

Choice and Consequences: Transparent Alternatives to the Individual Insurance Mandate

Robert E. Moffit, PhD

The proposal for an individual mandate requiring individuals to buy health insurance has emerged as the most controversial health policy issue in America's Presidential candidates' debate, reflecting similar divisions among a broad spectrum of health policy analysts.

Massachusetts was the first state in the nation to impose such a mandate, stimulating intense debate in other states, especially California. Presidential candidate, Senator Hillary Clinton (D-NY), proposes such a mandate to achieve universal health insurance coverage, which she holds to be a "core Democratic value and a moral principle."¹ Senator Barack Obama (D-IL), Clinton's opponent for the 2008 Democratic presidential nomination, opposes a mandate, arguing that it would compel Americans to buy health coverage they could not afford and, further, that such a mandate would not be enforceable.²

While the debate on the individual mandate for health insurance coverage has divided Democratic presidential candidates, the issue is neither narrowly partisan nor ideologically confined. Republicans and Democrats, liberals and conservatives, centrists and libertarians, on different occasions, have all proposed an individual mandate for health insurance coverage.

Analysts have offered many reasons

for imposing such a mandate. While not exhaustive, the list is impressive: the achievement of universal or near universal coverage; equal access to more affordable and effective healthcare; the reduction in adverse selection and improvement in the functioning and efficiency of the health insurance market; the elimination of the "free rider" problem and a reduction in cost shifting and uncompensated care; the protection of individuals and families against high medical costs; relief from the growing pressure on hospital emergency departments; and the establishment of a new social contract based on mutual rights and obligations.

A Better Policy: Transparency of Choice

The national debate on the individual mandate constitutes a head-on collision of thorny interrelated problems in ethics, economics, and politics. Imposing an individual mandate to buy health insurance is not just a practical matter of healthcare financing or enforcement. It is also a philosophical problem, one of defining carefully the proper role of the government and the need to balance prudentially the claims of society with the rights of the individual. In other words, this recent national debate is a reiteration of a standard theme of the American political and constitutional

HEALTH HIGHLIGHTS

tradition: the continuing American project to safeguard and reconcile individual liberty with the common good to be secured by public authority.³

Can policymakers reaffirm the traditional limitations on government power, preserve individual freedom and simultaneously resolve the most serious problems addressed by an individual mandate?

The achievement of these simultaneous objectives would consist in making the range of choices that individuals have practically available to them clear and direct—fully transparent—while also making the inevitable consequences of their personal decisions as clear, direct, and predictable as possible. The alternative to an individual mandate, to either buy health insurance or incur some penalty, is thus a transparency of choice: making the realistic range of options available; securing full consent of the intellect and will in writing to pursue one of these options; and acknowledging, also in writing, an understanding of the likely consequences and the individual's responsibilities to accept those consequences and whatever costs they may entail.

The Status Quo: An Individual Mandate on Taxpayers

The heated national debate over whether or not to impose an individual healthcare mandate often obscures a crucial point. Under the status quo, there is already an individual mandate on every taxpayer in the United States to guarantee the care of those who do not or cannot get health insurance.

The existing taxpayer mandate is grounded in two major statutes: the Emergency Medical Treatment and Active Labor Act of 1985 (EMTALA) and the Hill–Burton Act of 1946. Under Hill–

Burton, there is “the community service obligation.” It specifies that healthcare facilities receiving grants under Title XVI of the Public Health Service Act must provide uncompensated care. EMTALA was enacted as part of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (P.L. 99-272). The Act applies to hospitals participating in the Medicare program, a total of 6177 hospitals,⁴ or almost all American hospitals. EMTALA imposes a legal duty on providers to render emergency or stabilizing care regardless of a person's capacity to pay for it.⁵

The cumulative effect of federal and state law, litigation, and regulation has reaffirmed what is in effect the legal right of Americans of any class or condition to secure medical care regardless of their ability to pay. Hospital officials expend a great deal of time, energy, and effort in their attempt to chase down impecunious uninsured patients who often run up large medical bills that they simply cannot pay. This “bad debt”, attributable to patients who are unable to pay their bills, as well as to “charity care”, for which hospitals don't expect payment, constitutes the hospitals' share of uncompensated care costs. These costs are partially offset by special government payments from Medicare and Medicaid. Cost shifting to taxpayers has thus become a routine feature of American healthcare financing, and the taxpayers' healthcare mandate is an entrenched feature of current law.

