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Routing

Individual Mandates for Health Insurance

Slippery Slope to National Health Care

by Michael Tanner

Executive Summary

Proposals for achieving universal health insurance coverage are once again receiving serious attention. Among the ideas attracting bipartisan support is an individual health insurance mandate, a legal requirement that every American obtain adequate private health insurance coverage. People who don't receive such coverage through their employer or some other group would be required to purchase their own individual coverage. Those who failed to do so would be subject to fines or other penalties.

Proposals for an individual mandate respond to a legitimate concern about "free riders," the uninsured who nonetheless receive treatment and pass the costs on to taxpayers or individuals with insurance. In practice, however, an individual mandate is likely to be unenforceable because it would involve a costly and complex bureaucratic system of tracking, penalties, and subsidies.

More important, an individual mandate crosses an important line: accepting the principle that it is the government's responsibility to ensure that every American has health insurance. In doing so, it opens the door to widespread regulation of the health care industry and political interference in personal health care decisions. The result will be a slow but steady spiral downward toward a government-run national health care system.

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Introduction

Roughly 46 million Americans are currently uninsured.[1] That has sparked a national debate over how to expand coverage, with many people setting a goal of "universal coverage," that is, every American would have some form of health insurance. Some people have advocated a single-payer system under which the government would administer a taxpayer-financed system. Others have called for an employer mandate, requiring employers to provide their workers with insurance. Both of those approaches have obvious problems that have prevented them from gaining much public support.

As a result, a third approach to universal coverage is now getting serious attention—an individual mandate, a legal requirement that every American obtain adequate private health insurance coverage. People who don't receive such coverage through their employer or some other group would be required to purchase individual coverage.

Such a mandate, if federal, would be an unprecedented expansion of government power. As the Congressional Budget Office noted in 1994, "The government has never required people to buy any good or service as a condition of lawful residence in the United States."[2]

Despite that, proposals for an individual mandate have drawn a surprising degree of support from conservatives. The Heritage Foundation has supported such a mandate for more than a decade.[3] Senate Majority Leader Bill Frist (R-TN) has expressed general support for the idea.[4] Articles favoring an individual mandate have been featured in the *Weekly Standard*.[5] Ron Bailey endorsed the concept on the libertarian website, Reason.com.[6] Perhaps the latest such proposal comes from Gov. Mitt Romney of Massachusetts, an expected Republican candidate for president in 2008.[7]

An individual mandate is an attempt to address real problems in the American health care system. But there is ample reason to be skeptical of that approach.

The Case for a Mandate

Some observers have seen an individual mandate as an achievable step on the road to universal coverage. Having long equated insurance coverage with access to health care and access to better health, they see an individual mandate as producing better health outcomes. They argue, for example, that people will receive more preventive care if they are covered by insurance. In reality, however, the experience of rationing under national health insurance schemes in other countries shows that insurance coverage and access to care are entirely different things.[8] Moreover, evidence that insurance coverage or access leads to better health outcomes is uncertain at best.[9]

Other observers, including economists of all stripes, have tended to embrace individual mandates for another reason. When an individual without health insurance becomes sick or injured, he or she still receives medical treatment. In fact, hospitals are legally required to provide care regardless of ability to pay. Physicians do not face the same legal requirement, but few are willing to deny treatment because a patient lacks insurance.

However, such treatment is not free. The cost is simply shifted to others—those with insurance or, more often, taxpayers. In fact, uncompensated care costs an estimated $40.7 billion per year, with 85 percent of that cost borne by federal, state, and local governments.[10] Thus, to a large degree individuals without health insurance are "free riding" on the rest of us.

In addition, those most likely to go without health insurance are the young and relatively healthy. For example, although 18 to 24 year olds are only 10 percent of the U.S. population, they are 21 percent of the long-term uninsured.[11] For these young, healthy individuals, going without health insurance is often a logical decision. However, this becomes a form of adverse selection. Removing the young and healthy from the insurance pool means that those remaining in the pool will be older and sicker. That results in higher insurance premiums for those who are insured.[12]

Advocates of a mandate argue that if we can mandate automobile insurance in order to protect society from the costs imposed by uninsured drivers, we should be able to do the same for health insurance.[13]

Those are legitimate concerns and cannot be casually dismissed. But regardless of whether a mandate solves legitimate problems in theory, the practical problems of an individual mandate make it likely to be costly and difficult to administer. More important, it would likely set in motion forces that will lead slowly, but almost inevitably, to a government-run national health care system.

