

All the President's Mandates Compulsory Health Insurance Is a Government Takeover

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Executive Summary

The most hazardous health reform measure before Congress is not the so-called “public option,” but proposals to make health insurance compulsory via an individual or employer mandate.

Compulsory health insurance could require nearly 100 million Americans to switch to a more expensive health plan and would therefore violate President Barack Obama’s pledge to let people keep their current health insurance. In particular, the legislation before Congress could eliminate many or all health savings account plans. Making health insurance compulsory would also spark an unnecessary fight over abortion and would enable government to ration care to those with private health insurance.

Obama adviser Larry Summers writes that mandates “are like public programs financed by benefit taxes,” meaning that compulsory health insurance would also violate President Obama’s

promise not to increase taxes on the middle class. Under the House Democrats’ legislation, some middle-income earners would face marginal tax rates over 50 percent (before state taxes).

The experience in Massachusetts belies the claim that compulsory health insurance brings down health care costs. The “shared responsibility” ruse allows Massachusetts politicians to declare success for a compulsory health insurance scheme whose actual costs reveal it to be a failure. Massachusetts also demonstrates that compulsory health insurance enables, and ultimately requires, politicians and government bureaus to control nearly all aspects of health care and medical practice.

Rather than make health insurance compulsory, Congress should make it more affordable by letting individuals control their earnings and choose their own health plan from any state in the Union.

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Compulsory health insurance is a species of national health insurance, not an alternative to it.

Introduction

Amid negotiations over health reform legislation, Senate Finance Committee ranking member Sen. Chuck Grassley (R-IA) commented: “The federal government is in the process of nationalizing banks [and] nationalizing General Motors. I’m going to make sure we don’t nationalize health insurance, and [a] ‘public option’ is the first step to doing that.”¹ Yet Congress can also nationalize health insurance simply by making it compulsory.

The most hazardous health reform measure before Congress is not the so-called “public option” but proposals to make health insurance compulsory for most or all U.S. residents. All leading Democratic reform proposals—including legislation reported by three key House committees² and the Senate Health, Education, Labor, and Pensions Committee,³ as well as proposals forwarded by Senate Finance Committee chairman Max Baucus (D-MT)⁴ and President Barack Obama⁵—would require U.S. residents to obtain health insurance either on their own (an “individual mandate”) or through an employer (an “employer mandate”). In 2006, Massachusetts enacted both measures.⁶

Compulsory “private” health insurance would give government as much control over the nation’s health care sector as a compulsory government program. The non-partisan Congressional Budget Office explains that making health insurance compulsory would mark a radical change in the relationship between American citizens and their government:

A mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action. The government has never required people to buy any good or service as a condition of lawful residence in the United States. An individual mandate would have two features that, in combination, would make it unique. First, it would impose a duty on individuals as members of society. Second, it

would require people to purchase a specific service that would be heavily regulated by the federal government.⁷

This paper draws from the legislation before Congress and the experience in Massachusetts to show that compulsory health insurance is in fact a species of national health insurance, not an alternative to it.

First, making health insurance compulsory would give government sweeping new powers to regulate health insurance, and, by extension, all of medicine. As in Massachusetts, those powers would increase costs and reduce choice by eliminating low-cost health plans—forcing nearly 100 million Americans to switch to a more expensive plan. For example, the various bills before Congress could force many or all of the 8 million Americans with health savings account coverage to switch to another plan. In the process, compulsory health insurance would inevitably and unnecessarily open a new front in the abortion debate, one where either side—and possibly both sides—could lose. Compulsory health insurance enables, and ultimately would require, politicians and government bureaus to control nearly all aspects of health care and medical practice.

Second, the “duty” to purchase health insurance, whether directly or through an employer, is itself a tax on workers—a point that the president’s own advisers concede. Making health insurance compulsory for middle-income earners would therefore violate the president’s pledge not to tax the middle class. The fact that compulsory health insurance is a hidden tax makes it particularly pernicious, because it enables politicians to impose a heavier tax burden than voters prefer. The size of that tax would be substantial and likely to outweigh any benefit in terms of reducing uncompensated care.

