Part Three

Reforming the U.S. Health Care System

Chapter Twenty-three

Designing an Ideal Health Care System

Among people who believe the American health care system needs serious reform, attention invariably turns to the large number of people without health insurance. An estimated 43.6 million people, or 15.2 percent of the U.S. population, were without coverage for at least part of 2002.[1] What can be done about this problem?

There are typically two types of proposals: (1) force people to buy private health insurance whether they want to or not, or force their employers to buy it for them (which amounts to the same thing)[2]; and (2) have government pay for all or most of the cost of their insurance by subsidizing private premiums or enrolling them in public insurance.

The first proposal not only involves government coercion, but also constitutes a dangerous further intrusion of government into the medical marketplace. The second proposal would require new taxes and inject billions of additional dollars into a health care system that is already the most expensive in the world.

As we shall see in the next chapter, neither reform is necessary or desirable. In fact, we can have a workable form of universal health insurance without intrusive mandates or more government spending.

THE ROLE OF GOVERNMENT

But before turning to a solution, we should consider a more basic question. Why should government be involved at all?

The Free Rider Argument

Aside from the burden of providing charity care to the poor, is there any reason for government to care whether people have health insurance? The traditional argument for government intervention is that health insurance has social benefits apart from 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 can't pay for it. And the reason for that is that 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 they need it. In other words, being a free rider works. It works because of a tacit community agreement that no one will be allowed to go without health care. And this tacit agreement is so established that it operates as a social contract that many people substitute for a private insurance contract.

Evidence of a Free Rider Problem: The Growing Number of Uninsured

What evidence is there that free riders are a problem? One piece of evidence is the number of uninsured. According to the Census Bureau, a larger percentage of the population was uninsured in 2002 than a decade earlier (see figure 23.1). The rise in the number of uninsured occurred throughout the 1990s, a time in which per capita income and wealth, however measured, were rising.

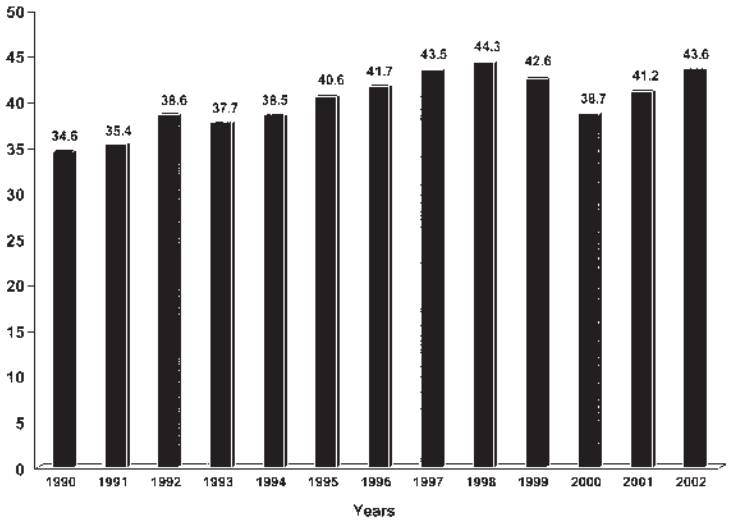
Although it is common to think of the uninsured as having low incomes, many families who lack insurance are solidly middle class (see figure 23.2). And the largest increase in the number of uninsured in recent years has occurred among higher-income families:

- About one in seven uninsured persons lives in a family with an income between $50,000 and $75,000, and almost one in six earns more than $75,000.
- Further, between 1993 and 1999, the number of uninsured increased by 57 percent in households earning between $50,000 to $75,000 and by 114 percent among households earning $75,000 or more.
- By contrast, in households earning less than $50,000 the number of uninsured decreased approximately 2 percent.

