether anybody is insured and by whom [10].

If a $100 bill were dropped on the emergency room floor at Parkland, it probably would not remain there for 60 seconds; but an application to enroll in Medicaid dropped on the same floor might remain there for hours. In the view of some commentators, the enrollment forms are a ticket to health insurance worth thousands of dollars and substantially more health care. But people do not act as thought they believe that is the case. To the contrary, they act as though the marginal value of enrollment is virtually zero.

For the millions of people who opt not to enroll in free government-provided health insurance, uninsurance is the result of voluntary choice. A lot of other people are also voluntarily uninsured. For example, about 9 million people (more than one in five of the uninsured) are eligible for employer insurance and decline to enroll even though the employee share of the premium is usually nominal [11].

It can be inferred that many other people are voluntarily uninsured, because they apparently have enough income to purchase insurance if they choose. Although it is common to think of the uninsured as having low incomes, many families who lack insurance are solidly middle class (Fig. 1). The largest increase in the number of uninsured in recent years has occurred among higher-income families. About one in three uninsured persons (14.8 million people) lives in a family with an income of $50,000 or higher and about half of those have incomes in excess of $75,000. Further, over the past decade, the number of uninsured increased by 54% in households earning between $50,000 and $75,000 and by 130% among households earning $75,000 or more. By contrast, in households earning less than $50,000 the number of uninsured decreased approximately 3% [12].

These results are contrary to the normal expectation of economists. Economic theory teaches that as people earn higher incomes, they should be more willing to purchase insurance to protect their income against claims arising from expensive medical bills.

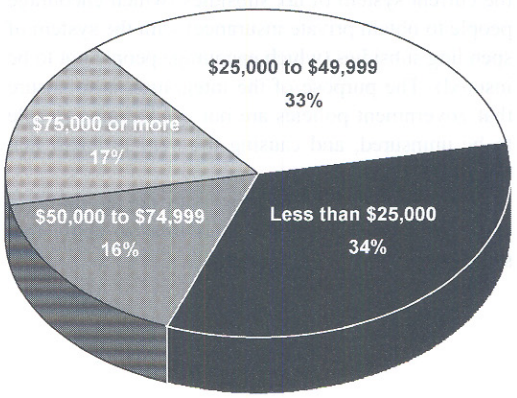

Fig. 1. Income distribution of the uninsured, 2003. (*From* DeNavas-Walt C, Proctor BD, Mills RJ. Income, poverty, and health insurance coverage in the United States: 2003. Current Population Reports, Consumer Income P60–226. Washington (DC): US Census Bureau, US Government Printing Office; 2004.)

Similarly, as people become wealthier the value of insuring against wealth depletion (eg, by a catastrophic illness) also rises. Insurance should be positively correlated with income and wealth accumulation. The fact that the number of uninsured rose over the past decade while incomes were rising and that the greatest increase was among higher-income families suggests that something else is happening to make insurance less attractive.

Some information about middle-class families who are voluntarily uninsured is provided by a California survey of the uninsured with incomes of more than 200% of poverty [13]. Forty percent owned their own homes and more than half owned a personal computer. Twenty percent worked for an employer that offered health benefits, but half of those declined coverage for which they were eligible. This group was not opposed to insurance in general, however, because 90% had purchased auto, home, or life insurance in the past.

The existence of voluntary uninsurance raises a profound public policy question. Economists assume that if people choose A rather than B they are revealing through their actions that they prefer A to B. Further, if people act in accordance with their preferences one is entitled to say they are better off from their own point of view.

From the economist's perspective, the case for doing something about the uninsured rests on its effects on people other than the uninsured. External effects, as shown below, are quite substantial; but if the goal of the reform is to minimize external costs for others, the reform looks quite different from a reform that focuses on the uninsured.

