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Free Rider – A Justification for Mandatory Medical Insurance under Health Care Reform?

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FREE RIDER – A JUSTIFICATION FOR MANDATORY MEDICAL INSURANCE UNDER HEALTH CARE REFORM?

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Section 1501 of the Patient Protection and Affordable Care Act[1] added section 5000A to the Internal Revenue Code to require most individuals[2] in the United States, beginning in the year 2014, to purchase an established minimum level of medical insurance. This requirement, which is enforced by a penalty imposed on those who fail to comply, is sometimes referred to as the "individual mandate."[3] The individual mandate is one element of a vast change that was made by Congress in 2010 to the provision of medical care.

The individual mandate has proved to be controversial and has been the subject of a number of lawsuits contending that it is unconstitutional.[4] It is not our purpose in this article to discuss its constitutionality.[5] Rather, this piece focuses on the viability of one of the justifications that often is put forth for the adoption of the individual mandate.

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[1] Public Law 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. Law 111-152, 124 Stat.1029 (2010).

[2] There are a number of categories of persons who are exempted from this mandate. See § 5000A(d)(2)-(4), (e) of the Internal Revenue Code.

[3] For an explanation of the operation of the individual mandate and an examination of the benefits and costs of the penalty that is employed to enforce it, see Jeffrey H. Kahn, *The Individual Mandate, (*to be published*)*.

[4] ADD CITES.

[5] For a sample of those arguments, see Steven J, Eillis and Nakku Chung, *Constitutional Decapitation and Healthcare*, 128 TAX NOTES 169 (2010)(arguing that it is unconstitutional) and Brian D. Galle, *Conditional Taxation and the Constitutionality of Health Care Reform*, YALE L.J. ONLINE (April 3, 2010)(arguing that it is constitutional).

A frequently stated defense of the individual mandate is that there are a vast number of persons who do not purchase medical insurance and then obtain free medical care when the need arises, and the individual mandate will require those persons (often referred to as "free-riders") to pay their share. For example, after the State of Massachusetts adopted a similar medical welfare program, Governor Mitt Romney defended the inclusion of an individual mandate by saying,"someone has to pay for the health care that must, by law, be provided: Either the individual pays or the taxpayers pay. A free ride on the government is not libertarian."[6] This same justification has been advanced in briefs in defense of the program[7] and is often advanced in discussion of the merits of the program.

It is the significance of this free-rider justification that we question. The medical welfare program that Congress adopted is not viable unless it includes an individual mandate or some comparable provision.[8] The defense of the individual

[6] Mitt Romney, *Health Care for Everyone? We Found a Way*, The Wall Street Journal, April 11, 2006, p. A16. By "taxpayers," Governor Romney means that the government pays when the individual does not. That is a bit of an overstatement. As we will see, only a small portion of the cost that is not borne by uninsured individuals is paid by the government.

[7] See e.g., Brief of Amici Curiae of Economic Scholars in the case of *Thomas More Law Center, et al. v. Barack Hussein Obama, et al.*, currently pending in the United States Court of Appeals for the Sixth Circuit. The Brief of the Amici Curiae in that case is hereinafter cited as "Amici Curiae Brief." While the focus of those briefs is to show that the failure of persons to be insured affects interstate commerce so that the individual mandate is in compliance with the Commerce Clause of the Constitution, the briefs also seek to show (albeit incidentally) that the 2010 Act is an appropriate response to the free-rider problem. For example, on page 16, the Amici Curiae Brief states, "The only economic solution to this dilemma [i.e., the free-rider problem] is to ensure broad participation in insurance pools by all people. The minimum coverage requirement is one way to do this."

[8] The 2010 Act prohibits an insurer from denying insurance coverage to an applicant because of their poor health. Section 2705 of the Patient Protection and Affordable Care Act, supra n.1. That provision creates a potential free-rider problem. If there were not an individual mandate, large numbers of persons would

mandate therefore is indirectly a defense of the entire program. So, it is worth considering whether the free-rider defense is valid since it bears on the determination of the merits of the entire program.