The Problem of Enforcement

To enforce a health insurance mandate, government would need some way to determine whether Americans are insured or not and to penalize those who have not complied with the mandate. But government's record of enforcing insurance mandates has not been an overwhelming success. For example, 47 states have laws mandating that drivers purchase automobile liability insurance. Yet roughly 14.5 percent of drivers in those states are uninsured.[14] In some states, such as Texas, the uninsured motorist rate runs as high as 18 percent. As many as 25–30 percent of Los Angeles drivers are uninsured.[15] By comparison, in the three states without mandatory auto insurance, roughly 15 percent of drivers are uninsured. Thus, it would appear that, despite penalties that can run from loss of license to fines as high as $5,000 or even the impounding of vehicles, millions of American drivers have chosen to ignore the mandate.[16] In fact, millions of Americans purchase "uninsured motorist" coverage to protect themselves in an accident in which the other driver is uninsured. It is also interesting to note that the percentage of drivers uninsured despite a mandate is roughly the same as the percentage of Americans who don't have health insurance.[17]

The closest example to a health insurance mandate in the United States is in Hawaii, which has long had a mandate that all employers provide their workers with health insurance. But roughly 10 percent of Hawaiian workers remain uncovered.[18] Even under Canada's national health care system, the government has encountered difficulties in ensuring that everyone is registered or pays required premiums, or both. For example, in British Columbia alone an estimated 40,000 people slip through the cracks. As a result, physicians in that province provide about $5 million to $10 million per year in unreimbursed services to people without insurance.[19] Although that is a tiny amount compared to the cost of treating the uninsured in the United States, it demonstrates the difficulties of forcing compliance with an insurance mandate.

How then will an individual health insurance mandate be enforced? The first problem is to track who is and is not insured. Here again the government's record is unpersuasive. No federal agency invests as much time, money, and effort in tracking Americans as does the Internal Revenue Service. Yet it consistently fails to track down millions of Americans who fail to file tax returns. And every 10 years there is a scandal when the Census Bureau cannot locate several million citizens.

The most commonly suggested solution is to require that Americans submit proof of insurance when they file their federal income taxes. But about 18 million low-income Americans are not required to file income taxes, mostly because their incomes are too low.[20] Another 9 million Americans who are required to file tax returns nonetheless fail to do so.[21] That is potentially 27 million Americans who would not be providing proof of insurance. To deal with that, the centrist New America Foundation, one of the leading advocates of an individual mandate, would mandate that even non–income tax filers submit their proof of coverage.[22] But the foundation provides no plan to deal with those who simply refuse to do so. And, after all, some of the nonfilers will be elderly, homeless, and mentally ill. Others will have changed their address, perhaps multiple times.

Moreover, only about 30 percent of uninsured Americans have been uninsured for a

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full year. In fact, nearly 45 percent will regain insurance within four months.[23] Therefore, many people who lack health insurance at some point in the year will be insured at the time they file their taxes. Presumably, the "proof of insurance" could include the length of time that the person was insured, but that would raise the complexity of compliance procedures considerably. It would also increase the incentive to lie.

If the government were able to determine that someone had not purchased health insurance, what penalty would apply? Ideas have been suggested ranging from loss of drivers' licenses to direct fines. However, some sort of tax penalty is the most common approach.

But that is much easier said than done. As Gene Steuerle of the Urban Institute has noted, the administrative and enforcement costs of collecting the penalty would be enormous. The IRS relies largely on voluntary compliance backed up by a slow and cumbersome legal process to collect taxes. And it does not require those with very small amounts of income to file. Even so, as noted above, millions of Americans cheat or fail to file. Collecting a penalty for failure to insure would be much more difficult. "The [IRS] is simply incapable of going to millions of households, many of modest means, and collecting significant penalties at the end of the year," Steuerle warns.[24]

Moreover, many of those who fail to comply with the mandate will be low-income Americans. Nearly one-quarter of those without health insurance today have household incomes of less than $25,000 per year.[25] Those individuals will almost certainly lack the resources to pay any penalty, particularly a lump-sum penalty assessed at year's end.