Policy proposals

A number of proposals seek to reduce or eliminate the problem of uninsurance. For example, Physicians for a National Health Program proposes a system of taxpayer-funded, free health care, making government the universal insurer of everyone [14]. Both major candidates in the 2004 presidential campaign proposed offering tax subsidies for private insurance, to individuals and to employers. All of these proposals are highly expensive relative to any reasonable estimate of their probability of success in insuring the uninsured. For example, the National Center for Policy Analysis estimated that Senator John Kerry's plan would have cost just over $1 trillion over 10 years [15]. An American Enterprise Institute study placed the cost of the Kerry plan at $1.5 trillion and President Bush's plan at $128.6 billion. This results in a cost of $1919 per newly insured individual for the Bush plan (almost $8000 for a family of four) and $5494 for the Kerry plan (almost $22,000 for a family of four). Using the candidates' own figures, the Bush plan would have cost $1667 per newly insured, whereas the Kerry plan would have cost about double that amount [16,17].

A different approach is to require individuals to purchase insurance (much as it is now required that people who drive a car have a driver's license) or to require employers to insure their own employees. Proposals to impose mandates on the private sector typically offer a pay-or-play option: either provide insurance or pay a sum of money to the government and let the government handle the problem. There are many problems with mandates, but the most important problem is this: with a pay-or-play approach, no mandate is actually needed.

To the advocates of mandates, the question can always be asked: What are you going to do with people who disobey the mandate? As a practical matter, no one is suggesting that they be put in jail. One is left with imposing a financial penalty (eg, a fine). But a system that fines people who are uninsured ipso facto is indistinguishable from a system that subsidizes those who insure, the subsidy being the absence of the fine. That is the system already in place.

Reasons for uninsurance

Although most people in health policy believe that the existence of millions of uninsured people is a major public policy problem, politicians at both the state and federal level are reflecting voter indifference through their failure to act. The probable reason for this indifference is that uninsured families discover how to get health care even if they have no insurance. They do so in one of two ways: they manage to get insurance after they get sick or they manage to get free care.

A proliferation of state laws has made it increasingly easy for people to obtain insurance after they get sick. Guaranteed issue regulations (requiring insurers to take all comers, 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 that 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 premium 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 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. 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 can also opt out of their 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.

The other lure is the existence of free care for those who cannot or do not pay their medical bills. Although no one knows what the exact number is, public and private spending on free care is considerable. A study by the Texas State Comptroller's office found that Texas spent about $1000 per year on free care for every uninsured person in the state, on the average (Fig. 2) [18]. A less comprehensive, but nonetheless nationwide, study by the Urban Institute estimated that in 2001 the uninsured received nearly $90 billion in care, of which more than one third was uncompensated charity care. Charity care by this calculation was equal to about $767 per uninsured individual. If uncompensated physician care is included (as it was in the Texas study), the total likely approaches $1000 [19].

The Texas estimate is almost 7 years old, and at an annual (health care) rate of inflation of 10%, spending doubles every 7 years. Assuming a more conservative increase of 50% puts spending on the uninsured at almost $1500 per person, or about $6000 a year for a family of four.

Interestingly, $6000 is a sum adequate to purchase private health insurance for a family in most Texas cities. One way to look at the choice many Texas families face is: they can rely on $6000 in free care (on the average) or they can purchase a $6000 private insurance policy with after tax income. Granted, the two alternatives are not exactly comparable. Families surely have more options if they have private insurance. To many, however, the free care alternative seems more attractive.

Rationale for government

Aside from the burden of providing charity care to the poor, is there any legitimate reason for government to care whether people have health insurance? Although many reasons have been offered, the main and by far the most persuasive is the "free rider" argument. According to this argument, health insurance has social benefits, over and above the personal benefits to the person who chooses to insure. The reason is that people who fail to insure are likely to get health care anyway, even if they cannot pay for it,