FIGURE 23-1

Growth in the Uninsured, 1990 to 2002

(millions)

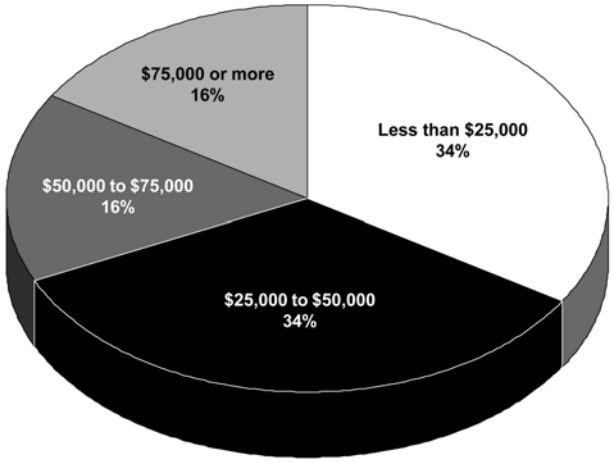


Source: U.S. Census Bureau.

FIGURE 23-2

Income Distribution of the Uninsured

(2002)



Sources: Robert J. Mills, *Current Population Reports, Health Insurance Coverage: 1999*, pp. 60-211, U.S. Census Bureau, September 2000.

More information about middle-class families who are voluntarily uninsured emerged from a recent California survey of the uninsured with incomes of more than 200 percent of poverty[3].

- 40 percent owned their own homes and more than half owned a personal computer.
- 20 percent worked for an employer that offered health benefits, but half of them (10 percent of the total) declined coverage for which they were eligible.
- This group was not opposed to insurance in general, as 90 percent had purchased auto, home or life insurance in the past.
- About 43 percent felt that health insurance was not a good value for the money, and rising insurance premiums will only increase this number.

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. Similarly, as people become wealthier the value of insuring against wealth depletion (say, by a catastrophic illness) rises. So insurance should be positively correlated with income and wealth accumulation. The fact that the number of uninsured rose while incomes were rising and that the greatest increase in lack of insurance was among higher-income families suggests that something else is making insurance less attractive.

Cause of the Problem: State Regulations That Favor Free Ridership

One cause of the problem is the proliferation of state laws that make 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 can obtain insurance if 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. From 1990 through 1996, sixteen states passed aggressive regulations to increase access to health in-

surance for people with health problems. The uninsured population in these states grew eight times as much as in the states that did not.[4]

Other regulations that raise the cost of insurance for the healthy exacerbate this condition. Among these are laws mandating coverage for such services as acupuncture, in vitro fertilization and even marriage counseling.[5] For example, a Duke University study showed that the probability an individual will become uninsured increases with each new mandate imposed by government.[6] A study for the Health Insurance Association of America (HIAA) found that 20 percent to 25 percent of uninsured Americans lack insurance due to benefit mandates.[7]

Cause of the Problem: Federal Regulations That Favor Free Ridership

Federal legislation has also made it increasingly easy to obtain insurance after one gets sick. HIPAA (1996) had a noble intent: guarantee that people who have been paying premiums into the private insurance system do not lose coverage simply because they change jobs. But 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 operation can save money by remaining uninsured until a family member gets sick. Individuals can also opt out of their employer's plan, then enroll after they get sick. They are entitled to full coverage for a preexisting condition after an eighteen-month waiting period.[8]

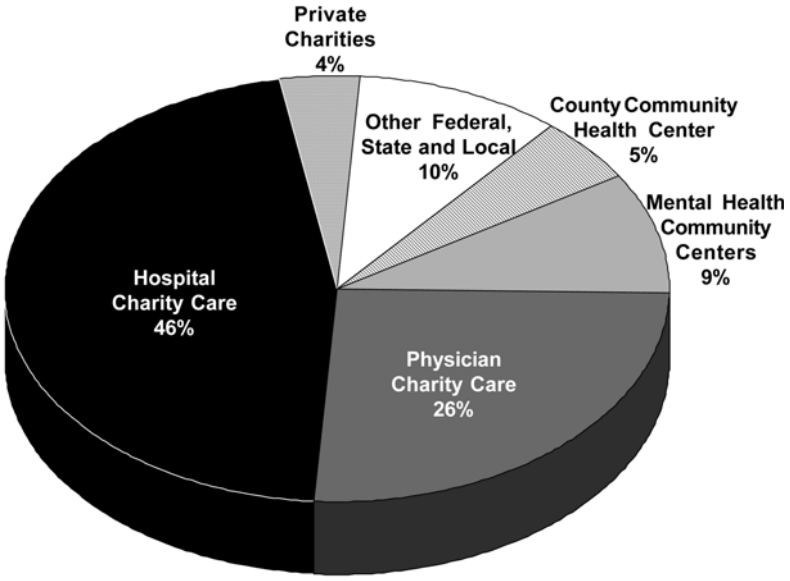
Cause of the Problem: National Spending on Indigent Health Care

