Connecticut Debate Association

State Finals, March 24, 2012

Wilton High School

Resolved: All US residents should be required to purchase health insurance.

Supreme Court Schedules Unprecedented Full Week for Obamacare

Newsmax, Associated Press, Monday, December 19, 2011 12:03 PM

WASHINGTON — The Supreme Court announced Monday that it will use an unprecedented week's worth of argument time in late March to decide the constitutionality of President Barack Obama's historic healthcare overhaul.

The high court scheduled arguments for March 26, 27, and 28 over the Patient Protection and Affordable Care Act, which aims to provide health insurance to more than 30 million previously uninsured Americans. The arguments fill the entire court calendar that week with nothing but debate over Obama's signature domestic healthcare achievement.

With the March dates set, that means a final decision on the massive healthcare overhaul will likely come before Independence Day in the middle of Obama's re-election campaign. The new law has been vigorously opposed by all of Obama's prospective GOP opponents. Republicans have branded the law unconstitutional since before Obama signed it in a March 2010 ceremony.

In an unprecedented move, the justices are hearing more than five hours of arguments over the health care overhaul. They will start the week of arguments that Monday with one hour on whether court action is premature because no one yet has paid a fine for not participating in the overhaul.
Tuesday's arguments will take two hours, with lawyers debating the central issue of whether Congress overstepped its authority by requiring Americans to purchase health care insurance or pay a fine.
Finally, Wednesday's arguments will be split into two parts, with justices hearing 90 minutes of debate over whether the rest of the law can take effect even if the health insurance mandate is unconstitutional and an extra hour of arguments over whether the law goes too far in coercing states to participate in the health care overhaul by threatening a cutoff of federal money.

Should Everyone Be Required To Have Health Insurance?

The Wall Street Journal, 23 January 2012

It is one of the most contentious issues in U.S. politics today: the federal health-care law's requirement that everybody have health insurance or pay a penalty.

Supporters of the mandate -- which is the central issue in the case before the Supreme Court challenging the law -- argue that it's the key to making health care more affordable and accessible to everyone. By expanding the pool of insured, the thinking goes, the burden of paying for the sick is covered by all.

But those against the mandate say a law that forces people to buy anything, including health insurance, violates guarantees of personal freedom enshrined in the Constitution. Relying on the government to extend health care to everyone this way, opponents say, also makes care more costly and inefficient. And they point to polls that show the individual mandate is unpopular.

Congress approved the mandate in 2010 as part of the Patient Protection and Affordable Care Act, though the law doesn't take full effect until 2014. Meantime, legal challenges and arguments over the mandate leave its implementation in question.

Yes: It's the Key to Reform

By Karen Davenport

All Americans should be responsible for holding insurance coverage. It's the key to making health care more available, more affordable and more reliable for everybody.

It's instructive to remember where the idea for an individual mandate began. In the late 1980s and early 1990s, a group of conservative health-policy experts began looking for an alternative to the employer-mandate proposal that ultimately

became a central pillar of Bill Clinton's health-care reform effort. The conservatives landed on an approach that called for individual responsibility, maintained a significant role for the private health-insurance market, and dealt with the "free-rider" problem of individuals who choose not to purchase health insurance and so pass their health-care bills on to those who do.

Sound familiar?

The Affordable Care Act is built on three premises: Health insurance must be more accessible, particularly to people with pre-existing conditions; more affordable, including for people with very low incomes; and always there, including for people with very high health-care costs.

To that end, the law makes important changes to the non-group insurance market, where most individuals and small businesses seek coverage. These changes include: requiring insurers to offer coverage to all applicants, regardless of health status; requiring insurers to renew coverage, regardless of the policyholder's claims history; requiring insurers to price premiums without regard to health status; and prohibiting insurers from using exclusions for pre-existing condition and lifetime or annual limits to restrict coverage.

Like in a masonry arch, the keystone of the individual mandate enables all the other pieces of reform to lock into place. Without it, the arch crumbles.

Think about it. People could wait until they were seriously ill to buy coverage, knowing that insurance companies could not turn them down. Insurers, because they would be covering mostly sick people, would need to raise premiums to stay afloat.

Some opponents of the mandate argue that making coverage mandatory will drive up overall premiums, and that requiring some to pay for others' health-care costs is unfair. Certainly, some individuals will pay higher premiums than they currently do -- for example, someone who is young and healthy, or who has bare-bones coverage today, will likely pay more. But the young and healthy person will not stay young, and might not stay healthy, while the person with bare-bones coverage may end up needing far more care than the policy will cover. We therefore share risk through insurance -- paying for sicker people's health-care costs when we are healthy, with the promise that if we need expensive care, others will cover the costs.

