The Individual Mandate:
Ineffective, Overreaching, Unsustainable, Unconstitutional, and Unnecessary

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March 23, 2012

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Note: An adapted version of this paper will appear this September as a chapter in Sage Debates on Health Care, published by SAGE Publications Inc.
Executive Summary

Whether or not the individual mandate in the Patient Protection and Affordable Care Act (PPACA) proves to be constitutionally valid, it is based on mistaken premises, faulty economic analysis, short-sighted politics, and seriously flawed health policy. The relationship between the mandate and the problems it purportedly could solve always has been tenuous and contradictory at best. Opponents find the mandate to be constitutionally improper, administratively challenging, politically implausible, and economically unnecessary.

The strongest constitutional law arguments against the PPACA’s individual mandate begin with the essential point that it is unprecedented and not bound by any limiting principle. It seriously threatens the concept that enumerated powers under the Constitution set some limits on the scope of permissible federal authority. The mandate also threatens to encroach on the traditional police powers reserved for state governments and may or may not be “necessary” to carry out and enforce other federal insurance regulation authorized under the new health law. But it is even less likely to be “proper” in accordance with ordinary means of execution and the letter and spirit of the Constitution’s structure that assigns powers among the federal government, the states, and the people.

But the mandate is troubling for other reasons. Defining and implementing a mandate entails many additional rules regarding exactly what it requires, how to carry it out, and who pays for it. Once we presume government is ultimately responsible for guaranteeing every American has purchased the required health insurance, we also guarantee a permanent and ever-more-intrusive role for politicians and their favored interest groups in translating that goal into practice.

Many politicians want to substitute “off-budget” mandated private funds in place of the far less popular taxes they would otherwise find hard to impose to meet their insurance coverage goals. Insurance mandates that conscript more individuals to pay for new, expanded coverage can act like a tax to help fund additional health spending. Why didn’t the drafters of the PPACA rely on a broader tax to finance expanded coverage? Because they knew that making the full costs of mandatory coverage more transparent would lack sufficient popular support.
Not surprisingly, an individual mandate has the least support from those it is purported to help: people who currently do not enroll in public coverage or employer-sponsored insurance or purchase individual coverage. Trying to force people to buy insurance they cannot afford or coercing them into paying more for coverage than its perceived value remains politically difficult.

The most frequent argument to justify the individual mandate both on policy and legal grounds is that without it, uninsured individuals will continue to receive lots of uncompensated care as “free riders” and private premium payers will pay for it. However, this “cost-shifting” argument remains exaggerated, misdirected, and short of convincing evidence. The actual amount of potential cost shifting to private insurance premium payers from uninsured Americans is very small. The individual mandate would, at best, reduce only a fraction of it.

The related expansion of Medicaid coverage under the PPACA also would aggravate problems of undercompensated care and overuse of crowded hospital emergency rooms. Medicaid consistently reimburses health care providers substantially below their actual costs to deliver care. Medicaid beneficiaries also are about 70 percent more likely than the uninsured to use hospital emergency department care.

Other effective ways exist to ensure necessary health insurance coverage for more Americans that are less onerous, less unpopular, and less constitutionally questionable than an individual mandate. They include extending protection against new medical underwriting because of changes in health status to those in the individual market if they maintain qualified, continuous insurance coverage, redistributing and prioritizing current insurance coverage subsidies, maintaining a backup system of safety-net protections, and improving the cost, quality, and value of health care.
**Introduction**

On March 27, the Supreme Court will hear oral arguments on the constitutionality of the unprecedented individual mandate in the Patient Protection and Affordable Care Act (PPACA), which was signed into law on March 23, 2010. The legal challenges to the law, and the mandate in particular, center on the claim that Congress lacked the authority to enact it under its constitutional power to regulate interstate commerce. Three different federal district courts and a federal circuit court of appeals agreed with one form or another of this argument, but several other federal courts have disagreed. The constitutional law issues are serious, complex, and contentious. Any final Supreme Court ruling on these issues later this summer is likely to carry historic consequences, in both legal circles and the political arena.

Whether or not the individual mandate at the heart of the PPACA proves to be constitutionally valid, it is based on mistaken premises, faulty economic analysis, short-sighted politics, and seriously flawed health policy. As passed by Congress two years ago, the mandate was ineffective, overreaching, unsustainable, unconstitutional, and unnecessary. It will continue to be so until it is either repealed by another Congress or struck down by the Supreme Court and then replaced with better alternatives.

**Individual Mandate Theory and Practice Diverge**

The case for an individual mandate to purchase health insurance has been constructed on a shaky foundation. It usually is presented as a necessary means to more popular ends: universal coverage, better access to health care for those with preexisting health conditions, and lower care costs for those already insured. However, the real evidence of the relationship between the mandate and the problems it purportedly could solve always has been tenuous and contradictory at best. Opponents find the mandate to be politically implausible, administratively challenging, constitutionally improper, and economically unnecessary.

An individual mandate, *in theory*, should be universal, simple to administer, and widely accepted. After all, does not everyone agree that purchasing a basic level of health insurance is what each of us needs to do and constitutes a basic responsibility to oneself and the rest of
society? Can we not all quickly settle on the level of insurance that everyone needs to have, what it should cost, and how much we may need to assist less fortunate Americans in obtaining it?

Not really. It turns out that the type of individual mandate that our political economy and health care system is most likely to deliver in practice (such as the one recently authorized, but yet to be implemented, in the PPACA) is very different and more complicated than this theoretical one. Defining and implementing a mandate requires many more additional rules regarding exactly what it requires, how to carry it out, and who pays for it.