Another source of the problem is the amount we spend on free care for those who cannot or do not pay their own medical bills. As noted earlier in this book, public and private spending on free care is considerable. For example, a study by the State Comptroller's office found that Texas currently spends about $1,000 per year on free care for every uninsured person in the state, on the average (see figure 23.3). This implies that the value of "free" care is about $4,000 a year for a family of four.

Interestingly, $4,000 is a sum adequate to purchase private health insurance for a family in many Texas cities. Therefore, many Texas families can rely on $4,000 in free care (on the average) or they can purchase a $4,000 private insurance policy with after-tax income. Granted, the two alternatives are not exactly comparable. Families surely have more options if they

FIGURE 23-3

Health Spending on the Uninsured in Texas



Sources: Estimated Texas Health Care Spending on the Uninsured, Texas Comptroller's Office, May 9, 2000.

have private insurance. But to many, the free care alternative appears more attractive.[9]

Consequences of Free Ridership: An Increasingly Fragile Safety Net

As we shall see below, when people elect to become insured, say by enrolling in an employer's health plan, they receive a tax subsidy from the federal government. However, when people drop insurance coverage the federal government 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 can't pay for their care by overcharging those who can. But as the market becomes more competitive, these overcharges are shrinking. There is no such thing as "cost shifting" in a competitive market.

This problem is not trivial. For example, preliminary findings from a RAND study show that safety net spending by the nation's hospitals is not keeping pace with the overall increase in per capita spending.[10] A National Academy of Sciences Institute of Medicine study found that the safety net of local clinics, hospitals and charities is "overburdened and threadbare" and "could collapse with disastrous consequences."[11]

CHARACTERISTICS OF AN IDEAL HEALTH CARE SYSTEM

Even if federal, state and local governments did not exacerbate the problem of the uninsured, some people would choose to be uninsured, giving rise to the "free rider" argument outlined above. Yet, if this is the reason why government has a legitimate interest in the health insurance decisions of individuals, then the public policies we adopt must solve the problem. As noted, the most commonly proposed solutions are to have government require people to purchase insurance and/or have taxpayers subsidize their insurance. Yet, government-imposed mandates and expensive new spending programs are neither necessary nor sufficient. The best solution limits the role of government and expands the choices open to every citizen. Here's how.

Characteristic No. 1: We Should Reward Those Who Insure and Penalize Those Who Do Not

To the advocates of mandates, we can always ask the question: What are you going to do with people who disobey the mandate? As a practical matter, no one is suggesting that we put them in jail. So we are left with imposing a financial penalty (e.g., a fine). But a system that fines people who are uninsured is a system that subsidizes those who insure—the subsidy being the absence of the fine.

Under the current system families who obtain insurance through an employer get a tax subsidy worth about $1,155, on the average.[12] Since an uninsured family with an average income doesn't get this subsidy, the uninsured family will pay about $1,155 more in taxes. So instead of describing our current system as one that subsidizes employer-provided insurance we could, with equal validity, describe it as one that penalizes the lack of employer-provided insurance.

We can describe any incentive system in one of two ways: (1) as one that grants subsidies to those who insure and withholds them from those who do not or (2) as one that taxes the uninsured and refrains from taxing the insured. Either description is valid, since a reward is simply the mirror image of a penalty.

