Public Forum 'CON' Analysis: March 2013

Recently, we discussed the arguments in favor of the Public Forum March resolution, **Resolved: The U.S. government should not require its citizens to have health insurance**.

Opponents of the mandate believe it is a costly solution to a problem that simply isn't that large – that the number of uninsured Americans who ultimately are unable to pay for care in the current system is small but that the cost of mandating they receive insurance is high enough to case ill effects on the many families that are currently happily insured.

Today, we will discuss the arguments in favor of the mandate. We will begin with the most basic argument in favor of the mandate: Health care is a good that everyone consumes over the course of their lives. Although some consume more than others, all consume some. The only question is whether or not that care will be covered by insurance.

Advocates of the individual mandate argue that those who consume care that is not insured pass the costs of that care onto the insured when they are unable to pay for it, a phenomenon called **free-riding**. Laurence Silberman explains:

Silberman, 2012 ["Mandatory Health Insurance: The Case For, and Against," Laurence, Senior Judge, Business Week.]
Appellants' primary argument is that Congress cannot require individuals with no connection to interstate commerce, and no desire to purchase a product, nonetheless to do so. The government counters that because virtually everyone will, at some point, need health services, no one is truly inactive. Congress found that those who do not purchase health insurance, and instead self-insure, **almost inevitably take health-care services they cannot afford.** Hospitals, by virtue of federal law and professional obligation, provide these services, and as a result, $43 billion in annual costs are shifted to the insured, through higher premiums. Indeed, were "activities" of some sort to be required before the Commerce Clause could be invoked, it would be rather difficult to define such "activity." For instance, our drug and child pornography laws, criminalizing mere possession, have been upheld no matter how passive the possession … on the theory that possession makes active trade more likely in the future. We acknowledge some discomfort with the government's failure to advance any clear doctrinal principles limiting congressional mandates that any American purchase any product or service in interstate commerce. It suffices for this case to recognize that the health insurance market is a rather unique one, both because virtually everyone will enter or affect it, and because **the uninsured inflict a disproportionate harm on the rest of the market.** That a direct requirement for most Americans to purchase any product or service seems an intrusive exercise of legislative power surely explains why Congress has not used this authority beforebut that seems to us a political judgment rather than a recognition of constitutional limitations. It certainly is an encroachment on individual liberty, but it is no more so than a command that restaurants or hotels are obliged to serve all customers regardless of race. **The right to be free from federal regulation is not absolute and yields to the imperative that Congress be free to forge national solutions to national problems**.

Essentially, here's what happens: In the U.S., it is illegal to refuse care to an individual that presents him or herself at an emergency room, regardless of their ability to pay. This is a measure that exists regardless of the mandate and which enjoys broad support among the public who find it (understandably) undesirable to refuse care to the dying poor. This causes a unique problem, however; the care consumed by the uninsured isn't truly "free," even though the uninsured individual does not pay for it. Those costs are passed on to the insured via higher **premiums** (the fees the insured need to pay for coverage). This is because hospitals lose money whenever they care for an individual "for free." They need to recoup those costs somewhere, so they charge insurance companies (and insured individuals) more in order to offset their losses.

As more and more individuals are becoming uninsured as a result of losing their jobs or employers cutting back on benefits, the amount of care given to uninsured individuals goes up. "CON" authors and "PRO" authors differ on what this means. While "PRO" authors argue that these uninsured individuals will either pay for their care out of pocket or just not seek care, many "CON" authors argue that they will seek care but without will do so without paying for it. This increases health costs for everyone through higher premiums (explained above). That makes insurance less and less affordable, leading to more uninsured, finally leading to a vicious cycle of rising health care costs.

