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In late January 1994, The Robert Wood Johnson Foundation and Princeton University sponsored a conference entitled “Universal Coverage: How Best to Achieve It?” At that conference several prominent economists and policymakers presented papers on the pros and cons of employer and individual mandates. In response, a number of others offered comments on various aspects of the mandate question. Here Health Affairs presents the views of two respondents.

Personal Freedom, Responsibility, And Mandates

by Robert E. Moffit

The national debate on universal health coverage is the latest incarnation of an ancient, enduring question of political philosophy: reconciling personal liberty and the authority of the State. It is the central problem of American political culture and is at the heart of nearly every major constitutional conflict in our history.

Americans—heirs of a classical liberal tradition, grounded in the political philosophy of John Locke and the spirit of Thomas Jefferson, in which personal freedom is paramount—harbor a deep distrust of governmental authority. We do not automatically assume that the individual is or should be subordinate to society, whether the issue is literary censorship or economic regulation. Therefore, any political limitation on personal freedom, regardless of prevailing wisdom, prejudices, or majority interests, must be based on a compelling argument.

The Taxpayer Mandate

Policy analysts at The Heritage Foundation have wrestled incessantly with this problem, while developing a “consumer choice” plan for comprehensive health system reform, now embodied in a major legislative proposal. Only after extensive analysis of the peculiar distortions of the health insurance market did Heritage scholars reluctantly agree to an individual mandate.

On this point, some observations are in order. First, much of the debate over whether we should have a mandate is, in a sense, a debate over a “metaphysical abstraction.” For all practical purposes, we already have a powerful and increasingly oppressive mandate: a mandate on taxpayers.

We all pay for the health care of those who do not pay, in two ways. First, people with private insurance pay through that insurance—even though that insurance is often the property of employers under current law. This reflects the ever-higher costs shifted to offset the billions of dollars of costs of uncompensated care in hospitals, clinics, and physicians’ offices. Second, if those who are uninsured get seriously ill and are forced to spend down their assets to cope with their huge medical bills, their care is paid for, not through employer-based or private insurance premiums, but through taxes, money taken by federal and state tax collectors to fund Medicaid or other public assistance programs that serve the poor or those impoverished because of a serious illness.
Hospitals also have legal obligations to accept and care for those who enter seeking assistance. No responsible public official is proposing repeal of these statutory provisions, and very few physicians, if any, are prepared to deny treatment to persons seeking their help merely because they cannot afford to pay. As taxpayers and subscribers to private health insurance, the American people pick up these bills.

Aside from current economic arrangements, the entire moral and cultural tenor of our society reinforces the taxpayer mandate. Those who are uninsured and cannot pay for their care will be cared for, and those who are insured and working will pay for that care.

So, we already have a mandate. But it is both inefficient and unfair.

A Snare And A Delusion

Employer-based health insurance in this country is the product of wartime economic and tax policy of the 1940s. There is no reason why health reform in the 1990s should be governed by those unique circumstances and outdated tax policies.

Uwe Reinhardt and Alan Krueger tell us that the tax treatment of employment-based health insurance now is sharply regressive. And, Mark Pauly confirms, it contributes to market distortions, high costs, and lack of portability in health insurance. Americans today get tax relief for health insurance on only one condition: that they get it from their employer. This has tied health insurance to the workplace in a way that no other insurance is treated. It means that if we lose or change a job, we lose our health coverage.

Pauly also tells us that employer-based insurance hides the true costs of health care. Thus, there is no normal collision between the forces of supply and demand on even the most basic level. Most workers do not purchase health insurance; it is purchased by somebody else, usually the company. For most workers, it is a “free good,” an extra, that automatically comes with the job. At least, we live with that comfortable illusion. But, in fact, it is not free at all, and the employer gives us nothing. Because too many people think that the employer’s contribution is the employer’s money and not theirs, the consumer’s perception is distorted (as is the provider’s), and health spending is not subject to market discipline. Likewise, because too many people still do not understand this reality, “hidden taxes” through the employer mandate are politically attractive. Such a mandate thus serves as a psychological snare and an economic delusion.

Karen Davis and Cathy Schoen suggest a payroll tax to finance reform, whereby the employer pays 8 percent and the employee pays 2 percent. If one of our tasks is to make the true costs transparent, this suggestion does not help very much.

In his otherwise enlightening paper, Reinhardt calls attention to the virtues of a “mandated purchase” of health insurance. And he warns that calling an employer’s “mandated purchase” a “tax” comes close to debasing the English language. But, in a similar context, Reinhardt uses the word contribution to describe suspiciously similar functions. Suffice it to say, the campaign for linguistic precision is hardly advanced by using the word contribution to describe the state’s forcible extraction of citizens’ money.

In another context, Reinhardt proposes perhaps the best single reform idea to date. He suggests a simple financial disclosure on the part of the nation’s employers, requiring every employer to put periodically on the pay stub of every worker in America something like the following: “We have paid you X thousand dollars in health benefits. This has reduced your wages by X thousand dollars.” We would add: “Have a nice day!”

Some Rules For Tax Relief

Pauly crisply outlines the economic rationale of an individual mandate: It would make individuals personally responsible for their spending decisions. But adoption of an individual mandate logically requires the provision of individual tax relief. The various tax credit proposals developed by The Heritage Foundation, for example, and modeled by Lewin-VHI, are far more equitable
than the tax rules that prevail today? If Congress should grant individual tax relief, then it should follow some simple principles.

Make the tax code neutral. Do not tie tax relief to only one kind of insurance, employer-based insurance, but rather to insurance offered by a wide variety of potential sponsors, including trade and professional associations, employee organizations and unions, and even churches and religious institutions. As Pauly notes, the establishment of an individual mandate does not necessarily mean the end of group insurance. Most individuals and families are likely to purchase health insurance in and through large organizations with which they have some affinity, such as labor unions. This is what many federal workers do right now.

