Public Forum 'Pro' Analysis: March 2013

The Public Forum March resolution, **Resolved: The U.S. government should not require its citizens to have health insurance,** is as timely as it is controversial.

The issues we're discussing this month span a whole host of issues but primarily focus on a single core controversy in the health care debate:

Does mandating that individuals buy health insurance decrease costs, increase well-being, and lead to a more equitable society? Or does it massively increase costs, create perverse incentives that decrease the quality and quantity of care, and entrench an anti-egalitarian, distorted market?

Most advocates agree on one thing: Care costs have been higher than we would like and not everyone is particularly well-served by the system. They strongly disagree, however, on the remedy.

Today, we'll discuss the ways in which compulsory, mandated health insurance (an "individual mandate") causes more problems than it could hope to solve in our "PRO" analysis.

First, we should discuss exactly how **insurance** works. Insurance is a way to manage financial risk. Health insurance companies are an attempt to spread the risk of serious health problems to a **risk pool.** A risk pool is a group of individuals who collectively pay a company to cover them in the event of an emergency. They pay less than they would pay if they didn't have insurance because they are all collectively betting that they won't need it. The idea behind insurance is that, it'd be a bad bet to bet that you will never need expensive health care but a better bet to bet that thousands of people in your risk pool will not need expensive care (for the same reason it's unlikely that 15 million people will all get the same very rare and expensive form of cancer). You pay your company a fixed amount every month (say, $100) to insure that, in the event that your health bill is more than you can afford (because you've come down with something rare and expensive), you won't be responsible for paying that full amount. Your insurance company will pay for you with money they have in surplus from those who are paying but not consuming as much care. The larger the risk pool, the less you'll (theoretically) have to pay because larger risk pools disperse risk over more individuals. The "individual mandate" is an attempt to make a risk pool as large as possible by forcing everyone to become insured. Advocates say this is the best way to keep costs down. Many believe this to be the exactly wrong approach.

One of the strongest arguments for repealing the individual mandate as envisioned in the Affordable Care Act ("Obamacare") is that **it will cause health care costs to spiral out of control, worsening the very problem it was designed to solve.**

Ramesh Ponnuru explains,

Ponnuru, 2011 ["Mandatory Insurance Is Wrong Fix for Health Care: Ramesh Ponnuru," Ramesh, senior editor for National Review, Bloomberg.]
The principal arguments for the mandate are three. The first is that the uninsured raise the premiums of everyone who has insurance. Obama made this point in his address on health care to a joint session of

Congress in September 2009: “Those of us with health insurance are also paying a hidden and growing tax for those without it -- about $1,000 per year that pays for somebody else’s emergency room and charitable care.” When Obama spoke, this figure had already been debunked by the Kaiser Family Foundation, which reached an estimate closer to $200 per year for a family. The Congressional Budget Office reached a similar estimate. So the cost the mandate is meant to address is smaller than Obama assumed. It could be driven still lower by means less intrusive than a mandate. State regulations drive up the cost of insurance by requiring that it cover services that not everyone wants. If young, healthy people were allowed to purchase cheaper insurance policies to cover the costs of catastrophic health problems, many of them would surely do so, and they would then pose less risk of generating costs for others. If a mandate forces these people to buy insurance policies they don’t want -- because the expense of the policies is out of proportion to their probable need for it -- then it isn’t a way to avoid cost-shifting. It’s a form of it. The mandate itself carries significant costs. If the government requires everyone to purchase insurance, it has to define what form of insurance meets the requirement. Medical provider groups have an incentive to lobby the government to make sure their service is required under the mandate. To the extent that they succeed, the cost of insurance goes up. (That’s how those state regulations arose.) And, of course, people who cannot afford to comply with the mandate must receive subsidies: another cost. And then there is the cost of enforcement. So much for the cost-shifting argument.

Ponnuru’s argument is simple: A mandate results in a baseline of insurance that’s too high, which is likely to raise everyone’s rates.