A Paradox

The current legal arrangement is a curious paradox. While proponents of single payer, universal health coverage often argue that healthcare is or should be a “right,” Americans already have a

unique legal right to healthcare that citizens in many other countries do not enjoy. Many citizens in other countries have an entitlement to government-financed healthcare or some form of national health insurance, but access is not guaranteed. There is a real and logical distinction between a legal entitlement to government health insurance and a legal access to medical care. In a government entitlement, one may be deemed legally eligible for certain benefits or services, but one's access to them may be blocked or limited by the political unwillingness of government officials to provide or pay for them. In a contract, parties may agree to a transaction, and the mutual obligations of fulfilling the agreement are legally enforceable. A legal entitlement, financed by a legislative body and administered by an administrative agency, is not necessarily a legal right, in the sense of a legally enforceable right grounded in contract.⁶

In the United States, the uninsured, who do not or cannot pay their hospital bills, are the major source of uncompensated care costs. Urban Institute analysts have estimated that the total national costs of the uninsured amounted to approximately \$41 billion (in 2004 dollars), with the bulk of that cost being borne directly by the taxpayers through various federal and state government health programs.⁷ In the state of Maryland, the additional health insurance premium cost for family coverage attributed to uncompensated care was estimated at \$948 annually.⁸

Based on a New America Foundation review of the data, low-income persons who fall below 100% of the federal poverty level (FPL) account for the largest share of uncompensated care at 37%, while those between 200% and

400% of FPL account for 22%, and those at 400% of FPL account for approximately 14%.⁹ Within the latter two income categories are where the classic "free riders" are found. Free riders can afford health insurance but choose not to purchase it or enroll in the health plans that are offered by their employers. Len Nichols, Director of the Health Policy Project for the New America Foundation, estimates that the number of free riders amounts to approximately 30% of the total uninsured.¹⁰ The data also show that recipients of uncompensated care are disproportionately young (aged 19 to 34), white (56 percent), and residents of Southern states.¹¹

Libertarian critics of the individual mandate make a compelling argument that it is a violation of personal liberty. This argument is of higher normative value in a philosophical sense than the Left's almost puritanical obsession with universal coverage, an ideal of numerical perfection that is practically unattainable. Other objections to the mandate center on the inability or unwillingness of political authorities to enforce a mandate. They point to the mixed record of auto insurance, as well as its likely contribution to a major expansion of government control over the financing and delivery of healthcare. Libertarian critics make a far less compelling assessment that the growing costs of tens of billions of dollars worth of uncompensated care is relatively insignificant in the overall scheme of national healthcare spending. For all practical purposes, then, the individual taxpayer mandate remains a feature of America's healthcare system, mostly ignored or unchallenged by libertarian critics of mandates.

There is, of course, one way that the libertarian argument could be internally consistent. To the extent that the status quo violates personal freedom by impos-

HEALTH HIGHLIGHTS

ing a legal and moral obligation on the rest of us to care for those who are unwilling or unable to care for themselves, policymakers could easily rectify the problem by allowing the irresponsible to face the direct and dire consequences of their decision to forego insurance coverage. They could repeal current law and permit medical personnel to deny care to those who do not have the financial capacity to pay for it. Even among libertarian health policy analysts, the strongest critics of the individual mandate, such pristine philosophical consistency is rarely championed.

Freedom, Responsibility, and the Transparency of Choice

On practical, political, and philosophical grounds, policymakers should avoid the imposition of an individual mandate for health insurance.

On practical grounds, an enforcement mechanism to secure universal coverage—in the literal sense of 100% coverage—is unlikely to achieve that goal. In a recent Health Affairs study of various legal mandates, including health insurance, researchers found that the range of compliance varied greatly.¹² In Massachusetts, the first state to enact an individual mandate with tax penalties and fines, the public authorities have already exempted approximately 60,000 persons from its terms.