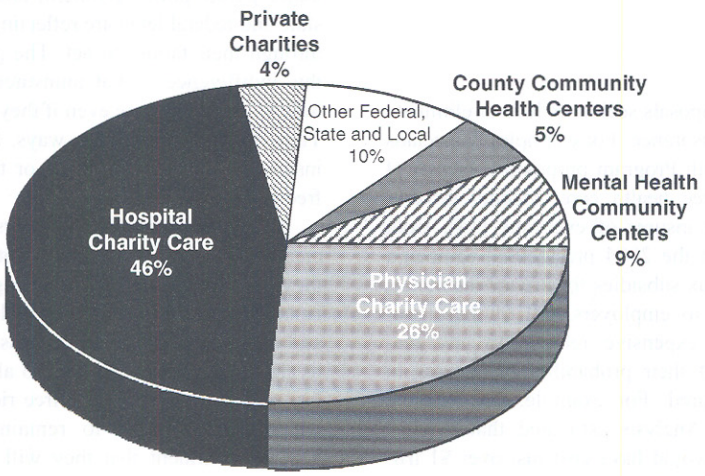

Fig. 2. Health spending on the uninsured in Texas. (*From* Estimated Texas health care spending on the uninsured. Austin (TX): Texas Comptroller's Office, Texas Comptroller of Public Accounts; 2000.)

because the rest of the community is unwilling to allow the uninsured to go without health care, even if their lack of insurance is willful and negligent.

This set of circumstances creates opportunities for some people to be free riders on other people's generosity. In particular, free riders can choose not to pay insurance premiums and to spend the money on other consumption instead, confident that the community as a whole will provide them with care even if they cannot pay for it when it is needed. Being a free rider works because there is a tacit community agreement that no one will be allowed to go without health care. This tacit agreement is so established that it operates as a social contract that many people substitute for a private insurance contract.

A proposal for reform

Fortunately, the concerns of the free rider argument can be met without the disadvantage of other reform proposals. There can be a system that provides a reasonable form of universal coverage for everyone without spending more money and without intrusive and unenforceable government mandates.

Changing the tax system

Currently, the federal government spends more than $189 billion a year on tax subsidies for private insurance [20]. The bulk of these subsidies arise from the fact that employer payments for employee health care are excluded from taxable employee income. Because state tax laws tend to piggyback on the federal tax system, these employer payments avoid state income and payroll taxes. Consider a middle-income family facing a 25% federal income tax rate; a (employer and employee combined) payroll tax rate of 15.3%; and a state income tax of, say, 4%, 5%, or 6%. The ability to exclude employer-paid premiums from taxation means that government is paying almost half the cost of the family's insurance.

These generous tax subsidies undoubtedly encourage people who would otherwise be uninsured to obtain employer-provided insurance. There are three problems, however, with these tax subsidies the way