Once we presume that government is ultimately responsible for guaranteeing that every American has the health insurance he or she is required to purchase, we also guarantee a permanent and ever-more-intrusive role for politicians and their favored interest groups in determining an accompanying set of issues that translate that goal into practice. The government must define what constitutes “adequate” insurance coverage for each person. It inevitably must specify the content of the insurance package people must purchase. It then has to decide how to provide mandatory health insurance to everyone in an “affordable” manner—in other words, how to subsidize it and regulate pricing.

The process of dictating how much, at what cost, to whom, and how health insurance is bought and sold would severely hamper, if not preclude, treating health care similar to the many other important goods and services we acquire through choice and competition in open markets. Mandatory health insurance and the heavy load of regulation, distorted price signals, and income redistribution that it requires strongly resists and restricts individuals’ ability to choose health insurance and health services in somewhat-varied bundles, types, and levels and to receive them based (at least in part) on their abilities and willingness to pay for them. (Not surprisingly, many other goods and services already are delivered more effectively, more efficiently, and less expensively than our highly regulated and subsidized health care goods and services are.)

The long-standing bias of our political system—particularly when it comes to health benefits brokered through government channels—is to promise more and deliver less, while blaming others for the resulting gap.
Shallow Political Support for a Mandate

Initial political support for an individual mandate most often comes from people who already purchase or offer insurance or who expect to gain more paying customers for their health care services. Insured individuals want to believe political promises that the mandate will make someone else pay more for coverage so that they can pay less for their own insurance. Some employers have supported an individual mandate as a defensive tactic to avoid enactment of an employer coverage mandate. Many medical service providers hope that a mandate would ensure more of their bills are paid. And insurers often find that the bitter pill of tighter political control of their operating rules becomes somewhat more palatable if they are promised more revenue from involuntary customers.

Many politicians also want to substitute “off-budget” mandated private funds in place of the far less popular taxes they would otherwise find hard to impose to meet their insurance coverage goals. Insurance mandates that conscript more individuals to pay for new, expanded coverage can act like a tax to help fund additional health spending. But they try to obscure the full political costs and obvious sticker-price shock to taxpayers because mandated private spending is not officially treated as part of the federal budget. Instead, employers and insurers are enlisted as surrogate “tax collectors” through less transparent and politically accountable means.

Another political rationale for an individual mandate appears to be that it will not only guarantee universal insurance coverage but also lead to lower overall health care costs. This argument defies the economic laws of (limited) supply and (overstimulated) demand, the history of ever-expanding entitlement programs within the US political economy, and even basic mathematics. Its vague promise of future savings comes close to adopting a “mutual hostage” theory in which the political system first places everyone in the same large but leaky (coverage) boat. It then assumes that someone onboard will be more motivated (or sufficiently desperate) to figure out a way to swim back to shore by providing health care at a lower cost (and perhaps with better quality) and eventually show the rest of us the way to safety. Not likely!

Several oft-stated rhetorical justifications for an individual mandate are that “It actually will improve people’s health,” or “Everyone should have ‘equal’ health care.” However, neither
the empirical evidence for the first proposition (Finkelstein and McKnight, 2008) nor the political support for the second one appears to have much historical strength in the United States.

Other arguments from supporters of such a mandate include:

- It will level the playing field so that those using publicly funded health services pay their “fair share” of the costs of care.

- It can ease the concerns of private insurers that new regulatory restrictions on risk-rating by insurers will aggravate adverse selection by “voluntary” insurance purchasers (too many bad risks, too few good risks, purchasing particular insurance products).

- It will force government bodies to commit to providing adequate subsidies for citizens subjected to otherwise unaffordable mandates (Glied, Hartz, and Giorgi, 2007).

Not surprisingly, an individual mandate has the least support from those it is purported to help: people who currently do not enroll in public coverage or employer-sponsored insurance or who do not purchase individual coverage. After all, coercing some people to do what they otherwise would not is the very point of a legal mandate.

**Failure to Close a “Bad Deal” Based on Boom and Bust**

Trying to force people to buy insurance they cannot afford or coercing them into paying more for coverage than it actually appears to be worth to them remains politically difficult. Some may wonder why, if buying some kind of health insurance offered to them is such a good idea, they should have to be forced by law to buy it.

An individual mandate often promises, but never manages, to pay for itself. The economic facts of life are that taxpayers already face huge present and future debt obligations for existing political commitments to finance public spending for health care and other purposes. They really cannot sell at a loss and “make it up on volume” by expanding even more the amount and levels of health insurance offered at below-market prices but heavily subsidized by taxpayers.
Insurance mandates create a perpetual conflict among their escalating costs, limited public and private resources to pay for them, and the false guarantee of rich coverage. Hence, such mandates must recycle a large portion of any projected increases in new premium “revenue” to health care providers and health insurers through expanded coverage right back into additional taxpayer subsidies to reduce nominal “net” premiums (or suppress the full premium costs of new health care services with tighter price controls). When such health benefit promises cost more than their immediate beneficiaries can afford, the difference is financed through some combination of higher taxes, reduced benefits, higher premiums, lower take-home pay, fewer economic opportunities, and less insurance coverage imposed on everyone else. Eventually, some of those hidden costs even are reimposed on the initially more “fortunate” beneficiaries.