Young and healthy people, Ponnuru argues, are not likely to consume very much health care because they are statsistically much less likely to have some of the chronic issues that come with age (high blood pressure, certain cancers, dementia, type 2 diabetes, etc.) Although there may be individual variation, as a group these individuals need fewer preventative measures, fewer tests, less medication, and fewer doctor appointments and hospital stays. Insurance companies try to attract these individuals (because they’re a “good bet”) by charging them lower rates in the status quo.

An individual mandate aims to guarantee that no one is under-insured. It does this by requiring that everyone have “good” insurance and thus needs to define what “good” insurance is. Allowing this to be determined by lawmakers runs the risk that powerful **lobbies** (groups of businesspeople who want to influence law and policy in a way that helps their business) will demand their goods and services be covered under whatever the government decides is “good” insurance. Before we know it, the cheapest insurance option will include all kinds of things that the average young and healthy person doesn’t want or need. Their **premiums** (the amount they have to pay the insurance company to cover them) will go up from what they’re currently paying, making care less affordable.

Also, the mandate demands a **subsidy** to people that can’t afford insurance. A subsidy essentially takes government money and covers the portion of the insurance premium that the individual can’t pay on their own. This raises taxes, meaning that everyone is still paying for the care of the uninsured but now is paying for all of them, not just the ones who seek emergency care.

Kahn and Kahn elaborate,

Kahn and Kahn, 2011 ["Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform?," Douglas A., Paul G. Kauper Professor of Law at the University of Michigan Law School, Jeffrey H., professor of law at Washington and Lee University School of Law.]
Moreover, even if one is willing to describe those who cannot afford insurance as free riders, their reliance on outside help is not eliminated by the adoption of the 2010 Act. For taxable years after 2013, certain low- and moderate-income individuals who purchase insurance under a health insurance exchange that the states are required to create will receive a refundable credit that subsidizes their purchase of that insurance.[8] To qualify, the household income of an individual (the aggregate of the modified adjusted gross incomes of that individual and of all individuals for whom the taxpayer is allowed a dependent-exemption deduction and who are required to file a federal income tax return) must at least equal the poverty level and must not exceed four times the poverty level for a family of the size involved.[9] According to the Social Security Administration, the current poverty level for a single individual is $10,830; thus a single individual can have household income of as much as $43,320 and still qualify to have his insurance cost subsidized by the government. For a family of four, the current poverty level is $22,050; such a family can have household income as large as $88,200 and still qualify for a subsidy. Since the poverty-level figures are adjusted each year to reflect inflation, the allowable-income figures will be even higher in 2014 when these provisions first become effective. This scheme suggests that Congress believes that most of the persons with eligible incomes would not purchase insurance without a subsidy because they could not afford it. It is likely, therefore, that persons who are currently using medical services that are paid by others will continue to be subsidized under the new regime.

This is compounded by the fact that, when people go from uninsured to insured, they tend to consume more care than they need. Kahn and Kahn explain,

Kahn and Kahn, 2011 ["Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform?," Douglas A., Paul G. Kauper Professor of Law at the University of Michigan Law School, Jeffrey H., professor of law at Washington and Lee University School of Law.]
Moreover, the increase of persons who are insured may cause an increase in the demand for medical services-that is, an insured person is more likely to seek medical services than is an uninsured person. Economic principles suggest that an increase in demand that is not matched by an increase in the available supply will cause a rise in the price charged for medical services. That increase in price may offset some of the reduction obtained by having a larger pool of insureds. Second, the brief argues that, based on empirical studies, when people who once refrained from buying insurance subsequently purchase it, they tend to incur larger medical care expenses than those who were insured earlier in life. The suggested reason for this is that the uninsured do not use preventive medical care that would lower their future medical costs. It would seem that the proper response to that situation is to permit the insurer to charge a larger premium to those who were previously uninsured. If there is an externality here, it is caused by the failure of the insurer to charge the previously uninsured an actuarially accurate premium rather than by the uninsured's decision not to purchase unneeded insurance.