As will be seen, we conclude that the free-rider problem, if it existed at all, likely was of minor significance and can hardly be said to justify the adoption of an intrusive and expensive health care program. The actual congressional reason for adopting the program seems to rest on an entirely different purpose, and the debate over the desirability of the program should focus on the merits of that other purpose.

The free-rider defense appears convincing until one examines it closely. An examination of the current situation and the manner in which the program operates shows that there are good reasons to doubt that there is much of a free-rider problem and, if there is such a problem, that the 2010 Act does much to solve it.

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not purchase insurance until they had a medical condition. That adverse selection would make the premium cost of insurance prohibitive, and the program would fail either because either large numbers of persons could not afford the insurance or the insurance companies would exit the market. The question addressed in this article is whether and to what extent a free-rider problem existed before the 2010 Act was adopted rather than whether the Act itself created one. It is our view that the introduction of the free-rider issue has prevented the debate over the merits of the program from focusing on the actual critical question of whether a redistribution of wealth from the young to the old and from the healthy to the unhealthy is an appropriate and desirable goal.

In addition to the free-rider problem created by the Act, there is another reason why the individual mandate is necessary to make insurance affordable for the elderly. If the elderly were charged the actual actuarially determined cost of insuring them, the insurance would be too expensive for many to afford. To reduce their cost, it is necessary to force healthy young people to buy insurance and pay premiums in excess of the actual actuarial cost of their coverage so that they will subsidize the elderly. It is this redistribution of wealth that appears to be the actual purpose of the Act.

There were approximately forty million persons in the United States. who were uninsured in 2007.[9] Fifty-seven percent of those uninsured persons used medical services that year.[10] The Amici Curiae Brief, citing a survey, states that, on average, the medical care costs of uninsured persons amounts to about $2,000 per person each year, and over 1/3 of those costs are paid by the uninsured themselves out of their own finances.[11] How is the rest of that cost financed? About one-half of the remaining cost is obtained by the providers' increasing the price of medical services so that the shortfall is borne by those who pay for their treatment.[12] The people who pay for that shortfall include those uninsured who pay for their own treatment.

The Amici Curiae Brief states that fourteen percent of the cost of the uninsured is borne by the government through Medicare, Medicaid, services through the VA, TriCare (medical insurance for the military and their families) and workers' compensation.[13] That statement needs some refinement.[14] Except for Medicaid, those are programs designed for specific purposes that have naught to do with whether the covered individuals would otherwise have private insurance. Indeed, it is unclear why people in those programs would be described as uninsured. If the government bears a portion of the medical costs of the

[9] See Amici Curiae Brief, n.12 and the text thereto. In light of the current economic situation, it is likely that the number of uninsured has increased since then.
[10] Id.
[11] Amici Curiae Brief, n. 28 and the text thereto.
[12] Id. at n. 29 states that 32% of the overall cost of the uninsured's medical services is obtained by that means, and that translates to about one-half of the cost that the uninsured themselves do not pay.
[13] See the text of the Amici Curiae Brief following n. 31.
[14] Moreover, in the case of workers' compensation, the government is really an agent distributing funds that were collected from employers.

uninsured, it is only through any additional price that the providers impose on all who purchase medical services. This is merely one aspect of the shifting of costs to those who pay for medical treatment. As to Medicaid, the recipients are persons who could not afford to purchase insurance; the government is not picking up the tab for shirkers who have failed to pay their share of medical expenses.

Who then are these people who are uninsured? The image left by those who advance the free-rider defense is that they are parasites who pass on their own medical costs to the rest of society by obtaining medical care without paying for it. They can avoid paying for insurance because they are assured that medical care will be provided without cost when they need it. To what extent does that image reflect reality?

Federal law requires that hospitals that take Medicare treat patients who come to their emergency rooms with emergency conditions regardless of whether those patients can pay for the treatment.[15] The hospitals are not required to provide free treatment if the patients have the means to pay for it. The hospitals can and do collect from such individuals. As previously noted, more than one-third of the cost of treatments provided to uninsured patients is paid for by the uninsured patients themselves. It would seem that there are only two possible reasons why the medical providers do not collect the remaining two-thirds of that cost. One reason is that many of the patients do not have the means to make the payments. As to those who have the means but do not pay, that situation is attributable to the collection methods employed by the medical providers. In most

[15] The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd.

cases, it is likely that the reason for a failure to collect is that the amount involved is too small to justify the cost of pursuing collection.

