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Statement to the Senate Finance Committee Hearing: “The Rising Cost of Health Care: Considering Meaningful Solutions for All Americans”

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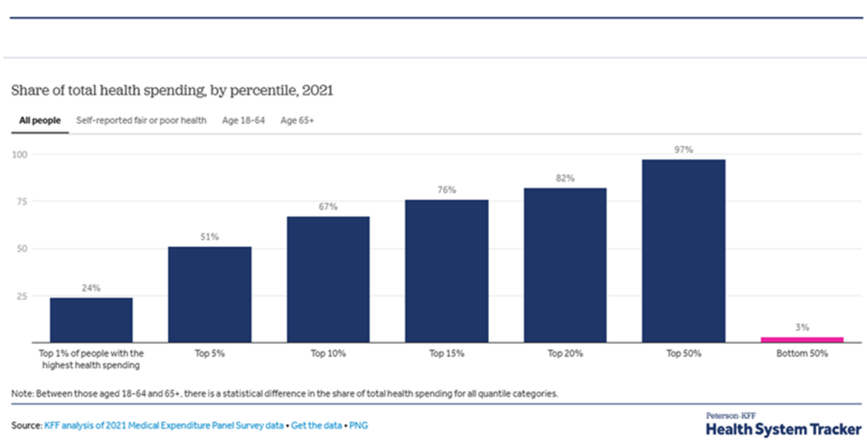
***The trouble with Trump’s cash-for-care idea*:**

Why Substituting Cash for Insurance Can Drive Up Both Total Costs *and* Individual Medical + Financial Risk

President Trump and many Republicans have proposed sending Americans cash instead of offering subsidized health insurance in ACA exchanges. Congress should exercise caution before taking this leap.

Insurance risk pools deteriorate with the departure of healthy, low-cost members, thereby driving up premiums and making coverage less affordable in the long run. As some sponsors of private-sector plans have no doubt experienced, providing individuals with a choice between cash and health insurance can result in total higher total costs. And some cash recipients may later face unexpected catastrophic medical costs they cannot afford to pay.

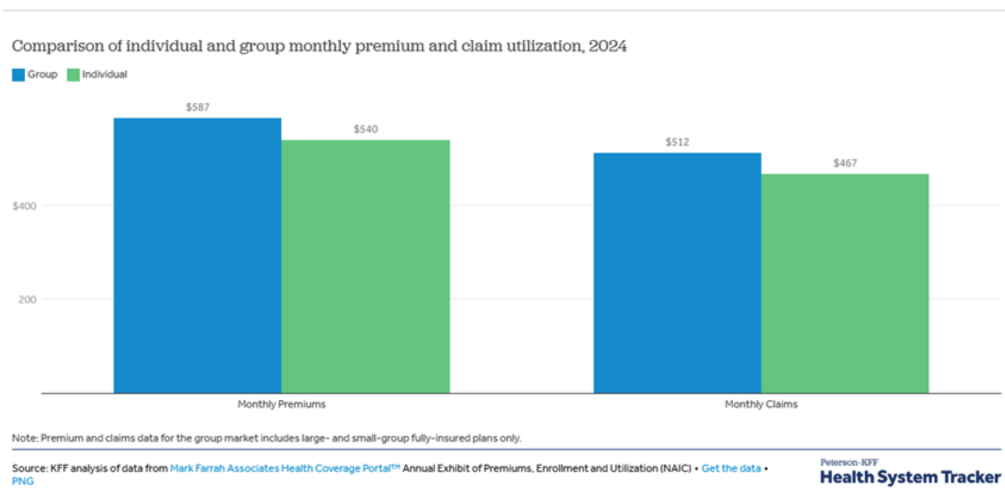
In rare cases, insurance companies could enjoy a windfall profit if enough cash recipients miscalculate and end up having high medical costs in the coming year. This can happen because in insurance risk pools, a small minority of people with expensive conditions drives most of the costs. Cash recipients who are fortunate enough to not need medical care can end up financial winners.



To avoid costly mistakes, policymakers need to understand how health care deviates from the classic classroom interaction of demand and supply. In contrast to more "competitive" markets (food for example), the intertwined markets for medical care and health insurance are fraught with peculiarities that economists call "market failures."

One of these deviations is "adverse selection," which stems from differences in information between buyers and sellers that result in distorted prices. People choosing health insurance plans know more about their own medical problems than insurers selling coverage, which can cause insurers to raise prices to cover the uncertainty of the resulting financial risk. Averse selection can unravel a health insurance plan. Unless bound together by a plan sponsor – typically an employer or the government – healthy individuals have an incentive to forego the cost of coverage and take the risk of being uninsured.

