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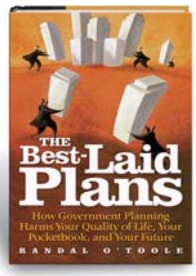


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# Cato Policy Report

**September/October 2007** **Vol. XXIX No. 5**


## Hazards of the Individual Health Care Mandate

**BY GLEN WHITMAN**

The latest fad in health care reform is the "individual mandate"—a law that requires individuals to purchase health insurance and threatens punishment for those who don't. Massachusetts, under the governorship of presidential hopeful Mitt Romney, has already created a health care policy with an individual mandate as its centerpiece. Gov. Arnold Schwarzenegger has proposed a similar plan for California. And politicians are not alone, as analysts from across the political spectrum have jumped on board. Even analysts who usually favor markets over regulation—like economist Gary Becker, legal scholar Richard Posner, Ron Bailey of *Reason* magazine, and Robert Moffit of the Heritage Foundation—have voiced support for the individual mandate.

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Congressmen Jeff Flake (R-AZ) and Charles Rangel (D-NY) don't agree on everything, but they agree that few policies are more misguided than the U.S. embargo on trade and travel with Cuba. At a June 14 Capitol Hill Briefing, they spoke about the embargo's ineffectiveness, hypocrisy, and lack of respect for freedom.

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Their support, however, is unjustified. The individual mandate will do little, if anything, to solve the problem of "free riders" whose health expenses are paid for by the rest of us. The mandate will do nothing to decrease the actual cost of health services. Worst of all, the mandate will create a set of political incentives that will likely drive up the cost of health insurance while impeding the adoption of more effective reforms.

## Is Free Riding Really the Problem?

Supporters of the individual mandate rely heavily on the problem of uncompensated care. People who lack health insurance nevertheless receive health care in this country, because hospitals and health care providers are unable or unwilling to turn them away. When recipients don't pay for their care, the rest of us end up footing the bill one way or another. Individual-mandate advocates contend, plausibly enough, that we should make the free riders pay for themselves.

But how big is the free-rider problem, really? First, we should note that not all free riders are uninsured. In fact, people with insurance consume almost a third of uncompensated care. Second, not all care received by the uninsured is paid for by others. Analysts at the Urban Institute found that the uninsured pay more than 25 percent of their health expenditures out of pocket.

So how much uncompensated care is received by the uninsured? The same study puts the number at about $35 billion a year in 2001, or only 2.8 percent of total health care expenditures for that year. In other words, even if the individual mandate works exactly as planned, it will affect at best a mere 3 percent of health care expenditures.

## The Problem of Noncompliance

But, of course, the mandate will not work exactly as planned. As anyone who's ever driven over 55 mph knows, mandating something is not the same as making it happen. Realistically, some individuals will not comply.

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Forty-seven states currently require drivers to purchase liability auto insurance. Do 100 percent of drivers in those states have insurance? No. For states with an auto insurance mandate, the median percentage of drivers who are uninsured is 12 percent. In some states, the figure is much higher. For example, in California, where auto insurance is mandatory, 25 percent of drivers are uninsured—more than the percentage of Californians who lack health insurance.

Of course, the number of uninsured drivers might be even higher without mandatory coverage. The point, however, is that any amount of noncompliance reduces the efficacy of the mandate. If the individual health insurance mandate succeeded in forcing half of the uninsured to get coverage, it would arguably affect a mere 1.5 percent of current health care spending (that is, half of the 3 percent of spending that covers uncompensated care for the uninsured; the precise figure would depend on which uninsured people obtained coverage).

With auto insurance, at least there is a reasonable argument that a well-enforced mandate could reduce insurance premiums. When many motorists are uninsured, those who do buy insurance need, and are sometimes required, to buy coverage for damage done to their vehicles by the uninsured. So when the uninsured become insured, others' premiums could fall. But this argument simply doesn't fly in the case of health insurance, because (as already noted) uncompensated care is such a small fraction of overall health spending. Furthermore, more than 85 percent of uncompensated care is paid for by governments, not by private insurance. That means less than 15 percent of uncompensated care—less than half a percent of all health care spending—contributes to higher private insurance premiums.

None of this means that the uninsured are not a problem. But the problem is not that they cost the rest of us too much. One reason uncompensated care is such a small fraction of health care spending is that uninsured people simply get less health care than others. (Though they do get some; health care and health insurance are not synonymous.) So if the real concern is making health insurance and health care available to those in need, we should focus on health care prices and insurance premiums.

