Health Care Reform: An Examination of the Case for Individual Mandates

Sarah Schares

Abstract. Senator Hilary Rodham Clinton has recently put forth a plan in which individuals would be required to purchase health insurance. Her plan has been the target of intense criticism. Individual mandates would target the free-riders of health care and would likely improve the health of the uninsured. Shortcomings of the mandate are the difficulty of enforcement and the unfair burden placed on lower-middle income people. Careful examination of the evidence suggests that the U.S. should not impose individual mandates for health insurance.

I. Introduction

There is considerable dissatisfaction with the current United States health care system. In a recent survey of 12,000 patients in seven industrialized nations (Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States), "one-third of the American respondents felt their system is so dysfunctional that it needs to be rebuilt completely- the highest rate in any country surveyed" [New York Times 2007, para. 1]. It comes as no surprise then that health care reform is one of the key topics in the current political debate. Senator Hilary Rodham Clinton, picking up on society's concerns, has proposed a system of individual mandates for health insurance. So, the question is - should the U.S. create a nationwide system of individual mandates for health insurance?

The proposal is radical. In fact, it would eliminate the freedom of choice Americans currently possess. Individuals would no longer have the option to not purchase health insurance. What's more, it would give the government an increased role in the daily lives of its citizens. Some have called individual mandates "socialist health care." On the other end of the spectrum, individual mandates are hailed as a potential solution for the current lack of insurance by many in the United States. Note that this paper will not attempt to measure the attractiveness of Senator Clinton's specific plan. Rather, this paper will address the appeal of individual mandates in general. After weighing the arguments for and against the mandate, this paper finds that the U.S. should not impose individual mandates for health insurance.

II. Background

A. TERMINOLOGY

An individual mandate for health insurance is a "regulation that requires individuals (eighteen and older) to be responsible for purchasing their own health insurance" [Sasser 2007, 63]. Like mandates for auto insurance, it requires individuals to hold a basic insurance policy as defined by the government. The basic health insurance plan, as defined in Senator Clinton's reform proposal, would emulate the private health care plans offered to Congress through the federal employee benefits program, as well as Medicare [Steinhauser and Crowley 2008, para. 13].

All insurers, including public programs, would be required to offer the basic health care plan [Lichiello et al. 2003, 5]. Employers who offer health insurance would also be required to offer at least the basic health care plan [Lichiello et al. 2003, 5]. The uninsured who could not afford to purchase the basic plan would be eligible for government subsidies or for coverage under public programs [Lichiello et al. 2003, 5]. The government would provide subsidies in the form a sliding scale premium price based on income, an income tax deduction or refund, or individual health accounts [Lichiello et al. 2003, 5]. In Massachusetts, subsidies are provided to low-income individuals in the form of a sliding scale premium price based on income; as one's income rises, the premium one pays increases along the sliding scale [Sasser 2007, 25]. Individuals who earn up to 150 percent of the federal poverty line pay no premium, while premiums for those with higher incomes range from $18 to $137 per month for a single adult [Sasser 2007, 25]. Individual health accounts, also referred to as health savings accounts, allow individuals ineligible for employer-provided health care to pay for health care coverage on a pre-tax basis; the savings incurred is the subsidy [Sasser 2007, 31].

As with any mandate, an enforcement mechanism would be necessary to ensure compliance. The most commonly proposed enforcement mechanism for individual mandates in the U.S. is the IRS, where individuals would have to show proof of health insurance when they file their income taxes. For those who fail to comply, their personal tax exemption might be withheld [Sasser 2007, 25]. Massachusetts currently uses this type of enforcement mechanism. There, individuals who failed to submit proof of health insurance coverage by December 31, 2007 forfeited their personal income tax exemption when they filed their 2007

income taxes [Sasser 2007, 25]. The penalty for noncompliance in 2008 has been raised to 50 percent of the "least costly, available insurance premium that meets the standard for creditable coverage" [Sasser 2007, 25].

B. INDIVIDUAL MANDATES IN PRACTICE

To develop a better understanding of individual mandates for health insurance and their likely effect on the United States, it pays to look at existing mandates. One problem with this approach is that individual mandates are not commonly used. Massachusetts, Switzerland, and the Netherlands are the only places to use individual mandates [Glied 2007, 1613]. The study of individual mandates in Massachusetts would provide the greatest insight regarding their probable impact on the United States. Unfortunately, mandates in Massachusetts are new, so this paper will look at their use in Switzerland. By no means, however, do the outcomes in these areas demonstrate the actual effects of individual mandates. That would require the ability to isolate the effects of individual mandates from other factors. No known scholarly attempts have been able to do so, although various reports about the success of individual mandates have been issued. The debate concerning individual mandates has been predominately theoretical.

In December 2007, the press reported estimates of the reduction in the uninsured in Massachusetts following the introduction of individual mandates. Prior to the reform, there were anywhere from 372,000 to 600,000 people without health insurance [Nuzzo 2008, para. 4]. Since the reform, 300,000 have purchased some form of health care coverage, leaving only 100,000 to 300,000 still uninsured [Nuzzo 2008, para. 5].

While the decline in the uninsured surely looks good, Massachusetts has seen a substantial increase in health care spending. For the fiscal year ending July 30, 2007 health care spending in Massachusetts increased approximately $1.2 to $1.4 billion [Nuzzo 2008, para. 13]. Much of the increase in health care spending was due to subsidies to low-income residents under Commonwealth Care [Nuzzo 2008, para. 14]. The actual cost of the subsidies was not reported but it could be assumed to be at least $720 million. Tim Murphy, Massachusetts Secretary of Health, estimated that the costs of providing subsidies to low-income residents would total roughly $720 million per year [Symonds 2006, para. 13]. According to Jon Kingsdale, director of the Massachusetts Health

Connector, "there's simply no question there is not a dollar-for-dollar offset from taking people out of the free care pool and adding them to the rolls of the insured on a subsidized insurance plan" [Nuzzo 2008, para. 16].