It's not the mandate that will drive up premiums. Quite the opposite. The mandate is meant to help keep a lid on premiums by ensuring that the risk pool includes enough healthy people to spread the costs. At the same time, payment and delivery system changes that reward high-quality, efficient care will produce systemwide savings that also reduce premiums. In a 2010 report by the Commonwealth Fund, a private foundation supporting health-care reform, experts predict that by 2019, these changes will save each family almost $2,000 a year in premiums.

Opponents tend to see the mandate as federal interference in a private decision of whether to buy insurance or accept the financial risks of being uninsured.

But let's be clear. Uninsured individuals who need care, particularly catastrophically expensive care, generally receive these services anyway. A decision not to pay for insurance -- to become a free rider -- leads hospitals and other providers to charge other patients more to make up the difference. People shouldn't have the freedom to shift the burden to everybody else.

And it's a real burden. Yes, uncompensated care in 2008 as measured by the Urban Institute was a modest proportion of total health spending in the U.S. But when you're talking about health care, "modest" is still a lot of money. In 2008, 2.2% of total spending equaled $56 billion.

To put this amount in context, the Affordable Care Act is expected to spend $56 billion on expanding coverage to 15 million people via the Medicaid program in 2015. So you can buy a lot of health coverage and care for $56 billion. To be sure, reducing unnecessary care would realize even more significant savings -- and the law promotes reforms to address that issue as well.

Opponents also charge that the individual mandate in Massachusetts has led to rationing. On the contrary, data show that access to care has improved on a variety of measures, including reduced levels of unmet health-care needs. In some cases, the critics suggest that payment changes under consideration in Massachusetts -- aimed at reducing the growth in health-care costs -- will, if implemented, lead to rationing. This charge ignores the fact that global payment approaches and other payment changes are designed to improve care for patients with chronic illnesses. Under these approaches, physicians and health-care systems would coordinate with each other and more carefully manage their patients to ensure that patients receive needed care and enjoy better health. They would likely provide less unnecessary care and generally reduce overtreatment -- thereby reducing potential risks to patients and reclaiming some of the 30% of health-care spending currently dedicated to unnecessary care.

Ms. Davenport is a research project director at George Washington University's department of health policy.

No: Premiums Will Rise

By Michael F. Cannon

When Washington begins penalizing people for not purchasing health insurance in 2014, it will mark the first time in history the federal government has required nearly all Americans to buy a private product as a condition of lawful residence in the U.S. No part of the health-care law is less popular, or more essential to preventing it from crumbling like a house of cards, than this individual mandate.

Even if the mandate were popular and constitutional, it would still be a bad idea. It will increase premiums, cost shifting and government rationing, while promoting irresponsibility. Indeed, its entire purpose is to enable supporters to avoid responsibility for their decisions.

Let's start with premiums. The mandate will increase premiums for households who currently do not purchase coverage, and tens of millions more (including at least half of employer-sponsored plans) who will have to purchase additional coverage to satisfy the mandate. A study issued by the left-leaning Commonwealth Fund estimates the law has already increased premiums 1.8% on average. That will rise as the mandate takes full effect. Some of the increase will reflect the cost of additional coverage -- but if consumers valued that coverage, they would have bought it already.

True, the law will force insurers to reduce premiums for the sick, and the mandate will magnify that effect. But those same government price controls will increase premiums for healthier customers -- and the mandate will magnify that effect, too. (Economist Jonathan Gruber, one of the law's biggest proponents, projects that for some who buy policies in the individual market, premiums will more than double.) At best, those two effects cancel each other out. But these provisions also create incentives for healthy people to drop coverage, driving average premiums higher still.

Then there's how a mandate leads to government rationing. Like President Obama, ex-Massachusetts Gov. Mitt Romney tied a mandate to subsidies that help people buy the mandatory coverage. The higher-than-projected cost of those subsidies, plus the premium increases caused by the mandate, are leading desperate state officials to reduce those costs by rationing care.

Officials have imposed price controls on premiums, which force insurers to limit services. They are pushing price controls on providers, which could exacerbate Massachusetts' already long waits for care. And they hope to impose Canadian-style "payment reforms" that would financially reward providers for limiting services. (An early experiment has delivered zero savings and in some cases increased spending, yet it may still be denying care to people.)