One way or another, the real costs to carry out an individual mandate outweigh the gains. The identifiable losers outnumber the mythical winners once all the longer-term costs and consequences unfold and are calculated. Political demand for health care explodes, government budgets tighten, market supply of medical providers struggles to keep up, and overcharged private premium payers resist paying more for less. Eventually, a large critical mass of unhappy consumers and taxpayers resists having to underwrite the cost of an individual mandate that fails to pay for itself. The unvirtuous cycle comes to rest temporarily, and the next round begins with more people farther behind.

**Weak Enforcement of “Mandatory” Insurance**

Hence, even though some modelers of the coverage take-up effects of an individual mandate appear to assume reflexively that its commands will be obeyed faithfully and executed with nearly flawless precision, actual proposals for enforcement of an individual mandate often provide more bark than bite. For example, the penalties for noncompliance with the mandate imposed under the PPACA are weak and unlikely to drive much of a permanent purchasing response.

One early indication is that the mandate does not even begin to apply until January 1, 2014, even though the law was enacted in March 2010. Although the penalties are supposed to
be enforced by the Internal Revenue Service and collected through taxpayers’ annual income tax returns, the agency will not be allowed to use many of its standard enforcement tools to ensure payment of these “taxes.” The law provides that anyone who fails to pay in a timely manner any penalty imposed by the mandate “shall not be subject to any criminal prosecution or penalty” and that the secretary of the Treasury shall not “file notice of lien” or “levy” on any property of a taxpayer by reason of such failure (Patient Protection and Affordable Care Act, 2010, 1501(g)(2)[(A) and (B)(i-ii)]).

The penalties for failing to comply with the insurance-purchasing mandate under the PPACA also are rather modest in proportion to the likely average premium cost of required coverage. The penalty will be the greater of a flat-dollar amount or a percentage of the violator’s income. After the penalty amounts are phased in over three years (ending in 2016), the flat-dollar version will equal $695, and the percentage-of-income version will equal 2.5 percent of income. The likely result is that a significant percentage of lower-income individuals will calculate that it is much less expensive to pay the penalty than to purchase mandatory insurance, so they will seriously consider that route. The law’s guaranteed-issue incentives for potential purchasers allow them to enroll “just in time” when sick and “go bare” when healthy (and pay less in penalties than in total premiums), further ensuring limited and erratic mandate compliance.

Moreover, the PPACA provisions for exemptions from the individual mandate—involving illegal immigrants, foreign nationals, religious prohibitions, and most importantly “unaffordability” (when one’s required health premium costs would be greater than 8 percent of household income)—reveal how various political and economic factors limit the enforceable scope of any theoretically universal mandate. In addition, reliance on the federal income tax system and the IRS as primary enforcers of the mandate fails to reach the millions of nonfilers.

Other complex administrative hurdles to enforcement also must be surmounted:

- First, how to determine whether a person is exempt from “unaffordable” mandated coverage;
- Second, if the person is not exempt, how to estimate whether he or she is eligible for various levels of premium subsidies—through Medicaid or tax credits—based on expected household income; and
Third, how to settle up later in the following tax year the final amount of subsidies versus premium payments to account for differences in actual household income reported to the IRS.

In their comprehensive review of the likely efficacy of mandates for health insurance, Glied, Hartz, and Giorgi (2007) concluded that predicting a target population’s response to a mandate is, at best, an inexact science. Performance of mandates varies greatly with such important factors as the affordability of costs of compliance, the size of penalties, and the probability that penalties will be imposed in a timely manner. For example, the percentage of motorists who lack automobile liability insurance coverage, which is mandatory in almost all states, ranges among states from about 4 percent to 33 percent. Moreover, a 1995 study found that the average uninsured motorist rate was actually lower in states without such auto insurance mandates (Kelly, 2004). Glied, Hartz, and Giorgi also noted that even the best mandate is unlikely to affect the behavior of those who are transient (in terms of place of residence or employment status) and have few assets.

Ironically, even the strongest version of an individual mandate to purchase health insurance would be too weak to guarantee what should be its ultimate objective—improvements in people’s health. Requiring that someone have health insurance is not the same as ensuring they actually receive all of the effective health care services they may need in a timely manner and comply with their physicians’ advice, let alone that we all take many other steps beyond even the delivery of covered medical services that might do more to improve their current and future health (McGlynn et al., 2003; McGinnis, Williams-Russo, and Knickman, 2002). To do that, one might need to mandate not just the purchase of health insurance but also delivery of the actual “treatment” itself! (And while we’re at it, don’t neglect mandating both that extra serving of broccoli and proof of its consumption!)

Yet somehow the image of closing the gap in delivering recommended care—which gets delivered only about half the time in current practice—with a mandate that all preventive and therapeutic “treatment” be received at the right time and right place (or even the right physical point of entry?) with no questions asked or informed consent required suggests more vividly the limits of government coercion in achieving health goals.
A Conflict of Fundamental Values

The recent debate over the individual mandate and its underpinning of the PPACA’s other provisions for health insurance regulation, health care financing, and delivery system restructuring requires a more realistic understanding of the limits of high-level government commands within our political system, the balance of power between government and citizens in our Constitution, and the long-standing societal values that sustain both. The individual mandate touches exposed nerves and offends core principles in ways that other elements of the modern regulatory state do not.

Many Americans are troubled by the idea of Congress imposing a legal mandate on citizens to purchase a private (but highly regulated) product, regardless of their wishes. They worry that an individual mandate would operate as a gateway drug to even greater addiction to government control of health care. Implementing a mandate inevitably requires more and more rules regarding exactly what it requires, how it is carried out, and who pays for it.