Across the Atlantic individual mandates have a longer history. They were introduced in Switzerland in 1996 under the Revised Health Insurance Law [Civitas 2002, 2]. The goals of the reform were to achieve universal coverage, make insurance more affordable for low and moderate income people, and control health care costs [Noble 2007, para. 4]. According to Noble, a notable Swiss journalist, individual mandates have achieved universal coverage in Switzerland. "Everyone has access to the same comprehensive health insurance coverage, at the same premiums, and to the same quality of medical care" [Noble 2007, para. 5]. The reform's goals of more affordable insurance for low and moderate income people and lower health care costs, however, have arguably not been realized. Switzerland, much like the United States, currently faces escalating health care costs. As a result, some middle income families in Switzerland spend as much as 16 percent of household income on health insurance coverage [Noble 2007, para. 7].

From reviewing individual mandates in Massachusetts and Switzerland it may seem like their effects are obvious - fewer uninsured and higher health care costs. However, such a conclusion would be premature. There are notable complications with identifying the effects of individual mandates in these areas. In Massachusetts, an employer mandate is also enforced, where firms with more than ten full-time equivalent employees are required to provide health insurance; they're also required to "make a fair and reasonable premium contribution towards the cost of their employees' health insurance" [Sasser 2007, 25]. It is possible that the decline in the uninsured in Massachusetts had more to do with the employer mandate. Similarly, the high cost of health care in Switzerland may have more to do with the Swiss's definition of the basic health care plan. In Switzerland, the basic health insurance plan resembles luxury health care plans in the U.S. or Germany [Civitas 2002, 2].

III. The Debate

The rising cost of health care and the increasing rolls of the uninsured have captured America's attention. To counter these problems,

politicians and researchers have created a variety of reform plans. The recent proposal for individual mandates has sparked a heated debate. Mitt Romney, who implemented individual mandates in Massachusetts just two years prior, has spoken out against using individual mandates nationwide. He, however, is just one of many caught up in the debate. Proponents of individual mandates emphasize the moral obligation to the uninsured. They also stress the positive effect increased health care coverage would have on society. Proponents also claim that individual mandates would eliminate the free-rider and adverse selection problems that currently exist. By eliminating these problems and the inefficiencies that result from them, it is believed that individual mandates may result in reduced health care costs. Proponents also argue that the benefits generated from extending coverage to the uninsured will exceed the cost of doing so.

Opponents question the likely efficacy of individual mandates, their equitability, and the cost implications. Critics of individual mandates argue that the mandates will not be enforceable. Opponents also claim that individual mandates are unfair. They would force people to purchase health insurance they may not be able to afford. Critics also doubt that individual mandates can reduce health care costs. Some even argue that reform may not be necessary.

A. REASONS FOR IMPLEMENTING INDIVIDUAL MANDATES

1. Moral Obligation to the Uninsured

Some people have proposed individual mandates in order to protect the uninsured. As one might expect, the uninsured receive considerably less care than the insured. In 2001, the full-year uninsured received care worth $1,253 per person as compared to $2,484 per person for the privately insured [Hadley and Holahan 2003, 70]. The uninsured "have fewer physician visits per year, are less likely to have a hospital stay and have shorter lengths of stay, are at a much greater risk for in-hospital mortality, and are more likely to die prematurely from avoidable disease-specific conditions" [Hisnancik and Coddington 1995, 10]. The Institute of Medicine has estimated that 18,000 Americans die each year due to lack of health insurance and the inability to receive routine care [2003, 2].

The uninsured are also subject to increased psychological stress. Uninsured families face the uncertainty of financial turmoil brought on

by a serious illness or injury [Institute of Medicine 2003, 1]. "Uninsured children also lose the opportunity for normal development and educational achievement when preventable health conditions go untreated" [Institute of Medicine 2003, 1].

Proponents of individual mandates stress the relatively worse health of the uninsured as evidence of the need for increased health care coverage. They contend that increased coverage would lead to improved health among the currently uninsured. They argue that when the currently uninsured receive health insurance they will likely seek more preventative care, thereby improving their health.

According to some opponents, there is an inherent problem with this argument. They claim that health care coverage does not guarantee access to health care, nor does it necessarily lead to better health [Tanner 2006, 2]. Tanner argues that the experiences of rationing in countries with national health care systems serve as proof of this claim. According to Tanner, "one million Britons are waiting for admission to National Health Service hospitals at any given time, and shortages force the NHS to cancel as many as 100,000 operations each year" [2006, 10]. Canada and New Zealand have similar problems. In Canada, more than 800,000 patients were on a waiting list to receive medical procedures in 2005 [Tanner 2006, 10]. "Access to a waiting list is not access to health care" [Wall Street Journal 2005, para. 4]. According to the Vancouver-based Fraser Institute, "Canadians wait an average of 17.9 weeks for surgery and other therapeutic treatments" and "the waits would be even longer if Canadians didn't have access to the U.S. as a medical-care safety valve" [Wall Street Journal 2005, para.4].

Despite the troubles with national health care systems, there is some evidence that health insurance does lead to improved health, although Tanner has suggested this evidence is "uncertain at best" [2006, 2]. Levy and Meltzer, professors at the University of Chicago, studied the relationship between health insurance and health, specifically looking for a causal relationship between the two. In most cases they observed that health insurance had a small, positive effect on health outcomes among infants, the elderly, and the poor [Levy and Meltzer 2001, 3]. There was some evidence that expansions in health insurance did not result in measurable improvements in health. In the end, Levy and Meltzer concluded that health insurance *can* improve health, especially among low-income individuals. It should be noted that they found no evidence at the time suggesting that increased health insurance would be superior

to other health promotion endeavors, such as campaigns to advertise healthy lifestyles [2001, 34].

