

An Individual Health Insurance Mandate: Could it Work for Connecticut?

Summary

Health care in Connecticut and the US more generally is broken. The US spends twice as much on health care per capita than other industrialized countries, but we are not getting our money's worth. By 2017 health care is projected to consume 20 cents of every dollar spent in the US. State and national leaders are considering options to reform our broken system. Some are considering an individual mandate as part of those reforms. An individual mandate is a legal requirement that every individual have health care coverage. If they do not have an affordable employer sponsored option and are not eligible for a public program, they must purchase it in the private market.

Research suggests that an individual mandate would not work.

- Mandates are no guarantee of compliance. Connecticut now requires under law that all drivers have auto insurance, but 12% are uninsured.
- The uninsured are responsible for only a very small part of health care costs. Uncompensated care makes up only 2% of all US health care spending.
- Very few people are uninsured by choice. Only 1.5% of uninsured Americans are uninsured because they believe they don't need coverage.
- Insurance in Connecticut is not affordable. Connecticut's family health insurance premiums are the third highest in the nation. Between 2000 and 2007 Connecticut health insurance premiums grew 8.2 times faster than our earnings.
- Connecticut's Insurance Department has approved many health policies that are not worth what consumers pay for them. In 2006 without public notice, the department approved limited benefit policies that cover as little as \$1,000 per year in health care treatments.
- Health insurance is no guarantee of access to care. Connecticut, like the rest of the country, is facing a shortage of primary care providers. Because of increased demand for health care services under their individual mandate, Massachusetts residents now wait up to a year for appointments.
- Connecticut can't afford an individual mandate. To enforce their mandate, Massachusetts created a new agency and engaged thirty lawyers to hear consumer appeals.

**An individual
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- Enforcement of an individual mandate would be problematic, raising difficult and conflicting interests among policymakers.
- A mandate is not the best way to improve overall health. Twenty two thousand Americans die each year due to lack of insurance, but between 44,000 and 98,000 die of medical errors just in hospitals.
- A mandate would invite legal challenges.

Other states have considered individual mandates, including Maine and Vermont, and decided against it. California's proposed reforms failed in large part because of the inclusion of an individual mandate. An individual mandate does nothing to address the flaws in our broken health care system - incentives for over-utilization and against quality, little emphasis on prevention and management of chronic illness, or fragmented payment systems promoting cost shifting. The difficulties in implementing an individual mandate would distract resources from fixing the real problems with our health care system.

Introduction

There is a growing consensus that our health care system is broken. Health care costs are skyrocketing and employers and government payers are struggling to keep up. Health care consumes 16 % of the US economy¹ and that proportion is expected to reach 20% by 2017.² The US spends twice as much on health care per capita than other industrialized countries, but we are not getting our money's worth.³ The worst part of the health care crisis is that 45.7 million Americans were without health insurance last year,⁴ including 326,000 in Connecticut. The uninsured get fewer medical services, are at significant financial risk if they become ill, and are 25% more likely to die prematurely.⁵

State and national leaders are considering policy proposals to address the broken health care system and the growing number of uninsured residents. As part of those potential reforms, some policymakers are considering including an individual mandate. This paper explores the advisability of such a mandate in Connecticut and the likely impact.

What is an individual mandate?

An individual mandate is a legal requirement that every Connecticut resident have health insurance coverage. If coverage is not available to them through employment or eligibility for a public program, they would be required to buy it in the individual insurance market. People who do not (or cannot) comply would face penalties possibly to include fines, tax penalties, wage garnishment, or even more harsh constrictions on liberty. Some have proposed mandates only on children,⁶ some only on adults,⁷ and some would apply the mandate to every resident.⁸

**Despite a legal
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Why would we impose an individual mandate?

Proponents have several reasons for arguing that a mandate is necessary. The most often cited reason is that we can't get to universal health coverage without it.⁹ This argument is based on economic modeling, computer simulations of how humans will act in various theoretical situations. That economic modeling is based, in turn, on adverse selection theory. The concept of adverse selection is that, under a voluntary system, people will only choose to buy insurance when they need it. If healthier people do not contribute to the total pool of funding for health care, this will raise the cost of insurance, making it less affordable.

Another contention is that it is only fair for everyone to contribute to the system.¹⁰ Polls have shown some support for a mandate.¹¹ In economic circles, the uninsured are labeled "free-riders".¹² Without coverage, they can wait until they incur costs they cannot pay and the bills will be shifted to the rest of the system, including providers, other payers and taxpayers. Everyone should contribute now and share the costs to be sure it will be there for those of us who need it. A voluntary system will always allow some to evade their responsibility.