Politically, the pursuit of an individual mandate would require an insistence on a level of public coercion by unspecified means that does not yet enjoy anything close to a public consensus. According to a recent survey on a legal requirement for all Americans to have health insurance, 47% support it, and 44% oppose it.¹³

If the goal of the mandate is not really

“universal coverage” but “near universal coverage,” then the goal of the individual mandate can be achieved by other, less coercive mechanisms. Other goals, such as reducing adverse selection and increasing market efficiency, can be achieved through risk-adjustment measures and insurance market reforms, which are far less intrusive than the imposition of an individual mandate.

A Bias for Liberty

On philosophical grounds, policymakers should retain a bias for personal liberty. In 1994, the Congressional Budget Office (CBO) reported that a federal individual mandate for health insurance would be unique and unprecedented because it would “impose a duty on individuals as members of society” and would “require people to purchase a specific service that would be heavily regulated” by the government.¹³ CBO analysts noted that the Congress never imposed a requirement for persons to buy a “good or service” as a condition of lawful residence. CBO determined that among all of the federal rules, the requirement that all young men register with Selective Service is the closest legal requirement to an individual mandate.¹⁴

Policymakers with a bias for personal liberty would automatically enhance the role of personal responsibility. Personal freedom means the right of individuals to control the flow of healthcare dollars in their choice of health plans, providers, and medical treatments. Personal responsibility means that one’s personal healthcare is one’s own responsibility; it is not the responsibility of employers, insurance executives, the medical profession, or state and federal government of-

ficials. When it comes to the reform of healthcare, a new policy would rest on three related propositions:

First, every individual has the personal responsibility to pay his or her own medical bills. Of course, the capacity for persons to exercise this responsibility differs greatly. As noted, the existing federal tax treatment of health insurance, almost exclusively based on the accident of one's employment, is both inequitable and regressive. It substantially penalizes those who do not or cannot get coverage through the place of work.¹⁵ For low-income persons, therefore, this proposition would not be meaningful unless the government were to change existing healthcare tax and subsidy arrangements. The government would need to provide direct financial help, either in the form of a refundable healthcare tax credit or a healthcare voucher. The same would hold true, of course, if policymakers were to pursue an individual mandate. It is wrong to force an individual to purchase a private product that that person cannot afford in order to secure some abstract ideal of universal coverage.

Second, every individual should have the freedom to self-insure. Individuals should not be forced to buy a health insurance product if they do not believe that health insurance is the best way for them to finance their personal healthcare. They should be free to make other arrangements or choose other forms of healthcare financing, such as pre-funding through savings accounts or other instruments that may emerge in a rapidly changing healthcare economy. Personal freedom, then, remains a core value in the pursuit of a sound national healthcare policy.

Third, every individual should explic-

itly accept or reject health insurance coverage, and those who reject coverage should be required to demonstrate that they are willing and able to pay their medical bills and formally acknowledge the potential consequences of their failure to do so. A new policy of transparency would take only one option off the table: It would no longer be acceptable to shift one's costs to others, including doctors and hospitals or the taxpayers, without a previously acknowledged consequence for the failure to make provision for insurance coverage.

Transparency of Choice

Consistent with a bias for liberty, the best alternative to an individual mandate for health insurance is policy that provides for transparency of personal choice—a policy to encourage the exercise of individual freedom and personal responsibility. But this exercise of personal responsibility can be realized only when all of the relevant choices are clear and transparent and the consequences of those choices are also clear and transparent. Personal responsibility is therefore dependent upon the clarity of the available options and a willingness to abide by the consequences of one's freedom of choice.

Freedom consists in the ability to accept personal responsibility for one's actions. Personal responsibility is not a product of external coercion, such as a mandate. It is a silly abuse of language to argue that "personal responsibility" somehow requires public officials to enact an individual mandate to make individuals do what they would not otherwise do. An individual mandate is incompatible with the internally directed exercise of the freedom of one's intellect and will and thus alien to any concept of personal responsibility.

HEALTH HIGHLIGHTS

The mandate takes the form of a specific command. There is a world of difference between (a) issuing such a command and (b) making the range of choices and consequences plain and transparent before the choice is exercised. One may do X, and Y consequence will follow (i.e., one will get access to the bounteous benefits of health insurance and reduce one's dependence on one's fellow citizens); or one may choose options A, B, or C, and each of these choices, too, will come with a specific consequence that one can and will understand beforehand.