As an alternative, therefore, some observers have suggested that the penalty be withheld in advance, as part of income tax withholding, then refunded to individuals who provide proof of insurance. However, there is an inherent unfairness to an approach that would impose lower take home pay on Americans regardless of whether they have health insurance. It would also increase compliance costs for employers who presumably have to track how much to withhold on the basis of a worker's marital status and number of children. (To be fair the penalty would have to vary with family size.) If the penalty was a flat rate rather than based on income as are other taxes, that would raise other issues for employers such as how to handle workers with more than one job. Should they pay twice?

Moreover, withholding would do nothing to collect from the unemployed. Yet we know that one reason many people lack health insurance for part of a year is that they are unemployed. Thus, withholding would penalize millions of workers with insurance but miss millions without.

Therefore Steuerle and others suggest some form of carrot-and-stick approach, whereby the penalty would be offset, at least in part, by some form of advance subsidy.[26] However, as discussed below, that has its own set of difficulties.

Finally, some people suggest that rather than impose penalties on individuals who fail to insure themselves, the government simply insure them by assigning them at random to either an insurer or a regional insurance pool (see below). The insurer would then be responsible for ensuring payment through normal collection methods. But, as we've seen, a large number of the uninsured lack insurance for only a short period of time. In many cases they would become insured again during the time it would take to identify, assign, and process them.

States are likely to have an even harder time enforcing a mandate, since they lack both a tracking infrastructure and the ability to impose large tax penalties. Of course, theoretically states could use their income tax systems to levy penalties, but given lower state tax rates, the penalty would be huge compared to the amount of taxes otherwise due. That would make the penalty a difficult proposition politically.

Governor Romney has suggested that Massachusetts withhold state income tax refunds for those without insurance. He would redirect the refund into an escrow

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account to be held against the individual's future health care expenses.[27] However, for most people, the withheld refund will almost certainly be less than the cost of insurance. The average state tax refund in Massachusetts last year was $401.[28]

In the end, most of the proposed penalties would likely be either too punitive or effective against only the minority of uninsured with moderate or high incomes.

The Complexity of Subsidies

The number-one reason that people give for not purchasing insurance is that they cannot afford it.[29] Therefore, if an individual mandate for health insurance is going to be effective, some form of subsidy for low-income Americans will have to be found. As the New America Foundation notes, "Making basic coverage mandatory for individuals necessitates making coverage available and affordable for all."[30] That raises three important design and implementation questions.

Voucher or Tax Credit?

Should the subsidy be in the form of a voucher payable to the insurer or a tax credit payable to the individual?

The most commonly suggested form of subsidy is a tax credit, most likely refundable. That would take advantage of a system already set up to make payments to millions of individuals. However, the strength of the system is also its weakness. There would be no way to provide the subsidy to those who didn't file tax returns. On the other hand, a voucher payable to insurers would require a potentially costly new administrative structure. Simply mailing the voucher to people who move or without a fixed address poses the potential for administrative chaos.

Flat Amount or Linked to Income?

Should the subsidy be a flat amount for all Americans, or should it be linked to income?

A flat subsidy would be easy to administer and relatively transparent. It would also be costly. After all, any subsidy must be large enough to cover all or most of the cost of insurance for low-income Americans, otherwise the mandate will amount to a highly regressive tax on those least able to pay. The cost of a health insurance policy for a family of four today averages more than $10,000 a year.[31] Clearly, low-income individuals would have difficulty absorbing such costs. Even if the cost could be reduced by mandating a more limited package of benefits or shifting to a high-deductible policy (with or without an accompanying health savings account), the burden on low-income workers would be substantial.[32]

Once the subsidy became available to individuals purchasing insurance on their own, businesses that currently provide their workers with health insurance would either demand equivalent subsidies or drop their health coverage altogether, only too happy to shift the cost of insuring workers to the taxpayer. That behavior is already clearly visible with Medicaid.[33]

That is why proponents of an individual mandate frequently combine it with an employer mandate. (The Heritage Foundation and Governor Romney have resisted that temptation.) Knowing that an employer mandate would ultimately result in lower wages or fewer jobs, proponents generally try to offset such costs by providing subsidies to employers as well as individuals. Thus, the federal government ends up indirectly paying a large part of the cost of health coverage, including coverage for people who are currently insured.