Though supporters claim the mandate will reduce cost shifting from uninsured free riders to the insured, the latter will see no savings. Researchers at the left-leaning Urban Institute estimate that in 2008, such cost shifting amounted to just $56 billion, or 2% of total health spending, and increased premiums by "at most 1.7 percent." For comparison, the Dartmouth Institute for Health Policy and Clinical Practice estimates we waste more than 14 times that amount on unnecessary care. More important, the Commonwealth Fund study shows the federal law has already increased premiums by more than the mandate could reduce them by eliminating free riding.

The federal law actually promotes free riding and cost shifting. My colleague Victoria Payne and I calculated that individuals could save up to $3,000 a year -- and families of four could save as much as $8,000 -- by dropping their health insurance, paying the penalty, and waiting until they are sick to purchase coverage. Massachusetts reported a nearly fivefold increase in such free riding after its mandate took effect. The federal law also offers $1 trillion in subsidies to tens of millions of Americans -- shifting $1 trillion of the cost of their health care to taxpayers.

The mandate's greatest pretense is the idea that it promotes personal responsibility. If that were the goal, Congress need only have enhanced the courts' ability to collect medical debts. Supporters instead demanded a mandate precisely because it lets them avoid responsibility for their decisions.

Here's how. The federal law promotes irresponsibility by allowing healthy people to wait until they get sick to buy coverage. It creates that free-rider problem, which has been known to make insurance markets collapse. Supporters of the law could have taken personal responsibility for this instability they introduced into the market -- say, by volunteering to pay the free riders' premiums. Instead, they imposed a mandate, which attempts to stabilize the market by depriving others of their money and freedom.

Forcing others to bear the costs of your decisions is the opposite of personal responsibility. It is selfishness, not altruism.

The mandate is not a conservative or free-market idea. Some Republicans who were for it are now against it, just as some Democrats once against it are now for it. A majority of conservatives and the overwhelming majority of libertarians always opposed it. It's snake oil, no matter who prescribes it.

Free markets -- which no living American has seen in health care -- would make health care better, more affordable, and more secure. The mandate makes such progress impossible.

If the public understood the rest of the health-care overhaul as well as it does the mandate, the law would already be history.

Mr. Cannon is director of health policy studies at the libertarian Cato Institute and co-author of "Healthy Competition: What's Holding Back Health Care and How to Free It."

Can Obama Make You Buy Health Insurance?

Slate, By Timothy Noah, Posted Tuesday, Aug. 4, 2009, at 6:59 PM ET

Barack Obama spent much of the 2008 presidential-primary season arguing with Hillary Clinton about whether health reform should include a so-called "individual mandate" requiring all Americans to purchase health insurance. Clinton argued that it should. Obama argued that it shouldn't (even though his own plan called for a more limited individual mandate requiring parents to purchase health insurance for their children). One of Obama's central arguments was that enforcing such a mandate would be impractical. "You can mandate it," Obama said, "but there still will be people who can't afford it. And if they can't afford it, what are you going to fine them?"

At the time I thought Obama had the better argument, not just on practicality but also with respect to the Constitution. "If you want to drive a car," I wrote,

it's accepted that you have to buy private auto insurance. But that's conditional on enjoying the societal privilege of driving a car; you can avoid the requirement by choosing not to drive one. A mandate to buy private health insurance, however, would be conditional on … being alive. I can't think of another instance in which the government says outright, "You must buy this or that," independent of any special privilege or subsidy it may bestow on you.

Nearly two years later, Obama has made peace with the individual mandate, which is included in the bills that cleared three House committees and one Senate committee. The House bill imposes on anyone who neglects to purchase health insurance for himself or his family a 2.5 percent tax on modified adjusted gross income. The Senate health committee bill imposes a minimum penalty of $750. (We're still waiting to hear from the Senate finance committee.) Yet I've continued to wonder whether the individual mandate is constitutional.

Should health reform pass, it seems a dead certainty that conservatives will go to court to challenge the individual mandate. A preview of their arguments can be found on the Web site of the conservative Federalist Society in the paper, "Constitutional Implications of an 'Individual Mandate' in Health Care Reform" by Peter Urbanowicz, a former deputy general counsel at the Health and Human Services department, and Dennis Smith, a former director of HHS's Center for Medicaid and State Operations. One of these turns out to resemble my earlier argument:

Nearly every state now has a law mandating auto insurance for all drivers. But the primary purpose of the auto insurance mandate was to provide financial protection for people that a driver may harm, and not necessarily for the driver himself. And the auto insurance mandate is a quid pro quo for having the state issuing a privilege: in this case a driver's license.