Hence, the individual mandate has consistently remained the most intensely unpopular provision of the new health law since it first took shape. More than a year after enactment of the PPACA, a clear majority of Americans continued to oppose the individual mandate and favored its repeal: for example, 67 percent in March 2011 (Henry J. Kaiser Family Foundation 2011) and 54 percent in June 2011 (CNN and Opinion Research Corporation, 2011).

A fundamental element of those concerns is the view that an individual mandate violates core principles of economic freedom, personal choice, and limited government under the US Constitution. The provision’s constitutionality was challenged in a number of lawsuits filed shortly after the PPACA was signed into law. At this point, three federal appellate courts have issued final rulings on constitutionality of the individual mandate: the Eleventh Circuit found it unconstitutional, the Sixth Circuit upheld it, and the DC Circuit upheld it, but the three-judge panels in each of those rulings were divided two to one. This reflects, to some degree, a previous split at the federal district court level, where the six leading cases addressing the merits on the constitutionality of the individual mandate had three judges declaring it unconstitutional as an unprecedented expansion of the federal government’s enumerated powers and three others ruling it legally appropriate under the Commerce Clause powers of the Constitution.
Thus far, all but one of the rulings on the PPACA’s version of the individual mandate has concluded that it was designed by Congress as a “penalty” rather than a tax. (On September 8, 2011, the Fourth Circuit Court of Appeals ruled somewhat differently, in another decision divided two to one that used some unusual legal reasoning to dismiss the appeal brought by Liberty University because of lack of jurisdiction. See Liberty University et al. v. Geithner et al., 2011.) Therefore, the enforcement provisions and constitutional legitimacy of the mandate must be linked to an enumerated power under the Constitution other than the General Welfare Clause. The federal government’s more sweeping taxation powers under the latter could not provide authority for the mandate’s penalties after the fact.

Why didn’t the PPACA drafters rely on a broader tax to finance expanded coverage? Because they knew that making the full costs of mandatory coverage more transparent would lack sufficient popular support. The political need to ensure passage of the new health law by any means necessary (and avoid being tagged with increasing taxes on most Americans) trumped the legal case for enforcing and financing the mandate more directly through the tax system (like Medicare) to provide a firmer foundation in traditional constitutional law. Instead, every additional private-sector dollar that could be required by law to pay for the expanded coverage under the PPACA meant one less dollar in official “tax increases” otherwise required to keep the new law from increasing the federal budget deficit under scoring rules of the Congressional Budget Office.

Of course, none of this kept the Obama administration’s attorneys from trying to reverse this position in subsequent court cases by claiming that the individual mandate was really a tax after all and was constitutional as part of the power of Congress to tax and spend for “the general welfare.” But whether you describe this tactic as a bait-and-switch deception or just using whatever arguments work best, the legal ploy has not succeeded thus far in court.

The Obama administration and its congressional allies essentially tried to accomplish legislative goals of nearly universal coverage and much tighter federal regulation of health insurance through constitutionally improper means. They placed a bet that, by relying on the commerce power, rather than the spending power, of Congress, they would succeed politically to
achieve narrow passage of the final law, but they could end up losing the legal end of the wager that this approach would survive a court challenge on constitutional grounds.

As we await Supreme Court review of the various legal arguments, the leading judicial opinion that finds the individual mandate unconstitutional comes from the *State of Florida et al. v. Dept. of Health and Human Services et al.* (2011) decision in the United States Court of Appeal for the Eleventh Circuit. In a two to one decision, the court ruled that the mandate exceeds the enumerated *commerce power* of Congress and that no judicially enforceable limiting principle exists to uphold it without “obliterating the boundaries inherent in the system of enumerated congressional powers.” It observed that never before has Congress sought to regulate commerce by compelling nonmarket participants to enter into commerce so that Congress may regulate them.

The court concluded that decisions to abstain from purchasing a product or service lack a sufficient connection to commerce. It found that, contrary to assertions by federal attorneys defending the mandate, an individual’s uninsured status (the conduct regulated by the individual mandate) in no way interferes with Congress’s constitutional ability to regulate insurance companies. The Eleventh Circuit court also emphasized that insurance and the health care industry fall within the sphere of traditional state regulation and an individual mandate imposed by the federal government would supersede many of the states’ policy choices in key areas of state concern.

On the other hand, another federal appellate court in the Sixth Circuit upheld the individual mandate on a two to one decision, finding it to be a constitutional means to carry out the PPACA’s broader policy goals (*Thomas More Law Center et al. v. Obama et al.*, 2011). Ultimately, these constitutional issues will need to be resolved more definitively by the Supreme Court, which agreed to consider the case during its 2011 term, hears oral arguments later this month and is expected to issue a final ruling on the individual mandate and other related issues by late June.

The strongest constitutional law arguments against the individual mandate begin with the essential point that it is unprecedented and not bound by any limiting principle. It seriously threatens the concept that enumerated powers under the Constitution set some limits on the scope
of permissible federal authority. The mandate also threatens to encroach on the traditional police powers reserved for state governments. Finally, the individual mandate may or may not be “necessary” to carry out and enforce other federal insurance regulation authorized under the PPACA. But it is even less likely to be “proper” in accordance with ordinary means of execution and the letter and spirit of the Constitution’s structure that assigns powers between the federal government, the states, and the people.

Regardless of how a close and controversial decision in either direction regarding the constitutionality of the individual mandate (and perhaps the rest of the PPACA as well) turns out, the debate over its policy and political merits will continue throughout the 2012 election season and into the next session of Congress in 2013.

