The Individual Mandate and Patient-Centered Care

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ONE YEAR AFTER THE HISTORIC PASSAGE OF THE Affordable Care Act (ACA), the individual mandate is subject to ongoing scrutiny both by the federal courts and Congress. This provision of the ACA would require most individuals to purchase health insurance, and recent attention has focused on the important legal issues associated with such a mandate. However, far less attention has been devoted to the potential effects of the mandate on the quality and cost of care and what that would mean—for US families and their physicians. The individual mandate is integral to the health reform legislation for at least 3 reasons. First, and critically for physicians, it strengthens the patient-physician relationship. Second, it generally stabilizes insurance premiums, increases access to health insurance coverage, and provides security against significant medical expenses. Third, it addresses the pernicious “free rider” problem that is unique to US health care because of the long dysfunctional health insurance market.

The Patient-Physician Relationship

The potential influence of the individual mandate on the patient-physician relationship is underappreciated. Patients with insurance are more likely to have physicians routinely involved in coordinating their care, are more apt to receive screening and other preventive services, and are less likely to engage in substance abuse. Moreover, patients with a single primary care physician are more likely to receive care consistent with evidence-based guidelines. These factors may contribute to the increased life expectancy observed among individuals with insurance compared with those without insurance.

Although some persons without insurance attend self-pay clinics, many seek care only in the emergency department and on a semi-urgent basis. This pattern of care-seeking behavior is costly and inefficient, and limits the ability of a physician to know a patient as an individual, rather than simply as a patient with an illness. Because clinicians and health care institutions should emphasize patient-centered care, the inviolability of the patient-physician relationship must be preserved. The individual mandate should help bolster that relationship by increasing health insurance coverage, and therefore encouraging and facilitating regular access for patients to physicians.

Health Care Costs for Families

By increasing the number of individuals with adequate coverage, the individual mandate should reduce their costs for accessing routine health care services and help provide financial security from potentially devastating health care costs. This also influences the way physicians deliver care, because recommendations must be tailored to a patient’s social and financial circumstances.

Health care costs are indisputably reaching crisis levels and inadequate health insurance coverage contributes to this problem. In 2008, an estimated $73 billion in uncompensated health care was provided in the United States. Although federal government payments are intended to help mitigate these costs, the effect of providing uncompensated care is significant. One estimate suggests that annual family health insurance premiums are likely increased by as much as $1000 as a result of cost-shifting from this uncompensated care. The individual mandate should substantially reduce the level of uncompensated care and the need to pass these excess costs on to those individuals with insurance.

Because the United States relies on a market-based insurance model, it is critical to provide incentives for healthier patients to obtain insurance coverage. By increasing the number of healthy individuals entering the market, the individual mandate should serve to stabilize premium costs for everyone. The Congressional Budget Office estimated that the individual mandate will reduce the number of uninsured by 16 million, improve the overall health of the risk pool, and reduce premiums in new nongroup policies by 15% to 20%.

The individual mandate may be an effective way to reduce the number of uninsured persons and the increasing cost of health insurance premiums. Although there are al-

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ternative methods for insurers to attract lower-risk patients without mandating the purchase of health care coverage—such as limiting enrollment periods, imposing long-term premium penalties for those who delay purchasing coverage, and implementing a broad auto-enrollment program with an “opt-out” provision—these alternatives, most likely, would not have as great an effect as the mandate. In addition, recent history suggests that bipartisan Congressional collaboration on additional health care legislation is unlikely.

The recent implementation of an individual mandate in Massachusetts provides a useful example of the mandate’s effectiveness in reducing adverse selection. Although the subsidies for insurance purchasing are more generous in Massachusetts than under the ACA, a recent assessment of the Massachusetts mandate found that, following its implementation, individuals purchasing coverage were 4 years younger, 50% less likely to be chronically ill, and had 45% lower health care costs.

Hospitals and other health care organizations generally charge the uninsured higher rates for medical services than rates ultimately negotiated by payers for the insured. By facilitating the purchase of insurance, the individual mandate reduces the costs of these services and should therefore increase the likelihood that individuals will be able to pay for the medical expenses they incur. Additionally, the mandate helps provide economic security for US families by protecting against potentially exorbitant and unanticipated health care expenses. For instance, more than 60% of personal bankruptcies result from medical expenses. Therefore, the individual mandate should help improve the financial well-being of many US residents, in addition to their physical health.

Paying for Health Care

The health care market is unique in that although nearly every person will seek and obtain care during his or her lifetime, many do not pay for it. For example, most hospitals around the country treat any patient who enters their emergency department without demanding proof of insurance coverage or ability to pay. Not only is this a requirement of the Emergency Medical Treatment and Active Labor Act, which Congress passed in 1986, but providing this care is “the right thing to do” as a part of health care professionals’ and hospitals’ responsibilities and national culture.

With rare exception, at some point every individual will require health care services. Therefore, the decision of many individuals not to purchase coverage—whether consciously or not—presents a free rider problem. These individuals will generally receive care, whether or not they are able to pay toward that care. For those individuals for whom health coverage is unaffordable, there is a societal obligation to create remedies. On the other hand, for those individuals who could afford to purchase coverage, yet choose not to, it should be clear that “free riding” cannot be sanctioned.

The individual mandate reinforces the traditional patient-physician relationship in promoting patient-centered care, helps stabilize insurance premiums, provides coverage to more individuals, and acknowledges the reality that the decision of some not to purchase coverage directly affects others. In addition, invalidating or eliminating the individual mandate might compromise the entire ACA, because many components of the ACA are interdependent, and the ramifications for US families could be substantial. As policymakers and the judiciary consider these challenging issues, the focus should remain on patients. In the end, the health of patients relies on the health of the system providing their care, so it is imperative to get it right.

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REFERENCES