Since I first wrote about this, it's been pointed out to me that the comparison with auto insurance is not a *legal* argument at all. (I am not a lawyer.) The legal question isn't whether it would be unusual for the government to compel people to buy health insurance. It's whether it would square with the Constitution. Mark Hall, a professor of law at Wake Forest University, argues that it would, in part based on the commerce clause, which since the New Deal has permitted the federal government to expand its power in various ways by defining various activities as "interstate commerce." Although health *delivery* is often local, Hall writes, "most medical supplies, drugs and equipment are shipped in interstate commerce." More to the point, "most health insurance is sold through interstate companies."

Yes, counter Urbanowicz and Smith, but "it is a different matter to find a basis for imposing Commerce Clause related regulation on an individual who chooses not to undertake a commercial transaction." Does the commerce clause cover your *refusal* to engage in interstate commerce?

Well, yes, Hall in effect answers, because when a person declines to purchase health insurance, that affects interstate commerce, too, by driving up health insurance premiums for everyone else:

Covering more people is expected to reduce the price of insurance by addressing free-rider and adverse selection problems. Free riding includes relying on emergency care and other services without paying for all the costs, and forcing providers to shift those costs onto people with insurance. Adverse selection is the tendency to wait to purchase until a person expects to need health care, thereby keeping out of the insurance pool a full cross section of both low and

higher cost subscribers. Covering more people also could reduce premiums by enhancing economies of scale in pooling of risk and managing medical costs.

In essence, the commerce clause enables the economic arguments for the individual mandate to become legal arguments as well.

Urbanowicz and Smith next reach for that perennial conservative favorite, the Fifth Amendment's takings clause, which says the government may not take property from a citizen without just compensation. "Requiring a citizen to devote a percent of his or her income for a purpose for which he or she otherwise might not choose based on individual circumstances," Urbanowicz and Smith write, "could be considered an arbitrary and capricious 'taking.' …"

But according to Akhil Reed Amar, who teaches constitutional law at Yale, the case law does not support Urbanowicz and Smith. "A taking is paradigmatically singling out an *individual*," Amar explains. The individual mandate (despite its name) applies to everybody. Also, "takings are paradigmatically about real property. They're about *things*." The individual mandate requires citizens to fork over not their houses or their automobiles but their money. Finally, Amar points out, the individual mandate does not result in the state taking something without providing compensation. The health insurance that citizens must purchase *is* compensation. In exchange for paying a premium, the insurer pledges (at least in theory) to pay some or all doctor and hospital bills should the need arise for medical treatment. The individual mandate isn't a *taking*, Amar argues. It's a *tax*.

But how can it be a tax if the money is turned over not to the government but to a private insurance company? William Treanor, dean of Fordham Law School and an expert on takings, repeated much of Amar's analysis to me (like Amar, he thinks a takings-based argument would never get anywhere), but instead of a tax he compared the individual mandate to the federal law mandating a minimum wage. Congress passes a law that says employers need to pay a certain minimum amount not to the government but to any person they hire. "The beneficiaries of that are private actors," Treanor explained. But it's allowed under the commerce clause. "Minimum wage law is constitutional." So, too, then, is the individual mandate.

*Timothy Noah is a senior writer at **Slate**.*

Strong success: Massachusetts health reform at 5 years

April 12th, 2011 by David E. Williams of the Health business blog

Massachusetts' 5 year old health reform law is the subject of fierce contention on the national stage, since it formed the foundation for the much-debated Patient Protection and Affordable Care Act (PPACA).

But within Massachusetts there's a lot less rancor. Discussion of repeal or defunding is not even on the table despite the challenging budget climate. A new comprehensive chart pack from the Blue Cross Blue Shield of Massachusetts Foundation (*Assessing the Results*) summarizes the law and presents findings on progress. Key takeaways, which are illustrated with extensive charts and graphs include:

- An increase of 400,000 state residents with insurance coverage, leading to the highest coverage rate in the US, with 98% covered
- Percent of employers offering coverage rising from 70 to 76% even as government subsidized options have increased
- Moderately high and stable support for reform among consumers, employers, and physicians
- No real progress on cost containment

The report emphasizes that the groundwork for near-universal coverage had been laid in the years leading up to 2006. That has made a big difference in reform's success and demonstrates why results in Massachusetts aren't so easily achievable in the country as a whole. (And although Republican primary voters may or may not buy in to it, it does mean Mitt Romney is not necessarily hypocritical in his support of MA reform and opposition to PPACA.) The key enabling factors for Massachusetts cited in the report include:

