View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by University of Michigan School of Law

University of Michigan Law School
University of Michigan Law School Scholarship Repository

Articles | Faculty Scholarship

2011

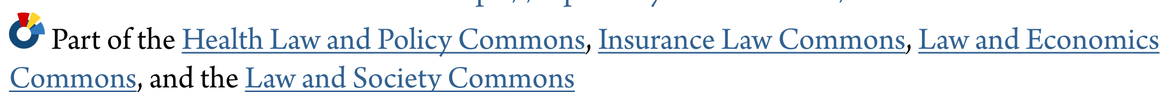
Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform?

Douglas A. Kahn
University of Michigan Law School, dougkahn@umich.edu

Jeffrey H. Kahn
Florida State University College of Law, jkahn@law.fsu.edu

Available at: https://repository.law.umich.edu/articles/542

Follow this and additional works at: https://repository.law.umich.edu/articles


Part of the Health Law and Policy Commons, Insurance Law Commons, Law and Economics Commons, and the Law and Society Commons

Recommended Citation
Kahn, Douglas A. "Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform?" J. H. Kahn, co-author. Mich. L. Rev. First Impressions 109 (2011): 78-85.

This Commentary is brought to you for free and open access by the Faculty Scholarship at University of Michigan Law School Scholarship Repository. It has been accepted for inclusion in Articles by an authorized administrator of University of Michigan Law School Scholarship Repository. For more information, please contact mlaw.repository@umich.edu.

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

Douglas A. Kahn[*] & *Jeffrey H. Kahn*[**] [†]

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." The individual mandate is one element of a vast change to the provision of medical care that Congress implemented in 2010. The individual mandate has proved to be controversial and has been the subject of a number of lawsuits contending that it is unconstitutional. It is not our purpose in this article to discuss its constitutionality. Rather, this piece focuses on the viability of one of the justifications that often is put forth for the adoption of the individual mandate: the "free-rider" problem.

I. A CURE FOR THE FREE-RIDER PROBLEM

A frequently stated defense of the individual mandate is that many persons do not purchase medical insurance, even if they have the resources to do so, and then obtain free medical care when the need arises. 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, "[S]omeone 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."[3] By "taxpayers," Governor Romney means that the government pays when the

---

* Paul G. Kauper Professor of Law, University of Michigan Law School.

** Professor of Law, Washington and Lee University School of Law. The authors would like to thank Professors Jill Horwitz, Nick Bagley, James Hines, Kyle Logue, and John Lopatka for their helpful comments and criticisms of this article.

† Suggested citation: Douglas A. Kahn & Jeffrey H. Kahn, Commentary, *Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform?*, 109 MICH. L. REV. FIRST IMPRESSIONS 78 (2011), http://www.michiganlawreview.org/assets/fi/109/kahn.pdf.

1. Pub. Law No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. Law No. 111-152, 124 Stat. 1029 (2010) [hereinafter "2010 Act"].

2. There are a number of categories of persons who are exempted from this mandate. I.R.C. § 5000A(d)(2)–(4), (e) (West Supp. 2010).

3. Mitt Romney, *Health Care for Everyone? We Found a Way*, WALL ST. J., April 11, 2006, at A16.

individual does not. That is a bit of an overstatement. As we will see, the government pays only a small portion of the cost that is not borne by uninsured individuals. This same justification has been advanced in briefs in defense of the program and is often advanced in discussion of the program's merits. For example, according to an Amici Curiae Brief written in defense of the program, "The only economic solution to [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."[4]

Given that only those without resources will qualify for free medical services when the need arises, we question the extent to which the free-rider problem exists. We conclude that the free-rider problem, if it exists at all, likely is 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 entirely different purposes (i.e., universal health coverage and the redistribution of wealth), and the debate over the desirability of the program should focus on the merits of those other purposes. Since universal health coverage cannot be achieved unless there is a redistribution of wealth, the latter objective is the focal point of the program.

II. The Medical Welfare Program's Viability Depends on an Individual Mandate or a Comparable Provision

The medical welfare program that Congress adopted is not viable unless it includes an individual mandate or some comparable provision. The defense of the individual mandate therefore is indirectly a defense of the entire program. It is worth considering whether the free-rider defense for the individual mandate is valid since it bears on the determination of the merits of the entire program. Let us see why the individual mandate is essential to the 2010 Act.

First, section 2705 of the 2010 Act prohibits an insurer from denying insurance coverage to an applicant because of poor health. That provision creates an adverse selection problem, which, if unabated, would result in the pool of insured patients ("insureds") consisting primarily of individuals who currently need medical services. If there were no individual mandate, many people would not purchase insurance until they had a medical condition. That adverse selection would make the premium cost of insurance prohibitive because otherwise virtually all of the insureds would be receiving payments from the insurer that exceed their premiums. The program would fail either because large numbers of persons could not afford the insurance or because the insurance companies would exit the market.