Rather than impose a compulsory health insurance scheme of dubious constitutionality⁸ and subsidize private insurers even more heavily than they already are, Congress should reduce the number of uninsured by making health insurance more affordable. Congress can do so by letting individuals control their

earnings and choose their own health plan from any state in the Union.

“Heavily Regulated by the Federal Government”

The Massachusetts experience demonstrates that on a national level, compulsory health insurance would effectively prohibit low-cost health plans and force tens of millions of already insured Americans—in particular those with HSA plans—to purchase more expensive coverage. Massachusetts further demonstrates that the power to control the terms of all private health insurance policies enables, and would ultimately require, politicians and government bureaus to control nearly all aspects of health care and medical practice. That includes the power to ration care to Americans with private health insurance.

Prohibiting Low-Cost Coverage

When government makes health insurance compulsory, it must define a level of coverage that satisfies the mandate, so that people will know if they are complying with the law. The necessity of specifying what constitutes “qualified” coverage gives politicians the power to dictate the terms of every American’s health insurance policy—a power that health care providers inevitably capture and use to increase the required level of insurance. After former Gov. Mitt Romney (R) made health insurance compulsory in Massachusetts, lobbyists, politicians, and government bureaus soon made the mandatory level of coverage more expensive by requiring consumers to purchase coverage involving

- Prescription drugs
- Preventive care
- Diabetes self-management
- Drug-abuse treatment
- Early intervention for autism
- Hospice care
- Hormone replacement therapy
- Non-IVF infertility services

- Orthotics
- Prosthetics
- Telemedicine
- Testicular cancer
- Lay midwives
- Nurses
- Nurse practitioners
- Pediatric specialists
- Limits on cost-sharing (e.g., maximum deductibles no higher than \$2,000 for individuals and \$4,000 for families)
- A ban on per-illness or per-year caps on total benefits, and
- A ban on coverage providing a “fixed dollar amount per day or stay in the hospital.”⁹

In a sign that the mandatory level of coverage will grow even more expensive over time, Massachusetts legislators have already introduced legislation that would require residents to purchase more than 70 additional types of coverage.¹⁰

“The effect,” writes the *Boston Globe*, “has been to provide more comprehensive insurance than in most other states but also to raise costs.”¹¹ A study by Massachusetts’ Division of Health Care Finance and Policy estimated that such requirements can increase the cost of insurance by 14 percent,¹² or nearly \$1,700 per year for family coverage.¹³

Ousting Millions from Their Current Health Plans

On a national level, compulsory health insurance would increase health insurance premiums for tens of millions of Americans. During the presidential campaign, candidate Obama hinted at a mandatory level of benefits that could require nearly 100 million individuals to switch to a more expensive health plan. Obama said he would require employers to offer “meaningful” coverage to their workers, which he defined as coverage at least as good as what members of Congress get through the Federal Employees Health Benefits Program.¹⁴ According to an analysis of Obama’s campaign proposal by former Medicare administrator Gail Wilensky and colleagues:

Compulsory health insurance would effectively prohibit low-cost health plans.

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The most popular FEHB plan [is] the Blue Cross Blue Shield Standard Option. . . . If the [minimum benefits package] is similar in coverage and cost to the \$12,000 a year Blue Cross plan, the premiums would not be affordable for many families. . . . Families would not be able to purchase less-expensive coverage, since all other insurance would be required to offer benefits at least as generous. . . . Senator Obama could . . . peg benefits to a lower standard . . . but [that] is probably not what the candidate's political base thinks he has promised.¹⁵

The mean and median premiums for employer-sponsored family coverage in the same year (2008) were just over \$12,000,¹⁶ which suggests that Obama's definition of "meaningful" coverage could eliminate the health plans that now cover as many as half of the 163 million Americans with employer-sponsored insurance as well as more than half of the roughly 18 million Americans who obtain health insurance on the individual market,¹⁷ where coverage is typically 30 percent less comprehensive.¹⁸ Any politically plausible mandate could therefore compel close to 100 million Americans to switch to a more comprehensive health plan with higher premiums, whether they value the added coverage or not. If history is any guide, the mandatory level of coverage would continue to rise, prohibiting even more low-cost health plans over time.