- Low rate of uninsurance. We already had many people covered through employment and a generous, effective Medicaid program
- An existing funding mechanism to pay facilities to take care of the uninsured, which could be redirected to subsidize the purchase of insurance
- A heavily regulated insurance market with guaranteed issue and community rating

I would add some other factors that the report omits. These are elements that the rest of the country could usefully emulate:

- Strong investment in public education that has led to a well educated workforce that attracts high-wage employers willing and able to provide health insurance. It's a lot easier for an employer to afford $10,000 of health insurance for a worker making $100,000 than for one making $20,000
- A spirit of collaboration among key stakeholders –employers, providers, consumers, health plans– who worked toward a solution everyone could agree to, and accepted the need for compromise
- A willingness of Democrats and Republicans to work together on a key issue for the state

As the document notes, Massachusetts health reform did not contain costs. That's hardly surprising because it wasn't designed to do so.

I'm cautiously optimistic that Massachusetts is now ready to tackle the cost problem. Now that almost everyone has health insurance, there's a willingness to address the affordability challenge in order to preserve what has been achieved.

I would argue that addressing costs on a serious scale requires near-universal coverage to be in place. That's a lesson the country as a whole may have to learn, too, and so I'm a lot less optimistic about cost containment at the national level than I am in Massachusetts.

The Massachusetts Health-Reform Mess

The Wall Street Journal, 1 March 2011, By John E. Calfee

The biggest problem with ObamaCare is that it is bereft of proven ways to curtail increases in health-care costs. This has given rise to unending speculation about what will happen to these costs when the law's main provisions go into effect in 2014.

To get a glimpse of the future, take a look at Massachusetts, whose 2006 health-care overhaul was by all accounts the model for the federal Patient Protection and Affordable Care Act passed last year. It was launched in promising circumstances: The Bay State already had the lowest percentage of uninsured people in the nation, and some of ObamaCare's provisions such as community rating (everyone can buy insurance at the same price, regardless of health) were already in place.

So, how are things going in Massachusetts? The easy part was getting more people insured. Coverage increased from about 88% to 96%. But the number of emergency room visits, which everyone expected to drop once people had to purchase insurance, is still going up. Surveys show roughly half the visits are unnecessary. Surveys also indicate that finding a primary care physician is becoming more difficult.

There are other troubling signs. Cities and townships were expected to move their employees into cheaper health policies through the new state-sponsored insurance exchange, the Health Care Connector. None have -- because unions fear the very tools that keep costs competitive in the private sector, such as co-pays. (Gov. Deval Patrick wants a new law to force the unions into the Connector.) Despite an individual insurance mandate, thousands of consumers wait to purchase coverage until they require costly procedures and then exit after paying a modest penalty. That makes insurance more expensive for everyone else.

Massachusetts reformers deferred cost control to the vague prospect of a "Round 2" of reform -- much as congressional Democrats did a year ago when they passed ObamaCare. Meanwhile, economists John Cogan, Glenn Hubbard and Daniel Kessler reported in the Forum for Health Economics & Policy (2010) that insurance premiums for individuals (alone or in employer-sponsored group plans) increased 6% to 7% beyond what they would have without the reform. For small employers, the increases are about 14% beyond those in the rest of the nation. Four years after reform, Massachusetts still has the highest insurance premiums in the nation, and the gap is getting wider.

In 2010, insurance firms announced premium increases of 10% to 30% in the individual and small-group market. Gov. Patrick, on the verge of a tough re-election race, had the state insurance commissioner deny the higher rates.

Insurance firms protested that they increased premiums because they had to deal with entrenched providers, especially hospitals, most notably the academic giants of Boston and Cambridge. Then the state prepared to introduce highly intrusive price controls over those providers -- only to discover that this would provoke formidable political opposition while encountering myriad practical difficulties.

Last month Round 2 arrived. Gov. Patrick introduced a bill that will impose de facto price controls on everyone from solo primary care doctors to prestigious academic hospital systems. An 18-member board will decide how and how much providers should be paid, and the bill gives regulators the power to force private insurers to accept these fiats. Some 30 states experimented with such rate-setting in the 1970s and '80s. Except for Maryland, all of them -- including Massachusetts -- deregulated in the 1990s because costs rose even as quality and choice declined.

In a mere four years, Massachusetts has demonstrated that the most important effects of its reform arise not from the letter of the law but from the law's unintended and unpredictable consequences. The state is lurching from one crisis to another as it attempts to construct a system vastly different from any seen before or anything contemplated when reform was first passed. Health care in the state is evolving toward a state-run version of Medicare combined with government reorganization of the delivery of medical care.