If the subsidy is linked to income or otherwise means tested, there are three ways to do so: 1) projected income for the current year, 2) last year's income, and 3) regularly adjusted weekly or monthly income. Each of those methods has problems.

Guessing future income is simply an exercise in crystal ball gazing. Relying on past income provides an accurate starting point but does not necessarily tell us about an individual's current subsidy need. For example, if

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a person was unemployed last year but finds a job this year, he would be eligible for a subsidy level that he would no longer need. Conversely, a person who was employed last year but lost his job this year would need the subsidy but might not be eligible.

Most traditional welfare programs deal with this problem by basing eligibility on weekly or monthly reporting. That provides for flexibility in dealing with income fluctuations and changes in circumstance. However, verification of such frequent reports is costly and manpower intensive, resulting in poor monitoring and widespread inaccuracy, not to mention outright fraud. There is also the question of who would be responsible for monitoring eligibility on a short-term basis. The IRS is not set up to deal with weekly or monthly income reports. State welfare agencies do so now in the case of Temporary Assistance to Needy Families, Medicaid, and similar programs, but those agencies have nowhere near the manpower or infrastructure it would take to collect and verify income information from every household in the state every week or month. Such a requirement would quickly bankrupt most states, to say nothing of the difficulties involved in coordinating the information, once collected, with the federal subsidizer.

Risk Rated?

Should the subsidies be risk rated or otherwise take into account the higher insurance premiums that are charged to families or individuals with preexisting conditions or other high-risk factors?

High-risk individuals cost more to insure than do individuals who are young and healthy. If their subsidy is not adjusted, they will face higher out-of-pocket costs, in some cases, prohibitive ones.

If people receive a higher subsidy simply because they are paying higher premiums, there is no burden on either the consumer to be a wise consumer or on the insurance plan to be efficient. Without intrusive government oversight, there is no reasonable way to determine whether a plan is charging higher premiums because it is insuring families with higher risks, because it is inefficient, or simply because it is attempting to maximize its profit margin.

However subsidies are ultimately calculated, they are apt to be expensive for taxpayers. By some estimates, the initial cost of subsidies nationally would top $75 billion per year.[34] The subsidies under Governor Romney's plan for Massachusetts would cost between $700 million and $1.2 billion.[35] To some degree savings from uncompensated care would offset those costs. On the other hand, increased coverage would almost certainly lead to increased usage, driving up overall health care costs and necessitating increased subsidies.

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Mandate Creep

To implement an insurance mandate, legislators and administrators will have to define what sort of insurance fulfills that mandate. Not surprisingly, given the early stage of the debate, most proposals have been vague about what sort of benefit package would meet the minimum requirements for the mandate. But there are a few proposals that contain enough detail to let us assess what a mandated package might look like.

For example, the New America Foundation suggests that the Blue Cross Blue Shield Standard Benefit offered under the Federal Employee Health Benefits Program provides a good model for the minimum benefits package.[36]

A plan developed by Blue Cross Blue Shield of California calls for "independent medical professionals" to develop the minimum benefit package, but specifies that it should include preventive care, physician services, hospital care, and prescription drugs.[37]

Governor Romney would give people a choice of plans offered by two government-created purchasing pools. Insurers participating in the pools would be able to offer what the governor has described as low-cost, no-frills plans, including plans with high deductibles.[38] Governor Romney has estimated that those

plans would cost between $134 and $160 a month, after taxes, per person, or between $350 and $500 for a family plan.[39] Some of the cost would be offset by subsidies, on a sliding scale, so that a single person making $23,925 a year would pay $18.46 per week for health insurance.[40] That would still be nearly $1,000 per year, a substantial burden for someone in that income range.

