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Why Should Health Insurance be Mandated in the U.S.?

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Abstract: ***In 2008, President Obama stated that healthcare insurance should be a right for every U.S. resident. Although this statement sounds noble, it does not affect uninsured healthcare inhabitants in United States statistics, with the number of uninsured residents reaching over 50 million in 2010. Such healthcare inequity has initiated a political drive towards transformation and the introduction of the Patient Protection Affordable Care Act (PPACA). The issue of individual mandate became a controversy. It is a most combative issue in healthcare politics today: According to Obama Care, every individual in the U.S. must have health insurance, or they will pay a penalty. The supporters say it is the primary key to making healthcare more affordable and accessible. In contrast, those against the individual mandate say a law that forces people to buy health insurance violates the assurance of personal freedom protected in the Constitution. Thus, federal government policymakers of an individual mandate must figure out its scope and the budget for people with pre-existing medical conditions and subsidies to bring insight into the possibility of success and compliance. When the path of the individual mandate is transparent, it would not be a punishment or a moral concern for the people as many of the mandates enacted already in the U.S. have remained helpful, such as the birth control mandate.***

Keywords: Affordable Care Act, Obama Care, Health Insurance

1. Introduction

Why Should Health Insurance be Mandated in the U.S.?

The United States has a distinguished healthcare system known for its complexity, and how it is designed leads to several challenges, arguments, commentaries, and questions about future healthcare. Presently, every individual in the United States desires affordable health care. Policymakers, political parties, and experts struggle to change the culture in the current health care system. Before changing the culture or desire for reform, one must think of possibilities of resolving fundamental issues that offer coverage to every person in the United States to reduce costs and improve affordability.

Since 1935, several U.S. presidents have tried to solve issues in the U.S. healthcare system but have been unsuccessful. Reform efforts primarily began when President Theodore Roosevelt wanted to offer health insurance to all U.S. citizens to improve their health (Hoffman, 2003 & Hoffman, 2001). President Franklin Delano Roosevelt tried to include health insurance in legislation that became the Social Security Act of 1935; however, Congress remained unsuccessful when the American Medical Association (AMA) turned against this entire effort. 1943, he started working on national health insurance legislation but died in 1945 before any bill was presented in the assembly. Their efforts showed how difficult healthcare reform would be. The other U.S. presidents, Truman, Johnson, Kennedy, Nixon, and Clinton, also tried to represent the ideologies of both political parties in the reform. However, President Johnson had significant success when he enacted the Medicare Act in 1965, though the reform was for a specific population (Engel, 2006). This act is specifically for elderly individuals but does not cover younger Americans.

The efforts of the Affordable Care Act (ACA) over the past six years to cover non-elderly individuals directly correlates to the increased accessibility of healthcare. Overall, there is broad agreement that an estimated 20 million to 22 million individuals have been newly insured since 2010 due to the expansion of Medicaid coverage through parents to young adults until age 26, as well as health care exchanges. However, more than 25 million U.S. residents remain without health insurance. The Federal government of the U.S. guarantees education, protection, and many additional federal- and state-funded services and facilities to its citizens. However, the government can merely promise that only a few of its people have access to health care due to increases in premiums (Bauchner, 2017). Critical problems in achieving universal health coverage are affordability and the need for enrollment in healthcare insurance.

A report from the Commonwealth Fund's Commission on a High-Performance Health System stated, "The failure in providing constant, affordable coverage that guarantees access and financial protection to the individuals in the U.S. contributes to the issues in the health system." Thus, the Affordable Care Act (Obama Care) focused on two things. Health insurance must be accessible to everyone, especially to people with pre-existing conditions, and more affordable, particularly for low-income groups, always there and for individuals with high healthcare costs (Wulsin & Dougherty, 2009). To bring accessibility, Congress approved an individual mandate in 2010 to make insurance affordable to lower-income groups.