There is an impression that many, even most, of the uninsured are able to pay for coverage, they just choose not to. It has been suggested that most uninsured are young and irresponsible (so called "young invincibles") who prefer to spend their money elsewhere.¹³

Others argue that having everyone covered will improve the health status of the population.¹⁴ The assertion is that insurers have a financial incentive to keep people healthy through paying for preventive care and supporting wellness programs. The uninsured do not have access to these services or incentives.

Those sound like good reasons. What's the problem?

It won't work.

Mandates are no guarantee of compliance. Connecticut law now mandates that all motor vehicle drivers have insurance, but 12% of Connecticut drivers are uninsured.¹⁵ That rate is significantly higher than our current 9.4% rate of residents without health insurance.¹⁶ Massachusetts has an individual health insurance mandate but 7% of working age adults are still without health coverage.¹⁷ A comprehensive study of legal mandates found that "mandates can, but do not always, increase participation in programs."¹⁸ In fact, when an individual mandate for health insurance was implemented in the Netherlands, their 99% insured rate actually dropped.¹⁹

Uncompensated care makes up only 2% of all US health care spending.

The premise of an individual mandate is based on faulty reasoning.

Uninsured free-riders are not a significant fiscal problem.

Uncompensated care, health care services delivered but not reimbursed, makes up only 2% of all health care spending in the US.²⁰ It is important to know that uncompensated care for insured Americans is 1.2% of all US health care spending.²¹ So even if we could get to universal coverage, there would still be billions of dollars in uncompensated care. Connecticut has fewer problems with uncompensated care than the rest of the US. Only 3.1% of Connecticut hospital costs are uncompensated;²² the national average is 5.8%.²³

In fact, a study of nearly 4000 physicians found that they actually make money on their uninsured patients. While physicians receive no payment on behalf of about one in four uninsured patients, another two thirds pay more for their care than insured patients do. Physicians often charge the uninsured "list prices" which are higher than the rates negotiated by insurers and government payers. Between 8.5 and 9.6% of patients paid more than twice what insured patients did for the same treatment. Overall, the authors estimate that US physicians make \$300 million more for uninsured patients than for insured patients.²⁴

The uninsured pay a very high price in many ways for their health care. Half of all US bankruptcies are due to medical bills.²⁵ Twenty three percent of uninsured Americans have borrowed money to pay medical bills. Thirty seven percent of the uninsured have been contacted by a collection agency about medical debt in the last five years.²⁶ Not surprisingly, the uninsured receive half the health care that privately insured residents do.²⁷

Very few Americans are uninsured by choice.

Only 1.5% of uninsured American adults are uninsured because they believe they don't need coverage.²⁸ As to the idea that most uninsured are "young invincibles" and don't believe they need health coverage, in fact 82% of uninsured young adults ages 19 to 29 have incomes below 200% of the federal poverty level (\$20,800 for a single person) and cannot afford to purchase coverage. More than one in three young adults report difficulty paying medical bills including trouble making payments, being contacted by a collection agency, significantly changing their way of life and paying off bills over time. Seventy three percent of young adults take health insurance if it is offered by their employer.²⁹

The proponents base their argument on economic modeling.

Economic modeling is predicting human behavior, such as the likelihood of purchasing insurance, with theoretical computer simulations based on assumptions developed by economists. There are numerous instances of policy errors resulting from flawed economic modeling.³⁰ The most recent Wall Street meltdown has been blamed on faulty economic modeling. Emanuel

Derman of Goldman Sachs stated, "To confuse the model with the world is to embrace a future disaster driven by the belief that humans obey mathematical rules." ³¹

The public is mixed in whether to support an individual mandate.

Polls have shown some support for a mandate on parents to provide care for children, but polls are mixed on a general mandate covering every resident.³² Earlier this year a poll of California voters conducted while that state debated a package of health care reforms, found that only 16% favor an individual mandate without limits on what insurers could charge. Even with accountability measures for insurers, support only rises to 32%. Seventy two percent believe that greater accountability for insurers must come before an individual mandate.³³ In this November's election, Arizona voters narrowly defeated Proposition 101 by less than one percent of the vote, which would have amended the state constitution to prohibit an individual mandate.³⁴

Only 1.5% of uninsured Americans lack coverage because they believe they don't need health insurance.