**Cost-Shifting Rationales Fall Short**

The most frequently used argument to justify the individual mandate both on policy and legal grounds is that without it, uninsured individuals will continue to receive lots of uncompensated care and private premium payers will pay for this free riding. According to the secretary of Health and Human Services and Obama administration lawyers, when the costs of uncompensated care are shifted to those who already are insured, increasing their average premiums, even more people will be unable to afford the more costly insurance and will become (or remain) uninsured. They argue that the uninsured’s decisions not to participate in the health insurance market have a collective effect on interstate commerce that poses a threat to a national market. Hence, the individual mandate is a “necessary and proper” measure under the Constitution to ensure the success of the larger health reforms in the PPACA (such as guaranteed issue and adjusted community rating, which ensure access to insurance for individuals with more costly preexisting health conditions), and it is “an integral part of the regulatory scheme” for the new health law’s plan to increase insurance coverage and lower health care costs.

Congress even inserted a number of legislative findings (PPACA, 2010, section 1501(a)) into the new law designed to bolster the conclusion that a failure to regulate the decision to delay or forgo buying insurance would shift the costs of that decision onto the larger health care system
and undermine the law’s comprehensive regulatory regime. Courts often defer to such congressional findings as long as there is some rational basis to support them. However, this cost-shifting argument remains exaggerated, misdirected, and short of convincing evidence.

President Obama himself has resorted to the cost-shifting rationale for an individual mandate on many occasions. For example, he told the American Medical Association in June 2009, “Each time an uninsured American steps foot into an emergency room with no way to reimburse the hospital for care, the cost is handed over to every American family as a bill of about $1,000 that is reflected in higher taxes, higher premiums, and higher healthcare costs; a hidden tax that will be cut as we insure all Americans” (WSJ Staff, 2009).

The “hidden tax” theory was stretched to its limits in a questionable advocacy paper by Families USA (2009) called *Hidden Health Tax: Americans Pay a Premium*. Based on various federal data sources such as the Medical Expenditure Panel Survey (MEPS), it claimed not only that Americans without insurance received approximately $42.7 billion in net uncompensated care in 2008, but that this entire amount was shifted to the private insured population (but not to anyone covered by Medicare or Medicaid) at annual costs of $1,017 per insured family and $368 per insured single person.

These estimates, which provided the primary empirical foundation for the cost-shifting arguments made by Obama administration attorneys before the Supreme Court, conflict noticeably with a more thorough empirical analysis of uncompensated care costs and burdens developed by a group of researchers led by Jack Hadley of George Mason University and published by the Kaiser Family Foundation in August 2008 (Hadley et al., 2008). The authors refined and updated their earlier pathbreaking work in 2003. They concluded that, under one method using MEPS-based estimates, uncompensated care received by the uninsured in 2008 amounted to $54.3 billion but that only half of it ($27.8 billion) came from “implicitly subsidized” care—that is, funds potentially cost-shifted to private insurance premiums. The rest ($26.5 billion) of that funding for uncompensated care represented payments from other public and private sources.

However, the Urban Institute researchers also cross-checked their findings with an alternative method based on independent data from other provider and government sources. The
overall estimate of uncompensated care from those sources amounted to $57.4 billion in 2008, leading to Hadley and his coauthors’ conclusion that the total cost of uncompensated care received by the uninsured that year was roughly $56 billion. But they also calculated that federal, state, and local government funds accounted for $42.9 billion available to pay for that uncompensated care, even after adjusting for possible misallocation of funds spent in the name of the uninsured. Their study concluded that attributing increased private health insurance premiums to any expanded costs of treating the uninsured is a misperception, particularly when a net balance of only about $14.5 billion was arguably financed by the privately insured in the form of higher (cost-shifted) private payments for care and, ultimately, higher insurance premiums. Indeed, they estimated that the amount of uncompensated care potentially available for private cost-shifting is most likely even lower—about $8 billion in 2008, which was less than 1 percent of the $829.9 billion in total private health insurance costs (Miller, 2008).

First, the inflated findings by Families USA first undercounted other sources of payment for care received by the uninsured, in some cases arbitrarily dismissing better estimates by others.

Second, they too crudely assumed that the costs of care for the part-year uninsured would be proportionate to the portion of the year that they were uninsured (unlike Hadley and his colleagues, who adjusted for the clustering of more health spending into periods of insurance coverage).

Third, Families USA also inflated MEPS healthcare costs for the uninsured by factors greater than those used by Hadley and his colleagues by overlooking the different rates of growth for insured versus noninsured health spending.

Fourth, the Families USA figures evidently failed to adjust the 2006 MEPS numbers they report for total private insured spending ($557 billion) to their 2008 value under the National Health Expenditure accounting methods used annually by actuaries at the Centers for Medical and Medicaid Services (CMS) to provide the most definitive analysis of national health spending.

Fifth, the Families USA estimates unconvincingly limited the entire amount of any possible cost-shifting of uncompensated care to only the smaller base of privately insured health
premiums, overlooking the catch-up cost shifting that also occurs in public health entitlement programs like Medicare. The latter involves the difference between reimbursement fee levels under administered pricing in government programs and subsequent behavioral changes adopted by health care providers to increase the reimbursed spending they receive through ordering a greater volume of services and upcoding the reimbursement category submitted for payment. By statistically suppressing the total size of the denominator and inflating the numerator, the Families USA methods raised the resulting percentage in the cost-shifting equation.