Ultimately, the appeal of individual mandates as a means of improving the health of the uninsured depends on the actual relationship between health insurance and health. If Tanner is correct and the relationship is "uncertain at best" one could not advocate individual mandates on the grounds that they would improve health among the uninsured. Problems with national health care seem to suggest that health insurance may not lead to better health even though some studies of European countries with national health insurance have reported a reduction in avoidable mortality [Hisnanick and Coddington 1995, 17]. Avoidable mortality is, however, a crude measurement of health; "studies that rely on these (as many do) may fail to capture changes in health-related quality of life" [Levy and Meltzer 2001, 2]. Since Levy and Meltzer appear to be authoritative figures, it is fairly safe to assume that their conclusion regarding the relationship between health insurance and health is accurate; this means that increased health insurance coverage can be assumed to improve the health of the poor uninsured. The relatively wealthy uninsured would not likely see a substantial improvement in their health; they probably do not forego needed treatment.

2. Protection of Society

In addition to specifically protecting the uninsured, individual mandates are believed to protect society. James Tobin, a renowned economist, made that very claim in a presentation to the University of Minnesota in 1994. "We don't want to allow a child or even an adult to behave in ways likely to do irrevocable self-damage. But generally protection of individuals from themselves is intertwined with protection of society" [1994, 2]. Tobin's argument makes sense. The uninsured put the insured population at risk. According to the Institute of Medicine, high uninsured rates lead to reductions in hospital services and health programs, such as communicable disease surveillance [2003, 1]. High uninsured rates within a community may drive health care providers out of the area altogether [Institute of Medicine 2003, 1]. Furthermore, the poorer health and premature death or disability of uninsured workers results in lost productivity, which "diminishes the economic vitality of the country" [Institute of Medicine 2003, 1]. Lower productivity results in

higher costs to employers, which could mean higher output prices or lower employee wages.

Much like the previous argument this one depends on the relationship between health insurance status and health status. As already established, increased coverage can be assumed to lead to improved health among the poor uninsured. Society should realize some benefits from increased health care coverage.

3. The Free-Rider Problem

There is a free-rider problem in the current U.S. health care system. The uninsured receive care, typically in an emergency room setting where they cannot be turned away for lack of health insurance or ability to pay, and then fail to pay for the care they receive. As any economics student knows, there's no such thing as a "free lunch". Someone must pay for the expenses the uninsured incur. The costs of treating the uninsured are passed onto tax-payers, the insured, and even physicians. In 2001, uncompensated costs totaled roughly $35 billion dollars [Hadley and Holahan 2003, 69]. Of that amount, $30.6 billion was paid by the federal, state, and local governments; the remaining $5.1 billion was provided by physicians, measured as the value of their time spent providing uncompensated care [Hadley and Holahan 2003, 72].

Proponents emphasize that individual mandates would eliminate the free-rider problem. But just how large a problem are the free-riders? In 2001, uncompensated costs of the uninsured were approximately 2.8 percent of total personal health care spending [Hadley and Holahan 2003, 69]. That 2.8 percent includes the care received by the uninsured that could not afford health insurance. The cost of the care received by these individuals should not be included in the cost of free-riders; after all, society will still have to pay for their health care. The uncompensated cost of this group would be reallocated to finance the subsidies they would receive. The insured also contribute to uncompensated costs. In 2001, the insured received $14.9 billion in uncompensated costs [Hadley and Holahan 2003, 69]. Relative to the costs of the insured free-riders, it would appear as though the uninsured free-riders are not that big of a problem.

Some opponents argue that individual mandates will not solve the free-rider problem. In a recent Cato Policy Report, Glen Whitman stated that an "individual mandate will do little, if anything, to solve the

problem of the free riders" [2007, para. 2]. As already noted, the uninsured are not the only free-riders. Individual mandates, however, would only target the uninsured free-riders. Also, in order to eliminate the free-rider problem individual mandates must be capable of persuading the uninsured free-riders to purchase health insurance. As will be discussed later, individual mandates may not be capable of doing so. The free-rider argument, though appealing, may not justify imposing individual mandates.

4. The Adverse Selection Problem

Individual mandates are believed to eliminate the adverse selection problem. The adverse selection problem, within the context of health insurance, has two dimensions. One is the problem created by the discrimination of insurance companies against individuals with preexisting conditions. Insurance companies, in an attempt to make profits in the competitive insurance industry, are sometimes said to "cherry-pick" their customers, whereby they insure the relatively healthy and deny coverage to the unhealthy. The unhealthy individuals denied coverage are then forced to rely on the providers of last resort. Because the uninsured seek treatment so late, their expenses are relatively higher. Emergency room visits are expensive and treatment for a prolonged illness is likely to require greater medical efforts. The treatment supplied by the providers of last resort is therefore expensive. It is also inefficient. More often than not the uninsured could be treated in a clinic. Moreover, had the uninsured been able to receive treatment early on the costs would have been substantially lower.

The adverse selection problem also refers to the higher risk associated with people who voluntarily buy insurance. When health insurance is voluntary, some individuals will not purchase it, despite being able to afford it. Meanwhile, individuals with poorer than average health will desire to purchase health insurance. The insured pool is then sicker than average, which results in higher premiums for all, including healthy people who want to buy insurance. Forcing the young and healthy, who make up a fair proportion of the currently uninsured, to buy insurance would reduce the overall risk of the insurance pool, and reduce premiums for all. With the recent concern over escalating health care costs, this would be an attractive move.