The cost problem in Massachusetts is not going to be solved anytime soon. The question to be asked is why we should plunge ahead with a national version of this model before we learn whether Masssachusetts's brave new world is one in which we want to live?

Health care challengers offer hypothetical mandates

By Richard Wolf, USA TODAY, March 15, 2010

WASHINGTON – Can Congress require Americans to buy broccoli? How about gym memberships? Or Chevy Volts?

Those or similar questions are likely to be posed to the Supreme Court later this month as it considers whether requiring Americans to buy health insurance is a law with a "limiting principle."

If President Obama's health care law — his landmark legislative achievement — is to withstand legal challenge, government lawyers must convince a majority of justices that the health care marketplace is unique. By not buying insurance, their argument goes, millions of Americans transfer $43 billion in health care costs to others in the form of higher premiums.

In dozens of briefs challenging just that argument, however, opponents of the law contend that the "minimum coverage requirement" — more commonly known as the individual mandate — would set a precedent that could apply to vitamin supplements, daily newspapers or kidney donations.

If Americans can be told to buy health insurance, Congress could seek to impose "a broccoli mandate, a car-purchase mandate, really any other mandate that you'd want," says Ilya Somin, a law professor at George Mason University who filed a brief for the Washington Legal Foundation, one of the dozens of groups opposing the law. "There are lots of interest groups that would love to lobby Congress to require people to buy their products."

Although the health care challenge is divided into four areas and will be argued over three days, many opponents say the critical test for the government is proving that a health insurance mandate won't lead to others. Never before, they say, has Congress forced Americans to buy something against their will.

The purpose of the mandate is to ensure that new insurance market reforms in the law work as intended. One limits the ability of health insurers to vary premiums based on factors such as gender and health status. Another prohibits insurers from denying coverage to applicants with pre-existing conditions.

Unless younger, healthier people — who often go without insurance until they get sick — are covered, the costs of those changes would be prohibitive, forcing premiums to rise even higher for those already covered.

In response to opponents' warnings that a mandate to buy insurance could lead to other government-required purchases, the Obama administration argued in one of its briefs that no such examples exist.

"Respondents acknowledge that states do have the power to enact purchase mandates, but they identify no example of any state ever having compelled its citizens to buy cars, agricultural products, gym memberships or any other consumer product," it said.

Mandating corn, metro cards

Nevertheless, opponents of the law raise these specters:

•Mandating insurance coverage could lead to requirements affecting basic human needs, such as food and transportation.

A brief submitted by 215 economists argues that food is even more basic to survival than health care and that virtually all Americans use some form of transportation. For that reason, their attorney, Steven Engel, contends, the government could go on to mandate purchases of corn or metro cards.

"Our view is that the health care industry is not so unique," Engel says. "It is not an economic fact that all people require health care."

•The insurance mandate could lead to virtually any type of mandate, no matter how unlikely.

In the brief filed on behalf of 26 state governments, former U.S. solicitor general Paul Clement contends that life insurance, burial insurance and flood insurance in flood zones are equally important for Americans to have. He extends the argument to even more basic needs.

"The same kind of cost-shifting is just as inevitable in markets for basic necessities such as food and clothing," his brief states. "The federal government spends billions of dollars feeding the hungry, clothing the poor and sheltering the homeless."

•Buying health insurance could become a basic requirement of living in the United States.

While the government can compel military service, jury duty and taxation, those are the costs of citizenship, opponents of the law argue. Health insurance premiums, by contrast, would be owed not to the government but to private companies.

"It's contrary to the notion that the federal government is a government of limited powers," says Paul Orfanedes, the lawyer for Judicial Watch, a conservative watchdog group that raised the Chevy Volt argument. "At some point, everybody in the country is going to require some type of transportation."

'A parade of hypotheticals'

For every argument that opponents mount, the administration and its allies have a counter-argument. They say:

•Mandates on what consumers eat would violate their right to privacy.

•The insurance mandate is paired with a reasonable alternative: a monetary penalty, rising by 2016 to $2,085 per family or 2.5% of household income, whichever is greater.

•Americans have another recourse to the insurance mandate: Vote out the lawmakers who imposed it.

The analogy for products such as cars doesn't hold, proponents of the law say, because the decision not to buy a car doesn't shift costs to others in the same way that going to the hospital without health insurance does.

A 2008 study in the journal *Health Affairs* found that the government spent $43 billion in 2008 to help pay the health care bills of the uninsured. In his brief on behalf of House and Senate Democratic leaders, former solicitor general Walter Dellinger said the analogy would apply only if people obtained $43 billion worth of cars without paying for them, imposing the cost on law-abiding car buyers.