Characteristics of an Ideal Health Care System

Characteristic No. 1: We should subsidize those who insure and penalize those who do not.

Characteristic No. 2: The subsidy/penalty should equal the value society places on insuring individuals, at the margin.

Characteristic No. 3: The revealed social value of insurance is the amount we spend on free care for the uninsured.

Characteristic No. 4: The tax penalties paid by the uninsured should be used to compensate those who provide safety net care.

Characteristic No. 5: The tax subsidies for the insured should, at the margin, be funded by reducing spending on free care for the uninsured.

Characteristic No. 6: Subsidies for being insured should be independent of how the insurance is purchased.

Characteristic No. 7: The optimal number of uninsured is not zero.

Characteristic No. 8: The principles of reform apply with equal force to all citizens, regardless of income.

Characteristic No. 9: Health insurance subsidies need not add to budgetary outlays.

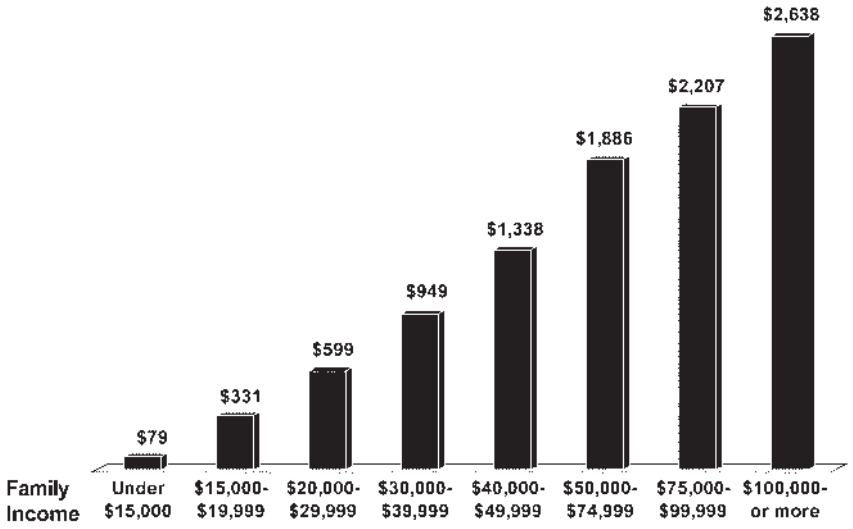
Characteristic No. 10: The federal government's role should remain strictly financial.

Characteristic No. 2: The Reward/Penalty Should Equal the Value Society Places on Insuring Individuals at the Margin

We should decide how much we care (in money terms) whether a person is insured and that should determine the size of the subsidy/penalty.[13] Any other policy would be indefensible and absurd. It would entail spending too much on subsidies and collecting too much in fines, or vice versa. Under an ideal system,

FIGURE 23-4

Average Tax Subsidy for Families



Includes subsidy from the income tax exclusion, the Social Security income tax exclusion and the health expenses deduction.

Sources: Lewin Group estimates.

- We should never pay more for (reward) good behavior than the good behavior's benefit to us, and we should never collect more from (penalize) bad behavior than its cost to us.
- Conversely, we should never pay less for good behavior than its benefit or penalize bad behavior less than its cost.

Current policy violates this principle in several ways. Although the average tax subsidy is worth about $1,155 per family, households earning more than $100,000 per year receive, on the average, $2,638 per year in subsidies. By contrast, those earning between $20,000 and $30,000 receive only $599 (see figure 23.4). One reason is that those earning higher incomes are in higher tax brackets. For example, a family in the 40 percent tax bracket gets a subsidy of forty cents for every dollar spent on their health insurance. By contrast, a family in the 15 percent bracket gets a subsidy of only fifteen cents on the dollar.

A uniform subsidy would offer the same tax reduction to everyone who obtains private insurance, and that subsidy should reflect the value our society places on having one more person insured. But what is that value?