The legislation before Congress would do the same. For example, the House Democrats' legislation specifies several types of coverage that all individuals must purchase, including

- "Professional services of physicians and other health professionals.
- "Such services, equipment, and supplies incident to the services of a physician's or a health professional's delivery of care in institutional settings, physician offices, patients' homes or place of residence, or other settings, as appropriate.
- "Prescription drugs.

- "Rehabilitative and habilitative services.
- "Mental health and substance use disorder services.
- "Preventive services . . .
- "Maternity care.
- "Well baby and well child care and oral health, vision, and hearing services, equipment, and supplies at least for children under 21 years of age."
- No cost-sharing for preventive services.
- No more than \$5,000 of cost-sharing for individuals and \$10,000 for families.
- A minimum actuarial value of 70 percent.

No doubt each type of coverage is valuable, yet consumers may prefer to pay for those services directly, rather than through the financial instrument of insurance. The House legislation would empower unelected bureaucrats to add to the mandatory level of coverage; emphasize copayments over coinsurance "to the maximum extent possible"; and define such terms as "other health professionals," "incident," and "appropriate."¹⁹ The Senate Democrats' bill would prohibit health plans with actuarial values below 76 percent.²⁰ During his health care address to Congress, President Obama endorsed requiring consumers to purchase coverage with government-imposed limits on cost-sharing and no annual or lifetime limits on benefits.²¹

Like the president's proposed standard, the House and Senate bills would outlaw the low-cost health plans that cover tens of millions of Americans. According to the Congressional Budget Office:

For employment-based plans, actuarial values—expressed as the share of a given population's medical claims that would be covered by the plan—are typically between 65 percent and 95 percent, with an average value that is between 80 percent and 85 percent. Deductibles and other cost-sharing requirements are typically larger for policies purchased in the individual insurance market, where actuarial values generally range from 40

percent to 80 percent, with an average value that is between 55 percent and 60 percent.²²

If forced to purchase coverage with an actuarial value of 70 percent or 76 percent, tens of millions of Americans with employer-sponsored insurance, and nearly all those with individual-market coverage, would be forced to switch to a more expensive health plan.²³ Like premiums, a plan's actuarial value is an imperfect measure of its comprehensiveness.²⁴ Yet both perspectives indicate that compulsory health insurance would increase the health insurance premiums of tens of millions of Americans.

Bye-Bye, HSAs?

One affordable coverage option that the House and Senate bills could eliminate is health savings accounts (HSAs). Congress created HSAs in 2003 to enable consumers to control a greater share of their health care dollars. HSAs allow individuals covered by a qualified health plan to save about \$3,000 tax-free for their out-of-pocket medical expenses. Families covered by a qualified plan can save about \$6,000 annually.²⁵

By design, HSA plans keep premiums low through greater cost-sharing. A self-only, HSA-qualified high-deductible health plan must have a deductible between \$1,200 and about \$6,000, while a family plan must have a deductible between \$2,400 and about \$12,000. Though no reliable data are available, one insurer reports that its HSA-qualified plans have actuarial values in the range of 50–65 percent.²⁶

Since neither the House nor the Senate bill would count HSA contributions toward an HSA plan's actuarial value, those bills could effectively eliminate HSAs and oust an estimated 8 million Americans from those plans.²⁷ In a sign that Democrats intend to curtail HSAs, the House Ways and Means Committee voted to prohibit the use of HSA funds for over-the-counter medications.²⁸ Congressional Democrats have waged similar campaigns against HSAs in the past.²⁹

An Unnecessary Abortion Fight

The power to dictate the terms of every health insurance policy would also spark an unnecessary fight over abortion, one that either camp—and possibly both—could lose.

