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Goodman, Part III: Health-Insurance Tax Credits Are "A Financial Mandate"

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Last year, I sat down with Goodman in the Cato Institute's Hayek Auditorium to discuss his latest book on health reform: A Better Choice: Healthcare Solutions for America(Independent Institute, 2015). Video of the event is availablehere.

This is part three of a (lightly edited) transcript of our conversation. Click here for parts one and two.

MICHAEL F. CANNON: Let's move on to your proposals now.

One of the principles that you lay out of your book is universal coverage. My question is, if we say that it's the government's role to provide universal health insurance or universal access to medical care, won't the government's role in health care continually increase? Won't advocates of more government spending on health care always win because they can say, well, we're going to make health care more universal by spending more?

JOHN C. GOODMAN: Well, let me just back up to a more fundamental point.

I think that health care is not like other goods and services. If someone doesn't have a house, we don't feel like we have to provide them with a house. If someone doesn't have food, we don't think we have to provide him with a steak dinner. Health care is different in this country. We just are not going to let hospitals throw people out on the street because they can't pay their bill. So health care is different. We're all going to be involved in paying for the care of people who can't pay for their own.

So if that is where we start, then what I would advocate is to make the role of government as small as we can possibly make it. So let's, pick a number, I would say $2,500 for an adult and, $8,000 for a family of four. That's what it costs on average, according to the Congressional Budget Office, to put new people into Medicaid.

So that would be my tax credit and it would be very much like the child tax credit. If you have health insurance, you get your $2,500 and that's all you get. That would buy you Medicaid-like

insurance and if you want more or better insurance you could add your own dollars or your employer's after-tax dollars. I think this converts a lot of money that's out there now being controlled by bureaucratic institutions in a very inefficient way into something that even the poorest people can participate in a real marketplace.

Now, once you have a credit there can be pressure to raise the credit, but that pressure would be counterbalanced by other budgetary needs. You'd think that, there would be pressure every year to raise the child tax credit, but it hasn't gone up and it's not indexed. It stays at $1,000. Anyway that's the model.

CANNON: About the credit, there's more than one way to use a tax credit for health insurance to increase the government's role. You and I have debated this, and so I want to pursue it a little.

My question is, isn't a health-insurance tax credit a lot like the individual mandate? Under a health-insurance tax credit, as you mentioned the book, if you don't buy what the government considers acceptable health insurance, you pay more in taxes; your tax liability is higher. But if you do buy the type of health insurance the government considers acceptable, you pay less money to the government—$2,500 or so.

GOODMAN: That's right.

CANNON: That's remarkably similar to an individual mandate, or at least it seems so to me.

I want to get your thoughts on that, and also if you could, isn't the same dynamic present under both a health-insurance tax credit and an individual mandate where, there is an incentive for special-interest groups to get the government to require you to purchase more and more stuff—their stuff—either to avoid the penalty or to get the credit?

GOODMAN: Think about how the health care system is right now. If you, through your employer, have health insurance you pay lower taxes. So, all of you have an incentive to take advantage of that opportunity. Now if you don't do it, you don't get insurance, you're going to pay higher taxes. So we already have a mechanism in which 150 million people at work are paying lower taxes because they took advantage of that provision in the tax law. And there are other people at work and not at work who are paying higher taxes because they didn't take advantage of that opportunity.

If you want to call my tax credit a financial mandate, I'm fine with that. The flip side of a subsidy is always a penalty. If you don't take advantage of the subsidy, then you will pay a penalty.

And let me just say something about where I think that penalty should go. I think we should offer everybody a universal health-insurance tax credit: $2,500 per adult and $8,000 for a family of four. There will be people who turn it down. There are millions of people turning the ObamaCare subsidies down. Of course, what ObamaCare has done is tell them what they have to buy, and what they have to buy is not attractive. I'm not going to tell them what to buy. I'm just going to say: as long as it's a credible insurance, you get your subsidy.

So what do we do about those people who turn us down? If people turn us down, where does the money go? Well, under ObamaCare and under most Republican proposals, if someone doesn't claim a tax opportunity, the money stays in the Treasury.

Instead, I'm saying that some portion of that money should go to local safety-net institutions. So money would follow people. If everybody in Dallas County decides to get health insurance, which is what we hope they would do, then the subsidy dollars go for private health insurance. But if everybody in Dallas decides to be uninsured, then some portion of those unclaimed credits would go to safety-net institutions.

And that's what I mean by universal coverage. No matter how you decide, you're not going to be out on the sidewalk if you can't pay your medical bill. It minimizes the role of government, ensures that there's something there that encourages you to be private. But if you decide not to, there's something like a backstop if you can't pay for your own medical care.