Schwarz further expands upon this point, arguing:

Schwarz, 2012 ["Individual mandate in Obama's health care law: good for freedom, bad for free-riders," John E., Senior Fellow at Demos, Christian Science Monitor.]
Opponents ask: If the federal government has the power to compel all Americans to purchase private health insurance, why couldn't it require every American to purchase broccoli and other foods that it deems healthy to reduce health-care costs? They claim that if the government has the authority under the interstate commerce clause to penalize even inaction – in this case, the decision not to buy insurance – there is effectively no limit on what government could require. As Judge Stanley Marcus of the 11th Circuit Federal Court of Appeals asked: "If they [the federal government] could compel this, what purchase could they not compel?" This idea has great currency in opponents' circles, but its rationale is utterly flawed. Why? Because of "free-riders." A free-rider is a person who benefits from something without paying for it, meaning that somebody else must shoulder the cost. A primary aim of the insurance mandate is to prevent free-riders who receive health-care services but do not pay for them because they lack adequate insurance coverage. In the health-care market, the only recourse that free-riders leave providers is to withhold their services in what are typically emergency circumstances – the very instances in which we all agree services should not be denied. It is often impossible, in any case, to determine whether individuals who are in severe pain or delirious can pay or not. Current law, in fact, does not permit providers to deny medical services in these circumstances. And beyond these logistical and legal obstacles, most providers are also reluctant to deny care for humanitarian reasons. Free-riding, in turn, shoves the free-riders' costs onto others through higher prices. This problem is so substantial that in 2009, Newt Gingrich castigated individuals who didn't purchase health insurance yet could afford it, calling them free-riders and saying that they ought to be required by law at least to post a bond. An insurance mandate aimed at stopping free-riders is in complete harmony with a free market. Indeed, the mandate is essential for a free market to be able to operate properly, which is why the Heritage Foundation, a fierce advocate of the free market, was among the first to propose mandating

the purchase of health insurance as a solution to both the free-rider problem and rising health-care costs.

The mandate, however could solve a lot of these problems even with weak enforcement. Ezra Klein explains:

Klein, 2012 ["The irony of the individual mandate," Ezra, Columnist at the Washington Post, as well as a contributor to MSNBC Wonkblog, Washington Post.]
There are many ironies in the furor around the individual mandate. The fact that it was originally a Republican idea tends to get the most attention. But here's another: There is no better deal in the legislation — and there has perhaps never been a better deal in the individual health-care market — than to go without insurance and pay the mandate's penalty. Here's what happens now if you decide to wait until you're sick to buy health insurance: Every health insurance company will tell you no, or they'll charge you an exorbitant rate, or they'll offer you insurance that will cover everything except your illness. Insurers, quite rightly, do not want to cover preexisting conditions, and there's little consumers can do to make them change their minds. Under the Affordable Care Act, here's what happens if you wait until you're sick to buy health insurance: You can buy health insurance and no insurer can charge you more for walking into their office with a lump the size of a golf ball. The catch is that between now and getting sick, if you can afford insurance — which the law defines as you have access to insurance that costs less than eight percent of your income — you have to pay a penalty of $695 a year (that's the 2016 number; after 2016, it rises with inflation) or 2.5 percent of your annual income, whichever is greater. The fact of the matter is that $695 a year or 2.5 percent of your annual income is likely to be a lot less than a decent insurance policy will cost you. In a way, paying the mandate is like buying an option to purchase insurance at some future date, when you need it more, **for a price that you could never have gotten before the mandate**. But let's say you try to eke out an even better deal than that: Let's say you don't buy insurance and you simply refuse to pay the mandate. What can the government do to make you pay? Well, unlike if you refuse to pay your taxes, it can't throw you in jail or put a lien on your home or other property (page 336 of the legislation). It can potentially reduce your tax refund, but that's really it. If you're not getting a tax refund, you're free and clear. Given these specifics, it's worth asking why anyone thinks the mandate will work at all. And it's worth saying that some don't. "Even as it exists today, the individual mandate is weak and still presents problems because the penalty is so low," Aetna Chief Executive Mark Bertolini told Reuters. "Obamacare individual mandate unlikely to work" wrote Marrill Matthews of the Institute for Policy Innovation, an organization that opposes the Affordable Care Act. Most analysts are more optimistic, and for two reasons. First, Americans want health insurance, they want access to care before they get sick, and with the subsidies in place, they're getting help to buy it. Second, Americans tend to follow the rules. In Massachusetts, where the mandate is similarly weak, compliance has been extraordinarily high.