The Heritage Foundation has taken perhaps the least prescriptive approach, with a mandate for catastrophic coverage, defined essentially as a "stop loss" policy protecting a family against total health care costs above a certain level.[41]

Whatever the initial minimum benefits package consists of, special interests representing various health care providers and disease constituencies can certainly be expected to lobby for inclusion under any mandated benefits package. To see this in action, one simply has to look to state mandates for health insurance benefits. The number of laws requiring that all insurance policies sold in a state provide coverage for specified diseases, conditions, and providers has been skyrocketing. In the 1960s there were only a handful of such mandates, but today there are more than 1,800.[42] The list includes mandates for coverage of hair transplants (Connecticut, Massachusetts, Maryland, Minnesota, Missouri, New Hampshire, and Oklahoma), massage therapy (Florida, Maryland, New Hampshire, and Washington), and pastoral counseling (Maine and North Carolina).[43]

Or consider Oregon's attempt to prioritize Medicaid services. In 1992 Oregon guaranteed all state residents under the poverty line a basic level of health care. At the same time, because funding was limited, the Oregon Health Services Commission drafted a priority-ranked list of medical services available to Oregonians. The state would fund services deemed priority on the basis of such factors as cost, duration of a treatment, benefit, improvement in the patient's quality of life, and community values. Services that did not qualify under those criteria would not be funded.[44] However, political calculations quickly became part of the ranking process, with the program a battleground for interests associated with various disease constituencies and health care specialties. Groups battled each other to make sure that their needs or services were included in the list of covered services. The list was repeatedly revised to reflect, not the best medical judgment, but outside pressure. The legislature repeatedly intervened. The U.S. Office of Technology Assessment concluded that Oregon's prioritization plan "has not operated as the scientific vessel of rationing that it was advertised to be. Although initial rankings were based in large part on mathematical values, controversies around the list forced administrators to make political concessions and move medical services 'by hand' to satisfy constituency pressures."[45]

And when the Clinton administration proposed a minimum benefits package as part of its 1993 health care reform plan, provider lobbying groups spent millions of dollars in advertising calling for the inclusion of specific provider groups or coverage of specific conditions.

Public choice dynamics is such that providers (who would make money from the increased demand for their services) and disease constituencies (whose members naturally have an urgent desire for coverage of their illness or condition) will always have a strong incentive to lobby lawmakers for inclusion in any minimum benefits package. The public at large will likely see resisting the small premium increase caused by any particular additional benefit as unworthy of a similar effort. It is a simple case of concentrated benefits and diffuse costs.

Spiraling Downward toward National Health Care

Individual mandates cross an important practical and philosophical line: once we accept the principle that it is the government's responsibility to ensure that every American has health insurance, we guarantee even more government involvement with and control over large portions of our health care system. Compulsory, government-defined insurance opens the door to even more widespread regu-

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lation of the health care industry and political interference in personal health care decisions. The result will be a slow but steady spiral downward toward a government-run national health care system.

To see this in action, one has only to look at the details of the comprehensive proposals containing individual mandates. For example, the New America Foundation would require insurers to accept all comers without any waiting period for preexisting conditions. The foundation also embraces community rating (a prohibition on charging different premiums based on factors such as age, sex, occupation, or health status) and would prohibit any risk rating of premiums.[46]

The New America Foundation also calls for the creation of "community purchasing pools" that would provide government-approved insurance plans to individuals on a collective basis.[47] Governor Romney's plan also calls for such pools, which were once a key ingredient of the Clinton health care plan.[48] (Massachusetts already has community rating.)

The pools would not actually be insurers. Insurance would still be provided by the private sector. Rather, the pools would function as clearinghouses, a sort of wholesaler or middleman, matching customers with "approved" providers and products. They would also allow small businesses and individuals to pool their resources to take advantage of the economies of scale available to large group plans.

However, when such pools are combined with community rating and restrictions on other types of risk rating, they can act as significant barriers to competition in the insurance industry. Since plans participating in the pools must offer the same package of core benefits, they can compete on the basis of services offered only at the margins. Price competition is also extremely limited since so many of those purchasing from the pools have their purchase costs subsidized. And the inability of insurers to reduce costs by managing risks will act as a further barrier to price competition.

Ultimately, the pools will squeeze out insurers outside the pools. That is particularly likely if insurers outside the pools are prohibited from offering lower premiums, as recommended by the New America Foundation.[49] In the end, the pools will become monopsony purchasers of health insurance, turning insurers into little more than public utilities.

These proposals for regulating the insurance market should not be seen as independent from the individual mandate; they are a direct outgrowth of it. "If you want to go down the road of an individual mandate, it's necessary to reform the entire health insurance system to make sure healthy people can get affordable coverage and sick people are not priced out of the market," says Gail Shearer of Consumers Union.[50] And because the mandate restricts the ability of the market to discipline itself, increased regulation will be seen as the only way to meet that goal.