Characteristic No. 3: The Revealed Social Value of Insurance Is the Amount We Spend on Free Care for the Uninsured

How do we know how much it is worth collectively for a given individual to insure? An empirically verifiable number is at hand, so long as we're willing to accept the political system as dispositive. It's the amount we expect to spend (from public and private sources) on free care for that person when he or she is uninsured.

To continue with the Texas example, if society is spending $1,000 per year on free care for the uninsured, on the average, we should be willing to offer $1,000 (say, in the form of a tax credit) to everyone who obtains private insurance. Failure to subsidize private insurance as generously as we subsidize free care encourages people to choose the latter.

One reason this principle is not generally understood is that many people think the uninsured are uncared for. In fact, they are not. They are simply participating in a different kind of health care system. As noted earlier, uninsured adults in Dallas County typically seek health care through the emergency room at Parkland Hospital. Uninsured children are typically treated next door, in the emergency room of Children's Medical Center.

Think of the system that provides these 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 being equal. The privately insured patient has more choices of doctors and hospital facilities. Further, safety net care is probably much less efficient (e.g., using emergency rooms to provide care that is more economical in a free-standing clinic). As a result, per dollar spent the privately insured patient probably gets more care and better care.

Characteristic No. 4: The Penalties Paid by the Uninsured Should Be Used to Compensate Those Who Provide Free Care to the Uninsured

What should be done with the penalties collected from people who choose to remain uninsured? They should be used to compensate providers who give free care to the uninsured, no more and no less.[14]

As noted above, 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 the extra taxes paid are simply lumped in with other revenues collected by the U.S. Treasury in Washington, D.C., while the expense of delivering free care falls to local doctors and hospitals.

Under an ideal system, the government would offer every individual a subsidy. If the individual obtained private insurance, the subsidy would be real-

ized in the form of lower taxes (say, in the form of a tax credit). If the individual chose to remain uninsured, the subsidy would be sent to a safety net agency in his or her community (see figure 23.5a). Such an arrangement is a system under which the uninsured as a group pay for their own free care. The very act of turning down a tax credit by choosing not to insure would impose on the uninsured taxes exactly equal to the average cost of free care given annually to the uninsured (see figure 23.5b).[15]

FIGURE 23-5a

The $1,000 Federal Guarantee

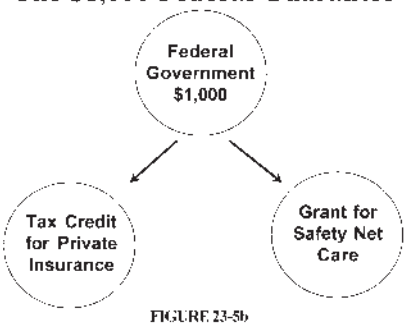


FIGURE 23-5b

The Marginal Effect of Choosing to be Uninsured

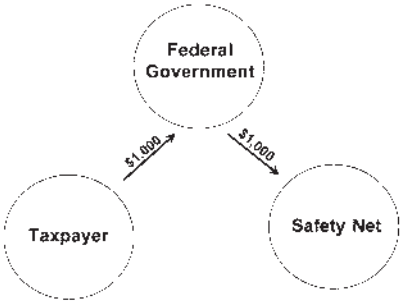
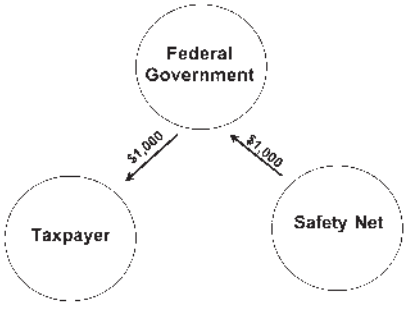


FIGURE 23-5c

The Marginal Effect of Choosing to be Insured



Characteristic No. 5: The Subsidies for the Insured Should, at the Margin, Be Funded by Reducing Spending on Free Care for the Uninsured

How should we fund subsidies for those who choose to move from being uninsured to insured? The answer: at the margin, the subsidy should be funded by the reduction in expected free care that person would have consumed if uninsured, no more and no less.