Having insurance in Connecticut is no guarantee of value.

Forcing low income people in Connecticut to buy worthless insurance does not promote health or protect their finances. It just places another burden on working families. More than one in four Americans who were continuously insured during the previous year had medical bill problems or medical debt. Problems include uncovered services, out of network fees, confusing and complex policies and billing procedures, insurance disputes and errors, pre-existing condition exclusions, deceptive marketing, and shrinking coverage. ³⁵

In health insurance, it is not always true that something is better than nothing. As part of their health reforms and the individual mandate, Massachusetts has created a strong regulatory structure and standards of coverage to ensure that consumers now mandated to purchase insurance are getting value for their money.³⁶ Unfortunately, Connecticut consumers cannot be confident that the same level of consumer protection is available in our state.

Connecticut's Insurance Department has approved many health insurance policies that are not comprehensive, and often are not worth what consumers pay for them. With no public notice, limited benefit or "mini-med" plans, covering as little as \$7,500, \$2,000 or even \$1,000 of health care per year, were approved by the Insurance Dept. in 2006.³⁷ If it were not for a whistleblower within the agency, we still would not know that these insurance products are approved for sale in Connecticut. The state legislature has failed to place any standards on these policies beyond disclaimer language.³⁸ Consumers who buy these plans are often unaware of the risks, including out-of-pocket costs that could easily exceed 10% of income, being forced to delay or forgo needed treatment, and disincentives to access preventive care.³⁹

In 2006 with no public notice, Connecticut's Insurance Department approved limited benefit health policies with annual limits on care as low as \$1,000.

Another affordable health insurance option available in Connecticut to low income consumers are consumer-directed health plans. These plans pair a high-deductible or catastrophic insurance policy with a tax-advantaged Health Savings Account.⁴⁰ Unfortunately, most uninsured Connecticut consumers are low income and their tax liability is not significant. High deductible plans offer little incentive to access preventive care or needed maintenance for chronic conditions. High deductible or catastrophic plans are often of little use to consumers with few assets to protect.

Also available to consumers, and approved by the Connecticut Insurance Dept., are medical discount cards. These programs are not insurance, but only offer, for a monthly fee, discounts off the "retail" price for health care services. Patients must pay at the time of service and it is questionable whether the cards offer any savings beyond what consumers could easily negotiate themselves. The Connecticut Insurance Dept. does not regulate what medical discount card companies may charge or that they have adequate provider panels.⁴¹ Many consumers buy these cards, believing they are buying insurance, and under an individual mandate might only find out they are not compliant with the law when they face a penalty.

The Connecticut Insurance Dept. also has a poor record of informing consumers of their rights and the risks they face. The agency's website was recently ranked "inadequate" by The Consumer Federation of America.⁴² The state Office of Health Care Advocate was created by the General Assembly largely to provide Connecticut's health care consumers with protections and advocacy they were not getting from the Insurance Dept.⁴³

Underinsurance is becoming as big a problem as uninsurance. Underinsurance is defined as having out-of-pocket costs that are over 10% of income (5% for those under twice the federal poverty level) or having deductibles that exceed 5% of income. Twenty five million Americans are underinsured and that rate is growing among all income levels.⁴⁴ Underinsured Americans have similar difficulties with accessing care and financial stress as the uninsured. The underinsured are far more likely to be in fair or poor health than most Americans, are twice as likely not to fill a prescription, more than three times as likely to skip a test, treatment or follow up care recommended by a doctor, are twice as likely not to have visited a doctor in the last year, and four times as likely to have been contacted by a bill collector in the last year.⁴⁵

There are not enough affordable coverage options in Connecticut and things are getting worse.

Over half of American voters voiced concerns about the affordability of health insurance in polls before the latest Presidential election. Twenty eight percent said paying for health care or insurance is a serious economic problem for their family.⁴⁶ Connecticut's health insurance premiums for families are

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third highest in the nation.⁴⁷ Seventy two million Americans have difficulty paying medical bills and are accumulating debt. Adults in all income groups are paying more for health care than in the past.⁴⁸ Health insurance premiums for Connecticut residents grew 8.2 times faster than median earnings from 2000 to 2007. Workers' share of those premiums grew even faster at 10.5 times the rate of median earnings.⁴⁹

Employer sponsored coverage, for those lucky enough to have it, is by far the most affordable option and best value. Only 5 to 10% of Connecticut large employer plan premiums go to administrative costs, while half or more of individual coverage premiums in Connecticut are lost to administrative costs and profits.⁵⁰ Proposed bills in Connecticut to set standards on medical loss ratios, the proportion of premiums that must go to medical care, have not passed.⁵¹