There are two ways that making health insurance compulsory could force taxpayers to finance abortions, a procedure that many consider to be infanticide. First, Congress could include abortion coverage among the mandatory coverage that Americans must purchase. Second, both the House and Senate legislation would create subsidies to help most Americans purchase the mandatory coverage. If Congress allows consumers to use those subsidies to purchase health insurance that includes abortion coverage, then that too would force taxpayers to fund abortions.

The only way to avoid taxpayer funding of abortions would be to prohibit abortion coverage in any health plan that receives federal subsidies. People who want to purchase abortion coverage would have to buy a separate rider with their own funds. Nineteen pro-life House Democrats wrote to House Speaker Nancy Pelosi (D-CA) that they “cannot support any health care reform proposal unless it explicitly excludes abortion from the scope of any government-defined or *subsidized* health insurance plan.”³⁰ Pro-life Rep. Bart Stupak (D-MI) claims to have lined up as many as 39 House Democrats to vote against any reform bill that allows taxpayer funding of abortions, which could block any reform.³¹ Yet those restrictions would be unacceptable to abortion rights activists. Since the new subsidies would apply to a majority of Americans, those prohibitions could effectively eliminate abortion coverage for many women.

At present, it appears that those who want to force taxpayers to fund abortions could prevail. The Senate Health, Education, Labor, and Pensions Committee defeated several amendments designed to prevent government from forcing individuals to subsidize abortions.³² But that could change. Congress could instead emulate the rule it adopted for the Federal Employees Health Benefits Program in 1995, which prohibits coverage for elective abortions

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in any such health plan.³³ Columnist Michael Gerson writes:

In fact, any national approach to this issue is likely to challenge the current social consensus on abortion. The House bill would result in federal funding for abortion on an unprecedented scale. But forbidding federal funds to private insurers that currently cover elective abortions (as some insurers do) would amount, as pro-choice advocates note, to a restriction on the availability of abortion.³⁴

Such conflict is inevitable when compulsory health insurance gives politicians or government bureaus the power to decide who pays for what medical services.

Government Rationing

The power to dictate the terms of private health insurance policies also gives government the power to ration medical care to non-elderly Americans. Simply by adjusting the definition of qualified health insurance, politicians and government bureaus can engage in both explicit rationing (e.g., denying coverage for specific services and revoking coverage for unpopular groups) and implicit rationing (e.g., via price and exchange controls). Responding to the cost pressures created by its compulsory health insurance scheme, Massachusetts is exploring each of these approaches.

In 2008, the Massachusetts legislature created a commission to suggest ways to reduce health care spending. For example, the legislature asked the commission to devise “evidence-based purchasing strategies,”³⁵ which is jargon for denying coverage for particular services. If a particular service does not offer sufficient benefit to the average patient to satisfy a state-appointed rationing board, then politicians or government bureaus would deny coverage for that service within government programs, and could discourage private insurers from covering those services.

The legislature also asked the commission to “recommend a plan for the implementa-

tion of the common payment methodology across all public and private payers in the commonwealth.”³⁶ A single, state-wide payment system is a type of exchange control that would enable the government to ration medical care indirectly, as well as dictate the relationships between private insurers and health care providers.³⁷

In 2009, the commission recommended that Massachusetts impose a Canadian-style payment system on its entire health care sector. Under that proposed exchange-control regime, known as “global payments,” providers would receive “a single, yearly fee [that is] intended to discourage doctors and hospitals from providing unneeded tests and treatments, so patients could find it harder to get procedures of questionable benefit.” The new payment system “would essentially put doctors and hospitals on a budget in an effort to restrain health spending.”³⁸ As in Canada and elsewhere, paying health care providers “a single, yearly fee” enables the government to ration care while delegating the actual rationing decisions to doctors and hospitals.³⁹ Solo practitioners and small physician groups are ill-equipped to provide all the services a patient needs, thus universal global payments would force those physicians to join larger practices—effectively giving politicians and government bureaus control over where doctors work at the same time the “evidence-based purchasing strategies” empower government to control how doctors practice medicine.⁴⁰