Klein argues that the uninsured population is made up of largely people who can't afford health insurance for one reason or another but would gladly buy insurance if they were able to pay for it. The mandate prices these individuals back into the market. Yes, they may still underpay relative to what they take, but if they all pay what they're able, the financial pool is large enough to eliminate and even exceed the total cost of care for everyone. Jonathan Gruber further explains this argument by outlining scenarios for lack of coverage that the mandate would remedy:

Gruber, 2011 ["Health Care Reform without the Individual Mandate," Jonathan, Professor of Economics at the Massachusetts Institute of Technology, Center for American Progress.]
We have a fairly good sense of how the world will look if health care reform includes the individual mandate. Both the Congressional Budget Office and independent modelers such as myself find that the majority of the uninsured would be covered.1 CBO and I both estimate that Affordable Care Act will cover about 60 percent of those who would be uninsured absent the law. We both find that there would be a very modest reduction of employer-sponsored insurance, that premiums in the nongroup insurance market for the same quality product would fall, and that there would not be much effect on premiums in the employer-provided insurance market. These estimates are consistent because we have a clear example to draw on in this case, the state of Massachusetts, which four years ago enacted a plan that is very similar to the new federal health reform law. In Massachusetts we have seen more than 60 percent of the uninsured gain coverage with little effect on employer-sponsored insurance premiums. We have seen a steeper drop in nongroup premiums that estimates suggest for the Affordable Care Act, however. According to insurance industry figures, nongroup premiums have fallen by 40 percent in Massachusetts while rising by 14 percent nationally.2 This much steeper drop in Massachusetts arises because the state has also given us a glimpse of what the world would look like if the mandate were stripped from the Affordable Care Act. In the mid-1990s, Massachusetts along with several other northeastern states passed insurance market reforms similar to those in the Affordable Care Act, eliminating or restricting the ability of insurance companies to discriminate against the ill either in prices or coverage exclusions. The result in each state was very high nongroup insurance prices as insurance companies worried that only the sick would enroll in insurance and priced their products accordingly. We do not, however, have an example of a state that has included the other major element of the Affordable Care Act—extensive subsidies for low-income individuals to buy insurance. This will offset to some extent the "adverse selection" that drives up premiums in the nongroup market by bringing some healthier individuals into the market. The extent of such offset, however, is unclear. CBO estimates that removing the individual mandate from the new federal health law will cut the number of individuals newly insured in half (from 32 million to 16 million), while I estimate that it will cut the number of newly insured individuals by three quarters (from 32 million to 8 million). CBO estimates that the reduction in employer-sponsored insurance will double with no mandate; I estimate that it will triple. CBO estimates that premiums in the nongroup market will rise by 15 percent to 20 percent; I estimate they will rise by 27 percent. Finally, CBO estimates that removing the mandate would lower net government spending by $47 billion in 2019, or roughly 25 percent of the costs of the policy. I estimate a cost reduction of 30 percent. 3 So there is agreement between CBO and myself that a bill without the individual mandate will cover significantly fewer persons, with more erosion of employer insurance, and lead to significantly higher premiums. Moreover, we both agree that removing the mandate would significantly lower the "bang for the buck" of health policy, reducing coverage by 50 percent to 75 percent while only lowering costs by 25 percent to 30 percent. But there is more uncertainty and divergence in the estimates. And this is a key point to highlight about removing or replacing the individual mandate—it will raise our uncertainty about what health care reform can accomplish. One advantage of the individual mandate is that we have an example to build on; alternatives put us in a much less clear world.

He continues,

Gruber, 2012 ["Why the Individual Mandate Is Effective and Efficient," Jonathan, Professor of Economics at the Massachusetts Institute of Technology, The Daily Beast.]