The individual mandate act did not fully come into the act until 2014. In the meantime, the individual mandate encountered several legal challenges and arguments, leaving its implementation in question. It is helpful to understand where the idea of an individual mandate began. During the late 1980s and early 1990s, a group of traditional health policy professionals started looking for an alternative to the employer mandate proposal, which eventually became essential support for Bill Clinton's healthcare reform effort. The conventional health policy experts landed on an approach that called for individual obligation,

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sustained a crucial role for the private health insurance market, and dealt with the "free rider" problem of individuals who do not want to have insurance and so passed their healthcare bills on to those who had insurance (Longest, 2016). Thus, Obamacare wanted to make essential changes in the system. According to these changes, insurers must provide coverage to all applicants without questioning their health status, including pre-existing conditions and policyholders' claim history. The ACA's provision of the individual mandate and employee mandate was meant to reduce uninsured rates and thus reduce high healthcare costs. It was expected that once the law had been enacted, the uninsured rate would be decreased to 47.1% (Woolhandler & Himmelstein, 2011).

However, the complexity of the U.S. healthcare coverage systems limited the accessibility to affordable private coverage and thus led its citizens without health insurance. Further, the uninsured problem prevailed and reached 41 million by 2013. However, in 2104, ACA's aggressive reform efforts helped many people access Medicaid coverage as expected. According to the eligibility criteria of the ACA, every adult with a low income at 138% of the poverty level in states will be eligible for tax credits who obtain coverage through a Health Insurance Marketplace. The Obama government has also created the healthcare government website for enrollment; as expected, millions of people enrolled on this website, and the uninsured rate has gone from 28 million to 44 million by the end of 2016. Primarily, coverage gains were huge for the low and middle-income people living in states that expanded Medicaid. Still, around 28.5 million in 2015 remained without coverage (Longest, 2016). ACA's steps towards reform showed historic results in covering the uninsured, but the final step to share risk to pool and improve market competition and stability became controversial.

The individual mandate became controversial because it has no specific direction for the following reasons. Before moving to an argument on the individual mandate's constitutionality, "consider whether" replacing health savings accounts and tax credits with the individual mandate could change people's mindset. If a health insurance market across state lines increased competition, the extent of the cutdown in the premiums would be helpful for the U.S citizens or leave states in confusion to decide on the care that must be provided to their citizens and lead to fewer health care networks with the insignificant competition. This research paper examines how policies were made and implemented within the insurance system in the last seven years, how many uninsured patients have been affected, and whether health insurance should be mandated in the U.S.

2. Literature Review

According to the federal government, in 2012 approximately 48.6 million Americans were uninsured in the U.S. (U.S. Census, 2012). Most of them were working individuals who were not insured, as they did not have access to employer-based coverage or could not afford the insurance offered by the employer. The growing rate of the uninsured and healthcare costs have caused healthcare reform to be the central issue in the healthcare industry for several years (Musgrave, 2013).

In 2010, the Affordable Care Act (ACA) was passed to reduce the number of uninsured. As a part of that, ACA includes substantial expansion of the Medicaid program, significant changes in the insurance policies, subsidies for low, moderate-income families and small businesses, an employer mandate, and an individual mandate (Musgrave, 2013). Under the ACA's mandate, everybody should purchase insurance unless it is unaffordable. If the person can afford the insurance and does not buy it at any cost, she should face an equal or more significant penalty of $695 per person in her household, up to a maximum of $2085 and 2.5% of household income (Monahan, 2011). Suppose the amount of pay exceeds the national average cost for the health plan that proposes bronze-level insurance. In that case, individuals with a low income below the federal poverty level who must file taxes will not be subject to the mandate. If the premium cost exceeds 8% of the family income, it is considered unaffordable for that family.

Two main components are considered while determining the affordability of the family: one is tax credits, and the other is employer contribution towards coverage. According to the individual mandate, it is assumed that every person would be able to spend 8% on health insurance, and there is no exception, like low-income people may not be able to pay as much as those with high incomes. Individuals and families and those who have income below 250%FPL and above the cut-off of government income tax filing will be considered for the individual mandate because that is the range where premiums are fixed to equal or less than 8% of family income further, people whose income between 250% and 400% FPL are entitled to tax credits as they need to pay more than 8% of their income towards premiums (Monahan, 2011).