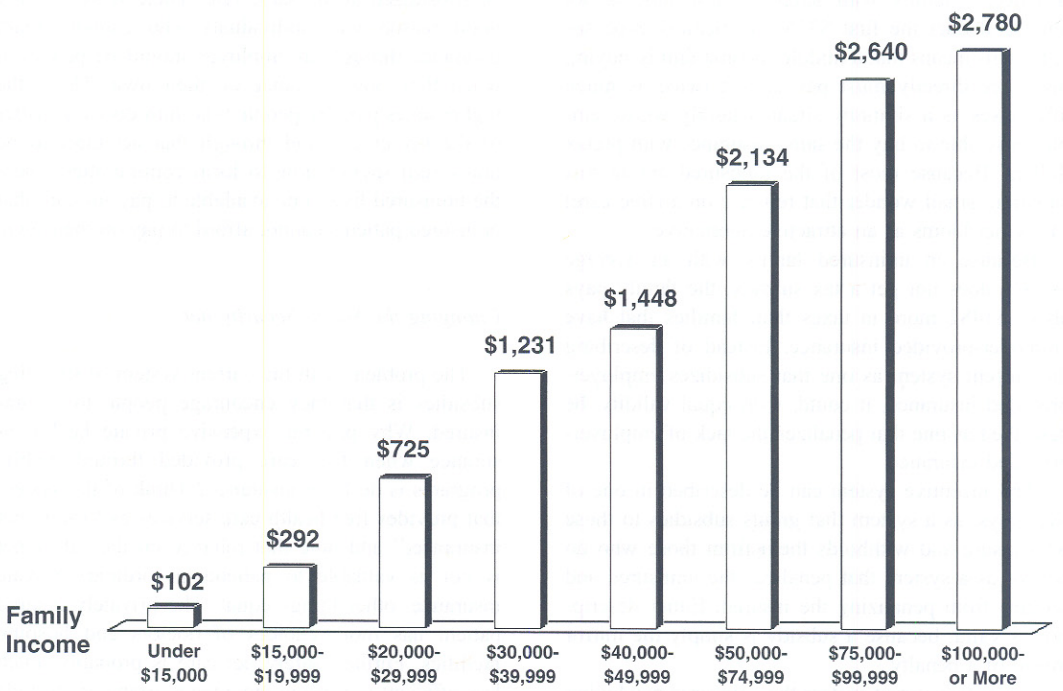

Fig. 3. Average tax subsidy for families, 2004. Lewin Group estimates using the Health Benefits Simulation Model. Average per family is $1482. Includes subsidy from the income tax exclusion, the Social Security income tax exclusion, and the health expenses deduction. (*From* Sheils J, Haught R. The cost of tax-exempt health benefits in 2004. Health Aff (Millwood) Web Exclusive, February 25, 2004. Available at http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1. Accessed July 24, 2005.)

they are structured: (1) the largest subsidies are given to people who need them least; (2) the subsidies are generally not available to most of the uninsured; and (3) the penalties for being uninsured do not fund safety net care.

Under the current system, families who obtain insurance through an employer obtain a tax subsidy worth about $1482 on the average [20]. Not everyone, however, gets the average tax subsidy. Households earning more than $100,000 per year receive an average subsidy of $2780. By contrast, those earning between $20,000 and $30,000 receive only $725 (Fig. 3). 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 their 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 virtually no tax relief if they purchase insurance. Individuals paying out-of-pocket for health care can deduct costs in excess of 7.5% of adjusted gross income. For instance, a family with $50,000 in income is not able to deduct the first $3750 in medical expenses [21]. This means that a middle-income family buying insurance directly must pay almost twice as much after taxes as a similarly situated family whose employer is able to buy the same insurance with pretax dollars. Because most of the uninsured are in this situation, small wonder that reliance on a (free care) safety net looms as an attractive alternative.

Because an uninsured family with an average income does not get a tax subsidy, the family pays about $1482 more in taxes than families that have employer-provided insurance. Instead of describing the current system as one that subsidizes employer-provided insurance, it could, with equal validity, be described as one that penalizes the lack of employer-provided insurance.

Any incentive system can be described in one of two ways: as a system that grants subsidies to those who insure and withholds them from those who do not; or as a system that penalizes the uninsured and refrains from penalizing the insured. Either description is valid, because a subsidy is simply the mirror image of a penalty.

Under the current system the uninsured pay higher taxes because they do not enjoy the tax relief given to those who have employer-provided insurance. These higher taxes are a "fine" for being uninsured. The problem is that the extra taxes paid are simply lumped in with other revenues collected by the US Treasury Department, whereas the expense of delivering free care falls to local doctors and hospitals.

How can these defects be corrected? First, a uniform, refundable tax credit should be offered to every individual for the purchase of private insurance. The Bush administration has proposed a $1000 per person refundable tax credit, or $3000 per family. This tax credit phases out as income rises, however, and virtually vanishes when family income reaches about $80,000 (the author helped formulate the administration's proposal). In general, social interest in whether someone is insured is largely independent of income. In general, a $100,000-a-year family can generate hospital bills it cannot pay almost as easily as a $30,000-a-year family. One can readily grant that there is no social reason to care whether Bill Gates is insured. There could be an income or wealth threshold, beyond which the subsidy-penalty system does not apply. As a practical matter, however, there are so few individuals who would qualify for an exemption that uniform treatment for everyone is administratively attractive. For this reason and practical considerations, the tax credit should be independent of income. Second, all forms of private insurance should be subsidized at the same rate. There is no socially good reason why individuals who cannot obtain insurance through an employer should be penalized when they buy insurance on their own. Third, the higher taxes paid by people who turn down the offer of the tax credit (and through that act elect to be uninsured) should flow to local communities where the uninsured live to be available to pay for care that uninsured patients cannot afford to pay on their own.