Most Americans get their health insurance **from their employer or the government**, through its Medicare and Medicaid plans. For those Americans, insurance works reasonably well: premiums are rising faster than we would like, but otherwise individuals are generally well insured against any medical catastrophe that might befall them. Not so for those individuals who have to rely on insurance purchased on their own in the "non-group" market. These individuals face a market where coverage is expensive and unreliable–which can lead to medical bankruptcy if individuals get an expensive illness. While it is fortunate that most Americans don't have to face this market, it also results in a lack of appreciation for the important law that will fix these problems: the Affordable Care Act (ACA). In my book I introduce the fictional character, Carlos, who has non-group insurance—and has a heart attack. Carlos is in real trouble. He will typically pay a very large share of his medical bill—or the whole thing if this heart attack reflects a pre-existing condition. His insurer may pay these bills, but it is likely to simply drop Carlos before he gets sick again. It turns out that individuals like Carlos don't have insurance in any meaningful sense. And it is not just individuals like Carlos who face this ugly market: anyone who might lose their job, or have an employer that stops offering insurance, can find themselves facing this nightmare. I show this happening to Anthony, who has good employer-provided insurance but loses that coverage and has to face the awful non-group insurance market as a result. This is a real threat to many with employer-provided insurance: the share of employees covered by employer-sponsored insurance has declined by more than 10% over the past decade. How can we fix this problem? A number of well-meaning states tried to do so in the mid-1990s. They passed regulations that outlawed discriminatory practices by insurers, like pre-existing conditions exclusions and charging sicker individuals higher prices. The result was a disaster. Insurers were afraid that if they had to charge everyone the same price, but that individuals could wait until they were sick to buy insurance, that this would become a money-losing business. So some insurers exited the markets, while the ones that stayed charged very high prices to offset this "adverse selection." Non-group insurance markets in these states were not saved, but rather largely destroyed. For example, in my home state of Massachusetts, by 2006 a non-group policy for a single individual cost $8,000 per year, twice the cost of an employer policy for an individual. Into this chasm stepped the hero of our story, Governor Mitt Romney, and his plan for health-care reform in Massachusetts. He realized that the solution to this problem was to ensure broad participation insurance markets by both the healthy and the sick. So he imposed an individual mandate, a requirement on Massachusetts residents to purchase insurance coverage. But he also realized that it would be both inhumane and impolitic to mandate that individuals purchase insurance they could not afford. For this reason he also provided for subsidies for individuals living below three times the federal poverty line to make insurance affordable. This "three-legged stool"—banning discrimination in insurance markets, mandating that individuals purchase insurance, and providing low-income subsidies for insurance purchase—became the basis for both our reform in Massachusetts and for the Affordable Care Act (ACA). The enormous success of health-care reform in the almost six years since its passage in Massachusetts can make us more confident that this three-legged stool will work for the nation as a whole. We have covered about two-thirds of uninsured Massachusetts residents, and have lowered the premiums in the non-group market by half relative to national premium trends. And we have done so with broad public support. Moreover, this reform succeeded without interfering with the employer-sponsored insurance market that works for most of our residents: employer-sponsored insurance coverage has actually risen in Massachusetts, while falling sharply nationally, and the premiums for employer-sponsored insurance rose no faster in Massachusetts than they did nationally. This was all possible because the individual mandate ended the "death spiral" of trying to obtain fairly priced insurance by just forcing insurers to charge everyone the same price. The bottom line is that we can't have fairly priced insurance for the healthy and sick alike without the broad participation that is

guaranteed by the mandate. **The mandate is the spinach we have to eat to get the dessert that is fairly priced insurance coverage**.

Several arguments here:

1. Gruber argues that the individual mandate is a tested solution because it's very similar to health reform that's passed in the state of Massachusetts. Using that data (and some more economic models of his own design), he extrapolates that the falling prices in Massachusetts are likely to be replicated on a larger scale once the individual mandate takes effect nationwide.
2. The mandate may be the only solution for two types of individuals that he explains above – those in the **non-group market** and those with **pre-existing conditions**, that is, conditions that they had before they obtained insurance.

Improving coverage has a number of benefits, aside from the elimination of "free-riders." More coverage ensures Americans will be healthier, happier, and less likely to go bankrupt because of health bills they didn't foresee and can't afford.

Charles Mouton explains why mandated care necessarily means better health outcomes for consumers:

Mouton, 2005 ["Universal Coverage Is the Linchpin," Dr. Charles P., professor and chairman of the Department of Community and Family Medicine at the Howard University College of Medicine, New York Times.]
Perhaps equally important to providing the fundamental change to the system, universal coverage will provide the opportunity for every American to have a physician who provides them a "medical home." No longer will millions of families seek routine medical care through hospital emergency rooms. Instead, they will have a family physician focused on coordinating care for their illnesses and assuring that they receive care that promotes health and wellness. Only through coverage for everyone will we begin to raise the health of Americans from 37th among industrialize countries to the top where it belongs.