Massachusetts has adopted an even more unsettling rationing measure: denying coverage to politically powerless or unpopular minorities. In early 2009, the legislature revoked coverage for 30,000 legal immigrants. In September 2009, Massachusetts announced that it would restore those immigrants’ coverage, but with fewer benefits.⁴¹ Those immigrants would also face up to a three-month interruption in coverage, which can pose severe hardships for the seriously ill.⁴² Legal immigrants play by the rules and pay the same taxes as U.S. citizens. Whereas low- and middle-income *citizens* can get some of their tax dollars back in the form of

insurance subsidies, Massachusetts has decreed that low- and middle-income *immigrants* will get less back from the government—even though both groups are subject to the same compulsory health insurance requirement. Massachusetts provides a stark reminder that whether the government creates its own insurance program or subsidizes private insurance, politically powerless or unpopular minorities are at greater risk of being hurt by government rationing decisions.

If Congress makes health insurance compulsory, the same rationing strategies are likely to appear nationwide. By adjusting the definition of qualified coverage, the federal government could dictate that all health insurance policies abide by government price and exchange controls or only pay for government-approved treatments—much like former Senate majority leader (and would-be Obama cabinet member) Tom Daschle proposed when he suggested leveraging the tax break for employer-sponsored health insurance to require private insurers to cover only those treatments approved by a Federal Health Board, even though “doctors and patients might resent any encroachment on their ability to choose certain treatments.”⁴³ President Obama’s proposed Independent Medicare Advisory Council would have the power to adjust price controls and coverage decisions within Medicare and could be expanded to do the same for private insurance.⁴⁴ House “Blue Dog” Democrats have proposed—and other leading House Democrats have embraced—the idea of creating a federal commission that would impose price controls on hospital services for both publicly and privately insured patients.⁴⁵ Sen. Baucus has proposed an even more robust version of the president’s IMAC proposal.⁴⁶

Compulsory Health Insurance Is Itself a Tax

President Obama’s National Economic Council chairman Larry Summers explains that because employer mandates force workers to purchase health insurance, they “are

like public programs financed by benefit taxes.”⁴⁷ The same can be said of an individual mandate: when government forces people to purchase something they do not value, or pay more than the market would require, that is a tax—even if the money never enters the public treasury. Princeton health economist Uwe Reinhardt writes that “[just because] the fiscal flows triggered by [a] mandate would not flow directly through the public budgets does not detract from the measure’s status of a *bona fide* tax.”⁴⁸

A Tax on Workers—Not Employers

From a tax perspective, there is little difference between an individual mandate and an employer mandate. Both are a tax on workers. In a recent survey, 90 percent of health economists agreed with the statement, “Workers pay for employer-sponsored health insurance in the form of lower wages or reduced benefits.”⁴⁹ The Congressional Budget Office explains that workers would also pay any government-imposed penalties: “if employers who did not offer insurance were required to pay a fee, employees’ wages and other forms of compensation would generally decline by the amount of that fee from what they would otherwise have been.”⁵⁰ An employer mandate should therefore be labeled an *employee* mandate.