Changing the Social Security net

The problem with the current system of spending subsidies is that they encourage people to be uninsured. Why pay for expensive private health insurance when free care provided through public programs is de facto insurance? Think of the system that provides free health care services as "safety net insurance," and note that reliance on the safety net is not as valuable to patients as ordinary private insurance, other things equal. The privately insured patient has more choices of doctors and hospital facilities. Further, safety net care is probably much less efficient (eg, using emergency rooms to provide care that is more economic in a free-standing clinic). As a result, per dollar spent the privately insured patient probably gets more care and better care. It is in society's interest not to encourage people to be in the public sector rather than the private sector.

To avert the perverse incentives the current system creates, people who rely on the free care system should be able to apply those dollars instead to the purchase of private insurance and the accompanying private health care that private insurance makes possible. A mechanism for accomplishing this result follows.

Integrating taxing and spending decisions

Let us now put the pieces together [22,23]. Under an ideal system, the government offers every individual a subsidy. If the individual obtained private insurance, the subsidy is realized in the form of lower taxes (in the form of a tax credit). Alternatively, if the individual chose to be uninsured, the subsidy is sent to a safety net agency in the community where the individual lives (Fig. 4).

The uniform subsidy should reflect the value society places on having one more person insured. But what is that value? An empirically verifiable number is at hand, so long as one is willing to accept the political system as dispositive. It is the amount one expects 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 $1500 per year on free care for the uninsured, on the average, one should be willing to offer $1500 to everyone who obtains private insurance. Failure to subsidize private insurance as generously as free care is subsidized 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 pay extra taxes equal to the average amount of free care given annually to the uninsured (Fig. 5).

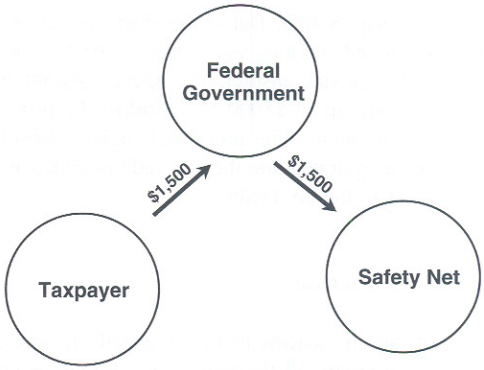

Fig. 5. The marginal effect of choosing to be uninsured.

How can the subsidies for those who choose to move from being uninsured to insured be funded? 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. Suppose everyone in Dallas County chose to obtain private insurance, relying on a refundable $1500 federal income tax credit to pay the premiums. As a result, Dallas County no longer needs to spend $1500 per person on the uninsured. All of the money that previously funded safety net medical care could be used to fund the private insurance premiums (Fig. 6).

In this way, people who leave the social safety net and obtain private insurance actually furnish the funding needed to pay their private insurance premiums, at least at the margin. They do this by allowing public authorities to reduce safety net spending by an amount equal to the private insurance tax subsidy. Some patients may be high cost. In a private insurance market, insurers do not agree to insure someone for $1000 if his or her expected cost

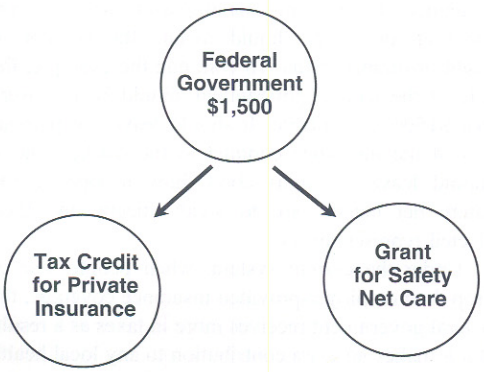

Fig. 4. The $1500 federal guarantee.

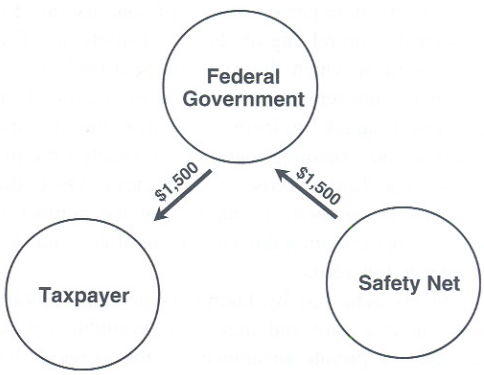

Fig. 6. The marginal effect of choosing to be insured.

of care is, say, $5000. But if the safety net agency expects a $5000 savings as a result of the loss of a patient to a private insurer, the agency should be willing to pay up to $5000 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.