The reduction in premiums that may result from the elimination of the

adverse selection problem depends on whether there are cross-subsidies in existing insurance pools [Tanner 2006, 10]. "If everyone's rates are actuarially fair, then young people's explicit or implicit premiums do not result in lower or higher premiums for anyone else" [Tanner 2006, 10]. If that is true, then the adverse selection problem could not be used to promote individual mandates. Cross-subsidization occurs within employer-provided insurance pools, where employees pay the same premium, given they have the same insurance plan and the same number of beneficiaries. If the young and relatively healthy uninsured purchase employer-provided insurance, it is possible that the premiums for all employees would be reduced. If, however, the uninsured purchase individual plans directly from a health insurance provider, it is not likely that premiums would be reduced. Individuals who purchase directly from health insurance providers are more likely to be charged an actuarially fair premium.

5. Cost vs. Benefit

Some argue that the benefits from extending coverage to the uninsured will outweigh the cost. According to the Institute of Medicine, "the estimated benefits across society in healthy years of life gained by providing health insurance coverage are likely greater than the additional social costs of providing coverage to those who now lack it" [2003, 4]. The Institute of Medicine projects gains due to "better health outcomes from continuous coverage for all Americans" would be worth between $65 and $130 billion each year. At the same time, the Institute of Medicine projects the cost of the uninsured to increase by $34 to $69 billion each year [2003, 2-3]. A similar study was conducted for the expected gains from increased coverage in Massachusetts, prior to the introduction of individual mandates. This study estimated that the value of better health would exceed the incremental cost of expanding coverage by a ratio of nearly 3:1 [Holahan et al. 2004, 8]. Len M. Nichols, director of the Health Policy Program of the New America Foundation, reported less optimistic figures. According to Nichols, the total economic costs of the uninsured are approximately equal to the cost of the low-income subsidies necessary to finance universal coverage in the United States [2007, 25].

There are problems with these studies. It is possible that the Institute of Medicine overestimated the benefits of increased coverage. In 2001,

one-third of the uninsured earned at least $50,000 [U.S. Bureau of the Census 2007, 21]. This group probably received treatment when needed and paid out-of-pocket. To assume that this group would incur significant gains in "healthy years of life" is optimistic. If the Institute of Medicine included these individuals in its estimate, then it likely overestimated the benefits.

Some believe that the Institute of Medicine also underestimated the cost of increased coverage. Joseph Newhouse, professor of Health Policy and Management at Harvard, claimed that the Institute of Medicine's "estimate is likely to be unrealistically low" [Newhouse and Reischauer 2004, 180]. Individual mandates would require that all individuals have at least the basic health insurance plan. Currently there are people who are underinsured. Under the individual mandate, the underinsured would be required to "beef up" their health insurance plan [Newhouse and Reischauer 2004, 180]. The underinsured probably lack a comprehensive health care plan because they cannot afford it, meaning some of the underinsured would be eligible for subsidies. The Institute of Medicine underestimated the cost of extending coverage to the uninsured because it failed to account for this group. One cannot know then whether the benefits from increased coverage would exceed the cost.

6. Cost Containment

Some argue that individual mandates will work to contain health care costs. By requiring individuals to purchase health insurance, the number of health insurance consumers increases. Santerre and Neun, authors of *Health Economics: Theories, Insights, and Industry Studies*, argue that in order to attract the business of the new consumers, health insurance companies will be compelled to offer "high-quality, low-cost insurance" [2006, 543]. They claim that the increased competition among health insurance providers will contain costs. Others argue that costs will be contained through elimination of the free-rider and adverse selection problems. As discussed earlier, forcing the relatively young and healthy to purchase health insurance may result in lower premiums for all. Similarly, forcing the free-riders to pay for their health care may encourage them to "shop" smarter, where they only seek treatment when the marginal benefit exceeds the marginal cost.

While some believe individual mandates result in reduced costs, there are those who disagree. Fuchs, an economics professor at Stanford

University and former president of the American Economics Association, argues that individual mandates would do little to reduce current overall costs, much less future inflation [Emanuel and Fuchs 2007, 14]. He contends that "only comprehensive reforms will eliminate the inefficiencies and perverse incentives of the existing system" [2007, 14]. While that may be true, there is a more basic point. Individual mandates would increase the demand for health insurance, which would increase the cost of health insurance. In Massachusetts premiums increased 12 percent in 2007, which was twice the national average [Dalmia 2008, para. 4; Claxton 2007, 1]. Although that increase cannot be directly attributed to the individual mandate, economic theory would suggest it was partly to blame.

Opponents also argue that further government regulation, such as an individual mandate, may lead to higher health care costs. Michael J. New found that "state-level regulations of health insurance are correlated with higher premiums" [New 2005, 5]. In New's study, the average monthly health insurance premium in states with more than twenty-six mandated benefits exceeded the average monthly premium in states with twenty-six or fewer mandated benefits; the difference in average monthly premiums was $23.58 [New 2005, 4]. Would federal-level regulations not have the same effect on health insurance premiums?

Individual mandates may also lead to higher administrative costs. The individual mandate would have to be enforced. Individuals who qualify for subsidies would have to be identified. Both tasks are likely to lead to a significant increase in administrative cost. Eugene Steuerle of the Urban Institute believes "the administrative and enforcement costs of collecting the penalty would be enormous" [Tanner 2006, 4].

B. REASONS AGAINST IMPLEMENTING INDIVIDUAL MANDATES

1. Efficacy

Many critics doubt the individual mandate's ability to increase health care coverage. They contend that some individuals will not comply with the mandate. According to Sherry A. Glied, a respected health policy researcher, "mandates can, but do not always, increase participation in programs" [2007, 1613]. Glied claims that "the effectiveness of a mandate depends critically on the cost of compliance, the penalties for

noncompliance, and the timely enforcement of compliance" [2007, 1613]. Eugene Steurle agrees with Glied's claim, stating that "a mandate is only as good as its enforcement mechanisms" [1994, 62].