Taxing the Middle Class

Either form of compulsory health insurance would thus violate President Obama’s pledge not to increase taxes on middle-class Americans. During the 2008 presidential campaign, candidate Obama vowed, “I can make a firm pledge: Under my plan, no family making less than \$250,000 a year will see *any form* of tax increase.”⁵¹

A look at just the penalties for noncompliance shows how individual and employer mandates would subject middle-income earners to exorbitant tax rates. Suppose a single, uninsured woman earns \$50,000 per year working for an employer who does not offer qualified coverage.⁵² Because she is uninsured, House Democrats would force her to pay a tax equal to 2.5 percent of income, while her employer

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The tax burden would not be “shared.” Employers, government, and insurers would pass the costs on to consumers and taxpayers in the form of lower wages, higher taxes, and higher health insurance premiums.

would pay a fine equal to 8 percent of payroll.⁵³ Summers, the Congressional Budget Office, and economists broadly agree that *the worker*—not her employer—would pay the 8-percent penalty, because that penalty would reduce her wages. In effect, she would pay an “uninsured tax” equal to 10.5 percent of her income. Add that to her 15.3-percent payroll tax and 25-percent marginal income tax rate, and House Democrats would push her effective marginal tax rate to 50.8 percent—and that’s before counting state income taxes.

Under the Senate Democrats’ legislation, the secretary of health and human services would have discretion to levy fines for non-compliance as high as \$3,000 per family member. Employers who do not offer coverage would have to pay a penalty of \$750 per full-time worker or \$375 per part-time worker.⁵⁴

President Obama cannot claim he did not see this coming. During the 2008 presidential campaign, he complained that Sen. Hillary Clinton’s (D-NY) proposed individual mandate would “have the government force uninsured people to buy insurance, even if they can’t afford it.”⁵⁵ Obama’s criticisms of compulsory health insurance were not timid:

You can have a situation, which we are seeing right now in the state of Massachusetts, where people are being fined for not having purchased health care but choose to accept the fine because they still can’t afford it, even with the subsidies. And they are then worse off. They then have no health care and are paying a fine above and beyond that.⁵⁶

Ironically, candidate Obama proposed an employer mandate and an individual mandate for children, which would scarcely be less coercive and would likewise leave many Americans worse off. Compounding the irony, President Obama executed an about-face and endorsed an individual mandate during his address to Congress.⁵⁷

“Shared Responsibility” = Hiding the Tax
Senate Democrats call their proposed

penalties for noncompliance “shared responsibility payments.”⁵⁸ As noted above, the tax burden would not be “shared.” Employers, government, and insurers would pass the costs of compulsory health insurance on to consumers and taxpayers in the form of lower wages, higher taxes, and higher health insurance premiums, respectively.

Politicians prefer hidden taxes, however, because voters are less likely to oppose a tax if they believe it is not a tax, or that it will fall on someone else. In a recent poll, 71 percent of respondents initially supported an individual mandate. When told, “this could mean that some people would be required to buy health insurance that they find too expensive or did not want,” 71 percent opposed the idea.⁵⁹ Another poll also put opposition to an individual mandate near 70 percent.⁶⁰

Yet a poll that tested the popularity of an individual mandate (with government subsidies for those with low incomes) against an approach that includes “requirements on individuals, *employers, the government, and insurance companies* so that everyone shares in the responsibility” showed that the shared-responsibility subterfuge resulted in a higher approval rating than a stand-alone individual mandate.⁶¹ This proves Larry Summers’ observation that mandates can “fuel the growth of government because their costs are relatively invisible.”⁶²

Massachusetts: A Model of Misdirection

Supporters often blatantly mislead the public about who bears the cost of compulsory health insurance and related measures. In 2006, Massachusetts made health insurance compulsory, created new subsidies for private health insurance, and expanded Medicaid eligibility. The Massachusetts Taxpayers Foundation, which supports those measures, claims the cost has been “modest.”⁶³

Yet the foundation bases that claim on the growth in new *state* spending, without incorporating mandated private-sector spending or matching spending by the federal government. According to the foundation’s estimates, new state spending accounts for just

one fifth of the law's total cost of \$2.1 billion in 2009. The individual and employer mandates pushed 60 percent of that cost off-budget. The Medicaid expansion pushed another 20 percent of the cost onto the federal government—that is, onto taxpayers in other states.⁶⁴