Mouton argues that coverage is key to care not just because it's an access point to a baseline. As we've already discussed, the uninsured do have some limited options for receiving emergency care for free. Better outcomes, he argues, can only happen when individuals have a **primary care physician** (a doctor who handles their care on a regular non-emergency basis) who can conduct consistent early interventions. This is for two reasons:

1. Consistency. Having a single doctor aware of an individuals' entire medical history is arguably important because it allows them to check for anomalies and provide care appropriate to unique needs that may not be apparent to an ER doctor (as they only see patients for a few hours and then possibly never again).
2. Preventative care. By the time an individual reaches the ER, the situation is an emergency. In many cases, subtler symptoms may precede an emergency. For example, an individual with a primary care physician will be monitored for high blood pressure and cholesterol. This patient will know of his or her heightened risk for a heart attack and be given preventative medication. An individual without a primary care physician may not know of their increased risk until they are actually having a heart attack, at which point their odds of survival are significantly reduced.

Richard Kirsch further explains why a mandate is key to adequate coverage:

Kirsch, 2012 ["The Economic Question at the Core of the Individual Mandate," Richard, Senior Fellow, Roosevelt Institute, Huffington Post.]
Regardless of what the Court rules about the constitutionality of the individual mandate, health care will still be a public good, even if our health care system continues to have a schizophrenic relationship with the economics of health care, treating it like a public good and a commodity at the same time. In the long run, the only way to achieve a health care system that provides quality care that is affordable to the nation will be for the system to recognize that health care is a public good. The ACA is a major step in that direction and would be so even without the mandate. The expansion of Medicaid, the incentives for employers to pay for coverage, and other features of the law that regulate insurance rates and change the way Medicare pays providers all treat health care this way. If the Supreme Court rejects the mandate, millions of people will go without health coverage, thousands of them will continue to die prematurely each year because they lack coverage, and tens of thousands will continue to suffer from crippling medical debt. Still, the economic pressures and tragic personal pain caused by our current health care system will continue to drive the United States in the direction of making health care a right. That will be true even if the Supreme Court decides that health care is more like broccoli than clean water and air.

Kirsch's argument is that it is unfair and untenable to treat something that everyone needs and that we agree everyone should have as a consumer good (something that people aren't guaranteed). He argues that under this system, inevitably some will go without life-saving care and that only a mandate can remedy that.

In addition, mandated coverage could conceivable improve the economy. Charles Mouton explains,

Mouton, 2005 ["Universal Coverage Is the Linchpin," Dr. Charles P., professor and chairman of the Department of Community and Family Medicine at the Howard University College of Medicine, New York Times.]
In his letter to Congress, President Obama indicated he might be supportive of a requirement that every American have health insurance, with employers sharing some of the cost. Coverage for every American is essential to any health care reform package. No longer can the public afford a system that shifts the burden of care for the uninsured onto those who have health insurance or onto the fragile health care infrastructure. As those who have lost their jobs through layoffs, plant closings and corporate failures lose their health coverage, attempts to recover from the economic downturn will likely be stopped in its tracks without health reform. The Obama administration understands this. Universal coverage is the necessary linchpin to stabilizing the health care system.

Mouton argues that, with the recent recession, many Americans have lost their jobs. It's conceivable that those same Americans may have had difficulty in finding new ones because unemployment has been so high and companies have been less likely to hire. It's possible, then, that during the time they were unemployed and without insurance they may have racked up lots of expensive health bills and debt as a result of an unforeseen injury or illness. If that happens, they're less likely to be able to emerge from poverty even when they become employed (because they're paying off the debt). If Americans with jobs don't spend their income in ways that stimulates the economy and instead use it to pay off mounting medical debt (or go bankrupt), the economy suffers because capital is drained without being re-injected as consumer spending.