"Consideration of the grave question of whether this court must invalidate a landmark act of Congress is not advanced by entertaining a parade of hypotheticals," he argued in his brief.

He carried the analogy further at a recent forum, noting that Americans who do not buy fancy televisions to watch this month's NCAA basketball tournament don't impose costs on others. If they did, he said, Congress might have passed the Emergency Flat-Screen Television Act.

Fox News Poll: Voters divided on constitutionality of health care law

By Dana Blanton, Published March 15, 2012 | FoxNews.com

American voters are about evenly divided over how the U.S. Supreme Court should decide the constitutional challenge to President Obama's health care reform law.

The Supreme Court begins hearing oral arguments in the case on March 26.

A Fox News poll released Thursday found 46 percent want the nation's high court to overturn the law, while 43 percent think it should uphold the Patient Protection and Affordable Care Act.

Click here for full Fox News poll results.

A year ago, by a 49-42 percent margin, voters wanted the law invalidated as unconstitutional (April 2011).

All four current Republican presidential candidates say they support legislation repealing President Obama's signature first-term legislative achievement.

Meanwhile, more voters disapprove (52 percent) than approve (43 percent) of the job Obama is doing on health care. His ratings on this issue have remained mostly unchanged for the last year.

A majority of voters wants Congress to repeal at least part of the health care law: 31 percent favor complete repeal and another 28 percent would like lawmakers to repeal parts of it.

A few voters -- 14 percent -- want lawmakers to leave the law in its current form. One voter in four (22 percent) would like to see it expanded. That's up from 18 percent who felt that way last year (April 2011).

Most Republicans want lawmakers to repeal all (56 percent) or parts (31 percent) of the law.

While few Democrats -- 7 percent -- think the health care law should be repealed entirely, about one in four (23 percent) would repeal some of it.

Most Democrats want the law expanded (39 percent) or left as is (24 percent).

A 63-percent majority of independents wants at least some of the law repealed.

The Fox News poll is based on land line and cell phone interviews with 912 randomly-chosen registered voters nationwide and was conducted under the joint direction of Anderson Robbins Research (D) and Shaw & Company Research (R) from March 10 to March 12. For the total sample, it has a margin of sampling error of plus or minus 3 percentage points.

Patient Protection and Affordable Care Act

From Wikipedia, the free encyclopedia

The **Patient Protection and Affordable Care Act** (**PPACA**)[1][2] is a United States federal statute signed into law by President Barack Obama on March 23, 2010. The law (along with the Health Care and Education Reconciliation Act of 2010) is the principal health care reform legislation of the 111th United States Congress. PPACA reforms certain aspects of the private health insurance industry and public health insurance programs, increases insurance coverage of pre-existing conditions, expands access to insurance to over 30 million Americans,[3][4] and increases projected national medical spending[5][6] while lowering projected Medicare spending….

PPACA includes numerous provisions to take effect over several years beginning in 2010. Policies issued before the law was promulgated are grandfathered from most federal regulations.

- Guaranteed issue and partial community rating will require insurers to offer the same premium to all applicants of the same age and geographical location without regard to most pre-existing conditions (excluding tobacco use).[17]
- A shared responsibility requirement, commonly called an individual mandate,[18] requires that all persons not covered by an employer sponsored health plan, Medicaid, Medicare, or other public insurance programs purchase and comply with an approved private insurance policy or pay a penalty, unless the applicable individual is a member of a recognized religious sect exempted by the Internal Revenue Service, or waived in cases of financial hardship.[19]
- Medicaid eligibility is expanded to include all individuals and families with incomes up to 133% of the poverty level along with a simplified CHIP enrollment process.[20][21]
- Health insurance exchanges will commence operation in each state, offering a marketplace where individuals and small businesses can compare policies and premiums, and buy insurance (with a government subsidy if eligible).[22]
- Low income persons and families above the Medicaid level and up to 400% of the federal poverty level will receive federal subsidies[23] on a sliding scale if they choose to purchase insurance via an exchange (persons at 150% of the poverty level would be subsidized such that their premium cost would be of 2% of income or $50 a month for a family of 4).[24]
- Minimum standards for health insurance policies are to be established and annual and lifetime coverage caps will be banned.[25]
- Firms employing 50 or more people but not offering health insurance will also pay a shared responsibility requirement if the government has had to subsidize an employee's health care.[26]
- Very small businesses will be able to get subsidies if they purchase insurance through an exchange.[27]
- Co-payments, co-insurance, and deductibles are to be eliminated for select health care insurance benefits considered to be part of an "essential benefits package"[28] for Level A or Level B preventive care.[29]
- Changes are enacted that allow a restructuring of Medicare reimbursement from "fee-for-service" to "bundled payments."[30][31]
- Additional support is provided for medical research and the National Institutes of Health.