CANNON: About the spending, that seems like a very clean way for the federal government to allocate spending between safety-net hospitals and people who purchase their own health insurance. If you take the credit, you get the money. If you don't, the safety-net hospital gets the money.

But if half the people in Dallas took the credit in the first year, and then in the second year everyone bought health insurance and took the credit, would the safety-net hospitals just give up that money? Would it work that neatly? Or would hospitals lobby to preserve the subsidies they had been receiving? If so, the government's influence over the health sector, the subsidies that it's providing, would go up by 50 percent.

GOODMAN: It's always a possibility that people are going to lobby in their own self-interest. But what I'm talking about is reforming a system under which there's no clear reason why hospitals get money. Right now it's all political. It's all influenced by lobbying. Let's turn it into something that is more rigid than that. And the rigid form that I'm suggesting again is that money follows people.

The amount of money that goes to Dallas County for safety-net purposes would be solely a function of the number of uninsured in the Dallas area. Yes, they could lobby and try to get some special deal for themselves. But if we began with a general formula and we all understand what the purpose of law is, it makes it more difficult for people who try to screw it up through lobbying.

CANNON: You mention people lobbying in their own self-interest, and I asked whether provider groups and others would lobby to have their services added to the conditions for receiving a tax credit.

You actually propose in the book conditioning not just a health-insurance tax credit, but the per-child tax credit, the standard deduction, and the earned income tax credit on people having proof of insurance. You suggested the government could condition those tax deductions or credits on people showing proof of health insurance.

If the advocates of free markets are proposing to impose lots of conditions on such tax breaks, wouldn't special interests add even more requirements to a universal health-insurance tax credit?

GOODMAN: What I mean by that is this. I offer you a $2,500 tax credit and you turn me down, then you pay $2,500 more in taxes.

But suppose you don't have any income. Well, then I propose there are other ways that we could impose financial penalties on you. If you are relying on the EITC system and you have children and you didn't insure them you could be penalized. You could have signed them up for Medicaid or SCHIP, or are simply claimed our credit. If you don't then I propose taking some money away from you.

There are other ways to penalize them. I don't want to make a big deal of that, though. I've been helping Congressman Pete Sessions (R-TX) on a bill that I think is pretty free-enterprise. It's pretty clean. We don't have all that stuff in it. It is just $2,500 for an adult, $8,000 for a family of four. This is what you get, if you get health insurance. If you don't, you don't get it.

CANNON: One of the things that people could do with the tax credit under your proposal is they could buy Medicaid coverage. You could buy into Medicaid regardless of their income. They could take that tax credit and say, I want that applied to Medicaid coverage for me and my family. Just as they could say, I want the tax credit applied to private insurance. Does that make Medicaid a public option under your plan?

GOODMAN: You know, I was willing to make this concession to the Left.

I just mentioned I'm helping Pete Sessions with a health bill; that's not in his bill. He allows people to leave Medicaid, he doesn't allow the rest of us to join if we want to.

But if it takes this to get the Democrats to sign on, I don't see what we have to fear. Their plan is Medicaid and that's their safety-net plan. If a private insurer can't compete against Medicaid, there's something wrong with that private insurer. So yes, I would let even Bill Gates join Medicaid, but if he has to pay the full price. We're not going to let him go in at a reduced rate. But if he wants to wait in line for his care, if he wants to be in a plan, knowing that a third of the doctors in Seattle don't take Medicaid, why not? But most people are going to want better than that.

CANNON: You and I were talking out in the hall about the paper that Cato published by John Cochrane titled, "Health-Status Insurance: How Markets Can Provide Health Security," and how that is the most important paper Cato has published on health policy—at least since I've been here, I've been here for 12 years—because of the insights he has about how markets would innovate to make health insurance more secure.

Cochrane and I were a couple of economists coming up with a title for that paper. We ended up calling it "health-status insurance," because we don't know how to market things. Since then, I've given it some more thought. I think a better way to describe the innovations he foresees is "health insurance with a total satisfaction guarantee."

I could talk about why that is. But his argument is that this innovation would emerge spontaneously. Health insurance would become more secure, particularly for the sick, because such innovations will emerge spontaneously if government just gets out of the way.

In your book, you talk about how the government should require or direct that process. Why the difference?

GOODMAN: Because we have to start where we are now. And where we are now is not just government getting out of the way. And we're not going to ever do that. Government is not going to say, "OK all bets are off. You sick people are out there on your own. Let's hope the market takes care of you." You have to start where you are now and move to the better place. And John Cochrane and I discussed this.