As already mentioned, the enforcement mechanism for individual mandates in the U.S. would most likely be the IRS. However, there are problems with using the IRS as the enforcement mechanism. Approximately 18 million Americans are not required to file their income taxes with the IRS because they do not make enough money, and another 9 million fail to file [Tanner 2006, 3]. That is potentially 27 million whose health insurance status would not be tracked [Tanner 2006, 3]. How then will the government ensure that these individuals comply?

David Hyman, an adjunct scholar at the Cato Institute, has studied the likely efficacy of individual mandates in the United States. Studying the system in Massachusetts, he found that "the sanctions for noncompliance are far too low to encourage the purchase of coverage" [2007, 5]. There, individuals who fail to comply with the mandate face a $200 fine the first year and $1,200-$1,500 in subsequent years; it would have cost them roughly $2,400-$3,000 to pay for health insurance [Hyman 2007, 5]. Hyman argues that even with the imposition of higher penalties, Massachusetts would not likely see a substantial increase in coverage [2007, 5]. In making this claim, he relied on the noncompliance rates with mandates for auto insurance, despite the strict penalties associated with noncompliance. The penalties for driving without auto insurance include license suspension, substantial fines, and even jail time, yet 14 percent of motorists in the U.S. are uninsured [Hyman 2007, 5].

Opponents often refer to noncompliance with mandates for auto insurance as evidence that people will not comply with an individual mandate for health insurance. The argument seems logical, but it is an "imperfect analogy" [Tanner 2006, 10]. Individuals that do not like the mandate for auto insurance can choose not to drive [Tanner 2006, 10]. As Tanner points out, individuals would not have that option with a mandate for health insurance; they would not stop consuming health care [2006, 10]. Tanner also notes the difference in motivation for enforcing each type of mandate. Mandates for auto insurance are enforced to protect society, not the motorist [Tanner, 2006, 10]. Mandates for health insurance would be enforced primarily to protect the individual.

2. Reform Not Warranted

Despite the dissatisfaction with the current health care system, there may not be a need for health care reform. The media has claimed that the current health care system is failing. In making their claim, they have used figures such as the number of uninsured in the U.S., the proportion of individual income spent on health care, and the life expectancy and infant mortality rates in the U.S. as compared to Canada. While their approach seems reasonable, it fails to paint an accurate depiction of the U.S. health care system.

According to the U.S. Census Bureau, the number of uninsured Americans in 2006 reached 47.0 million, an increase of 2.2 million from 2005 [2007, 18]. The 47.0 million, however, does not refer to the number of Americans that cannot afford or are denied health insurance, as is often implied in the media. In fact, this 47.0 million includes illegal immigrants, the young and healthy who choose not to purchase health insurance, and individuals eligible for Medicaid [Mankiw, 2007, para. 14]. Only a fraction of the 47.0 million are Americans who cannot obtain health insurance. To illustrate this point, about one-third of the uninsured in 2006 earned at least $50,000, and 19 percent earned at least $75,000 [U.S. Census of the Bureau 2007, 21]. Clearly, these individuals are capable of purchasing health insurance. Should society be concerned about these individuals?

Furthermore, there are approximately twelve to thirteen million illegal immigrants currently residing in the U.S, according to the Center for Immigration Studies. Others estimate the number of illegal immigrants to be anywhere from seven million to twenty million [Camarota 2007, para. 4; Knickerbocker 2006, para 2]. Jeffrey S. Passel, a senior research associate at the Pew Hispanic Center, estimated that 59 percent of the undocumented non-citizen adult immigrants in 2004 lacked health insurance [2005, 35]. With approximately 8.8 million adult illegal immigrants in 2004, the number of uninsured totaled roughly 5.5 million [Passel 2005, 18]. Assuming the number of adult illegal immigrants held steady at 8.8 million through 2006 and the same proportion were uninsured, one could conclude that 5.5 million illegal immigrants were uninsured in 2006. Considering the recent influx of illegal immigrants and the decline in employer-provided insurance, it is likely that the number of uninsured illegal immigrants exceeded 5.5 million in 2006. When society speaks of the trials and tribulations of the uninsured does

it mean to include illegal immigrants?

Excluding these two groups leaves approximately twenty-three to twenty-four million uninsured. We have effectively halved the number of the uninsured individuals in the U.S, and that still includes those people who are eligible for Medicaid but have not applied for it. Twenty-nine percent of the uninsured in 2006 were probably eligible for Medicaid or the State Children's Health Insurance Program [Wall Street Journal, 2008, para. 8]. That potentially eliminates another thirteen million from the total uninsured, leaving only ten to eleven million.

Concerns about rising health care costs in the U.S also may not be warranted. Health care costs as a percentage of U.S. GDP have risen over the years, and now account for approximately 16 percent of U.S. GDP [Mankiw 2007, para. 19]. So, what does this mean? Can the high costs be equated with inefficiency in the current health care system or are there additional or alternative forces at work? Mankiw argues that a greater proportion of income spent on health care is not necessarily bad. In fact, he says it may be "a symptom of success", reasoning that Americans spend more on health care due to technological advances and greater income [2007, para. 19]. In supporting this claim, he relies on the work of economists Charles I. Jones and Robert E. Hall, who characterize an increasing share of income spent on health care as "a modern form of progress" [Mankiw 2007, para. 21]. They make an excellent point. "As we grow older and richer, which is more valuable: a third car, yet another television, more clothing- or an extra year of life?" [Mankiw 2007, para. 20].