If food markets were prone to adverse selection, giving people food stamps – a cash equivalent – could experience similar problems. How efficient would it be if the government provided all poor citizens with a year's worth of food stamps on Jan. 1 if only half of all people needed to eat during the coming year?



Another imbalance is that doctors and hospitals know much more about medical care than patients, putting them in stronger position to influence prices. Along with this "asymmetry of information," the medical profession, hospitals, and insurance companies command financial resources that dwarf the bargaining power of ordinary consumers. How long can a tourist with $6,000 stay in a poker game against a Vegas or Jersey casino?

In the simple illustration below, adverse selection results in an 8.2% increase in total costs one year after the program sponsor offers a $6,000 cash equivalent to 100 insured employees. Total cost for the group rises from $690,000 to $746,550. This happens because the cash provided to 10 healthy employees opting out of the insurance pool is much greater than a slight savings from their leaving the insured group. The five people whose medical care makes up half the group's claims are most likely to stay insured.

Example:

Initial impact of cash-or-insurance option: group of 100*

Year 1: **All 100 members are insured. None receive a cash alternative.**

Total medical claims: $600,000 (assuming average of $6,000/person.)

Total insurance costs (add 15% to claims): $690,000

Total employer/sponsor expense: $690,000

Year 2: **Employees are offered the option of $6,000 in cash instead of health insurance. Ten people – likely among the healthiest, most affluent – choose the cash. Those with expensive chronic conditions or high expected medical costs are unlikely to opt out of insurance.**

Total medical claims: +/- $597,000 (small savings due to healthy people dropping out)

Total insurance costs: $686,550

+ Total cash expenditure: $60,000

Total expense: $746,550

**** This illustration assumes a "typical" claims cost distribution based on national data: 1 employee with cancer: $150,000; five employees with the most medical expenses: $300,000; 20 employees with most expenses: $500,000; the least expensive 50% cost a total of $18,000.***

What Happens in Year 3 and Beyond

Unless one of the people opting for cash develops an expensive illness, in the second year of the new program more of the healthiest are likely to opt for cash, thereby leaving a more compromised risk pool. If the plan sponsor finds that total costs have gone up, he or she may consider design features to prevent further losses and the prospect an insurance death spiral.

Sponsors also may alter the parameters in response to the small chance that someone opting for cash instead of insurance came down with an expensive illness and complained that the program caused financial hardship or left them with untreated medical needs. To mitigate the risk of participant bankruptcy, the sponsor might reduce the amount of cash, pairing it with catastrophic or high-deductible insurance. Such a modification could resemble the existing combination of health savings accounts (HSAs) and high-deductible coverage already offered by many employee health plans.

In the above illustration, a cash/insurance hybrid could stabilize the risk pool -- and still result in higher total program costs than before. It also would make the new program much more complex and need careful management – at a level beyond what a federal government agency might be expected to provide. More complexity is certainty not what Trump and Republican policymakers promoting the cash-for-coverage idea have in mind.

No matter how many adjustments the government might make, giving people money to leave the risk pool and bargain on their own with the players in health system undermines the basic concept of insurance – which is pooling risk and resources to make hard-to-predict future expenses more affordable.

Karl Polzer is founder of the Center on Capital & Social Equity, which explores economic inequality and advocates for the 'bottom 50%'. He has been analyzing health policy for 40 years.

Sources:

Adverse Selection Explained: Definition, Effects, and the Lemons Problem

2025 Employer Health Benefits Survey | KFF

How ACA Marketplace costs compare to employer-sponsored health insurance - Peterson-KFF Health System Tracker

How do health expenditures vary across the population? - Peterson-KFF Health System Tracker

High deductible health plans and health savings accounts : U.S. Bureau of Labor Statistics

ff-457-highcostclaimants-9mar23.pdf

average number of pregnancies among working population each year - Search

average cost of pregnancy and birth for working woman claims - Search

Fast Facts: Health and Economic Costs of Chronic Conditions | Chronic Disease | CDC

Estimating diabetes mellitus incidence using health insurance claims data: A database-driven cohort study - PMC

Chronic Conditions in the US Workforce: Prevalence, Trends, and Productivity Impacts

Financial Burden of Cancer Care | Cancer Trends Progress Report