In addition, we have already seen that there will be enormous special interest pressure to add benefits to the mandated package. As more benefits are added, the cost of the mandate will increase. That will place legislators in a very difficult position. If they increase subsidies to keep pace with the rising cost of the mandate, the cost of the program will explode. On the other hand, if they hold subsidies steady, the increased cost will be borne by consumers, who will have no choice but to continue purchasing the ever more expensive insurance. Since consumers would have little or no leverage over insurers (they can no longer refuse to buy their products), they can eventually be expected to turn to the only entity that can hold down their costs—the government. Attempts to scale back benefits would certainly meet political opposition from powerful constituencies and complaints about "cuts." The only other alternative would be for the government to intervene directly by capping premiums.

To see this dynamic in action, just look at the recent Bush administration budget proposals for Medicare. Faced with exploding program costs as a result of the president's prescription drug program, the administration has reacted, not by cutting back on benefits, but by cutting back on payments to providers, de facto price controls.[51]

Insurers unable to charge more for an increasingly expensive product can be expected to trim costs by cutting back on their reimbursement rates to hospitals and physicians. The result will ultimately be rationing and a lack of available health care goods and services.

An individual mandate, therefore, should not be seen in a vacuum. It is more akin to the first in a series of dominoes. By distorting the health care marketplace, an individual mandate would set in place a cascading series of additional mandates and regulations resulting, ultimately, in a government-run health care system.

Conclusion

There is no easy answer to the free-rider problem. Human nature being what it is, as long as we make the decision to help those who cannot (or will not) pay for their own health care, we will provide an incentive for people to take advantage of society's generosity. Although universal coverage schemes sound desirable in theory, in practice none is likely to reach every American, and all carry significant price tags, both in terms of dollars and in terms of unintended consequences for the health care system as a whole. On the other hand, being a compassionate society, we are unlikely to refuse health care to those without insurance (or other resources with which to pay for it) as punishment for their lack of foresight.

This conundrum, how to provide care to those who truly need help while discouraging free riding, must be dealt with whether the decision to provide for the needy is made by government or civil society (although government complicates the issue when it mandates that providers provide uncompensated care thereby preempting experimentation with ways to discourage free riding). Rather than let one government mandate spawn another (and another, and another . . .), the best, although admittedly imperfect, answer might be to make existing government mandates more flexible as a way to encourage more innovative approaches to dealing with the free-rider problem.

An individual mandate would be an unprecedented expansion of government power and intrusion into the American health care system. As the CBO puts it:

> An individual mandate has two features that, in combination, make it unique. First, it would impose a duty on individuals as members of society. Second, it would require people to purchase a specific service *that would have to be heavily regulated* by the federal government (emphasis added).[52]

On a practical level, such a mandate is likely to prove unenforceable. More important, an individual mandate will almost certainly lead to a cascading series of additional mandates and regulations resulting in a government-run health care system. However we ultimately deal with the uninsured and the free-rider problem, we should bear in mind the Hippocratic Oath: "First do no harm." An individual mandate, then, is clearly not the way to go.

On a fundamental level we must shift the health care debate away from its single-minded focus on expanding coverage to the bigger question of how to reduce costs and improve quality. That will require the introduction of market mechanisms to give consumers more control over and responsibility for their health care decisions.

In doing so, we can actually increase coverage and reduce the free-rider problem. In particular, if young, healthy people are able to purchase low-cost catastrophic insurance, they are more likely to see becoming insured as in their self-interest. And, to the degree that health care and health insurance become less expensive, more low-income people can be brought into the system.

That would be a better, more realistic, and far less risky approach than individual mandates.

Notes

1. Carmen DeNavas-Walt, Bernadette Proctor, and Cheryl Hill Lee, "Income, Poverty, and Health

By distorting the health care marketplace, an individual mandate would set in place a cascading series of additional mandates and regulations resulting, ultimately, in a government-run health care system.

Insurance Coverage in the United States, 2004," U.S. Census Bureau, August 2005, http://www.census.gov/prod/2005pubs/p60-229.pdf.