Mechanisms of Choice

There are a variety of ways to realize such a level of personal responsibility, and public policy can serve to make these personal choices both transparent and consequential without imposing an individual mandate to buy health insurance. Such measures could be enacted and implemented singly or in combination and achieve a reasonable goal of "near universal" coverage within a policy framework that maximizes personal freedom and responsibility. Consider three potential options:

Create a Universal Tax Credit System

There is a growing bipartisan consensus on the need to reform the federal tax treatment of health insurance because it is inequitable, inefficient, and regressive. It directly undermines access to health insurance, particularly among persons who do not or cannot get health coverage through the place of work. Most uninsured persons are in low-income working families and are disproportionately employed in small businesses that do not offer health

insurance coverage.

President Bush has proposed a universal standard deduction for health insurance that would provide a generous deduction of \$15,000 per family and \$7,500 per individual, resulting in a significant middle-class tax cut through the voluntary purchase of health insurance. In their analysis of the Bush proposal, analysts at the Brookings Institution and the Urban Institute note that the design of the Bush proposal would have a "powerful behavioral incentive" for securing coverage, for a family's opportunity to deduct \$15,000 from their taxable income is a large and attractive tax break.¹⁶ They further note that refusal to take advantage of the provisions of the tax break operates much like the standard penalty for an individual mandate: "In fact, the administration's proposal is very much like the Massachusetts mandate—in effect everyone would get a \$7,500 or \$15,000 deduction and the 'punishment' for not getting health insurance would be to lose the deduction."¹⁷

The one central difficulty with the Bush proposal is that it does not reach far enough down the income scale to capture a large portion of the population without significant tax liability who are nevertheless uninsured. That is why a system of advanceable, refundable healthcare tax credits would be a better option than the use of the tax deduction as a mechanism to expand coverage.

Universal healthcare tax credits, refundable tax credits, or subsidies (for those who are too poor to have a tax liability) can establish an even more powerful incentive for individuals and families to secure health insurance coverage. Based on analysis of the data on the uninsured, it is apparent that most of those who are uninsured are in and out of cov-

erage because of life or job transitions.¹⁸ In a major *Health Affairs* study of the total population of America's uninsured over a four year period, researchers found that only 12 percent of that cohort were chronically uninsured, while the rest had coverage for given periods of time, but lost it or experienced gaps in coverage.¹⁹ A universal healthcare tax credit system, targeting tax breaks to persons regardless of their employment, could make insurance fully portable and thus help to reduce churning to stabilize the nation's health insurance markets. The creation of portable insurance, which people can take from job to job, would significantly reduce the numbers of the uninsured simply by enabling the coverage to stick to the person, not the job.

The level of per capita assistance delivered to individuals and families to secure a desired level of coverage is an empirical matter: It raises the same issue of personal and taxpayer affordability that would apply to every other option to expand health coverage, including an expansion through public programs. Ideally, tax breaks or refundable credits should be structured to enable individuals or families to secure an adequate package of benefits that would at a minimum guarantee them ample protection against catastrophic illness.

Once again, if the insurance and the subsidies are made clearly available, then one's decision not to take advantage of the insurance and the tax break or subsidy, in writing, affirmatively rejecting both, in effect constitutes its own "penalty." If an individual is offered a \$2,500 tax credit, for example, to buy insurance and refuses to do so, that person obviously incurs a \$2,500 tax penalty. But it is a tax penalty that is self-inflicted, not

externally imposed. In either case, under the new tax regime, the law would impose a tax penalty just as it would under an individual mandate.

Automatic Enrollment

Combined with a new system of health insurance tax breaks or subsidies to low-income people to make health insurance affordable, policymakers could also establish a policy of automatic enrollment in health insurance. This could be accomplished either through employers or through the state health insurance agencies, enabling persons to be enrolled in a basic health plan if they themselves do not make an affirmative choice. Medicare Part B operates through a program of automatic enrollment, and more than nine out of ten seniors elect coverage under the arrangement. An employer-based enrollment system, where the employer can serve as a clearinghouse for different health plans, would be particularly attractive, because more than eight out of ten uninsured persons are in working families.