Not all free riders are trying to take advantage of their fellow citizens. For many, health insurance premiums are just too high. Yet the individual mandate does nothing to make insurance more affordable. There do exist regulatory reforms that could make it more affordable, but those reforms are desirable independent of the individual mandate. The mandate seeks to command a better outcome—more insured people—while doing nothing to make it happen. You can't get blood from a stone.

The architects of the Massachusetts plan, recognizing the affordability problem, have already effectively admitted defeat on this front: they have exempted 20 percent of the uninsured from the tax penalties for noncompliance. That's arguably another one-fifth reduction in the already small fraction of health care spending affected by the mandate.

Furthermore, the Massachusetts plan also creates a system of public subsidies (in the form of vouchers) to help low-income people buy insurance. As far as policies to encourage more private coverage go, you could do worse—and it would be possible to have the subsidy without the mandate. But to the extent that the public has to subsidize the formerly uninsured, the free-riding problem has not been solved—it has

merely been shifted. It's wrong to say we "solve" the free-rider problem if all we're doing is paying for the free riders in a different way.

To make matters worse, there is no way to ensure that subsidies will go only to people who would otherwise be uninsured. Some people who would otherwise have paid their own way will tap the subsidy. As a result, the taxpayers could actually be subject to more cost shifting than before.

## Defining the Minimum Benefits Package

If you're going to mandate something, you have to define it. Under an individual mandate, legislators and bureaucrats will need to specify a minimum benefits package that a policy must cover in order to qualify. It's not plausible to believe this package can be defined in an apolitical way. Each medical specialty, from oncology to acupuncture, will pressure the legislature to include their services in the package. And as the benefits package grows, so will the premiums.

Limiting the mandate's scope with vacuous phrases like "basic health care products and services" will not solve the problem, because what is basic to some is crucial to others. Does contraception constitute basic health care? How about psychotherapy? Dental care? Chiropractic? The phrase "medically necessary" is just as problematic, because there is no objective definition of necessity. And even if there were, it wouldn't matter, because the content of the law will be determined by the legislative process. The "basic" package might initially be minimal, but over time it will succumb to the same special-interest lobbying that affects every other area of public policy. If psychotherapy is not initially included in the package, eventually it will be, once the psychotherapists' lobby has its way. And likewise for contraception, dental care, chiropractic, acupuncture, in vitro fertilization, hair transplants, ad infinitum.

This is not mere speculation. Even now, every state in the union has a list of mandated benefits that any health insurance policy must cover. Mandated benefits have included all of the services listed above—yes, even hair transplants in some states. All states together have created nearly 1900 mandated benefits. Given that medical interest groups have found it worth their time and money to lobby 50 state legislatures for laws affecting only voluntarily purchased insurance policies, mandatory insurance will only exacerbate the problem. If the benefits package is established at the federal level, the incentive to lobby will be that much greater.

> "Health care providers have a strong financial incentive to assure that patients have low deductibles and copayments so that they will consume more services."

Medicare and Medicaid provide further evidence. Given the massive funds at stake in those programs, it should come as no surprise that lobbying has affected the list of covered benefits. A public outcry prevented Viagra from being covered by Medicare and Medicaid, but other drugs and services have not attracted that kind of scrutiny. In 2004, after heavy lobbying by pharmaceutical companies that make anti-obesity drugs, Medicare reclassified obesity as an illness (or rather, removed language saying it was not an illness), thereby clearing the way for coverage of obesity treatments including diet pills, weight-loss programs, and bariatric surgery. Although by law Medicare can pay only for "medically necessary" services, the obesity story aptly demonstrates the subjective and ultimately political meaning of that term.

Mandated benefits drive up insurance premiums; after all, insurance companies can't make more payouts without higher revenues. Existing mandates have increased premiums by an estimated 20 to 50 percent, depending on the state. There is every reason to believe the same process will affect the minimum benefits package under an individual mandate. As a result, even more people will find themselves unable to buy insurance and decide not to comply. Others will buy the insurance, but only by relying on public subsidies. A health policy intended to rein in free riding and cost shifting will tend to encourage more of the same.

## Limiting Flexibility in Health Insurance Policies

In addition to defining a minimum benefits package, an individual mandate must also specify other features of qualifying insurance policies—such as their maximum payouts, deductibles, and copayments. The same political pressures that affect the benefits package will also affect these other characteristics. Health care providers have a strong financial incentive to assure that patients have low deductibles and copayments so that they will consume more services.