Under the ACA, premium rates can differ according to family size, geographic location, and tobacco use. For example, suppose one person earns $50,000 annually when the cost of living is low. In that case, the person may be required to get insurance, whereas another person earning the same salary in another location, which is very expensive, cannot be required to get the insurance (Monahan, 2011).

According to the Commonwealth Fund, a comprehensive report states that the U.S. spent 17.6% of the Gross Domestic Product on healthcare, while other industrialized nations spent half of that amount. In many cases, the U.S. spends twice the amount different countries spend while ranking last in terms of quality and access. Further, every other developed nation has universal healthcare through national healthcare insurance, and they spend less per dollar or similar on healthcare than the U.S. (Woolhandler & Himmelstein, 2011). Estimates are that the U.S. spent $2.8 trillion on health care in 2013 alone. The federal government paid $800 billion through Medicare for people with disabilities and people over 65, Medicaid for people with low incomes, and the other $2 trillion for those who

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are not insured through private insurance companies (Brill, 2013).

3. History of the Individual Mandate

Before discussing the controversies surrounding individual mandates, this paper will review their history. It all began in 1986 when the Emergency Medical Treatment and Active Labor Act (EMTALA) section was passed by a Democratic House and a Republican Senate and signed by Ronald Reagan. EMTALA is a part of a larger budget bill called Consolidated Omnibus Budget Reconciliation Act, or COBRA, which allows people who lost their jobs to continue purchasing insurance through their old employer's group plan, also contained four pages of the act named EMTALA. This act required any hospital to be a Medicare member and provide emergency care to the sick, irrespective of their insurance plans and affordability. EMTALA resembles the Universal healthcare plan, an unfunded mandate in American History (Koeninger,2013). The main aim of EMTALA was preventing patient dumping, which means that before COBRA, hospitals used to have much discrimination based on individual insurance status. For example, the priority of the hospitals before COBRA was Medicare, then Medicaid, and finally, distant and uninsured. This discrimination leads to an estimated 250,000 emergency clients being shifted out without caring each year and the hospital's inability to care for poor, uninsured people who were in the emergency known as "patient dumping" (Koeninger, 2013). Although the EMTALA mandate was started with a good reason, as it was unfunded, it created progressive consequences in U.S. health care. According to EMTALA, any individual who comes to the hospital in an emergency with a sickness must be treated by the hospital regardless of financial ability. Otherwise, they will be charged with some sought of acceptable (medical negligence). Still, the mandate will not provide any budget to the providers to treat them. This reason further led to a considerable cost shift in the healthcare. Thus, providers and hospitals started attracting individuals with private coverage to the emergencies by advertising themselves as providing emergency care for low cost in thirty minutes to stabilize their cost shifts. Eventually, Medicaid clients started overusing emergencies to avoid their long-time writing at primary healthcare centers. In the attempt to resolve these issues, a few reforms have come up, like tort reform, but they have yet to have significant success in bringing down the cost. The current individual mandate also attempts to reform healthcare (Koeninger,2013). The story of individual mandate began in Massachusetts with Romney on April 12, 2006. According to that bill, every citizen in Massachusetts had to buy health insurance (Individual Mandate); this bill became a model for Obamacare—and Romney's signature on the bill fulfilled Democrats' long-term goal, which is universal healthcare to all.