Sixth, one of the clinching arguments for the Hadley and his colleagues’ view of cost shifting is their statistical demonstration that the share of hospitals’ overall costs due to uncompensated care remained remarkably stable over time amid rising levels of uninsurance—even as hospitals’ cost-to-charge markup ratio for private payers (which might otherwise suggest hospitals’ different relative degrees of cost-shifting response in the form of higher or lower markups for privately insured patients) has fluctuated for other reasons in a completely uncorrelated manner. In other words, the cost-shifting rationale the Obama administration used to justify the PPACA’s individual mandate failed to distinguish accurately between uncompensated care costs financed by taxpayers and those financed by private premium payers.

More recently, an amicus brief was submitted to the Supreme Court by a group of economists supporting the position by twenty-six state governments and several other private respondents that the individual mandate is not authorized by the Commerce Clause of the Constitution. It argues that the primary people regulated by the individual mandate are not cost shifters but young and healthy individuals who forgo purchasing insurance (and receive relatively modest amounts of uncompensated care—less than $13 billion a year). Because those individuals do not use much health care, they contribute little to any purported cost shifting. In 2010, the voluntarily uninsured (those not otherwise covered by Medicaid, not likely to gain coverage under new insurance rules providing greater access to private coverage for those with preexisting health conditions, and not poor enough to be exempted from the mandate) consumed, on average, only $854 in health care services. Hence, even though they generally overcompensate the market for their own care when they need it—because they generally are not able to obtain care at discounted prices negotiated by insurance
providers or Medicaid programs—they remain more likely to decide to pay the penalty associated with the mandate as a more economically rational choice than paying much more for mandated health insurance than it is worth to them (Bradbury et al., 2012).

On the other hand, the main cost shifters largely are persons who either are exempted from the mandate penalty (primarily because mandatory coverage is not “affordable” for them) or will be covered by the PPACA’s Medicaid expansion for low-income adults (Bradbury, et al., 2012). Unfortunately, the amici economists chose to start their estimates of mandate effects by using the inflated figure of $43 billion in annual uncompensated care costs, as calculated by Families USA and endorsed by congressional findings in the PPACA. As noted above, the more accurate estimate in 2008 by Hadley and his colleagues of the amount of uncompensated care that is not financed by other government funding and is likely to be subject to cost shifting to the privately insured was much lower.

In any case, the amount of potential cost shifting to private insurance premium payers because of uninsured Americans is very small (though not nonexistent). And the individual mandate would, at best, reduce only a fraction of it.

Who Really Is Crowding Emergency Rooms?

The Obama administration’s cost-shifting argument also failed to acknowledge another inconvenient truth related to the PPACA’s other plans to expand Medicaid coverage substantially. They would aggravate problems of undercompensated care and overuse of crowded hospital emergency rooms.

The oft-stated, oversimplified political storyline for cost shifting, and why an individual mandate is needed to reduce or eliminate it, presumes that most, if not all, cost shifting is due to free-riding uninsured people who postpone necessary medical treatment until they land in overcrowded and expensive hospital emergency rooms, as President Obama indicated in his 2009 remarks (WSJ Staff, 2009). However, the statistical reality is that among the under-sixty-five population, the uninsured were no more likely than the insured to have had at least one emergency department (ED) visit in a twelve-month period, but persons with Medicaid coverage
were more likely to have had multiple visits to the ED than both the insured and uninsured under age sixty-five (Garcia, Bernstein, and Bush, 2010). ED visits by the uninsured were no more likely to be triaged as “nonurgent” than were visits by those with private insurance or Medicaid coverage. Adults with Medicaid accounted for most of the increase in ED visits from 1997 to 2007 (Tang et al., 2010). Medicaid beneficiaries currently are about 70 percent more likely than the uninsured to use hospital emergency department care. The uninsured represent only about 15 percent of all emergency department visits (Pitts et al., 2008).

To the extent that free-riding and uncompensated care occurs in hospital emergency rooms, it is due largely to the requirements of another federal law—the Emergency Medical Treatment and Active Labor Act, enacted in 1986. This law requires hospitals that participate in the Medicare program and accept Medicare patients and CMS payments (virtually all hospitals) to provide emergency care to anyone who needs it, regardless of ability to pay, citizenship, or legal status. This is an unfunded federal mandate to provide uncompensated care. However, emergency care as a whole (not just this federally mandated stabilization care for those entering hospital emergency rooms) still comprises less than 3 percent of the total health care market, and only about half of that care goes uncompensated (American College of Emergency Physicians, 2012). Other forms of uncompensated hospital care account for most of the remaining amounts of uncompensated care, because physicians actually appear to earn more on net from their uninsured patients than their insured patients. Gruber and Rodriguez analyzed 2004–05 survey data that took into account how much uninsured patients paid in higher, “undiscounted” prices for physician care. Even their most conservative estimates suggested that uncompensated care by physicians amounted to no more than $3.2 billion (Gruber and Rodriguez, 2007).