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Free rider problem

In economics, collective bargaining, psychology, and political science, a free rider (or freeloader) is someone who consumes a resource without paying for it, or pays less than the full cost. The **free rider problem** is the question of how to limit free riding (or its negative effects). Free riding is usually considered to be an economic problem only when it leads to the non-production or under-production of a public good (and thus to Pareto inefficiency), or when it leads to the excessive use of a common property resource. The term *free rider* comes from the example of someone using public

transportation without paying the fare. If too many people do this, the system will not have enough money to operate. Another example of a free rider is someone who does not pay his or her share of taxes, which help pay for public goods that all citizens benefit from, such as roads, water treatment plants, and fire services.

Adverse selection

The term adverse selection was originally used in insurance. It describes a situation where an individual's demand for insurance (either the propensity to buy insurance, or the quantity purchased, or both) is positively correlated with the individual's risk of loss (e.g. higher risks buy more insurance), **and** the insurer is unable to allow for this correlation in the price of insurance.[1] This may be because of private information known only to the individual (information asymmetry), or because of regulations or social norms which prevent the insurer from using certain categories of known information to set prices (e.g. the insurer may be prohibited from using information such as gender, ethnic origin, genetic test results, or preexisting medical conditions, the last of which amount to a 100% risk of the losses associated with the treatment of that condition). The latter scenario is sometimes referred to as 'regulatory adverse selection'.[2]

The potentially 'adverse' nature of this phenomenon can be illustrated by the link between smoking status and mortality. Non-smokers, on average, are more likely to live longer, while smokers, on average, are more likely to die younger. If insurers do not vary prices for life insurance according to smoking status, life insurance will be a better buy for smokers than for non-smokers. So smokers may be more likely to buy insurance, or may tend to buy larger amounts, than non-smokers. The average mortality of the combined policyholder group will be higher than the average mortality of the general population. From the insurer's viewpoint, the higher mortality of the group which 'selects' to buy insurance is 'adverse'. The insurer raises the price of insurance accordingly. As a consequence, non-smokers may be less likely to buy insurance (or may buy smaller amounts) than if they could buy at a lower price to reflect their lower risk. The reduction in insurance purchase by non-smokers is also 'adverse' from the insurer's viewpoint, and perhaps also from a public policy viewpoint.[3]

Furthermore, if there is a range of increasing risk categories in the population, the increase in the insurance price due to adverse selection may lead the lowest remaining risks to cancel or not renew their insurance. This leads to a further increase in price, and hence the lowest remaining risks cancel their insurance, leading to a further increase in price, and so on. Eventually this 'adverse selection spiral' might in theory lead to the collapse of the insurance market.

To counter the effects of adverse selection, insurers (to the extent that laws permit) ask a range of questions and may request medical or other reports on individuals who apply to buy insurance, so that the price quoted can be varied accordingly, and any unreasonably high or unpredictable risks rejected. This risk selection process is known as underwriting. In many countries, insurance law incorporates an 'utmost good faith' or *uberrima fides* doctrine which requires potential customers to answer any underwriting questions asked by the insurer fully and honestly; if they fail to do this, the insurer may later refuse to pay claims.

In studies of health insurance, an individual mandate requiring people to either purchase plans or face a penalty is cited as a way out of the adverse selection problem by broadening the risk pool.[15] Mandates, like all insurance, increase moral hazard.

Moral hazard

In economic theory, **moral hazard** is a tendency to take undue risks because the costs are not borne by the party taking the risk. The term defines a situation where the behavior of one party may change to the detriment of another after a transaction has taken place. For example, a person with insurance against automobile theft may be less cautious about locking their car, because the negative consequences of vehicle theft are now (partially) the responsibility of the insurance company. A party makes a decision about how much risk to take, while another party bears the costs if things go badly, and the party insulated from risk behaves differently from how it would if it were fully exposed to the risk…

The name comes originally from the insurance industry. Insurance companies worried that protecting their clients from risks (like fire, or car accidents) might encourage those clients to behave in riskier ways (like smoking in bed or not wearing seat belts). This problem may inefficiently discourage those companies from protecting their clients as much as the clients would like to be protected.