Suppose everyone in Dallas County chose to obtain private insurance, relying, say, on a refundable $1,000 federal income tax credit to pay the premiums. Dallas County no longer would need to spend $1,000 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 (see figure 23.5c).

How could this scheme be implemented? Since 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 Texas for Medicaid and other programs. This arrangement is a system in which people who leave the social safety net and obtain private insurance 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 exactly equal to the private insurance tax subsidy.[16]

Characteristic No. 6: Subsidies for Being Insured Should Be Determined Independently of How the Insurance Is Purchased

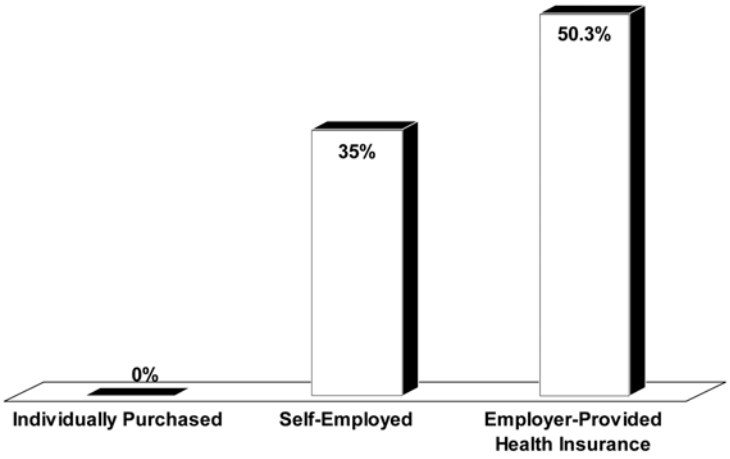
The American health care system is largely an employer-based system; more than 90 percent of people with health insurance obtain it from an employer. In recent years many have questioned the wisdom of having employers choose health plans for their employees. Interest in a personal and portable insurance has increased, and many individuals would prefer to take their insurance with them as they change jobs and have employers make defined-contribution premium payments to the plans their employees choose.

These issues should be resolved in the marketplace, rather than by the tax-writing committees of the U.S. Congress.

Figure 23.6 shows that a typical middle-income family with employer provided coverage gets a tax subsidy equal to about half the cost of insurance. By contrast, families who purchase their own insurance get virtually no relief under the tax law. An ideal system would give the same tax relief, regardless of how the insurance is purchased (see figure 23.7). If the playing field were level under tax law, the employer's role would be determined through competition and choice.

FIGURE 23-6

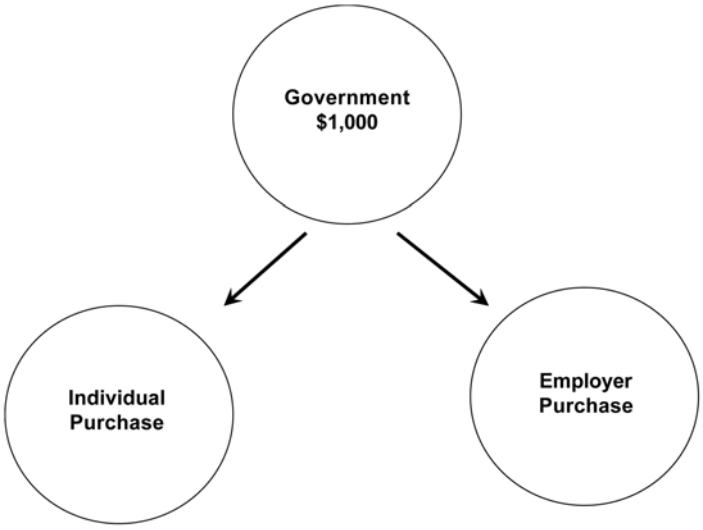
Federal and State Tax Subsidies for Private Insurance



Note: Assumes taxpayer is in the 28 percent federal income tax bracket, faces a 15.3 percent payroll (FICA) tax and a 7 percent state and local income tax.