Nevertheless, Massachusetts politicians are struggling to come up with their 20-percent share.⁶⁵ State officials have increased taxes on tobacco, hospitals, insurers, and employers (that is, workers). In an effort to constrain spending, they have imposed barriers to entry for new clinics and surgical centers.⁶⁶ Officials are considering further taxes, including a sales-tax increase,⁶⁷ and further price controls (including limiting prices for medical services to 110 percent of Medicare rates⁶⁸ and capping health insurance premium growth⁶⁹), in addition to the rationing measures discussed above.

The “shared responsibility” ruse allows Massachusetts politicians to declare success for a compulsory health insurance scheme whose actual costs reveal it to be a failure. In 2009, that scheme covered previously uninsured families of four at a cost of at least \$20,000, which is 50 percent greater than the nationwide average cost of employer-sponsored family coverage.⁷⁰ That estimate should be considered conservative, because it does not include the cost of the additional coverage that Massachusetts requires already insured residents to purchase. That cost is even more exorbitant considering that 86 percent of uninsured Massachusetts adults were in “good, very good, or excellent” health⁷¹ and therefore should have cost less to insure than the average person.

Massachusetts belies the claim that making health insurance compulsory will bring down health care costs. Federal, state, and private-sector health care spending have all increased under compulsory health insurance. Private health insurance premiums are growing 21 percent to 46 percent faster than the national average.⁷² In 2010 health insurance premiums will rise by 10 percent according to a survey of insurers, compared to increases of 5 percent to 7 percent nationwide.⁷³ A report funded by the BlueCross BlueShield Foundation of Massachusetts indicates that overall public and pri-

vate spending on health insurance has grown 66 percent faster than it would have otherwise—yet the report practically hails the genius of Massachusetts politicians for hiding those costs.⁷⁴

Summers writes, “If policymakers fail to recognize the costs of mandated benefits because they do not appear in the government budget, then mandated benefit programs could lead to excessive spending on social programs.”⁷⁵ Massachusetts offers a perfect illustration.

The Insured Would Pay More, not Less

Supporters claim that compulsory health insurance would prevent the uninsured from shifting the cost of their medical care to others. President Obama told the American Medical Association, “Each time an uninsured American steps foot into an emergency room with no way to reimburse the hospital for care, the cost is handed over to every American family as a bill of about \$1,000 that’s reflected in higher taxes, higher premiums, and higher health care costs.”⁷⁶ Yet making health insurance compulsory would likely impose greater burdens on taxpayers and the insured than free-riders do.

Uncompensated care for the uninsured does not appear to be the major cost driver that the president claims. According to the Urban Institute:

It is commonly argued that the privately insured pay for uncompensated care through cost shifting—that is, health care providers offset uncompensated care “losses” by charging higher prices to privately insured patients. . . . Private insurance premiums are at most 1.7 percent higher because of the shifting of the costs of the uninsured to private insurers in the form of higher charges.⁷⁷

Including the cost of uncompensated care covered by taxpayers, the authors concluded, “Uncompensated care represents 2.2 percent of health spending in 2008.”⁷⁸ The Congressional Budget Office agrees: “Uncompensated

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care is less significant than many people assume.”⁷⁹

Making health insurance compulsory is unlikely to eliminate the problem of uncompensated care. (In Massachusetts, an estimated 4 percent of residents remain uninsured.)⁸⁰ Even if it did, however, those who already purchase coverage would see their health care spending fall by at most 2.2 percent. In the process, compulsory health insurance would impose costs on the already insured that would almost certainly exceed those savings. The insured would pay more, not less.

Yet Another Bailout?