2. Robert Hartman and Paul van de Water, "The Budgetary Treatment of an Individual Mandate to Buy Health Insurance," Congressional Budget Office memorandum, August 1994.

3. The Heritage Foundation first spelled out the details of its proposal in 1994. Stuart Butler, "The Heritage Foundation Proposal," presentation to a Heritage Foundation conference on "Is Tax Reform the Key to Health Care Reform?" Heritage Lecture no. 298, October 23, 1990. However, it has reaffirmed its support for an individual mandate as recently as 2003. Stuart Butler, "Laying the Groundwork for Universal Health Care Coverage," Testimony before the Senate Special Committee on Aging, March 10, 2003. In addition, the Heritage Foundation hosted a forum for Governor Romney this year, during which they implied support.

4. Bill Frist, "Transforming Health Care: A Patient-Centered, Consumer-Driven and Provider-Friendly Vision," Address to National Press Club, July 12, 2004.

5. Ross Douthat and Reihan Salam, "The Party of Sam's Club," *Weekly Standard*, November 14, 2005, http://www.weeklystandard.com/Content/Public/Articles/000/000/006/312korit.asp.

6. Ronald Bailey, "Mandatory Health Insurance Now!" November 2004, http://www.reason.com/0411/fe.rb.mandatory.shtml.

7. Associated Press, "Romney Plan Would Require All to Buy Health Insurance . . . Or Else," June 23, 2005.

8. For example, one million Britons are waiting for admission to National Health Service hospitals at any given time, and shortages force the NHS to cancel as many as 100,000 operations each year. Roughly 90,000 New Zealanders are facing similar waits. In Sweden, the wait for heart surgery can be as long as 25 weeks, while the average wait for hip replacement surgery is more than a year. And in Canada more than 800,000 patients are currently on waiting lists for medical procedures. See Michael Cannon and Michael Tanner, *Healthy Competition: What's Holding Back Health Care and How to Free It* (Washington: Cato Institute: 2005), pp. 36–37.

9. See, for example, Helen Levy and David Meltzer, "What Do We Really Know about Whether Health Insurance Affects Health?" in *Health Policy and the Uninsured*, ed. Catherine McLaughlin (Washington: Urban Institute, 2004), pp. 179–204.

10. Jack Hadley and John Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" Kaiser Commission on Medicaid and the Uninsured, May 10, 2004.

11. Rob Stewart and Jeffrey Rhoades, "The Long-Term Uninsured," U.S. Census Bureau, Research Note, September 2004, http://aspe.hhs.gov/health/long-term-uninsured04/report.pdf.

12. This argument is true only if there are cross-subsidies in existing pools. If everyone's rates are actuarially fair, then young people's explicit or implicit premiums do not result in lower or higher premiums for anyone else. These two views of health insurance—ex ante versus no ex ante redistribution—are actually the basis for much analysis and policy prescription in health care.

13. This is an imperfect analogy, however. First, it has long been recognized that driving is a privilege, subject to all manner of regulatory requirements. If one does not like the regulations, including an insurance mandate, one can choose not to drive. A health insurance mandate would not generally give people such a choice. Second, the reason states mandate auto insurance is for the protection of *others* rather than oneself. Most states do not mandate that you carry insurance for your own injury or repair costs.

14. Greg Kelly, "Can Government Force People to Buy Insurance?" Council for Affordable Health Insurance, Issues & Answers no. 123, March 2004, citing data from the Insurance Research Council, http://www.cahi.org/cahi_contents/resources/pdf/n123GovernmentMandate.pdf.

15. Stephanie Jones, "Uninsured Drivers Travel under the Radar," *Insurance Journal*, August 18, 2003.

16. Kelly.

17. Ibid.

18. "Hawaii: Health Insurance Coverage of the Total Population, States (2003–2004), U.S. (2004)," Kaiser statehealthfacts.org, Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

19. Heather Kent, "BC Doctor Seeks Class-action Suit over Payment for Uninsured Patients," *Canadian Medical Association Journal* 163, no. 9 (October 31, 2000): 1184.

20. Peter Orszag and Matthew Hall, "Nonfilers and Filers with Modest Tax Liabilities," Tax Policy Center, Urban Institute, and Brookings Institution, *Tax Notes*, August 4, 2003, http://www.urban.org/

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