Romney is a republican but accomplished Democrat's goal by signing on the bill. Thus, by combining three old-fashioned policies. Massachusetts would help its uninsured individuals buy private health coverage, creating an open online marketplace and necessitating everyone who must carry insurance. Romney also announced that uninsured people would no longer use emergency rooms for their primary care and would pass their bills to the insured. "It is the Republican way of reforming the market." Romney later stated that day, having 30 million uninsured people in the country, having those people show up in the emergency when they get sick and pass their bills to others, is a Democratic approach that is not appropriate. The Republican approach is to say, "Everybody should have insurance; they must pay what they can afford to pay, and we will be there to help for them, but no more "free ride" (Bebinger, 2012)

Although few influential libertarians criticize Romney, many conservatives, such as Robert Motif, a policy expert at the conservative Heritage Foundation, praised and supported his bill in Massachusetts during the ceremony (Lizza, 2017). However, Romney said Newt Gingrich prompted the idea of the individual mandate, and Newt got it from the Heritage Foundation. According to the Heritage -health policy chief Stuart Butler, understanding the origin of the individual mandate is more complicated than most people assume. Stuart said that the confusion arises from the fact that 20 years ago, he wanted some form of obligation to purchase insurance, which required a Universal insurance market to prevent massive instability that may yield from the "adverse selection" (Insurers avoiding high risks and healthy people declining coverage) (Nixon, 2013).

According to Stuart, the conservative plan he proposed against Hillary's Universal plan and Heritage will not support the individual mandate., Firstly, a conservative plan requires people to buy coverage that protects them in emergencies such as disasters and tsunamis. In contrast, Obamacare (Individual mandate) forces individuals to purchase expensive health insurance. Secondly, the conservative plan initially motivated and improved enforceability by giving tax credits to people who purchase insurance. However, Obama's care obligates every individual to buy health insurance or pay a penalty (Nixon, 2013).

On the contrary, Heritage's critics say the individual mandate was proposed in 1989 by Heritage before Bill and Hillary Clinton. However, the basic structures of Obamacare and Romney Care are the same, and both require the purchase of individual insurance plans. However, Obama used a combination of new tax savings from changes to Medicare, and Romney used revenue from the federal government. Also, Obama has tools that can bring healthcare costs into control (Lizza, 2017).

Free rider problem

The most influential reason for government involvement in the argument for health coverage and the purpose of the individual mandate for decades is the "free rider" problem. "Free rider" addresses the people who choose not to be insured and consume healthcare free of cost despite their potential to pay for insurance. Almost 20% of people have the financial ability to pay for health insurance and choose not to pay as these people know they get emergency care when it is necessary without insurance. Thus, free riders

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transfer their bills to others through taxes and high premium rates (Wulsin & Dougherty, 2009).

Individual mandate supporters say it will prevent premiums from going high and create shared responsibility by U.S. citizens. However, opponents say a mandate will_increase the pool's level of risk instead of decreasing it, and more than this small element of national health expenditure is needed to justify bringing such significant change to the law. For example, to support the assumption of an increase in the risk of the pool, if one state enacts an individual mandate while obligating insurance companies to cover individuals with pre-existing conditions, unhealthy, uninsured individuals might create a chance for the free riders to migrate in from other states to take advantage of the regulation. Supporters of an individual mandate say migration of free riders from one state to another state to take advantage of regulation can be combated by a few small policies like obligating insurance companies to cover people who have pre-existing conditions only if they had previous insurance (Wulsinn & Dougherty, 2009).
To uphold an individual mandate, the government must ensure it will enhance health care's affordability, availability, and enforcement. When individual mandates are enacted, insurance rates should not exceed the family's affordability rate. To make this possible, the government must subsidize people who cannot afford insurance based on their income percentages. However, the basic coverage under the current HMO plan is affordable only for young and single at 400 percent of the poverty rate. Thus, an individual mandate requires widespread subsidies before its enactment. Tax refunds must be provided monthly or quarterly to improve the approach's effectiveness. According to the analysts, if the individual mandate is enacted, tax rates and subsidy levels must be audited frequently to maintain the balance-between them (Wulsin & Dougherty, 2009).

Enforcement and penalty size

According to Blumberg and Holahan, the most crucial step in healthcare administration is to make enrollment and compliance to [the] insurance process as easy as possible for people (as cited in Wulsin & Dougherty, 2009). Education and outreach programs must be conducted for people at different levels, such as schools, offices, healthcare providers, and media, to improve societal compliance and enrollment (Wulsin & Dougherty, 2009).