There are a variety of ways to set up a system of automatic enrollment. It is not uncommon to find such a system in employer-based pension plans, and the results are encouraging. In a National Bureau of Economic Research study on 401(K) participation in a large company, the adoption of automatic enrollment procedures resulted in an increase of participation from 61% to 86%, besting other attempts to secure participation such as employer-provided financial education or even increasing the employer match.²⁰ In this study, employees who did not pick a specific pension option or chose to "opt out" of the company pension program were enrolled in a low-cost "default" plan. The researchers found that one of the ben-

HEALTH HIGHLIGHTS

efits of such a process was that it greatly increased the participation of employees who might not otherwise enroll in the pension program, including minorities and younger or lower-income employees.²¹ With modifications, a similar process, including enrollment in a “default” health plan, could be replicated with health insurance, thus dramatically reducing the adverse selection that the individual mandate is designed to remedy.

Another advantage of employment-based enrollment is that it can be combined with the administration of a healthcare tax credit system. Lynn Etheredge, a health policy analyst with George Washington University’s Health Insurance Reform Project, has proposed a system whereby employees select their choice of health plan at the place of work, employers send the appropriate payroll deductions (a single check with the appropriate employee information) to a statewide “service” center that would handle plan payment and related transactions, and the health plans notify the Department of the Treasury of the employees’ enrollment to receive the tax credit due for the period of enrollment.²² Etheredge emphasizes that the advantage of this approach is that most of the structure is pre-existing, and the existing platform of employment-based payroll deduction is an economically efficient process. Large and small firms already use the payroll and deduction system for a variety of functions, including Social Security and Medicare payments, state and federal income taxes, unemployment, and disability insurance.²³

In a variant of the same idea, employers could also automatically enroll their employees in a statewide health insurance exchange. A state-chartered health insurance exchange would serve as a mechanism for allowing a variety of health plans to compete directly for the business of employers,

and employees and their families.

Like Etheredge’s proposed “service center,” the health insurance exchange would serve as a “clearinghouse” that matches up competing health plans, enrollees, and funding. For example, the exchange would provide objective and comparative information on health plans and benefits, enroll employees and their dependents in the health plans of their choice, collect defined contributions from employers and any additional premium payments from employees, administer relevant government subsidies, transmit payments to competing health plans, and perform any necessary administrative tasks.

Because the exchange would function as a central administrative mechanism of employer group health insurance, under the terms and conditions of existing federal employment law, the employer contributions and the value of the health benefits package would be *tax-free* to both employers and employees.²⁴ This means that state residents, enrolled in the health insurance exchange, would be able to buy the health insurance policy of their choice without a tax penalty, own the policy, and take it with them from job to job. The exchange, in other words, would secure personal ownership and thus portability of health insurance. It would reduce churning in the insurance market and thus the number of the uninsured.

In 2007, legislators introduced bills in 15 states to establish some form of a health insurance exchange.²⁵ The most prominent example of an operating health insurance exchange is the Massachusetts “connector”, enacted as a key component of the Massachusetts health reform in 2006 to provide employees

in small businesses with easy access to competing health plans. At the national level, the popular and successful Federal Employees Health Benefits Program (FEHBP) functions in a fashion similar to the proposed state health insurance exchange. The federal government, as the employer, provides defined premium contributions to millions of federal employees and their dependents who choose among private health plans in a competitive environment.

Beyond creating a large stable group, the statewide health insurance exchange could also administer government tax credits or subsidies for low-income persons, providing them with financial help to get coverage.

In every case, however, through a process of automatic enrollment, a person would retain the right to decline both the health insurance and any subsidy or tax break that comes with that insurance and would do so in writing. Policymakers could also couple any affirmative decline of coverage or subsidies or tax benefits with a formal notice that individuals may be subject to specific penalties for a failure to pay their medical bills, listing those penalties and any process for enforcement. The person declining such insurance and financial benefits would acknowledge these consequences in writing.