Reports comparing the life expectancy and infant mortality rates in the U.S. and Canada are also somewhat misleading. Yes, the life expectancy is lower in the U.S. than in Canada. Also, infant mortality rates in the U.S. are higher than in Canada. These statistics do not imply that Canada's health care system is superior to the United States'. In fact, there is sufficient evidence to suggest otherwise. The lower life expectancy in the U.S. is likely due to the higher incidence of homicides and accidents in the United States [Mankiw 2007, para. 5]. Higher infant mortality rates in the United States are more likely the result of higher rates of teen pregnancies in the U.S than in Canada [Mankiw 2007, para. 9].

Taking these factors into consideration, can society really say that the current health care system is failing as has been reported? Moreover, can society make a case for health care reform? One thing is certain: "As we

look to reform plans, we should be careful not to be fooled by statistics into thinking that the problems we face are worse than they really are" [Mankiw 2007, para. 22].

3. Equity Issues

Critics have claimed that requiring individuals to purchase health insurance, which they may not be able to afford, is unfair. Indeed, forcing low-income individuals to purchase health insurance would be unfair. To overcome this problem, the government would provide subsidies to these individuals to offset any hardship. The concern then is not low-income people, but rather the lower-middle income class who are ineligible for subsidies. Opponents claim that individual mandates would force the lower-middle income class to "divert funds from more pressing needs" [Dalmia 2008, para. 2].

If taxes were raised to finance the subsidies to low-income people, the lower-middle income class would bear the greatest burden. Charles L. Ballard and John H. Goddeeris measured the efficiency and distributional effects of financing individual mandates with a tax increase of .12 percent [Ballard and Goddeeris 1999, 49]. They found that the individual mandate imposes a 20 to 38 percent increase in the marginal tax rate on lower-middle income families [Ballard and Goddeeris 1999, 43].

To avoid imposing an unfair requirement, the United States government might exempt certain individuals from the mandate. Massachusetts has exempted 60,000 individuals from the mandate based on their income, and it has created an exemption process for those who feel they cannot afford to purchase health insurance, regardless of their income level [Sasser 2007, 25].

4. Path to Single-Payer System

As has been previously mentioned, individual mandates are sometimes equated to "socialist health care". Michael Tanner has publicly expressed such a belief, stating that "by distorting the health care marketplace, an individual mandate would set in place a cascading series of additional mandates and regulations resulting, ultimately, in a government-run health care system" [2006, 9].

As extreme as that statement is, it has some merit. Switzerland, a long-standing employer of individual mandates, has recently seen a push

for a single-payer system. In March 2007 the Socialist Party and the Popular Group of Families proposed a single-payer system in Switzerland [Noble 2007, para. 6]. The proposition was voted on shortly thereafter and was overwhelmingly defeated. In fact, only two states out of twenty-six voted in favor of the single-payer system [Noble 2007, para. 10]. Although it was defeated it has prompted "modifications to the law from all sides" [Noble 2007, para. 16]. The modifications Noble refers to are not explicitly mentioned, but surely they would include increased regulations. Whether or not they would stimulate the transition to a government-run health care system is uncertain.

It is worth noting that individual mandates were not imposed overnight in Switzerland. The Swiss initially opposed individual mandates. Only after a century of debate were individual mandates employed in Switzerland. It is possible then that a single-payer system is in the works but that is uncertain.

IV. Economic Analysis of the Debate

Many of the supporting arguments for individual mandates presume that universal coverage is optimal. Proponents argue that compared to other means of achieving universal coverage, such as an employer mandate or a voluntary system with subsidies for low-income individuals, individual mandates are superior. This paper will not attempt to determine whether the United States should strive for universal coverage. There is no consensus on whether universal coverage is optimal. This analysis will focus on whether individual mandates would improve the current health care system.

As previously mentioned, the uninsured rate in the United States has increased over the past few years. In 2006 it increased from 15.3 percent to 15.8 percent [U.S. Bureau of the Census 2007, 18]. Rising uninsured rates are problematic, especially when the uninsured are primarily individuals who cannot afford health insurance. As already noted, high uninsured rates place financial stress on health care providers. Individual mandates could potentially resolve the uninsurance problem. Their ability to do so depends on whether the currently uninsured will comply with the mandate. So, will the uninsured comply? It is likely that the individual mandate will be capable of reducing the uninsured population but the size of the reduction is uncertain.

In Massachusetts, the uninsured population was reduced by

approximately 50-82 percent, depending on the number of uninsured prior to the reform [Nuzzo 2008, para. 5]. It is doubtful that the United States would see such a large reduction in the uninsured. As previously mentioned, the reduction in the uninsured in Massachusetts may have had more to do with the employer mandate that was simultaneously introduced. The increase in the uninsured in Massachusetts, prior to the reform, was primarily due to the decline in employer-provided health insurance [Sasser 2007, 6]. As a result of the employer mandate, employees who previously lost employer-provided insurance were once again provided this benefit. The reduction in the uninsured may have had little to do with the individual mandate. It could have been that the people who purchased health insurance following the reform did so of their own accord. This would suggest that the individual mandate would have less success reducing the uninsured in the United States.

Another reason individual mandates in the United States may have less success in reducing the uninsured is that they are difficult to enforce. As discussed earlier, the likely enforcement mechanism for individual mandates has serious shortcomings. It would potentially fail to track the health insurance status of approximately 27 million Americans [Tanner 2006, 3]. An employer mandate is relatively easier to enforce. It is easier to ensure compliance with large firms. This could have compensated for the difficulties associated with enforcing the individual mandate in Massachusetts.