Enforcement through tax refunds has already brought significant results in compliance and enrollment, suggesting it is an excellent method to improve enforcement. The other tool that plays a vital role in enforcement is electronic monitoring, which ensures the names of enrollees and compares current health insurance status with baseline status (Wulsin & Dougherty, 2009).

Finally, supporters say that the most effective method to improve insurance compliance is through penalties, which are currently being implemented. However, penalty costs should be high enough to influence people to enroll. According to the Urban Institute, individuals must also be subject to tax penalties if they are uninsured during tax filing, and the fines collected from them should be spent on subsidies (Wulsin & Dougherty, 2009).

For the individual mandate to be successful, coverage for people with pre-existing conditions from insurance companies must take place in the market, as high premiums are the reason to be uninsured, especially in the low-income group. ACA must provide advanced refundable tax credits as subsidies for individuals at or below 400% FPL (Wulsin & Dougherty, 2009). Individual mandate policy is essential for healthcare reform because under the ACA, health insurance companies must cover all individuals with pre-existing conditions, and companies are limited to varying the premiums based on their decisions. This change in the insurance market would significantly attract the high-risk (pre-existing) groups to purchase insurance. Nevertheless, people who choose to remain without insurance will be in the same position, causing significant disequilibrium in the market, thus causing issues in the market even more so than now. Therefore, to prevent this issue, the individual mandate seeks everyone, especially healthy people (who are low risk), to purchase health insurance with the concern of social responsibility and accept the risk pool. Thus, premium rates would be low (Monahan, 2011).

The importance of the individual mandate

Supporters of the individual mandate say enacting it is necessary to reduce societal adverse selection. The ACA encourages adverse selection by obligating insurance companies to cover pre-existing conditions; thus, the number of unhealthy enrollees for insurance is increasing, and healthy individuals are forgoing insurance. This imbalance in the risk pool causes high premium rates and leaves healthy people in non-group insurance markets (Chandra et al., 2011).

Opponents of the individual mandate argue and assume that community ratings will work if subsidies plan a design well and they could attract healthy enrollees. Such subsidies are generally tax credits, acknowledging people with income between 133 and 400% of the poverty level. The government considers families at the poverty level when the income of a family of four is $22,000 per year. The states cannot provide such significant subsidies with community ratings, so we cannot consider this as a forecast of whether the mandate is needed for the reform. It is critical to understand the role of the individual mandate in the current healthcare reform (Chandra et al., 2011).

In addition, to understand the importance of the individual mandate in the reform, much research has been conducted in Massachusetts as it has already enacted the mandate in healthcare. Before the Massachusetts state government decided to implement the mandate, the typical wealth program covered the people below the poverty level in 2006. The state government automatically enrolled people below the poverty line for insurance and told others they should also get enrolled but must pay the premiums (Chandra et al., 2011).

The mandate came into effect on July 01, 2007, in Massachusetts. Researchers considered three periods to

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observe consumer behavior: July 01 to November 2007 to July 01, 2017, and when the full mandate came into effect, December 2007 to mid-2008 (Chandra et al., 2011).

According to the Commonwealth Care data, almost 50% of people who are chronically ill enrolled first, and then people with high health care costs enrolled second. Finally, healthier people got enrolled before the mandate came into effect. Opponents of the individual mandate assumed that the people with high healthcare costs would enroll first, and then healthier people would enroll over time. However, commonwealth care data in Massachusetts does not support their assumption. As chronically ill individuals enrolled first, premium rates increased in the insurance market. Whereas at the beginning of the mandate (July 01, 2007), data exhibited a more significant increase in the healthy population enrolled than enrollees with pre-existing conditions. At the end of 2007 (when the mandate became exclusively practical), enrollment in the healthy population hit peaks, according to the data, and a minimal increase was seen in the number of chronically ill enrollees.