This is an argument about **incentives**. If people are made to shoulder the entire cost of their insurance, they're likely to only consume the health care that they need. If their insurance is subsidized, however, they are unlikely to feel the need to consume only as much care as they truly need because it's so

cheap. If we suddenly give everyone more care, they'll consume drastically more care, making it more expensive for everyone because the **risk pool** is demanding more payouts.

Kahn and Kahn also argue that there could be a short-term shock to prices because the uninsured were less likely to seek preventative care or screenings for diseases. Once they get insurance, their conditions may be more expensive to treat in the short term. This could cause prices to spike quickly once coverage is made mandatory.

Whitman explains how this price spike, coupled with Ponnuru's lobbies argument, means the mandate will **over-provide expensive care and cause runaway costs**.

Whitman, 2007 ["Hazards of the Individual Health Care Mandate," Glen, Associate Professor of Economics at California State University Northridge, Cato Institute]
Limiting the mandate's scope with vacuous phrases like "basic health care products and services" will not solve the problem, **because what is basic to some is crucial to others**. Does contraception constitute basic health care? How about psychotherapy? Dental care? Chiropractic? The phrase "medically necessary" is just as problematic, because there is no objective definition of necessity. And even if there were, it wouldn't matter, because the content of the law will be determined by the legislative process. The "basic" package might initially be minimal, but over time it will succumb to the same special-interest lobbying that affects every other area of public policy. If psychotherapy is not initially included in the package, eventually it will be, once the psychotherapists' lobby has its way. And likewise for contraception, dental care, chiropractic, acupuncture, in vitro fertilization, hair transplants, ad infinitum. This is not mere speculation. Even now, every state in the union has a list of mandated benefits that any health insurance policy must cover. Mandated benefits have included all of the services listed above — yes, even hair transplants in some states. All states together have created nearly 1900 mandated benefits. Given that medical interest groups have found it worth their time and money to lobby 50 state legislatures for laws affecting only voluntarily purchased insurance policies, mandatory insurance will only exacerbate the problem. If the benefits package is established at the federal level, the incentive to lobby will be that much greater. Medicare and Medicaid provide further evidence. Given the massive funds at stake in those programs, it should come as no surprise that lobbying has affected the list of covered benefits. A public outcry prevented Viagra from being covered by Medicare and Medicaid, but other drugs and services have not attracted that kind of scrutiny. In 2004, after heavy lobbying by pharmaceutical companies that make antiobesity drugs, Medicare reclassified obesity as an illness (or rather, removed language saying it was not an illness), thereby clearing the way for coverage of obesity treatments including diet pills, weight-loss programs, and bariatric surgery. Although by law Medicare can pay only for "medically necessary" services, the obesity story aptly demonstrates the subjective and ultimately political meaning of that term. Mandated benefits drive up insurance premiums; after all, insurance companies can't make more payouts without higher revenues. Existing mandates have increased premiums by an estimated 20 to 50 percent, depending on the state. There is every reason to believe the same process will affect the minimum benefits package under an individual mandate. As a result, even more people will find themselves unable to buy insurance and decide not to comply. Others will buy the insurance, but only by relying on public subsidies. A health policy intended to rein in free riding and cost shifting will tend to encourage more of the same.

As Whitman explains, if all the factors discussed above cause **premiums** to increase, the tax bill will go up for everyone. This is because people who could afford insurance before it became too expensive

would now qualify for the government **subsidy** on insurance. Thus, insurance will not only be more expensive but the taxpayers will need to pay for net more of it. So, the choice is theoretically between a world where most people can afford insurance but a minority cannot (and taxes are lower) and a world where most people can't afford insurance anymore (and taxes are also high). Advocates of the resolution argue we should choose the latter.