Many of the persons who cannot afford the cost of their medical treatment could not afford to pay the premiums for medical insurance. As noted, the average cost of medical treatment to the uninsured is about $2,000 per person. Some will incur a larger expense, some less, and some not at all. The cost of insurance likely would exceed $2,000 per year,[16] and so a significant percentage of those who do not pay the full cost of their treatment could not have afforded to purchase insurance either. Free-rider is not an apt description of persons in that predicament. Moreover, even if one is willing to describe such persons as free-riders, their reliance on outside help is not eliminated by the adoption of the 2010 Act. For taxable years after 2013, certain low and moderate income individuals who purchase insurance under a Health Insurance Exchange that the states are required to create will receive a refundable credit that subsidizes their purchase of that insurance.[17] To qualify, the household income[18] of the individual must at least equal the poverty level and must not exceed four times the poverty level for the family of the size involved.[19] The poverty level is determined by section

[16] In a letter to Senator Olivia Snow, the Director of the CBO stated that the CBO estimates that, in 2016, the annual premiums for a Bronze level plan under a Health Insurance Exchange program will average between $4,500 and $5,000 for an individual and between $12,000 and $12,500 for a family policy. The Bronze level will have the lowest premium of any of the four levels provided by the Exchange program.

[17] § 36B of the Internal Revenue Code.

[18] The household income of an individual is the aggregate of the modified adjusted gross incomes of that individual and of all individuals for whom the taxpayer is allowed a dependent exemption deduction and who are required to file a federal income tax return. § 36B(d)(2).

[19] § 36B(c)(1)(A). There are additional requirements that must be satisfied.

2110(c)(5) of the Social Security Act.[20] Currently, the poverty level for a single individual is $10,830, and so a single individual can have household income of as much as $43,320 and still qualify to have his insurance cost subsidized by the government.[21] For a family of four, the current poverty level is $22,050, and so such a family can have household income as large as $88,200 and still qualify for a subsidy. Apparently, Congress felt that persons with income as high as those figures could not afford to purchase insurance without some financial assistance.[22] That suggests that most of the persons with those incomes would not purchase insurance without a subsidy because they could not afford it. Moreover, for such persons who purchase insurance at the silver coverage level,[23] the federal government will pay the insurer to lower the individual's co-pay element of the insurance.[24]

As to persons in low and moderate income levels, and the amount of their income can be fairly high, the individual continues to be subsidized by others through the government's grant of a refundable credit and paying part of the individual's co-pay. If such persons are to have been considered free-riders before the passage of the 2010 Act, they would seem to still be such after the passage of

[20] § 36B(d)(3).
[21] The amount of the government's subsidization of premium costs is reduced in stages as the amount of the individual's household income increases.
[22] Since the poverty level figures are adjusted each year to reflect inflation, the allowable income figures will be even higher in 2014 when these provisions first become effective.
[23] The Health Exchange programs will provide four levels of insurance coverage – the "bronze," "silver," "gold," and "platinum" levels.
[24] Section 1402 of the Patient Protection and Affordable Care Act, supra n. 1.

the Act. Moreover, many of the persons who cannot afford to purchase insurance are exempted from the individual mandate and so are not required to be insured.[25]

Those uninsured persons who can afford to pay for their medical services and do not do so should be relatively few if the medical providers are diligent in collecting debts owed to them. If the medical providers are not diligent, and that seems unlikely, the proper cure is for them to improve their collection process rather than for the government to adopt an expensive and intrusive new medical care program.

It seems then that the pre-2010 free-rider problem is of minor consequence and played a very small part, if any, in the decision to adopt the insurance mandate. The two-fold reasons that the insurance mandate was adopted are: (1) to deal with the free-rider problem created by the Act's requiring insurers to provide insurance regardless of the health of the applicant, and (2) to require young healthy persons to purchase insurance at a premium in excess of the actuarial cost of that coverage so that their payments will subsidize lower premiums for older or unhealthy insureds.[26] It is ironic that the supporters of the insurance mandate complain that current uninsureds are passing on their medical costs to those who are insured when the health care program that supposedly cures that situation rests on allowing the elderly and unhealthy to pass on a portion of the cost of their

[25] § 5000A(e)(1), (2), and (5).