Consequently, the massive number of healthy people enrolled for the insurance after the individual mandate narrowed the gap between people under risk and those who were not. So, this information shows that healthier people who enrolled for insurance were slow before the mandate enactment in Massachusetts: this was not because of the chronically ill people's enrollment but because of their adverse selection. Consumer behavior in Massachusetts demonstrates the importance of the individual mandate in healthcare reform when it applies to all states. Enforcing people who are healthy to buy insurance with subsidies is less effective than implementing it with a combination of individual mandates and subsidies (Chandra et al., 2011).

The individual mandate is constitutional or not?

The American legal system is interested in deciding whether individual mandates in the ACA are constitutional. U.S. courts are considered constitutional under the 6th Circuit and unconstitutional under the 11th Circuit. As it is so confusing, it should still be analyzed before declaring it is constitutional under the commerce clause. Generally, the commerce clause allows the government to control significant activities related to interstate commerce, and in the current society, we observe almost everything under the control of interstate commerce (Keane, 2012). Still, Congress's powers must be limited to those the Constitution protects. Supreme Court has steadily maintained the power of commerce to balance federal-state stability in the Constitution.

Supporters of the individual mandate argue on the concept of needs versus options. Healthcare is a need, only an option for some when it is required and inevitable. Also, nobody can predict when disease, disability, or death occurs. The mandate concept is a responsibility when payment will be made for a product everyone requires and cannot be avoided (Keane, 2012). Opponents of the individual mandate say this concept is an obligation for people to buy insurance because they are alive, and the federal government has taken people's freedom by showing its power. This power must be limited or controlled as it is not constitutional (Keane, 2012).

The individual mandate is a reason for many ethical dilemmas, and supporters who argue based on the inevitability of healthcare must still analyze and determine the circumstances, such as end-of-life care and expensive diagnostics that can be ignored, like repeated mammograms and MRIs (Keane, 2012). The other argument and primary concern about individual mandate is whether it is moral. Proponents say purchasing insurance at lower premium rates increases access to healthcare. They also say obligating individuals to buy insurance is like taking their liberty to share the risk problem with a group. It is like forcing people to buy gym memberships or eat broccoli (Mariner et al., 2011).

In contrast, without passing their bills to others, purchasing insurance is everyone's moral duty. They are free riders, as they know providers are mandated to render health services when individuals are in an emergency. Providers are responsible for rescuing the uninsured person, and every other individual is responsible for contributing to the same person in an emergency by purchasing insurance and sharing their burden equally with everyone. By doing so, individual liberty will not be compromised and will not require a person to buy a gym membership or eat broccoli (Rulli et al., 2012). Everyone must rescue others by taking their burden in an emergency. A few professions, like police, firefighters, and doctors, must help others when the risk increases. This responsibility of the providers is included under the Emergency Medical Treatment and Active Labor Act (EMTALA), which legally mandates healthcare centers to render services to people in an emergency, irrespective of their insurance status. Healthcare delivery to the uninsured is estimated to cost almost tens of billions annually (Hadley et al., 2008). The moral duty of rescue policy also shares its burden with corresponding area rescuers. For example, when Japan had the Tsunami, it was announced in the U.S. that surfers in California must avoid dangerous waters to protect themselves and others who are required to be rescued. To protect a victim, he must meet a few requirements according to the example. Firstly, the victim should have a good chance of survival. Secondly, the burden of rescuing the victim must be significant. Finally, the cost and burdens of preventive measures must be under the budget. So, people who choose not to be insured also meet this criterion in catastrophic situations like tsunamis and earthquakes (Ruli et al., 2012).

Buying health insurance is a responsibility.

Many people neglect to buy insurance by thinking they are healthy for now, but if premiums go high, including young adults, everyone is at risk. Fifteen percent of young people (aged between18-29) are suffering from various diseases such as asthma, diabetes, hypertension, and arthritis. There are 2.9 million live births among women similar in age, and comparatively different sexually transmitted diseases and emergency admits with trauma are high in young people (Ruli et al., 2012).