Another related argument is that this harms the economy. NCPA explains,
National Center for Policy Analysis, "A 'Right' to Health Care?" Daily Policy Digest, June 29, **2007.**
Further: As a result of universal care, patients would demand far more medical care because additional consumption would cost them little; higher tax rates would discourage work and productivity, yielding less economic growth and wealth. Another difficulty is how to deliver all this medical care -- declaring health care to be a right does nothing to solve the problem of getting the right resources to the right place at the right time.

The argument is simple – higher taxes reduce the incentive for people to work and be productive. This is because they get to keep less and less of the money they make. When taxes hit a certain point, many may decide that they'd rather do something less productive than work. When people leave the labor force or stop hiring employees because of high taxes, the economy suffers.

Slom explains the ways in which this particularly harms small businesses:

Slom, 2010 ["Hawaii's Compulsory Health-Care System Is No Model," Sam, economist and National Review Online Contributor, January 6.]
In praising the PHCA, Anthony Wright neglects to mention that in 1972, prior to its enactment, under a totally voluntary system, nearly 90 percent of Hawaii's working population was already covered by medical insurance. It is true that over the first decade of the law, coverage did increase to more than 95 percent, but it has since declined. It is also true that the victims here are the small-business owner-employers who must provide ever-costlier medical premium care to their employees while finding in many cases they cannot adequately have enough left to pay for themselves and their own families. Hawaii's unions and other original proponents of the PHCA said at the outset that their ultimate goal was "universal single payer" government insurance. That has not occurred. Instead, the state has seen the creation of a crazy quilt of changes and amendments.

In the U.S., employers pay for insurance for their employees most of the time. If costs go up, small businesses may not be able to afford to pay their employees' salaries plus the cost to insure them. That may lead them to close their businesses or be otherwise harmed. Small businesses are particularly critical to the economy because they employ most of the American workforce (or at least a disproportionate amount to their size). Without small businesses thriving, many people would not have jobs.

Additionally, many argue that **an individual mandate would result in worse health care for a number of reasons**.

1. **Insurers will try to find more ways to avoid paying for high-cost case for the sick. John Goodman explains,**

John **Goodman,** "Four Trojan Horses," National Center for Policy Analysis, John Goodman's Health Policy Blog, April 15, **2010.**
Perverse Incentives for Health Plans. We have heard much from the White House and Congressional leaders about how insurance companies are abusing people. You haven't seen anything yet. Inside the health insurance exchange, no insurer will be able to charge a sick person more or a healthy person less. So insurers will try to attract the healthy and avoid the sick — even more than they do today! Furthermore, after enrollment the perverse incentives will not end. Health plans will tend to overprovide to the healthy (to keep the ones they have and attract more) and underprovide to the sick (to discourage the arrival of new ones and the departure of the ones they already have). Of course, there are countervailing forces: professional ethics, malpractice law, regulatory agencies. But ask yourself this question: Would you want to eat at a restaurant that you know does not want your business? You should think the same way about health plans.

Right now, insurers can manage whom they insure by charging people commensurate to their risk. Thus, a healthy person who is unlikely to need a lot of expensive care may be charged much less by an insurance company than an ill person likely to need lots of care. This may sound unfair, but it's an important part of keeping insurance companies profitable so they can continue to provide their valuable services; charging everyone a low rate would mean they wouldn't be able to afford to cover healthy people in emergencies (and a vast majority of people are healthy). Sick people may need to pay more, but this is necessary for insurance to be able to afford to cover them and a number of other healthy customers. Everyone still consumes proportionately more than they pay for (after insurance).

Under a mandate, cost variation can't happen because everyone will need to be charged the same. Insurance companies will have to find other ways to attract healthy people (probably by providing them many goods and services) and deny the sick (probably by excluding services the truly ill need the most). The result is the healthy will get a lot of care they don't need and the sick will not get the care they do need and would have gotten (although for slightly more money) without a mandate.