FIGURE 23-7

Government Neutrality toward How Health Insurance Is Purchased



Characteristic No. 7: The Optimal Number of Uninsured Is Not Zero

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 we are socially indifferent 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 we induce 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 we satisfy this condition, 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 our example, the government guarantees that $1,000 is available, depending on the choice of insurance system. From a policy perspective, we are indifferent about the choice people make.

Characteristic No. 8: The Principles of Reform Apply with Equal Force to All Citizens, Regardless of Income

None of the first six points is in any way dependent for its validity on the income of the person who elects to be insured or uninsured. As a practical matter, one could argue that the high-income uninsured are likely to pay more out-of-pocket (get less free care) than the low-income uninsured, and therefore their reward/penalty should be smaller. Against that is the observation that high-income people (because of greater sophistication) are more adept overall at spending other people's money once they enter the health care system.

Waiving these considerations, a $100,000-a-year family can generate hospital bills it cannot pay almost as easily as a $30,000-a-year family, and our social interest in whether someone is insured is largely independent of income. For this reason as well as practical considerations, the tax credit should be independent of income.[17]

Characteristic No. 9: Health Insurance Subsidies Need Not Add to Budgetary Outlays

A common misconception is that health insurance reform costs money. For example, if health insurance for forty million people costs $1,000 a person, some conclude that the government would need to spend an additional $40 billion a year to get the job done. But we already spend $40 billion or more

on free care for the uninsured, and if all forty million uninsured suddenly became insured they would—in that act—free up the $40 billion from the social safety net.

At $1.5 trillion 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. As Gene Steuerle has shown, we can simply make some portion of people's tax liability contingent on proof of insurance.[18] Getting all the incentives right may involve shifting around a lot of money (i.e., reducing subsidies that are currently too large and increasing subsidies that are too small), but it need not add to budgetary outlays.

For families who already pay substantial federal income taxes, the trick is to make some portion of tax liability contingent on proof of insurance. For example, the child credit (originally $500 per child, scheduled to rise to $1,000) could be tied to proof of insurance. Families that fail to provide proof would lose the credit and pay an additional $1,000 per child in taxes. Similarly, $1,000 of the personal exemption could be tied to proof of insurance.

Families who have children and earn between, say, $10,000 and $30,000 a year generally qualify for the Earned Income Tax Credit (EITC). Even though they owe no income tax, these families can complete a tax return and get a "refund" of as much as $3,000 or $4,000 per year from the Treasury. The payments also could be contingent on proof of insurance, including enrollment in Medicaid, S-CHIP, an employer plan or a privately purchased plan.

Characteristic No. 10: The Federal Government's Role Should Remain Strictly Financial

Currently, the federal government "spends" more than $141 billion a year on tax subsidies for employer-provided insurance. However, the tax code says almost nothing about what features a health insurance plan must have in order to qualify for a tax subsidy.[19] Insurance purchased commercially, around two-thirds of the total, is regulated by the state governments. The federal tax subsidy applies to whatever plans state governments allow.[20]

In this sense, the federal role is strictly financial. 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 our example, the role of the federal government should be to insure that $1,000 is available. It should leave the particulars of the insurance contract to

the market and the decisions about safety net health care to local citizens and their elected representatives.

IMPLEMENTING REFORM

Reform of the U.S. health care system is less complicated than it at first might appear. The building blocks of an ideal system are already in place. The federal government already generously subsidizes private health insurance as well as safety net care. The main problem of the current system is its perverse incentives.

One could reasonably argue that government is doing more harm than good, that a laissez faire policy would be better than what we have now. Nonetheless, if government is going to be involved in a major way in our health care system we should act quickly to replace perverse incentives with neutral ones. In particular,

- 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.
- Government policy also should be neutral between individual and employer purchase, allowing the role of the employer to be determined by individual choice and competition in the market place.

If we applied these two principles and no others, we would go a long way toward creating an ideal health care system.