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The burden of acute and emergency care is increasing each day. The expected vaginal delivery costs $9600 currently, and a cesarean section costs $21,000. Unless uninsured people pay their bills or suffer from debts, healthcare expenses will not come down and will not burden insured people, providers, and health organizations. According to 2008 estimates, the budget spent on uncompensated care was almost $56,000 (Hadley et al., 2008). Also, the burden of emergency rescues is increasing because 10% of uninsured people whose income levels are more than 400% of government poverty level (Ruli et al., 2012).

4. Discussion

In this paper, the researcher provides an overview of an individual mandate's history, structure, advantages and disadvantages, and possible consequences. Based on the arguments in the literature review, enacting individual mandates improves access and shared responsibility. Everyone must purchase health insurance. It is a moral responsibility, but according to the researcher's analysis, there is no clear source for financing subsidies. There is no guarantee that individual mandates will improve affordability due to the issues mentioned in the previous discussions. The mandate of insurance in Massachusetts produced mixed results in its healthcare system. Massachusetts' results show that generalizing mandates to all states would increase coverage but not guarantee healthcare cost reduction. If mandates were enacted and premiums went high, reform would be more complex than now. When the EMTALA act was initiated with a vital moral concern, which was to stop patient dumping, people came up with overusing emergencies, and providers came up with attractive advertisements to protect their sources for profitability. Thus, when any mandate or act enactment occurs in response, few people, providers, and political parties search for loopholes for their profit. Although there are no pitfalls in the system, it is the nature of the few habitats or politicians to drill them (for example, the Birth control mandate, because this mandate was enacted for the benefit of women's health, and it did not obligate women to go for contraception). In this scenario, individual mandates should have a clear scope and proper design before they get into enactment. Otherwise, it may end up with no adverse results on society. For example, if an individual mandate comes into passage, according to the mandate, every individual should buy insurance; if not, they will be charged with the penalty. So here the question is: how much is the penalty? If the annual penalty cost is less than the premium cost, free riders will choose the penalty rather than paying premiums, whether it is moral or not. So, the mandate must be transparent with its design and criteria before its enactment. Moreover, it should not be a punishment for the citizens; it must bring positive change to the system and stop the free riders. All mandates already enacted in the U.S. were not punishments and brought substantial positive changes to the system and its Constitution.

In conclusion, as ACA took many steps towards reform, such as enrollment and accessibility, it should take one more individual mandate with people's compliance by creating hope in the people with its precise design and scope. Further, policymakers need to make a practical reform apt for the U.S. healthcare system as the U.S. has a significant private business system, decentralized health operations across the states, and political power lacking enough to make mandates. Further, Americans have more freedom, unlike other nations where civilians do not always support the mandates. It would be beneficial to recommend initiatives that increase the social responsibility of private-government corporations and citizens to promote public health for primary care. Further, manufacturers and service lines display the transparent cost without insurance. Finally, government/not-for-profit organizations should take over the health care system and revise such a health system in Cuba.