2. **Even if that doesn't happen, mandated care will make it impossible for insurance companies to innovate**. Glen Whitman explains,

Whitman, 2007 ["Hazards of the Individual Health Care Mandate," Glen, Associate Professor of Economics at California State University Northridge, Cato Institute]
Consequently, the individual mandate will have a deleterious impact on the flexibility of health plans. Health care buyers and insurers need the opportunity to experiment with different types of coverage. Higher deductibles and copayments, for example, give patients an incentive to weigh the potential benefits of health services against their costs — a key component of any effective plan to control health care costs. (Health Savings Accounts, or HSAs, could allow people to save tax-free dollars for out-of-pocket health expenses, with unused dollars rolling over to their retirement accounts.) Insurers might also want to experiment with other policies, such as plans that offer full coverage for only certain treatments for particular conditions, while requiring patients to cover the difference in price between covered treatments and more expensive ones. But the individual mandate's one-size-fitsall approach **cuts off such innovation at the knees**. Limitations on deductibles and copayments might be justified on grounds that out-of-pocket payments deter patients from getting necessary care. But the evidence does not support that position. In a famous RAND study, patients with firstdollar insurance coverage consumed 43 percent more health care than patients who had to pay a large deductible, and yet the

two groups experienced indistinguishable health outcomes. The obvious conclusion is that many health services have negligible benefits, but patients will get them anyway unless they face at least some portion of the costs. More important, health insurance plans with lower deductibles and copayments are more expensive. Regulations that mandate more generous plans drive up premiums, thereby pricing some people out of the market. The result is more uninsured people, more people insured only via public subsidy, or both.

That is, either what John Goodman describes above will happen (insurance companies will do whatever they can to discourage unhealthy people from seeking their services by manipulating what they cover) or, in response to this, the government will require them to cover certain services. That would also potentially be very bad because it would decrease the incentive not to consume unnecessary care. If your insurance is forced to cover a whole host of procedures that no one really needs, you have no reason not to get them and your doctor has no reason not to prescribe them. Studies show that people who consume a lot of care aren't really healthier than people who don't but rather are just spending much more money. The goal of the mandate is to make people healthier, but it may just make basic care more expensive.

3. If everyone consumes all care offered, they will overwhelm the system.

John **Goodman,** "Empty Promises," National Center for Policy Analysis, John Goodman's Health Policy Blog, October 13, **2010.**

So what would it take to provide these services, if all the beneficiaries opted to take full advantage of them? In a 2003 study researchers at Duke University Medical Center estimated that it would require 1,773 hours a year of the average doctor's time — or 7.4 hours every working day — for the average doctor to counsel and facilitate patients for every procedure recommended by the Task Force. And remember, every so often a screening test turns up something that requires more testing and more doctor time. Overall, it's probably fair to say that if everyone took full advantage of all of the services the Task Force recommends, we would need every family doctor in America working full-time on the task — leaving no time left over for any other medical services! Not only can the current supply of medical personnel not come anywhere close to providing what has been promised, there will be collateral damage when patients try to get these services. For one thing, health care costs will rise. Numerous studies have shown that screening tests and similar services add to health care costs, rather than reduce them. For the individual whose cancer is caught in its early stages, say, treatment costs are lowered because of early detection. But this savings is more than offset by the cost of screening thousands of healthy people who do not have cancer. Another consequence: As millions of healthy people try to get free preventive services they will crowd out care for sick patients whose need for care is greater. This will especially be true if patients are in insurance pools that pay doctors different rates. Patients in higher-paying plans seeking preventive services will tend to displace the more urgent needs of patients in lower-paying plans.

By encouraging people to get care they don't need (by making it free or very close to free at point of service), an individual mandate would overwhelm the system. We simply don't have enough doctors to provide that much care to as many as may want it. Aside from being expensive, the time doctors will need to spend screening people who are healthy and show no symptoms "just in case" will detract from the time they have to spend on individuals who are more seriously ill.