[26] Unmarried persons under the age of 26 may be covered by their parents' insurance since group insurance plans are required to provide coverage for such adult children. Section 2714 of the Patient Protection and Affordable Care Act, supra n. 1. Those children will not need to purchase insurance until they cease to be covered by their parents' plan.

insurance coverage to the young and healthy. To quote a venerable adage, it would seem that what is sauce for the goose would be sauce for the gander.

The insurance mandate requires young healthy people who are not covered by their parents' insurance to purchase insurance at a cost that is greater than the value that they receive. Although insurers are allowed to take the age of the insured into account in setting rates, they are restricted as to the amount of variance permitted among adults.[27] The insured cannot take the health of the insured into account in setting a rate.[28]

The Amici Curiae Brief[29] contends that even uninsureds who do not incur medical expenses increase the cost of health insurance for those who purchase it. That contention is intended to serve the dual purpose of showing an externality that affects interstate commerce and a justification for requiring nearly universal health insurance coverage. The Brief makes two points that purportedly demonstrate the correctness of that contention. Under scrutiny, neither of those points holds up well.

The first point that the Brief makes is that by not buying insurance, the uninsured raise the cost of insurance for those who purchase it. The only reason that the uninsured's acquisition of insurance would lower the premium cost of those who already purchase it is for the premiums charged to the uninsured to be greater than the actuarial cost of their insurance. The healthy are deemed to have caused an externality because they chose not to subsidize the medical expenses of

[27] Section 2701(a)(1)(A)(iii) of the Patient Protection and Affordable Care Act, supra n. 1, provides that the rate cannot vary by more than 3 to 1 for adults.
[28] Section 2701(a) of the Patient Protection and Affordable Care Act, supra n. 1.
[29] Supra n. 7.

the unhealthy. It seems a strained characterization of that consequence to refer to it as an externality; but, if it is one, it is very different from the types of costs inflicted on others that ordinarily are referred to by that term

By way of comparison, consider the case of a group of persons who decide not to purchase an automobile and to rely instead on public transportation. If those persons had purchased automobiles, there would have been more workers employed by automobile manufacturers and dealers. It seems more than strange to say that their failure to buy an automobile imposed an externality on those workers who were thereby deprived of employment. Yet, that is the essential thrust of the contention that the failure of the healthy to purchase insurance imposed a cost on those who do purchase it. The circumstance of the healthy who do not purchase insurance is even further removed from causing an externality since the price of an automobile does not include a subsidy for others.

Moreover, the purchase of insurance by the uninsured may cause an increase in the demand for medical services that will result in an increase in the cost of those services and a resulting increase in the price of insurance. If persons who are currently uninsured purchase insurance, they are likely to increase their use of medical services. The increase in demand will cause a rise in the price charged for medical services, and that increase in price may well offset any reduction obtained by having a larger pool of insureds.

The Brief's second point is that when people who refrained from buying insurance subsequently purchase it, studies show that they then incur larger medical care expenses than do those who were insured earlier in their life. The

suggested reason for this is that the uninsured do not use preventive medical care that would lower their future medical costs. It would seem that the proper response to that situation is to permit the insurer to charge a larger premium to those who were previously uninsured for a period of time. If there is an externality here, it is caused by the failure of the insurer to charge the previously uninsured an actuarially accurate premium rather than by the uninsured's decision not to purchase unneeded insurance.

In conclusion, the 2010 Health Act is designed to redistribute wealth from the young and healthy to the elderly and ill. There are many governmental activities and requirements that cause a redistribution of wealth. There is much to be said in favor of that redistribution and much to be said against it. The discussion of the merits and negatives of the health program would more likely join issue, and thereby reach a sound conclusion, if the program were characterized honestly as a redistributive venture rather than to cloak it in the guise of a solution to a free-rider problem which has little or no significance.

The redistribution adopted in the 2010 Health Act is unusual in that it transfers wealth from the young to the old and from the healthy to the ill without regard to the income or wealth of either party except that the poor are excluded from both sides of that transfer.