References

[1] Bauchner H. Health Care in the United States: A Right or a Privilege. JAMA. 2017;317(1):29. doi:10.1001/jama.2016.19687
[2] Bebinger, M. (2012, September 01). Personal Responsibility: How Mitt Romney Embraced The Individual Mandate In Massachusetts Health Reform. Retrieved October 05, 2017, from http://content.healthaffairs.org/content/31/9/2105.full.
[3] Brill, S. (2013, March 4). A bitter pill: How outrageous pricing and egregious profits destroy our health care. Time, pp. 181, 18–55.
[4] California Research Bureau. (Wulsinn & Dougherty, 2009) retrieved from https://www.library.ca.gov/crb/09/09-007.pdf
[5] Chandra, A., PhD., Gruber, J., PhD., & McKnight, R., PhD. (2011). The importance of the individual mandate -- evidence from Massachusetts. The New England Journal of Medicine, 364(4), 293-5. doi: http://dx.doi.org.nuls.idm.oclc.org/10.1056/NEJMp1013067
[6] Engel, J. (2006). Poor people's medicine: Medicaid and American charity care since 1965.
[7] Durham: Duke University Press.
[8] Hadley J, Holahan J, Coughlin T, Miller D. Covering the uninsured in 2008. Health Aff (Millwood). 2008;27(5):w399-w415PubMedArticle 360 Link
[9] Kaiser Commission on Medicaid and the Uninsured. (2012). How will the Medicaid expansion for adults impact eligibility and coverage? Retrieved March 29 from http://www.kff.org.
[10] Keane, M. J. (2012). A Critical Analysis of the Constitutionality of Government-Mandated Health Insurance: An Apple a Day Keeps the Commerce Clause at Bay. Mayo Clinic Proceedings, 87(3), 216–218. http://doi.org/10.1016/j.mayocp.2012.01.008
[11] Koeninger, W. D. (2013, Winter). The statute whose name we dare not speak: EMTALA and the Affordable Care Act. Journal of Gender, Race, and Justice, 16(1), 139+. Retrieved from https://nuls.idm.oclc.org/login?url=http://go.galegroup.com/ps/i.do?p=AONE&sw=w&u=nu_main&v=2.1&it=r&id=GALE%7CA328421823&asid=8e1f2e867cd640df77c0b8f534923368
[12] Lizza, R. (2011, June 6). Romney's Dilemma. The New Yorker, 87(16), 38. Retrieved from https://nuls.idm.oclc.org/login?url=http://go.galegroup.com/ps/i.do?p=AONE&sw=w&u=nu_main&v=2.1&i

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t=r&id=GALE%7CA258164418&asid=33e1456356a91c6af38b1174455d114
[13] fLongest, B. B., & Association of University Programs in Health, A. (2016). Health Policymaking in the United States. Chicago, Illinois: Health Administration Press.
[14] Mariner WK, Annas GJ, Glantz LH. Can Congress make you buy broccoli? N Engl J Med. 2011;364(3):201-203PubMedArticle 360 Link
[15] Maruthappu, M., Ologunde, R., & Gunarajasingam, A. (2013). Is Health Care a Right? Health Reforms in the USA and their Impact Upon the Concept of Care. Retrieved August 19, 2017, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4326121/ (Maruthappu et al., 2013)
[16] McKee, G. (2017, June 26). Why are Republicans trapped on health care? Because Democrats stole their best idea. Washingtonpost.com. Retrieved from https://nuls.idm.oclc.org/login?url=http://go.galegroup.com/ps/i.do?p=AONE&sw=w&u=nu_main&v=2.1&it=r&id=GALE%7CA497035474&asid=fea9aa80aac3e1489b63db2e555b9a6c
[17] Monahan, A. B. (2011). On subsidies and mandates: A regulatory critique of ACA. Journal of Corporation Law, 36(4), 781-806. Retrieved from https://nuls.idm.oclc.org/login?url=https://search-proquest-com.nuls.idm.oclc.org/docview/881623477?accountid=25320
[18] Musgrave, Jeralynn C., "The influence of the Individual Mandate provision of the Affordable Care Act on Uninsured Patients and Nonprofit Hospitals in Southern Illinois" (2013). Research Papers. Paper 453. http://opensiuc.lib.siu.edu/gs_rp/453
[19] Nixon, J. P. (2014, January 10). Alternative medicine: getting to the right of Obamacare. Commonweal, 141(1), 8.
[20] Rulli T, Emanuel EJ, Wendler D. The Moral Duty to Buy Health Insurance. JAMA. 2012;308(2):137–138. doi:10.1001/jama.2012.5648
[21] U.S. Census Bureau. (2012). Income, poverty, and health insurance coverage: 2011 http://www.census.gov/prod/2012pubs/p60-243.pdf
[22] Woolhandler, S., & Himmelstein, D. (2011). Healthcare reform 2.0. Social Research, 78(3), 719-730.
[23] Wulsin, L., & Dougherty, A. (2009). Individual mandate: a background report. Sacramento, CA

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