Even if that doesn't happen, too many people versus too few doctors are just a numbers game. **People will have to wait longer and longer for care and may die awaiting treatment:**

Michael **Tanner and** Michael **Cannon,** "Universal health care's dirty little secrets," Orlando Sentinel,April 10, **2007.**
What these politicians and many other Americans fail to understand is that there's a big difference between universal coverage and actual access to medical care. Simply saying that people have health insurance is meaningless. Many countries provide universal insurance but deny critical procedures to patients who need them. Britain's Department of Health reported in 2006 that at any given time, nearly 900,000 Britons are waiting for admission to National Health Service hospitals, and shortages force the cancellation of more than 50,000 operations each year. In Sweden, the wait for heart surgery can be as long as 25 weeks, and the average wait for hip replacement surgery is more than a year. Many of these individuals suffer chronic pain, and judging by the numbers, some will probably die awaiting treatment. In a 2005 ruling of the Canadian Supreme Court, Chief Justice Beverly McLachlin wrote that "**access to a waiting list is not access to healthcare**."

There are also a number of moral/libertarian arguments against an individual mandate. Many argue that the individual mandate is dangerous because it may give us too much reason to try to restrict other peoples' choices. Whitman explains,

Whitman, 2007 ["Hazards of the Individual Health Care Mandate," Glen, Associate Professor of Economics at California State University Northridge, Cato Institute]
Community rating also forces low-risk patients to subsidize high-risk patients — another form of cost-shifting. Yet the justification of the individual mandate was to reduce cost-shifting. The subsidy to higherrisk patients generates a political incentive to regulate personal lifestyles — such as diet choices or sexual behaviors — that affect health risks. We have already observed this mechanism at work: the cost of treating motorcycle accident victims has been used to justify helmet laws; the cost of Medicaid to treat cigarette smokers was used to justify lawsuits against the tobacco industry. The public is notably more willing to restrict choice when the costs are socialized — and that means individual liberty is at stake.

An individual mandate, by spreading the risk pool, would force all taxpayers to contribute some money to national health care and well-being via subsidizing the care of those who cannot afford insurance. Whitman argues that we care more about something when we're forced to pay for it.

Thus: right now we don't care when people engage in behaviors we know or suspect to be unhealthy (smoking, eating unhealthy foods, failure to exercise, etc.). We mostly don't care because those unhealthy choices have nothing to do with us and don't reasonably affect us. If we're required to pay for the higher levels of health care that these individuals might potentially need as a result of their lifestyle choices, however, we're likely to care a lot more. It is likely in this world that the public will lobby the government to restrict these choices to keep costs down, thus destroying the ability of the individual to have the liberty of choice.

Dubina and Hull explain how choice is further impacted by a mandate, arguing:

Dubina and Hull, 2012 ["Mandatory Health Insurance: The Case For, and Against," Joel, Chief Judge, and Frank, judge, Business Week.]
We conclude that the individual mandate exceeds Congress's commerce power. Properly formulated, we perceive the question before us to be whether the federal government can issue a mandate that Americans purchase and maintain health insurance from a private company for the entirety of their lives. … Every day, Americans decide what products to buy, where to invest or save, and how to pay for future contingencies such as their retirement, their children's education, and their health care. The government contends that embedded in the Commerce Clause is the power to override these ordinary decisions and redirect those funds to other purposes. Under this theory, because Americans have money to spend and must inevitably make decisions on where to spend it, the Commerce Clause gives Congress the power to direct and compel an individual's spending in order to further its overarching regulatory goals, such as reducing the number of uninsureds and the amount of uncompensated health care. Given the attractiveness of the power to compel behavior in order to solve important problems, we find it illuminating that Americans have, historically, been subject only to a limited set of personal mandates: serving on juries, registering for the draft, filing tax returns, and responding to the census. These mandates are in the nature of duties owed to the government attendant to citizenship, and they contain clear foundations in the constitutional text. Additionally, all these mandates involve a citizen directly interacting with the government, whereas the individual mandate requires an individual to enter into a compulsory contract with a private company. In these respects, the individual mandate is a sharp departure from all prior exercises of federal power. In sum, the individual mandate is breathtaking in its expansive scope. It regulates those who have not entered the health-care market at all. It regulates those who have entered the health-care market, but have not entered the insurance market (and have no intention of doing so). The government's position amounts to an argument that the mere fact of an individual's existence substantially affects interstate commerce, and therefore Congress may regulate them at every point of their life.