Here's the key: you cannot allow one plan to dump its sick people on another plan. That is the bottom line principle that gets to the heart of everything that's going wrong now and what has to be corrected. Under ObamaCare, the states were allowed to dump their sick people into the Exchange. The city of Detroit was able to dump its more costly, older workers into the Michigan Exchange. You just can't allow a plan to do that. And remember, earlier I said that the plans were trying to avoid the sick. Once they are enrolled, the plans have incentives to try to chase them away. You just cannot allow that to happen.

So how do we stop that from happening? Again, you have to have a mechanism so that if somebody leaves my plan and they go to Michael's plan—and this person could be a very sick person—and that person moves from a silver to silver plan, he pays the same silver premium as everyone else in Michael's plan pays. But then I have to top it up, and so that what Michael gets is an actuarially fair premium. I now have an incentive to take more care of that patient, than under ObamaCare.

Also, once actuarially fair premiums are going to be paid, plans can specialize. You could specialize in cancer care, AIDS care, heart care. That's exactly what would happen. We would have a market for sick people with all the innovation that you're imagining. And you could have special relationships. You could have Cancer Treatment Centers of America say to Blue Cross, "We will take all your cancer patients." In fact, they almost did a deal like this with Kaiser and came very close, but didn't work out. But that's what we want, a market for sick people. We want the providers to have good incentives and then they'll be competing on price and quality and access.

CANNON: Two more questions.

You write that there is bipartisan agreement that the tax-credit approach is better than all the others. The Republican presidential candidate with the most health policy experience by far is Louisiana Governor Bobby Jindal. He would disagree that the tax credit approach is the best approach. He proposes a standard deduction for health insurance, rather than a tax credit. What would you say to Governor Jindal?

GOODMAN: Well, it satisfies the one thing that the economists want, and that is it limits the amount of subsidy that anybody can get. The problem with the current system is that the subsidy is unlimited. So, if I'm in the 50-percent tax bracket and I'm spending $20,000 on my health insurance, the government's paying for half of it. So health insurance only has to be worth 51 cents to me in order for me to want to spend a dollar on it. That's the perversion in the current system.

So what Jindal is talking about is, having some standard deduction for health insurance. It's just another way of saying you're going to get a certain number of dollars. It's going to be pretty much the same for everybody, and that's it. That part of it is good. What's not good about that approach is that if you don't pay income taxes, the standard deduction is not worth anything. And half the population basically isn't paying income taxes, or not enough for that to matter. We leave out everybody that ObamaCare is focused on anyway.

Also, a standard deduction is worth more to people in higher tax brackets. The way we subsidize health insurance today, through the tax system, is very, very regressive. The higher your marginal tax rate, the bigger the subsidy you get. We're giving most of the subsidies to people who don't need them. I'm going to sound like a progressive or liberal here, but we're giving away a lot of money and not getting anything accomplished. We're giving away money to people who would have purchased insurance anyway.

Either you have to decide the government has a role here or it doesn't. In an ideal world, we would separate government and health care in the same way we separate the state and religion. But if that's not possible, and if government is going to be involved, then I say let's minimize the role of government. Make it as small as possible. Make it is as unobtrusive as possible. Get rid of all the perverse incentives and let individual choice and markets work.

CANNON: And then finally, in your book you write that under your proposals, everyone's economic incentives are ideal and your proposals will lead to high quality affordable health care for all.

Are you over-promising? Are there drawbacks to your proposals? Who are the losers under your proposal?

GOODMAN: I'm glad you asked that question. The way Republicans think about the world is the same way Democrats do. They think there's always going to be winners and losers. Think about what Speaker of the House Paul Ryan (R-WI), proposes for Medicare and Social Security. People who are seniors now, can stay where they are, but in the future we're going to cut the benefits. And so there are winners and losers in those reform plans. I am now writing a book which is totally focused on win-win solutions to entitlement programs.

Once you understand how much inefficiency there is in the system, I think it's possible to create reforms under which everybody is better off. I can't guarantee that we will get 100-percent there, but I think a strong case can be made that you can design reforms so that a broad group of people think, "Okay, I think I'd be better off."

Let me just give one example. Let's say that I am rich and the C.E.O. of my company. I'm in the 50-percent tax bracket, and my employer buys $20,000 worth of health insurance for me and my family every year. Since I'm in the 50-percent tax bracket, I'm getting a $10,000 subsidy. But to get the subsidy I have to buy $20,000 worth of insurance. Now Goodman comes along and says we're not going to let you have $10,000, we're only going to give you $8,000. That's all you're going to get. So initially it looks like I'm worse off. But with Goodman's plan I get the eight for the first $8,000 that I spend and that next $12,000 is all after-tax. So if I can figure out a way of cutting down on costs. If I can find some efficiencies, every dollar I save I get to take home. I

don’t have to share half of it with the government. So, I think that even people who look like they’re going to lose under what we’re talking about here could turn out to be gaining.

That’s what I mean by win-win.

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