Champlin and Knoedler provide a related argument,

Dell P. **Champlin and** Janet T. **Knoedler,** "Universal Health Care and the Economics of Responsibility," Journal of Economic Issues, Vol. XLII, no. 4, December **2008**.
The presumption that health care costs are the responsibility of individuals is supported by orthodox economics, which treats health care as a consumer good.' In this framework, there is no shared responsibility for health care. There is only individual demand for health care with employers and governments in a supporting and, ultimately, market-distorting role. It is difficult to see how universal health care can be built upon such a philosophy. On the other hand, institutional economics views health care very differently. As Dennis Chasse (1991) notes, John R. Commons, John Andrews and other early institutionalists understood that the social and economic structure of modern capitalism left workers with little bargaining power. As a result, workers "bore an unreasonable share of the costs of economic growth and financial speculation - instability, unemployment, hazardous working conditions, and low pay" (Chasse 1991, 805). J.M. Clark also recognized that problems like poverty, unemployment and industrial accidents are systemic in nature and beyond the reach of individual choice and personal responsibility (Clark 1936). Clark also stressed that the benefits of good health accrue not only to individuals but to employers and the community as well: "there is a minimum of maintenance of the laborer's health and working capacity which must be borne by someone, whether the laborer works or not," or else "the community suffers a loss through the deterioration of its working power" (Clark 1923, 16, quoted in Stabile 1993, 173). More recently, institutional economists and others have questioned the applicability of the choice theoretic framework to health care, since the choice of health care services is, at best, a joint decision, and is often made by others (Bownds 2003; Keaney 1999; 2002). In short, in the institutionalist view health care is treated as a social good that is fundamentally a matter of collective responsibility.

The argument here is that we can't consider health in an economic vacuum. The employed American people, taken all together, make up what is known as the "workforce." The American workforce does best when many people have jobs and can do them very well – quickly, productively, etc. Think about how many goods and services you use every day, just to get through the day: you need the teachers and staff to run your school, the tech companies to maintain your wireless and cell phone networks, and even the staff at restaurants to make your lunch. Without all of those moving parts, you can't do your job.

If the American workforce becomes sicker because they can no longer afford rising health care costs and need to miss work or report to work while sick (which spreads disease and often ensures they aren't as productive), everyone suffers a slowed-down economy. For Champlin and Knoedler, an investment in the health care of others is really an investment in ensuring all the goods and services we consume run smoothly.

There are, as with the "PRO" side, a number of liberty and morality arguments associated with the "CON" side of the resolution. The first is an extension of the **free-riders argument** explained above. Schwarz explains,

Schwarz, 2012 ["Individual mandate in Obama's health care law: good for freedom, bad for free-riders," John E., Senior Fellow at Demos, Christian Science Monitor.]

The court, instead, will have ruled for the one-sided autonomy of free-riders and rejected the freedom of providers, taxpayers, and consumers, subjecting them all to what is essentially a form of stealing. Providers will be legally required, not to mention under the influence of professional obligations going back to the Hippocratic Oath, to deliver services to the free-riders without knowing or often even being able to determine whether they will be compensated. To have to work without compensation is a core characteristic of forced labor. The providers then will be forced to finagle third-party consumers and their insurers – innocent bystanders – to pay for the free-riders' costs by charging them higher prices. If this is a victory for freedom, it will be for a **fraudulent anything-goes notion of freedom that is amoral**. And if this is a victory for limited government, it will be so only in the false sense of a government rendered so impotent as to be incapable of protecting its own citizens from free-riders.

A mandate, he argues, remedies two potentially serious moral lapses. First, it prevents doctors from having to work for no or indeterminate pay (something he likens to forced labor). Second, it prevents the insured for being penalized for nothing more than having insurance via higher prices. Schwarz argues that both of these rob individuals of their resources in service of those who take a service they will inevitably need without having adequately arranged for it.

Jonathan Gruber offers a related argument:

Gruber, 2012 ["Why the Individual Mandate Is Effective and Efficient," Jonathan, Professor of Economics at the Massachusetts Institute of Technology, The Daily Beast.]
Finally, some claim that the mandate is unconstitutional. While this will ultimately be decided by the Supreme Court, the vast majority of legal scholars who have weighed in on this topic, both liberal and conservative, have said that this is a laughable argument. Former Reagan Solicitor General Charles Fried went so far as to state that he would "eat his [kangaroo skin] hat" if the mandate is found unconstitutional. All individuals will require health care at some point in their lives, and that health care will most often be unaffordable for the typical family. Even if families can't pay for their health care, however, hospitals are required by law to deliver it, and those costs (amounting to more than $40 billion per year) are passed on in the form of higher insurance premiums. Moreover, by choosing to be uninsured until they are sick, healthy uninsured individuals impose higher costs on all those who buy insurance. Therefore, the decision to remain uninsured clearly impacts interstate commerce and can be regulated under the Constitution's commerce clause.