In addition to the adverse selection problem created by the 2010 Act, the individual mandate is also necessary to make insurance affordable for the elderly. If the elderly were charged the actuarially determined cost[5] of insur-

---

4. Brief for Economic Scholars in Support of Appellees as Amici Curiae, Thomas More Law Center v. Barack Hussein Obama, 16 (6th Cir. 2011) (No. 10-2388) [hereinafter "Economic Scholars' Brief"].

5. The "actuarially determined cost" refers to the amount that accurately reflects the risk that the insured will incur a certain amount of medical expenses in the year of coverage. For example, if data shows that 1 percent of individuals of *X* age and *Y* health will incur medical expenses of

ing them, the insurance would be too expensive for many to afford. To reduce this cost, healthy, young people must buy insurance and pay premiums in excess of the actuarial cost of their coverage to subsidize the elderly. It is this redistribution of wealth that appears to be the actual purpose of the act. Thus, the advancement of the free-rider justification has prevented the debate over the merits of the program from focusing on the 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 a commentary, Gregg D. Polsky proposed an alternative to the individual mandate. [6] While it is beyond the scope of this piece to comment on that proposal, we will make one observation. Professor Polsky bases his proposal on the view that the purpose of the health reform program is *not* to require individuals to purchase insurance but rather is to prevent insurers from denying coverage to unhealthy applicants or to charge them higher premiums. To the contrary, insurers cannot afford to ignore the poor health of insured patients ("the insured") in setting their premiums unless a large number of healthy individuals buy insurance and pay larger premiums than the value they receive. Consequently, an important purpose of the program is to force healthy individuals to be insured and thereby subsidize the coverage of the unhealthy.

III. The Exaggeration of the Free-Rider Problem

The free-rider defense appears convincing until one examines it closely. According to the Economic Scholars' Brief mentioned above, there were approximately forty million persons in the United States who were uninsured in 2007. Fifty-seven percent of those uninsured persons used medical services that year. The Economic Scholars' Brief cites a survey stating that, on average, the medical care costs of uninsured persons ("the uninsured") amounts to about $2,000 per person each year, and over one-third of those costs are paid by the uninsured out of their own finances. How is the rest of that cost financed? The Economic Scholars' Brief states that 32 percent of the overall cost of the uninsured's medical services is obtained through an increase in the price of medical services. Consequently, patients who pay for their treatment—insured patients and those uninsured who pay completely for their own treatment—bear that portion of the shortfall. That accounts for about one-half of the cost that the uninsured do not pay.

The Economic Scholars' Brief states that 14 percent of the cost of the uninsured is borne by the government through Medicare, Medicaid, Veterans Affairs services, TriCare (medical insurance for the military and their families), and workers' compensation. That statement needs some refinement: 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

---

$10,000 in the year of coverage, then the actuarial cost for one year's medical coverage for an individual of that age and health will be 1 percent x $10,000 = $100. That figure does not take into account administrative expenses that the premium also must cover.

6. Gregg D. Polsky, Commentary, *Reconstructing the Individual Mandate As an Escrow Account*, 109 Mich. L. Rev. First Impressions 73 (2011), http://www.michiganlawreview.org/assets/fi/109/Polsky.pdf.

programs would be described as uninsured. If the government bears a portion of the medical costs of the uninsured, it is only through any additional price that the providers impose on all who purchase medical services. This is merely one aspect of a medical provider's 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.

The image left by those who advance the free-rider defense is that the uninsured are parasites who choose to pass on their own medical costs to the rest of society by obtaining medical care without paying for it. That image does not 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 their treatment.[7] 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 those with the means. As previously noted, more than one-third of the cost of treatment provided to uninsured patients is paid for by the uninsured patients themselves. It would seem that there are two likely 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. The other reason is attributable to the collection methods employed by the medical providers. As to why the medical providers sometimes do not enforce collection from those who have the means but do not pay, it is likely that in most cases the amount involved is too small to justify the cost of pursuing collection. 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.

Many people who cannot afford their medical costs also cannot afford to pay medical insurance premiums. As noted, the average cost of medical treatment to the uninsured is about $2,000 per person. Some will incur a larger expense, some a smaller expense, and some no expense at all. The cost of insurance likely exceeds $2,000 per year. In a letter to Senator Olivia Snow on January 11, 2010, the Director of the Congressional Budget Office ("CBO") stated that the CBO estimates that in 2016 the annual premiums for a bronze level plan under a health insurance exchange program—the subsidized insurance program that is part of the 2010 Act—will average between $4,500 and $5,000 for an individual and between $12,000 and $12,500 for a family policy. The program will provide four progressively more expensive levels of insurance coverage—the "bronze," "silver," "gold," and "platinum" levels. The bronze level will have the lowest premium available in the exchange program. Thus, a significant percentage of those who cannot pay for their medical costs now will not be able to afford to purchase insurance at more than twice the cost. To a lay reader, the characterization of a person as a free rider suggests that the person has voluntarily taken an action or inaction that imposes costs on others. Those who cannot afford insurance do not choose to be in this predicament; thus

---

7. 42 U.S.C. § 1395dd (2006).

the term is inappropriate to use in common parlance even if it may be within the economist's use of the term.