A final indication that compulsory health insurance is a flawed concept is that the health insurance lobby supports it.⁸¹ Indeed, making health insurance compulsory would deliver an unjustified windfall to an already heavily subsidized private health insurance industry. All leading Democratic proposals would force tens of millions of Americans to purchase private health insurance, would give incumbent insurers a guaranteed customer base, would increase federal subsidies for private insurers, and would protect private insurers from competition by standardizing product design. Compulsory health insurance is less health care reform than yet another industry bailout.

Make Coverage Affordable, Not Compulsory

Rather than make health insurance compulsory, Congress should make it more affordable. First, Congress should put greater pressure on insurers to cut costs by letting workers control their earnings and choose their health plan. The current tax preference for employer-sponsored health insurance effectively allows employers to control roughly \$10,000 of the earnings of each worker with family coverage.⁸² Eliminating that tax preference—such as with “large” health sav-

ings accounts⁸³—would return that \$10,000 to the workers and free them to purchase coverage from any source, without penalty. Second, Congress should free workers to purchase health insurance across state lines.⁸⁴

Those two steps would dramatically reduce costs and the number of Americans who lack health insurance. Consumers would choose lower-cost plans and put greater pressure on insurers to eliminate unnecessary administrative costs and other waste, both because the costs of inefficiency would be salient to consumers and because they would have the power to do something about it. Freeing individuals and employers to purchase health insurance across state lines would enable them to avoid the unwanted regulatory costs that politicians, bureaucrats, and special interests—such as those in Massachusetts—are eager to impose on their captive clientele. Like similar proposals, Large HSAs would expand coverage without increasing government spending or the federal deficit.⁸⁵ Letting people purchase health insurance across state lines could reduce the number of uninsured by as much as one third⁸⁶ without any new government subsidies.

Conclusion

In 1989, Larry Summers observed that “conservatives tend to prefer mandated benefits to public provision, as evidenced, for example . . . in proposals in the 1970s to mandate employer health insurance as the ‘conservative’ alternative to national health insurance.”⁸⁷ Yet the Massachusetts experience demonstrates that simply making health insurance compulsory gives government as much control over health care as would a compulsory government program. Either an individual or employer mandate would increase costs, reduce choice, and lead to government rationing of medical care. Either measure would effectively socialize health insurance, leaving the U.S. health care sector “private” in name only.⁸⁸ Compulsory “private” health insurance is a species of national health insurance, not an alternative to it.

**The insured
would pay more,
not less.**

Enthusiasm for Massachusetts' compulsory health insurance scheme, although initially strong, may be on the wane.⁸⁹ A recent poll found that Massachusetts voters who believe the reforms have been a failure outnumber those who believe the reforms have been a success by 37 percent to 26 percent. Three times as many Massachusetts voters believe the law has reduced the quality of care (29 percent) than believe it has improved quality (10 percent). And more voters believe the Massachusetts law has made health insurance less affordable (27 percent) than believe it has made coverage more affordable (21 percent).⁹⁰

If Congress wants to make health insurance affordable, it must preserve the freedom *not* to purchase health insurance.

Notes

1. *Face the Nation*, July 5, 2009, <http://media.bulletinnews.com/playclip.aspx?clipid=8cbcbdb98161dcf>. For more on proposals to create a new government program, see Michael F. Cannon, "Fannie Med? Why a 'Public Option' Is Hazardous to Your Health," Cato Institute Policy Analysis no. 642, July 27, 2009, <http://www.cato.org/pubs/pas/pa642.pdf>.
2. The three House committees are the committees on Ways and Means, Energy and Commerce, and Education and Labor. See, for example, U.S. House of Representatives Committee on Education and Labor, "The House Tri-Committee Health Reform Discussion Draft Summary," June 19, 2009, <http://edlabor.house.gov/documents/111/pdf/publications/DraftHealthCareReform-BillSummary.pdf>.
3. Douglas W. Elmendorf, director, U.S. Congressional Budget Office, letter to the Honorable Edward M. Kennedy, July 2, 2009, <http://www.cbo.gov/ftpdocs/104xx/doc10431/07-02-HELPltr.pdf>.
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