Bonds and Accounts

In reforming state health insurance markets, state officials may wish to create a process whereby residents either buy health insurance or self-insure while offering proof of their ability to pay for medical care for themselves and their dependents. Some residents may have ideological or religious objections to buying

insurance, even if the insurance is nothing more than coverage for catastrophic illness. Self-insuring residents could demonstrate a willingness to pay for medical expenses by presenting a bond of some specified amount or depositing a specified sum in an interest-bearing escrow account to be used for the payment of medical bills, particularly hospital emergency room bills. Health Savings Accounts would also qualify for that purpose.

If a resident fails to post a bond or open an escrow account, state officials could establish such an account in the resident's name and deposit any state tax refunds for that resident to be used solely for the payment of uncompensated care that the resident incurred. In the event that a hospital or healthcare provider secures a judgment against the resident for unpaid medical bills, state officials could garnish the resident's wages to secure that judgment. This would relieve the hospital and the medical professionals of the costly burden of hiring lawyers and going back to court a second time if the resident refuses to comply with a court order to pay outstanding medical bills.

Former Governor Mitt Romney originally submitted a variant of this proposal to the Massachusetts state legislature in 2005 as part of the Governor's program for comprehensive reform of the Massachusetts healthcare system. Under the Romney proposal, residents who wished to forego the purchase of health insurance would be required to post a bond in the amount of \$10,000 or deposit \$10,000 in an interest-bearing account held by his proposed state health insurance exchange.²⁷ Romney's original version of what was to become, with significant modifications, the Massachusetts health insurance "connector."

While the Massachusetts legislature re-


HEALTH HIGHLIGHTS

jected Romney's "personal responsibility" proposal in 2006 in favor of a straight mandate to purchase health insurance or pay tax penalties and a fine, lawmakers in other states could rely upon Romney's model. It is another method for coping with the problem of cost-shifting and uncompensated care while preserving personal liberty and encouraging personal responsibility.

Conclusion

The individual mandate has emerged as the most controversial item in healthcare reform, transcending traditional partisan and ideological divisions, with supporters and opponents from radically different philosophical and political camps often on the same side of this debate, and often for the same reasons.

A promising alternative to the individual mandate, which could achieve many of the same objectives, is found in the restructuring of the tax treatment of health insurance; a reform of the health insurance markets to expand participation; the adoption of new processes for enrollment and decision-making, such as automatic enrollment; and the creation of clear alternatives to insurance coverage, such as bonds or escrow accounts, that would make the decisions to enroll in health insurance clearer, easier, and more plainly consequential than the system that exists today.

A practical alternative to the individual mandate is individual freedom, properly understood, and thus the implementation of a policy that enhances individual's ability and willingness to take clear and direct responsibility for decisions. 

References

1. Kevin Sack, "In Health Debate, Clinton Remains Vague on Penalties," *The New York Times*, February 4, 2008, at www.nytimes.com/2008/02/04/us/politics/04checkpoint.html?_R=14/scp=1+sQ=SAC (March 20, 2008).
2. Michael Cooper, "It Was Clinton Versus Obama on Healthcare," *The New York Times*, November 16, 2007, at www.nytimes.com/2007/11/16/us/politics/16facts.html (March 20, 2008).
3. On this point, see Alpheus T. Mason and Richard H. Leach, *In Quest of Freedom: American Political Thought and Practice* (Englewood Cliffs, N.J.: Prentice-Hall Inc., 1960); see also Orestes Augustus Brownson, *The American Republic* (New York: P. O'Shea Co., 1865), a classic work of American political theory.
4. Estimate based on regional data supplied by the Centers for Medicare and Medicaid Services (CMS) for the number of hospitals getting Medicare funding as of December 2006, at <http://www.cms.hhs.gov/MedicareContractingReform/Downloads/PrimaryABMACJurisdictionFactSheets.pdf> (April 23, 2008).
5. For a more detailed discussion of this issue, see John S. O'Shea, M.D., "The Crisis in Hospital Emergency Departments: Overcoming the Burden of Federal Regulation," Heritage Foundation Backgrounder No. 2050, July 9, 2007, at www.heritage.org/research/healthcare/bg2050.cfm (March 29, 2008).
6. The United States Supreme Court has already recognized this distinction in the matter of Social Security benefits. The Court held that Congress reserved to itself the right to change benefits and that beneficiaries enjoyed no contract right to Social Security payment. *Flemming v. Nestor*, 363 U.S. 603 (1960).
7. Jack Hadley and John Holohan, "The Cost of Care for the Uninsured: What We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" *The Kaiser Commission on Medicaid and The Uninsured*, Issue Update, 2004.
8. Rex Cowdry, M.D., Executive Director, The Maryland Healthcare Commission, "Compendium of Policy Options," a staff