His argument is, in essence, that there are two kinds of individuals who could end up without insurance:

1. **Those whose health has gotten so poor and health costs so high that they can no longer afford to pay for them.** In this instance, he argues that it would be immoral to deny them care. Denial of care to individuals based on their inability to pay essentially condemns the poor to poor health and denies them life-saving medical advances. He argues that this is destructive to society because health is a human right, not a privilege.
2. **Those who are irresponsible with their money and choose not to buy insurance because they know that their costs will be covered in an emergency.** These individuals are acting immorally for the reasons Schwarz outlined above and should be compelled to pay a reasonable portion of their income toward the risk pool.

Finally, there are some defensive arguments to consider in answer to some of the 'PRO' arguments we presented recently. While I'm sure you're aware of the ways in which the free-riders argument interacts with the "rising costs" PRO argument, Jonathan Gruber addresses the claim that the individual mandate will cause spiraling health care costs thusly:

Gruber, 2012 ["Why the Individual Mandate Is Effective and Efficient," Jonathan, Professor of Economics at the Massachusetts Institute of Technology, The Daily Beast.]
If the individual mandate is struck down by the Supreme Court or otherwise undermined by politicians, then the ACA becomes a much less effective law, covering only half as many uninsured, according to the Congressional Budget Office (CBO), and leading to premiums that are 20% higher. But it doesn't become a much cheaper law; the CBO estimates that it will still cost three quarters as much even though it only does half the lifting. Moreover, alternatives to the individual mandate aren't effective, nor are they any more politically feasible. The bottom line is that the individual mandate is necessary for ending discrimination in health-insurance markets, the key accomplishment of health-care reform. It won't apply to the vast majority of Americans, who already have health insurance, and it will not force anyone to buy insurance that they cannot afford. And with no realistic alternative, removing the mandate will result in a health-care reform that is less effective but without much government savings.

Gruber argues that, given the current state of health insurance premiums (rising) and the number of uninsured Americans, something will need to be done about insurance in the U.S. He then concludes that, of the available solutions, a mandate would be the most efficient use of cash because, while all solutions will require government money, not all solutions will necessarily tackle the problem of the uninsured as directly. You can use this argument as a uniqueness argument – arguing that rising health care costs are inevitable and a costly solution will need to happen regardless (to take out the advantage) and that only a mandate solves.

Finally, to the charge that the mandate will require individuals to buy expensive insurance that they don't need, Joanne Kenen says,

Kenen, 2012 ["5 myths of the individual mandate," Joanne, Politico Contributor, Politico.]
3) Young and healthy people must buy expensive policies they can't afford and don't need. While the young and healthy will be required to have health insurance, the law has some incentives for them. Young adults under age 26 can stay on their parents' plans, if they don't have an alternative through a job. People under age 30 can buy a lower cost "catastrophic plan" through state exchanges, which means they'd be covered in the event they were hit by the proverbial bus. Still, Republicans argue rates for the young and healthy could increase, even with the new provisions.

Gruber underscores this point, arguing that for many people a mandate wouldn't even be noticeable:

Gruber, 2012 ["Why the Individual Mandate Is Effective and Efficient," Jonathan, Professor of Economics at the Massachusetts Institute of Technology, The Daily Beast.]
There have been a variety of complaints about the individual mandate, but they are unfounded. It is important to remember that the vast majority of Americans will be unaffected by the mandate because they are already covered; indeed, when individuals are informed of this fact, public support for the

mandate almost doubles. Moreover, no one will be forced to buy insurance that they cannot afford; the mandate includes an "affordability exemption" that excludes any individual who cannot find insurance for less than 8% of their income. In Massachusetts we have a similar exemption and we have had no public outcry about the mandate and only a very small number of appeals of mandate penalties.

That's all for today! We hope you enjoyed our 'CON' analysis, and we wish you luck on the March topic! As always, let us know if you have questions in the comments or via e-mail. When you finish your March cases, don't forget to send them for a free critique to lauren.sabino@ncpa.org! Good luck this season!