Implementing reform

How can this scheme be implemented? To implement the program, all the federal government needs to know is how many people live in each community. In principle, it is offering each of them an annual $1500 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 is $1500 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.

How does 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.

Advantages of reform

The goal of health insurance reform is not to get everyone insured (indeed, everyone is already in a loose sense insured). Instead, the goal is to reach a point at which there is societal indifference about whether one more person obtains private insurance as an alternative to relying on the social safety net. That is the point at which the marginal cost (in terms of subsidy) to the remaining members of society of the last person induced to insure is equal to the marginal benefit to the remaining members of society (in terms of the reduction in cost of free care). Once this condition is satisfied, it follows that the number of people who remain uninsured is optimal, and that number is not zero.

This is achieved by taking the average amount spent on free care and making it available for the purchase of private insurance. In the previous example, the government guarantees that $1500 is available, depending on the choice of insurance system. From a policy perspective, there is indifference about the choice people make.

A common misconception is that health insurance reform costs money. For example, if health insurance for 40 million people costs $1500 a person, some conclude that the government needs to spend an additional $65 billion a year to get the job done. What this conclusion overlooks is that $65 billion or more is already being spent on free care for the uninsured, and if all 40 million uninsured suddenly became insured they would free up the $65 billion from the social safety net.

At nearly $2 trillion dollars a year [24], there is no reason to believe the health care system is spending too little money. To the contrary, attempting to insure the uninsured by spending more money has the perverse effect of contributing to health care inflation. Getting all the incentives right may involve shifting around a lot of money (ie, 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 [25]. It need not add to budgetary outlays.

There is virtually nothing in the tax code about what features a health insurance plan must have to qualify for a tax subsidy. The exceptions are mandated maternity coverage and coverage of a 48-hour hospital stay after a well-baby delivery if requested by a patient and physician. Insurance purchased commercially, around two thirds of the total, is regulated by the state governments. But the federal tax subsidy applies to whatever plans state governments allow to be sold [26]. In this sense, the federal role is strictly financial. That is, the current tax break is based solely on the number of dollars taxpayers spend on health insurance, not on the features of the health plans themselves.

This practice is sensible and should be continued. Aside from an interest in encouraging catastrophic insurance, there is no social reason why government at any level should dictate the content of health insurance plans. To continue the example, the role of the federal government should be to ensure that $1500 is available. It should leave the particulars of the insurance contract to the market, and it should leave decisions about how to operate the safety net health care to local citizens and their elected representatives.

Under the current system, when people lose or drop their employer-provided insurance coverage, the federal government receives more in taxes as a result. But it makes no extra contribution to any local health care safety net. As a consequence, the growth in the uninsured is straining the finances of many urban

hospitals. The problem is exacerbated by less generous federal reimbursement for Medicaid and Medicare and by increasing competitiveness in the hospital sector. Traditionally, hospitals have covered losses that arise from people who cannot pay for their care by overcharging those who can pay. But as the market becomes more competitive, these overcharges are shrinking. There is no such thing as "cost shifting" in a competitive market.

Under this proposal, there is a guaranteed, steadily stream of funds available to local communities who provide indigent care. The funding expands and contracts as the number of uninsured expands and contracts.

Summary

Reform of the United States health care system is less complicated than at first might appear. The building blocks of an ideal system are already in place. The federal government already generously subsidizes private health insurance and safety net care. What is wrong with the current system is that there are too many perverse incentives.

One could reasonably argue that government is doing more harm than good, and that a laissez faire policy is better than what is now in place. Nonetheless, if government is going to be involved in a major way in the health care system, perverse incentives should be replaced with neutral ones. At a minimum, government policy should be neutral between private insurance and the social safety net, never spending more on free care for the uninsured than it spends to encourage the purchase of private insurance. Careful application of this principle would go a long way toward creating an ideal health care system.

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