MOFFIT: ALTERNATIVES TO THE INSURANCE MANDATE

- presentation to the Maryland Healthcare Commission, February 15, 2007.
9. Sarah Axeen and Elizabeth Carpenter, "Who Receives Uncompensated Care?" New America Foundation, Health Policy Program," Issue Brief, March 2008, 2. at www.newamerica.net/healthpolicy (March 29, 2008).
 10. Len M. Nichols, "Point: An Individual Mandate Is Necessary to Cover All Americans," in *Public Policy Debate Book: Point/Counterpoint* (Washington, D.C.: National Association of Realtors, 2008), 15.
 11. Axeen and Carpenter, "Who Receives Uncompensated Care?" p. 3.
 12. Sherry A. Glied, Jacob Hartz, and Genesa Giorgi, "Consider It Done? The Likely Efficacy of Mandates for Health Insurance," *Health Affairs*, 26, No. 6 (November/December 2007), 1612-1621.
 13. Congressional Budget Office, "The Budgetary Treatment of An Individual Mandate to Buy Health Insurance," CBO Memorandum, August 1994, 1. As CBO analysts observe, "The government has never required people to buy any good or service as a condition of lawful residence in the United States."
 14. *Ibid.*, 2.
 15. There is a powerful consensus on this point among health policy analysts of different philosophical persuasions. See Grace-Marie Arnett, ed., *Empowering Healthcare Consumers Through Tax Reform* (Ann Arbor: University of Michigan Press, 1999).
 16. Len Burman, Jason Furman, and Robertson Williams, "The President's Health Insurance Proposal—A First Look," Urban Institute and Brookings Institution, Tax Policy Center, January 23, 2007, 5.
 17. *Ibid.*, 6.
 18. Michelle C. Bucci, "America's Unstable Health Insurance System: Recommendations for Increasing Stability and Coverage," Heritage Foundation Backgrounder No. 2115, March 12, 2008, at www.heritage.org/research/healthcare/bg2115.cfm (April 2, 2008).
 19. Pamela Farley Short and Deborah R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, 22, No.6 ((November/December 2003), 244-255.
 20. Brigitte C. Madrian and Dennis F. Shea, "The Power of Suggestion: Inertia in 401(K) Participation and Savings Behavior," National Bureau of Economic Research Working Paper No. 7682, May 2000, at <http://www.nber.org/papers/w7682> (March 29, 2008).
 21. *Ibid.*
 22. Lynn Etheredge, "How to Administer Health Insurance Tax Credits," Heritage Foundation Backgrounder No. 1516, January 31, 2002, at <http://www.heritage.org/Research/HealthCare/BG/1516.cfm> (April 1, 2008).
 23. *Ibid.*
 24. For a discussion of this issue, see Robert E. Moffit, "The Rationale for a Statewide Health Insurance Exchange," Heritage Foundation WebMemo No. 1230, October 5, 2006, at www.heritage.org/research/healthcare/wm1230.cfm (April 2, 2008); see also Stuart M. Butler, "Evolving Beyond Traditional Employer Sponsored Health Insurance," Brookings Institution, Hamilton Project, May 2007.
 25. Susan S. Laudicina, Joan m. Gardner and Angela M. Crawford, "State Legislative Healthcare and Insurance Issues," Blue Cross and Blue Shield Association, Office of Policy and Representation, December 2007, x.
 26. Edmund F. Haislmaier and Nina Owcharenko, "The Massachusetts Approach: A New Way To Restructure State Health Insurance Markets and Public Programs," *Health Affairs*, 25, No. 6 (November/December 2006), 1580- 1590.
 27. The Commonwealth of Massachusetts, In the Year Two Thousand Five, an Act to Increase the Availability and Affordability of Private Health Insurance to the Residents of the Commonwealth, Chapter III A, Individual Health Insurance Coverage, Section 2 (c).