They argue that, in almost every case, the Constitution guarantees us the liberty to do as we please. The mandate, however, by dictating how we are to spend our money, robs us of the choice of how to spend it and forces us to buy a product we may not want or need from a private company. The justices argue that this is a serious example of government over-reach that endangers the integrity of our overriding right to choose in almost every instance.

Advocates of the mandate argue that it's immoral to allow people to choose not to buy insurance (not to contribute to the risk pool) and then consume care anyway by showing up to an emergency room where they can't legally be turned away. Ramesh Ponnuru makes a comparative analysis as to why even the immorality of restricting choice is direr than the immorality of potentially making oneself a burden:

Ponnuru, 2011 ["Mandatory Insurance Is Wrong Fix for Health Care: Ramesh Ponnuru," Ramesh, senior editor for National Review, Bloomberg.]
The second justification proffered for a mandate is that people who can do so have a moral obligation to provide for their own and their families' health care so as not to become the responsibility of others. This is true. But there are many similar moral obligations that we don't use the law to enforce. If you impoverish yourself through heavy drinking, you may well end up on public assistance of some form or another, but we don't use intrusive means to stop you from making these choices. Compassion moves us to cover the emergency-care costs of those who can't pay their own way: A federal law, which the

vast majority of Americans support, forbids hospitals from turning patients away. But we aren't morally entitled to insist that our compassion be cost-free, or that the potential objects of our compassion take action to minimize the costs that compassion might move us to bear.

Finally, there are those who argue that many of these most alarming consequences of the mandate won't happen, but not because the mandate will work. They argue that **the mandate simply won't work at all because of its weak enforcement and other factors**. Whitman explains,

Whitman, 2007 ["Hazards of the Individual Health Care Mandate," Glen, Associate Professor of Economics at California State University Northridge, Cato Institute]
But, of course, the mandate will not work exactly as planned. As anyone who's ever driven over 55 mph knows, **mandating something is not the same as making it happen**. Realistically, some individuals will not comply. Forty-seven states currently require drivers to purchase liability auto insurance. Do 100 percent of drivers in those states have insurance? No. For states with an auto insurance mandate, the median percentage of drivers who are uninsured is 12 percent. In some states, the figure is much higher. For example, in California, where auto insurance is mandatory, 25 percent of drivers are uninsured — more than the percentage of Californians who lack health insurance. Of course, the number of uninsured drivers might be even higher without mandatory coverage. The point, however, is that any amount of noncompliance reduces the efficacy of the mandate. If the individual health insurance mandate succeeded in forcing half of the uninsured to get coverage, it would arguably affect a mere 1.5 percent of current health care spending (that is, half of the 3 percent of spending that covers uncompensated care for the uninsured; the precise figure would depend on which uninsured people obtained coverage).

The argument here is simple: people break laws. Given the amount of uninsured people is relatively low, if even a small percentage of the uninsured don't use the mandate, it will fail. Further, there's no mechanism by which to enforce it other than reducing the size of a violators' tax refund if they refuse to pay a fine (they can't, say, go to jail).

In sum, advocates of the resolution worry about costs, liberty, and quality of care for those who are currently able to afford it (arguably the majority of people in the U.S.)

We hope today's analysis was very helpful! As always, please send us your cases for a free critique whenever you finish them and, as always, direct any questions to the comments section or via e-mail at lauren.sabino@ncpa.org. Good luck this season!