Although individual mandates would reduce the uninsured population (by some amount), the cost implications would not likely support individual mandates. As already discussed, individual mandates would likely lead to higher health care costs, both in terms of total personal health care spending and the cost of health insurance. The increase in demand for health insurance would lead to higher prices. Increased government restrictions might also lead to higher premiums. Higher premiums might price some individuals out of the market, which means the government would have to increase the subsidies it provides. By extending health care coverage to the uninsured, the uninsured are likely to consume more health care, meaning greater health care spending. What's more, enforcement of the individual mandate is likely to lead to higher, possibly "enormous", administrative costs. As noted earlier, health care spending in Massachusetts in 2007 increased $1.2 to $1.4 billion and premiums increased twice as much as the national average [Nuzzo 2008, para 13; Dalmia 2008, para. 4; Claxton 2007, 1].

Much of the appeal of individual mandates is their ability to make the free-riders pay for the health care that they receive. However, as already mentioned, the free-rider problem may not justify individual mandates for health insurance. Moreover, they may not solve the free-rider problem. It is likely that some individuals will not comply with the mandate. Some might prefer to remain uninsured. The young and relatively healthy might be better off paying the penalty for noncompliance and paying for their health care out-of-pocket. As mentioned earlier, the initial penalty for noncompliance in Massachusetts was only $200, while the cost of a health insurance plan ranged from $2,400 to $3,000 [Hyman 2007, 5]. As long as individuals consumed less than $2,200 to $2,800 in health care, they were better off paying the penalty. Individuals who take especially good care of their health may prefer to pay out-of-pocket for their health care.

Ultimately, the appeal of individual mandates in the United States is determined by society's goals. If U.S. citizens are most concerned with reducing health care costs, individual mandates should probably not be imposed. If, however, the U.S. is most concerned about reducing the uninsured population, then individual mandates might be an attractive option. The ideal health care reform policy would work to reduce the cost of health insurance, making it more affordable for low-income individuals, thereby reducing the uninsured population. Yet it seems that if a policy were known that would reduce the cost of health insurance without sacrificing the quality of health care, it would already be in place. As mentioned earlier, it is possible that the United States is not in need of health care reform.

V. Conclusion

While both sides present some valid arguments, the opponents overall make a stronger case. There is evidence to suggest that health care reform is not warranted. The free-rider argument is in fact relatively weak. Despite proponents' claims, individual mandates are likely to lead to higher health care costs. It is also uncertain whether the benefits from increased coverage would exceed the cost of extending coverage to the uninsured. For these reasons, this paper finds that the U.S. should not create a nationwide system of individual mandates for health insurance. Further research is needed regarding the total cost and benefits of individual mandates, specifically under the premise of only a partial

decrease in the uninsured. At this point in time, all cost-benefit analyses have been performed under the presumption that individual mandates lead to universal coverage. If the benefits were found to exceed the cost of implementation with anything less than universal coverage, the decision regarding individual mandates would be subject to change.

References

Ballard, Charles L. and John H. Goddeeris. 1999. Financing universal health care in the United States: A general equilibrium analysis of efficiency and distributional effects. *National Tax Journal* 52, no. 1 [March]:31-51. http://0-web.ebscohost.com.unistar.uni.edu/ehost/pdf?vid=5&hid=6&sid=18ca3f68-be1d-4666-8c76-2fa9a7104862%40SRCSM1 [accessed February 4, 2008].

Camarota, Steven A. Immigrants in the United States, 2007: A profile of America's foreign-born population. Center for Immigration Studies. http://www.cis.org/articles/2007/back1007.html [accessed March 12, 2008].

Civitas: The Institute for the Study of Civil Society. The Swiss healthcare system, 2002. http://www.civitas.org.uk/pdf/Switzerland.pdf [accessed March 13, 2008].

Claxton, Gary, Bianca DiJulio, Benjamin Finder, Eric Becker, Samantha Hawkins, Jeremy Pickreign, Heidi Whitmore, and Jon Gabel. 2007. *Employer health benefits*. Henry J. Kaiser Family Foundation and Health Research and Educational Trust. http://www.kff.org/insurance/7672/upload/76723.pdf [accessed March 29, 2008].

Dalmia, Shikha. 2008. Saying no to CoerciveCare. *Wall Street Journal*, eastern edition. January 31. http://0-proquest.umi.com.unistar.uni.edu/pqdweb?index=0&did=1421356141&SrchMode=1&sid=2&Fmt=3&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1209611039&clientId=8553 [accessed April 4, 2008].

Emanuel, Ezekiel J. and Victor R. Fuchs. 2007. Vouchsafe. *The New Republic* 236, no. 8/9 [February 19-26]:14-15. http://0-web.ebscohost.com.unistar.uni.edu/ehost/detail?vid=1&hid=5&sid=14ca97fc-8488-4ff0-964d-22208d8a2620%40sessionmgr2 [accessed February 14, 2008].

Glied, Sherry A., Jacob Hartz, and Genessa Giorgi. 2007. Consider it done? The likely efficacy of mandates for health insurance. *Health Affairs* 26, no. 6 [November/December]:1612-1621. http://0-proquest.umi.com.unistar.uni.edu/pqdlink?Ver=1&Exp=03-07-2013&FMT=7&DID=1384874481&RQT=309 [accessed February 13, 2008].

Hisnanick, John J. and Dale A. Coddington. 1995. Measuring human betterment through avoidable mortality: a case for universal health care in the USA. *Health Policy*, 34:9-19.

Hadley, Jack and John Holahan. 2003. How much medical care do the uninsured use, and who pays for it? *Health Affairs*: 66-81. http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.66v1.pdf [accessed February 19, 2008].

Holahan, John, Randall Bovbjerg, and Jack Hadley. 2004. *Caring for the Uninsured in Massachusetts: What Does It Cost, Who Pays and What Would Full Coverage Add*

to Medical Spending? The Urban Institute. http://www.bcbsmafoundation.org/foundationroot/en_US/documents/roadmapReport.pdf [accessed March 5, 2008].