NOTES

1. Robert J. Mills and Shailesh Bhandari, "Health Insurance Coverage in the United States: 2002," Current Population Reports P60-223, U.S. Census Bureau, U.S. Department of Commerce, September 2003; Bureau of the Census, "Health Insurance Coverage—1993," Statistical Brief, SB/94-28, U.S. Census Bureau, U.S. Department of Commerce, October 1994.

2. John C. Goodman, "Characteristics of an Ideal Health Care System," National Center for Policy Analysis, NCPA Policy Report No. 242, April 2001.

3. Jill M. Yegian et al., "The Nonpoor Uninsured in California, 1998," *Health Affairs* (July/August 2000).

4. Melinda L. Schriver and Grace-Marie Arnett, "What States Can Teach Congress about Health Care Regulation," Heritage Foundation, Backgrounder No. 2107, July 23, 1998.

5. John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 134, November 1988.

6. Frank A. Sloan and Christopher J. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry* 3 (1998): 280–93.

7. Gail A. Jensen and Michael A. Morrisey, "Mandated Benefit Laws and Employer-Sponsored Health Insurance," *Health Insurance Association of America,* January 1999.

8. A group health plan can exclude preexisting medical conditions from coverage for no more than twelve months except when individuals enroll after the open enrollment period. Exclusions on the latter can apply for eighteen months.

9. Jack Hadley and John Holahan, "How Much Medical Care Do The Uninsured Use, And Who Pays For It?" *Health Affairs* (February 12, 2003) (Web Exclusive W3-66).

10. Health Care Financing and Organization: News and Progress (March 2000): 5–6.

11. "Indigent Care: Insurers Are 'Overhurdened and Threatbare,'" *American Health Line* (March 31, 2000), reporting the conclusions of Marion Ein Lewin and Stuart Altman, eds, *American Health Safety Net: Intact but Endangered* (Washington, D.C.: National Academy Press, 2000).

12. Lewin Group estimates using the Health Benefits Simulation Model.

13. An ideal subsidy would not distort decisions at the margin. People would be able to choose on a level playing field between health care and nonhealth care and between health care today and health care tomorrow. See Mark V. Pauly and John C. Goodman, "Tax Credits for Health Insurance and Medical Savings Accounts," *Health Affairs* 14, no. 1 (Spring 1995): 126–39.

14. Low-income families who do not otherwise owe any federal income tax will not literally be paying their own way. But in forgoing, say, a $1,000 refundable tax credit they will be making a decision that allows the $1,000 to be deposited in a local safety net.

15. To our knowledge, this idea as first proposed in John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, D.C.: Cato Institute, 1992). Also, see Lynn Etheredge, "A Flexible Benefits Tax Credit for Health Insurance and More," *Health Affairs,* special Internet-only publication, available at www.healthaffairs.org/2003Etheredge.pdf.

16. Some patients may be high cost. In a private insurance market, insurers will not agree to insure someone for $1,000 if his or her expected cost of care is, say, $5,000. But if the safety net agency expects a $5,000 savings as a result of the loss of a patient to a private insurer, the agency should be willing to pay up to $5,000 to subsidize the private insurance premium.

17. Society has no reason to care whether Bill Gates is insured. So there could be an income or wealth threshold beyond which the subsidy/penalty system does not apply. However, as a practical matter so few individuals would qualify for an exemption that uniform treatment is administratively attractive.

18. C. Eugene Steuerle, "Child Credits: Opportunity at the Door," Urban Institute, 1997. Although Steuerle does not say so, one way to insure is to self-insure. So proof of insurance could include evidence of a self-funded Health Savings Account.

19. The exceptions are mandated maternity coverage, federal mandates requiring a forty-eight-hour hospital stay after a well-baby delivery if requested by patient and physician, and mandated mental health parity.

20. M. Susan Marquis and Stephen H. Long, "Recent Trends in Self-Insured Employer Health Plans," *Health Affairs* 18, no. 3 (May/June 1999): 161–66.