IV. Those Who Cannot Afford Insurance Continue to Rely on Others to Pay Their Medical Costs

Moreover, even if one is willing to describe those who cannot afford insurance 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.[8] To qualify, the household income of an individual (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) must at least equal the poverty level and must not exceed four times the poverty level for a family of the size involved.[9] According to the Social Security Administration, the current poverty level for a single individual is $10,830; thus 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. For a family of four, the current poverty level is $22,050; such a family can have household income as large as $88,200 and still qualify for a subsidy. 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. This scheme suggests that Congress believes that most of the persons with eligible incomes would not purchase insurance without a subsidy because they could not afford it. It is likely, therefore, that persons who are currently using medical services that are paid by others will continue to be subsidized under the new regime.

Persons with low- and moderate-income levels may have fairly high income and still qualify for government subsidies through the grant of refundable tax credits and by paying part of their co-payments. If such persons would be considered free riders before the passage of the 2010 Act, they would seem to still fit that term after the passage of 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.[10] Thus, the 2010 Act does not alter the fact that medical expenses of such persons will be borne by others (i.e., the taxpayers). If, contrary to their financial incentives, medical providers are not diligent in collecting payments from uninsured patients who actually can pay, the proper cure is for providers to improve their collection process rather than for the government to adopt an expensive and intrusive new medical care program.

---

8. I.R.C. § 36B (West Supp. 2010).

9. § 36B(c)(1)(A). There are additional requirements that must be satisfied.

10. I.R.C. § 5000A(e)(1), (2), (5).

V. REDISTRIBUTION OF WEALTH

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. Congress adopted the insurance mandate for two reasons: (1) to deal with the adverse selection problem created by the 2010 Act's requirement that insurers provide insurance regardless of an applicant's health, and (2) to subsidize lower premiums for older or unhealthy insured persons. Congress facilitates the latter goal by requiring healthy, young persons to purchase insurance at a premium in excess of the actuarial cost of that coverage—meaning they pay more than the value they receive. Note, however, that some unmarried persons under the age of twenty-six are covered by their parents' group insurance, and so they need not purchase insurance until they cease to be covered by their parents' plan. It is ironic that the supporters of the insurance mandate complain that the current uninsured 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 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 they receive. Although the 2010 Act permits insurers, in setting rates, to take age into account, the act provides that the rates cannot vary by more than three to one for adults.[11] The insurer also cannot take the health of the insured into account in setting a rate.[12] The restriction on variance allowed and exclusion of health considerations mean that 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 they receive.

The Economic Scholars' Brief contends that even the uninsured who do not incur medical expenses increase the cost of health insurance for those who purchase it. While that contention is intended to show that there is an externality that affects interstate commerce, it is also advanced as 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.

First, the Economic Scholars' Brief argues that by not purchasing insurance, which would increase the size of the pool of insureds, 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 insurance 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 the unhealthy. It seems a strained characterization of that consequence to call it an externality; but, if it is one, it is very different from the types of costs inflicted on others that the term

---

11. § 2701(a)(1)(A)(iii).

12. *See* § 2701(a).

ordinarily refers to. A common example of an externality is the cost of factory pollutants on surrounding neighbors. The latter group must involuntarily bear the cost of sickness, decrease in property values, and other negative consequences so that the factory can continue its production for profit.

By way of comparison, consider the case of a group of persons who decide not to purchase automobiles and instead rely 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 imposes 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 increase of persons who are insured may cause an increase in the demand for medical services—that is, an insured person is more likely to seek medical services than is an uninsured person. Economic principles suggest that an increase in demand that is not matched by an increase in the available supply will cause a rise in the price charged for medical services. That increase in price may offset some of the reduction obtained by having a larger pool of insureds.

Second, the brief argues that, based on empirical studies, when people who once refrained from buying insurance subsequently purchase it, they tend to incur larger medical care expenses than those who were insured earlier in 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. 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.

VI. The Debate over the Merits of the 2010 Act Should Focus on the Merits of Redistribution

In conclusion, the 2010 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 the 2010 Act's redistribution and much to be said against it. Those discussing the merits and negatives of the health program would more likely respond to each other's points and thereby reach a sound conclusion if the program were characterized honestly as a redistributive venture rather than as a solution to a free-rider problem that has little or no significance.

The redistribution adopted in the 2010 Act is unusual in that it transfers wealth from the young to the old and from the healthy to the ill, whereas a traditional redistribution would seek to transfer wealth from those with money to the poor. In fact, the redistribution in the 2010 Act disregards the

income or wealth of either party except that the poor are excluded from both sides of the transfer. While there is nothing improper about that type of redistribution, its unusual nature may have caused the proponents of the new welfare program to be fearful of declaring that redistribution is the actual primary purpose and function of the program.