In Massachusetts, no health insurance policy with a deductible greater than $2,000 for an individual or $4,000 for a family will satisfy the mandate. In addition, qualifying policies may not have any maximum annual or per-condition payout. And this is merely the regulatory starting point for a law that has not yet gone into full effect (some aspects of the plan won't kick in until 2009). We should expect further regulations to accumulate with the passage of time.

Consequently, the individual mandate will have a deleterious impact on the flexibility of health plans. Health care buyers and insurers need the opportunity to experiment with different types of coverage. Higher deductibles and copayments, for example, give patients an incentive to weigh the potential benefits of health services against their costs—a key component of any effective plan to control health care costs. (Health Savings Accounts, or HSAs, could allow people to save tax-free dollars for out-of-pocket health expenses, with unused dollars rolling over to their

retirement accounts.) Insurers might also want to experiment with other policies, such as plans that offer full coverage for only certain treatments for particular conditions, while requiring patients to cover the difference in price between covered treatments and more expensive ones. But the individual mandate's one-size-fits-all approach cuts off such innovation at the knees.

Limitations on deductibles and copayments might be justified on grounds that out-of-pocket payments deter patients from getting necessary care. But the evidence does not support that position. In a famous RAND study, patients with first-dollar insurance coverage consumed 43 percent more health care than patients who had to pay a large deductible, and yet the two groups experienced indistinguishable health outcomes. The obvious conclusion is that many health services have negligible benefits, but patients will get them anyway unless they face at least some portion of the costs.

More important, health insurance plans with lower deductibles and copayments are more expensive. Regulations that mandate more generous plans drive up premiums, thereby pricing some people out of the market. The result is more uninsured people, more people insured only via public subsidy, or both.

## Free Riders and Hitchhikers

Individual mandates are frequently pitched as an alternative to other forms of regulation. In practice, they will assuredly be accompanied by a package of other interventions—some desirable, most not.

As noted earlier, the Massachusetts plan creates new public subsidies for health insurance. Worse, the plan requires community rating, which means that insurance firms may not charge differential premiums based on health risks. This might seem an attractive idea (everyone should pay the same amount), but, in fact, community rating creates an incentive for lower-risk patients to go uninsured because the coverage isn't worth the price. The mandate is supposed to prevent dropouts, but compliance cannot be guaranteed.

> "A better approach to health reform would focus on removing, or mitigating the effect of, existing mandates that drive up insurance premiums."

Community rating also forces low-risk patients to subsidize high-risk patients—another form of cost-shifting. Yet the justification of the individual mandate was to reduce cost-shifting. The subsidy to higher-risk patients generates a political incentive to regulate personal lifestyles—such as diet choices or sexual behaviors—that affect health risks. We have already observed this mechanism at work: the cost of treating motorcycle accident victims has been used to justify helmet laws; the cost of Medicaid to treat cigarette smokers was used to justify lawsuits against the tobacco industry. The public is notably more willing to restrict choice when the costs are socialized—and that means individual liberty is at stake.

Governor Schwarzenegger's proposal, meanwhile, couples an individual mandate with an employer mandate: any employer with 10 or more employees would have to provide health coverage or pay an additional payroll tax. This regulation would constitute a direct tax on employment, as businesses will find it in their interest to hire fewer employees (possibly compensating with more hours per worker) to minimize health insurance costs. Meanwhile, businesses with fewer than 10 employees will have a strong incentive not to expand, as doing so could expose them to the mandate.

Effective health care reform would involve making customers more cost-conscious. The individual mandate, sadly, will tend to shield customers from costs and impede innovations that could push costs down. Rising insurance premiums, as a result of a growing mandated benefits package, will fuel greater public dissatisfaction with the health care system. Further regulations that hitchhike on the individual mandate will only make matters worse. Ironically, free markets rather than government will likely catch the blame, thus fueling demand for more intrusive interventions into the health care market.

A better approach to health reform would focus on removing, or mitigating the effect of, existing mandates that drive up insurance premiums. States that genuinely want to help the uninsured ought to repeal some or all of their mandated benefit laws, allowing firms to offer low-priced catastrophic care policies to their customers. If special-interest pressures hamper this solution, the federal government could assist by using its power—under the Constitution's interstate commerce clause—to guarantee customers the right to buy insurance policies offered in any state, not just their own. That would enable patients to patronize firms in states with fewer costly mandates. As an added bonus, state legislatures might feel pressure to ease regulations to attract more insurance business from out-of-state customers. Removing mandates would do far more to expand health care coverage than adding new mandates ever could.



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