Thoughtful observers might reflect on such numbers and consider the possibility that increased ED visits primarily reflect broader health system delivery problems (for example, physicians not offering evening or weekend hours or answering e-mail and provider resistance to low-cost clinic competition) rather than increases in the number of uninsured Americans. They might also wonder whether the new health law’s plan to increase coverage primarily through expansion of Medicaid (as an important supplement to the individual mandate imposed on Americans not eligible for Medicaid or other public health programs) will help or aggravate the emergency care overuse problem.
Early evidence from Massachusetts, where an individual mandate was recently implemented, suggests that promises this individual mandate would eliminate the need for most uncompensated emergency care for the uninsured (and provide sufficient savings to finance much of the cost of subsidies for increased insurance coverage) were significantly overstated. The costs of the state’s quite generous “uncompensated care pool” were indeed reduced by about 37 percent—but far from eliminated—after the mandate was implemented (from $661 million in fiscal year 2007 to $414 million in fiscal year 2009). The percentage of the uninsured state population declined from 5.7 percent to 2.7 percent. On the other hand, hospitals’ emergency visit volume actually increased 14 percent, and demand for payments to hospitals for emergency care rose 15 percent from fiscal year 2009 to fiscal year 2010; state-administered payments increased less, but only because of a $70 million funding shortfall, otherwise known as “really uncompensated” care (Massachusetts Division of Health Care Finance and Policy, 2010).

The Added Costs of “Undercompensated” Care

Moreover, the overall costs to Massachusetts and federal taxpayers for the state’s experiment in increasing coverage through expansion of Medicaid and implementation of an individual mandate far exceeded the above modest savings in uncompensated care expenses (Klein, 2012). Because Medicaid consistently reimburses health care providers substantially below their actual costs to deliver care, the program’s substantial expansion in Massachusetts (and, in future years, across the nation under the PPACA) will further increase the total costs of undercompensated care that are more likely to be shifted to taxpayers and private premium payers (Cogan, Hubbard, Kessler, 2011). Even by estimates provided by actuaries at Milliman Inc., the actual amount of estimated cost shifting to private insurance by the low-paying Medicaid and Medicare programs (to the extent that such cost shifting actually occurs) is nearly twice the amount of any purported cost shifting because of uncompensated care for the uninsured (Fox and Pickering, 2008).

The costs of being uninsured are indeed serious and significant. However, a relatively small portion of them are shifted to private insurance premiums. Instead, they show up primarily in poorer health, less adequate medical care, and forgone subsidies for the uninsured.
How Effective Is the Individual Mandate?

Advocates of the individual mandate make various claims beyond that it will substantially reduce uncompensated care costs. The mandate also is supposed to help the country achieve nearly universal coverage while lowering future health insurance premiums. In reality, even under the relatively optimistic assumptions the Congressional Budget Office (CBO) used in its 2009 estimates of the proposed health legislation’s effects, the individual mandate was projected to increase privately purchased (and highly subsidized) insurance coverage by about 16 to 17 million people by 2021. About the same number of newly insured would receive their coverage through Medicaid, and about 23 million Americans would remain uninsured in 2021. Any such estimates of overall coverage effects remain approximations, subject to different assumptions and measurement times. (The CBO slightly updated those coverage estimates earlier in March.)

Even more differences of opinion involve the effect of the individual mandate on future coverage increases. For example, a recent study by the Lewin Group estimates that if the mandate were lifted, the PPACA still would cover 23 million people who would have been uninsured without the law. In other words, about 8 million people would lose such future coverage without the mandate (Sheils and Haught, 2011). Using different assumptions, the Rand Corporation concluded that, if the individual mandate is overturned by the Supreme Court, the number of people covered through the PPACA would drop from 27 million to 15 million as of 2016, but it would not send premiums into a death spiral that would make health insurance unaffordable for those not qualifying for new government subsidies (Eibner and Price, 2012).

Future effects of the individual mandate on health insurance premiums are more difficult to pinpoint, depending on which segments of the private health insurance you analyze. However, the CBO’s initial projections in November 2009 assumed that the greater amount of coverage (more benefits) required in the individual market—where the effects of the PPACA’s mandate would be greatest—would increase premiums by 27 to 30 percent above average premium levels otherwise expected in that nongroup market by 2016. Other CBO assumptions about the effects of new insurance rules and a different mix of insured people within that market would lower that net premium hike to about 10 to 13 percent overall (Congressional Budget Office, 2009).
Even Weaker Arguments for an Individual Mandate

Individual mandate defenders often adopt a “throw in the kitchen sink” medley of lesser arguments to try to bolster their case, such as past support (several decades ago) from Republican members of Congress and conservative-leaning think tanks, denials of coverage or higher premium charges for those with preexisting health conditions in “voluntary” insurance markets, and personal bankruptcies due to high medical costs and lack of health insurance. Some brief rebuttals follow.

It Seemed Like a Bad Idea at the Time: Congressional Republicans dropped their misguided tactical dalliance with an individual mandate by the spring of 1994 (in opposing the Clinton administration’s proposed Health Security Act). An overwhelming majority of Republicans at the grassroots level, plus right-of-center policy organizations, always opposed it before then and have ever since (Roy, 2012). I should know, as I wrote the first and leading think tank study opposing the individual mandate—on policy grounds—in the spring of 1994 (Miller, 1994). Shortly thereafter, Senator Don Nickles (R-OK) dropped the mandate from his proposed bill to reform health care. Although it had attracted support from many conservative Republican senators, its provision for an individual mandate enforced through the federal tax code began to lose support.

Yes, the individual mandate first was championed prominently by health policy analysts at the Heritage Foundation, beginning in 1989 and continuing at least into the mid-1990s. Several other health policy researchers crafted a 1991 proposal for “Responsible National Health Insurance” that was published by the American Enterprise Institute. But leaders need followers, and these initial individual mandate proposals failed to draw much support from conservatives outside Washington. They were quietly abandoned by the mid-1990s and never revived, let alone embraced, by Republican officeholders in later decades (except in the sui generis state of Massachusetts).