Hyman, David A. 2007. The Massachusetts health plan: The good, the bad, and the ugly. *Policy Analysis*, no. 595 [June 28]:1-11. http://www.cato.org/pubs/pas/pa-595.pdf [accessed February 27, 2008].

Institute of Medicine. 2003. *Hidden costs, value lost: uninsurance in America*. Report brief prepared by the Committee on the Consequences of Uninsurance. http://www.iom.edu/Object.File/Master/12/327/Uninsured5FINAL.pdf [accessed February 15, 2008].

Knickerbocker, Brad. 2006. Illegal immigrants in the US: How many are there? *Christian Science Monitor.* May 16. http://www.csmonitor.com/2006/0516/p01s02-ussc.html [accessed March 12, 2008].

Levy, Helen and David Meltzer. 2001. What do we really know about whether health insurance affects health? Working paper, University of Michigan. www.umich.edu/~eriu/pdf/wp6.pdf [accessed April 5, 2008].

Lichiello, Patricia, Gary Packingham, and Jack McRae. 2003. *Everybody in the pool: New strategies for covering the uninsured.* University of Washington. http://www.forumsinstitute.org/publs/wash/pooling.pdf [accessed March 10, 2008].

Mankiw, Gregory N. 2007. Beyond Those Health Care Numbers. Economic View. *New York Times*. November 4. http://www.nytimes.com/2007/11/04/business/04view.html [accessed January 20, 2008].

New, Michael J. 2005. The effect of state regulations on health insurance premiums: A preliminary analysis. The Heritage Foundation. http://www.heritage.org/research/healthcare/cda05-07.cfm [accessed March 30, 2008].

Newhouse, Joseph P. and Robert D. Reischauer. 2004. The Institute of Medicine Committee's clarion call for universal coverage. *Health Affairs*. [March 31]:179-183. http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.179v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=clarion+call+for+universal+coverage&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT [accessed February 28, 2008].

New York Times, late edition. 2007. Editorial. November 1. http://0-www.lexisnexis.com.unistar.uni.edu/us/lnacademic/results/docview/docview.do?risb=21_T3353356377&format=GNBFI&sort=BOOLEAN&startDocNo=1&resultsUrlKey=29_T3353356380&cisb=22_T3353356379&treeMax=true&treeWidth=0&csi=6742&docNo=3 [accessed March 18, 2008].

Nichols, Len M. 2007. Mandatory and Affordable Health Insurance. *Federal Reserve Bank of St. Louis Regional Economic Development*, 3, no. 1:24-28. http://research.stlouisfed.org/publications/red/2007/01/Nichols.pdf [accessed January 30, 2008].

Nuzzo, Candace. 2008. The Uninsured in America. PBS. The Online NewsHour. http://www.pbs.org/newshour/indepth_coverage/health/uninsured/massachusetts_update.html [accessed March 5, 2008].

Passel, Jeffrey S. 2005. *Unauthorized migrants: Numbers and characteristics.* Background briefing prepared for Task Force on Immigration and America's Future. June 15. http://pewhispanic.org/files/reports/46.pdf [accessed March 25, 2008].

Santerre, Rexford E. and Stephen P. Neun. 2006. *Health economics: Theories, insights, and industry studies.* 4th ed. Mason, OH: Thomson South-Western.

Sasser, Alicia. 2007. *Reaching the goal: Expanding health insurance coverage in New England. Current strategies and new initiatives*. New England Public Policy Center. Research Report 07-1. http://www.bos.frb.org/economic/neppc/researchreports/2007/rr0701.pdf [accessed March 8, 2008].

Steinhauser, Paul and Candy Crowley. 2007. Clinton unveils mandatory health care insurance plan. CNN.com. September 18. http://www.cnn.com/2007/POLITICS/09/17/health.care/index.html [accessed February 9, 2008].

Steuerle, C. Eugene. 1994. Implementing employer and individual mandates. *Health Affairs* 13, no. 2 [April 1]:54-68. http://healthaff.highwire.org/cgi/reprint/13/2/54 [accessed March 15, 2008].

Symonds, William C. 2006. In Massachusetts, health care for all? *BusinessWeek*. April 4. http://www.businessweek.com/investor/content/apr2006/pi20060404_152510.htm [accessed April 8, 2008].

Tanner, Michael D. 2006. Individual mandates for health insurance: Slippery slope to national health care. *Policy Analysis,* no. 565 [April 5]:1-12. http://www.cato.org/pub_display.php?pub_id=6243 [accessed January 25, 2008].

Tobin, James. 1994. Health care reform as seen by a general economist. Lecture, University of Minnesota, Twin Cities, MN. April 29. http://cowles.econ.yale.edu/P/cd/d10b/d1073.pdf [accessed January 25, 2008].

U.S. Bureau of the Census. 2007. *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, by Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica Smith. http://www.census.gov/prod/2007pubs/p60-233.pdf [accessed February 10, 2008].

Wall Street Journal, eastern edition. 2008. The wages of HillaryCare. February 7. http://0-proquest.umi.com.unistar.uni.edu/pqdweb?index=0&did=1425014991&SrchMode=1&sid=3&Fmt=3&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1209911361&clientId=8553 [accessed February 13, 2008].

Wall Street Journal**,** eastern edition. 2005. Unsocialized Medicine. June 13. http://0-proquest.umi.com.unistar.uni.edu/pqdweb?index=1&did=853003321&SrchMode=1&sid=1&Fmt=3&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1209910953&clientId=8553 [accessed March 20, 2008].

Whitman, Glen. 2007. *Hazards of the individual health care mandate*. Cato Policy Report, 2007. [September/October]. http://www.cato.org/pubs/policy_report/v29n5/cpr29n5-1.html [accessed March 8, 2008].