Target tax relief to need. Beyond a basic level of tax relief for every household, policymakers should base the generosity of tax relief on family health care needs. More help should go to lower-paid families or families with higher health care bills. Also, a substantial reservoir of funding for tax credits and vouchers is already available.

Base funding on current tax breaks. The current tax breaks for employer-based insurance should serve as the financial foundation of a new national tax credit system. Dollar for dollar, these funds could be channeled directly to American families. While members of Congress should make such comprehensive tax relief budget-neutral, avoiding massive new taxation or larger deficits, the dollars available for vouchers also could be enriched by cuts in federal spending, especially if one wanted a deeper reservoir of funding for low-income families.

By What Right?

Libertarian economists offer the most serious philosophical objection to an individual mandate. They view the establishment of any such mandate, even a minimal obligation to buy catastrophic insurance, as an unjust infringement on personal freedom.

While this objection may be theoretically coherent, its pristine logic misses the practical point: It ignores the “free-rider” problem. Indeed, it practically ends up sustaining the current and increasingly burdensome taxpayer mandate. Absent a specific mandate for at least catastrophic health insurance coverage, some persons, even with the availability of tax credits to offset their costs, will deliberately take advantage of their fellow citizens by not protecting themselves or their families, with the full knowledge that if they do incur a catastrophic illness that financially devastates them, we will, after all is said and done, take care of them and pay all of the bills. They will be correct in this assessment. But the rest of us should realize that we are thus being victimized by deliberate irresponsibility.

An individual mandate for insurance, then, is not simply to assure other people protection from the ravages of a serious illness, however socially desirable that may be; it is also to protect ourselves. Such self-protection is justified within the context of individual freedom; the precedent for this view can be traced to none other than John Stuart Mill. It does not necessarily follow, however, that we would have a right to prescribe anything beyond our own self-protection. For example, if we were to impose a comprehensive health benefit package, outlining in meticulous detail what specific medical benefits or services we think our fellow citizens should or should not have, we would be in clear violation of Mill’s admonitions and thus coercing rather than “persuading” our fellow citizens to do what we think is good for them, regardless of their personal judgments on these matters.

A mandate for basic or catastrophic protection is not burdened by such a philosophic disability, for it is designed to protect us. It otherwise leaves free and equal individuals the liberty to make their own choices and seek their own good.

In the spirit of creativity, let us imagine exceptions to our own rules. Historically, on religious or moral issues, Western societies have given at least lip service to the sanctity of individual conscience but have normally required some evidence of sincerity. Such an exemption surely would be appropriate if Congress were to mandate a comprehensive health benefit plan. If for religious or moral
reasons a person had a genuine conscientious objection to enrolling in such a health care plan, we would have no more right to suppress that person’s objection to the ministrations of a national health board or commission than we would to violate a pacifist’s conscientious objection to combat conscription by a military draft board.

Consider another variation on this idea, particularly relevant to an individual mandate. Assume that the American people establish a new “social contract” in the provision of health care, with a legal right to tax credits, balanced by a legal responsibility to purchase at least a basic catastrophic plan. Perhaps we also should provide an explicit consent for persons to withdraw from this new social contract, allowing a very specific exemption to the general legal requirement that ordinary Americans sign up for at least catastrophic coverage. This would entail a person’s signing a legally binding document, declaring his or her soundness of mind and will, financial ability to buy such insurance, refusal to do so, and decision in the event of serious illness to refuse all medical assistance he or she cannot pay for—liberating doctors, hospitals, insurers, and taxpayers from any moral or legal obligations to this person. If freedom is the ability to accept responsibility, it is hard to be more explicit about personal responsibility than an arrangement like this. Stuart Butler, my colleague at The Heritage Foundation, has previously suggested such an exemption, without endorsing either the practicality or popularity of such a dramatic proposal.

Such an individual exemption as the condition of a new social contract is in some respects not far removed from the idea of a “living will.” Whether the judicial system would uphold such a novel agreement to forgo treatment because of a deliberate and self-inflicted financial incapacity, or whether members of a civilized society, especially physicians, would tolerate it and allow individuals or their families to suffer its terrible consequences, is another question. Ingenious and resourceful, the American people would find a way to treat such people anyway. The sole purpose of surfacing such an exemption is not because it is desirable, but because it serves to clarify the real terms of the philosophical discussion. It is idle to talk about personal freedom outside of personal responsibility; comprehensive reform of the health care system that simultaneously devalues both personal freedom and responsibility is not worth the price.

NOTES

1. From a close reading of the Clinton plan, one detects little anguish over these kinds of questions. Indeed, the Clinton plan contains both mandates.
2. One argument that is not compelling concerns the administrative ease with which government agents can enforce federal mandates. The convenience of the Internal Revenue Service (IRS) should not rank very high in our hierarchy of values.
4. The inspiration for the phrase comes from Edmund Burke, the father of modern conservatism and Ireland’s greatest contributor to the art of statecraft and British parliamentary politics in the eighteenth century.
7. Approximately one-third of all federal workers and dependents are enrolled in plans sponsored by labor unions or employee organizations. For a discussion of the FEHBP, see R.E. Moffit. “Consumer Choice in Health: Learning from the Federal Employees Health Benefits Program,” Heritage Foundation Backgrounder 878 (6 February 1992).
8. Combined federal and state tax exclusions on the monetary value of employer insurance, plus miscellaneous tax breaks for health insurance, amount to approximately $88 billion in 1991 dollars. The estimates were made by Lewin-VHI. See Butler, “A Policy Maker’s Guide to the Health Care Crisis.”