Objections to the constitutionality of the individual mandate arose more recently, when the Obama administration tried to justify it, for tactical reasons, as an unprecedented exercise of
the power of Congress under the Constitution to regulate interstate commerce, rather than to tax and spend for the general welfare (Oliphant, 2011).

**Preexisting Conditions:** Insurance coverage problems for several million Americans with serious preexisting conditions are significant but vastly exaggerated by the more extreme advocates of the PPACA (Herring, Song, and Pauly, 2008; Miller and Capretta, 2010; Pauly and Herring, 2007). They can be dealt with much more effectively through policy mechanisms other than an individual mandate. (See “Health Reform with Incentives” section.)

**Personal Bankruptcies:** Similarly, a few recently published studies that are long on ideological advocacy and short on empirical methodology have misstated the underlying causes of rates of personal bankruptcies over the last decade as primarily being lack of sufficient health insurance coverage, rather than other, more important, ones (Miller and Mathur, 2011).

**Health Reform with Incentives, Not Mandates**

Other effective ways exist to ensure necessary health insurance coverage for more Americans that are less onerous, less unpopular, and less constitutionally questionable. A better mix of policy reform ingredients would rely first on persuasive incentives rather than coercive commands. Part of this approach actually was proposed first in the House Republican alternative to Obamacare, back in November 2009 (House Amendment 510, 2009). The basic idea is to extend insurance portability rights and protection against new medical underwriting due to changes in health status (already provided since 1996 by the Health Insurance Portability and Accountability Act’s requirements for employer group health plans) to those entering, exiting, or remaining in the individual health insurance market—as long as they maintain continuous, qualified insurance coverage. In short, this plan would strengthen the incentives to get insurance and maintain it, and switching between group and individual markets would become less complicated and stressful. However, those who delay obtaining coverage when healthy, or drop
it and stay uninsured for too long, would run the risk of paying higher premiums in the future or facing restrictions for coverage of preexisting conditions they develop in the interim.

Second, we need to redistribute and prioritize current insurance coverage subsidies. The current excessive levels of tax expenditures and public program benefits try to foster the illusion that we can pay most, or at least a substantial share, of everyone’s health insurance premiums with other people’s money. But there simply is not a sustainable line of credit or enough tax revenue ahead to keep financing these efforts. We should not, and actually do not, need to bribe upper-middle-class and wealthier Americans to purchase and maintain insurance coverage. But we could instead lower their other taxes to offset the net effects of reducing or even eliminating their access to current tax subsidies for health care spending (like the tax exclusion for the cost of health insurance paid by their employers). This policy reform would help make the full unsubsidized costs, and the real value, of their current coverage and care more transparent to them. It would encourage more efficient health care choices, without raising their overall taxes.

However, that does not mean that additional subsidies (offset by other spending reductions in the health care portion of the federal budget) will not be needed to help other populations targeted on the basis of their lower-income and higher health-risk needs. Those dollars can pay for some, and sometimes all, of the actuarially equivalent costs of their basic care. But almost everyone needs to start seeing more of the real price tags in more competitive and accountable health care markets again, instead of the fake ones at the government discount store.

Third, no system of coverage incentives and need-based subsidies is foolproof. We have to maintain a backup system of safety-net protections for those who fall through the cracks or must be protected from the unbearable consequences of their irresponsible behavior. Beyond a narrowed base of Medicaid assistance for the temporarily low-income and more permanently disabled, the next layer of taxpayer support should involve more sustainably financed, high-risk pools operated by states within basic federal parameters. Such subsidized coverage would still cost more than the conventional insurance for standard-risk customers, but premiums would be capped in proportion to an enrollee’s income and likely risk-related health costs (Capretta and Miller, 2010).
Intelligent design of a limited high-risk pool solution may begin in Washington, but its creation must be completed in the states. It can strengthen the rest of the private insurance market while protecting millions of vulnerable Americans. Health researchers John Cogan, Glenn Hubbard, and Dan Kessler recently noted how a similar approach worked in the development of Medicare disability coverage in 1973. By publicly subsidizing the tail of higher-cost people with that condition, private insurance coverage for the rest of the market expanded. They found a 0.7 percent increase in parallel coverage for people who had some problems going to work relating to their health status but were not qualified for Medicare disability (Cogan, Hubbard, and Kessler, 2008).

Fourth, no matter how much money taxpayers decide they can afford to throw at the wall of insurance coverage problems, the real key to affordability is health care that is delivered more quickly, simply, cheaply, consistently, and effectively. An individual mandate tries to ignore those problems because it cannot solve them. To do this, we need better incentives for more efficient health care. Less affordable health insurance is a secondary symptom, not the primary cause, of high-cost health care. We should insist as private purchasers and taxpayers that insurers and health care providers find ways to offer different mixes and methods of care and coverage that cost less and are worth more.

Instead of trying to prop up a controversial and ineffective individual mandate, we should focus on the most important unmet tasks of true health reform: improving the value of health care (and its related insurance financing) delivered to patients so that more people can and will purchase it voluntarily and investing in other, more effective ways to boost their lifetime health. The number of Americans covered by health insurance can still be increased through less intrusive means, such as the risk of higher premiums for those who delay or fail to maintain coverage, the help provided by more targeted and equitable subsidies, and better products that customers will purchase voluntarily.
Further Readings and Resources


Hadley, J. et al. (2008). Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage. Henry J.