Unfortunately, Connecticut residents not lucky enough to have an employer offer of benefits or to qualify for public programs are at the mercy of the individual market. Premiums in Connecticut's individual market are not community rated (moderating rates across the population), there is no minimum benefit standard, and no guaranteed offer or renewal.⁵² Only recently did it become illegal in Connecticut for insurers to cancel policies for members who had faithfully paid premiums often for years, when they became ill.⁵³

Connecticut's attempts to offer affordable coverage for those left out of the private market have not been very successful. Connecticut's high risk pool, offering coverage to those denied in the private market, charges rates between 150 and 200% of average premiums. Premiums for a couple in their early fifties this year are \$1,616.65 per month.⁵⁴ The new Charter Oak program designed to cover Connecticut's uninsured, while keeping premiums at a monthly maximum of \$259 per person, includes significant deductibles, coinsurance and co-pays. Charter Oak does not cover important services and has very few participating providers making access to care illusory.⁵⁵ Demonstrating the questionable value of Charter Oak, even though enrollment at this writing is still very low, already a "handful" of members have called the state to ask for a refund of their premiums.⁵⁶

The growing lack of affordable health insurance options will force low income Connecticut families, also facing rising energy, food and housing costs, to pay the individual mandate penalty in lieu of paying for health coverage. This lack of choice benefits no one - families pay a penalty they can't afford but still don't have coverage and Connecticut's uninsured rate is not reduced.

From 2000 to 2007, health insurance premiums for Connecticut workers grew 8.2 times faster than median earnings.

Health insurance coverage is no guarantee of access to health care services.

Most areas of the US, including Connecticut, are facing a shortage of primary health care capacity. In Massachusetts, an unintended consequence of their individual mandate is that it has deepened that shortage. Many Massachusetts residents are now paying for insurance but have to wait a year or more for an appointment for an office visit.⁵⁷ The number of Massachusetts internists whose practices are closed to new patients is up to 42% this year from 33% in 2004. To address the shortage, the state has increased spending by millions on loan repayment programs, medical school tuition scholarships, and a housing loan program to help doctors buy houses.⁵⁸ A recent study by the Massachusetts Medical Society found that the shortage of primary care physicians is growing and the specialties of family medicine and internal medicine are now in critical short supply.⁵⁹ Connecticut already faces our own primary care shortage. Four in ten Connecticut primary care physicians report a decrease in the number of their colleagues. Three in ten physicians report that it is getting harder to retain physicians in Connecticut. Average time to recruit a doctor in Connecticut is 17 months.⁶⁰

HUSKY is Connecticut's largest insurance purchasing pool covering over 340,000 low income children and their families. However, while HUSKY members have coverage, accessing care has been a constant struggle. Only half of children in the program receive check ups each year and few providers participate in the program. SAGA members, another state-run coverage program, have similar difficulties accessing care.⁶¹ Clearly coverage does not guarantee access to health care in Connecticut.

Connecticut can't afford an individual mandate.

Connecticut's state budget is facing a \$6 billion deficit for the next biennium.⁶² To responsibly implement an individual mandate would require large expenses for enforcement, consumer protection, public education, and consumer appeal resolution.

As part of responsibly administering an individual mandate, the state would have to ensure that affordable insurance options are available to every resident. Massachusetts has access to an extra \$4.3 billion in federal funds over the next three years to support the subsidies necessary for their individual mandate, through a pre-existing Medicaid 1115 waiver that was recently renewed. Massachusetts also increased cigarette taxes by \$1 per pack and appropriated another \$89 million in July to cover the expanding costs of health reforms.⁶³ Connecticut does not have access to anything approaching those funds and the growing liability of offering even modest subsidies would place huge burdens on future budgets.

The costs of enforcing an individual mandate are enormous. In response to the needs of health care reform, including the individual mandate,

Premiums in Connecticut's high risk pool for a couple in their early fifties this year are \$1,616.65 per month.

Massachusetts created a large new agency, the Connector, to administer the program. Last year the Connector engaged thirty lawyers and associated support staff across the state just to hear appeals under the individual mandate; it is not clear how many attorneys will be needed this year. The Connector has many highly paid staff to provide numerous other functions beyond enforcing the individual mandate including research and analysis, public education, outreach, consumer counseling and assistance finding coverage.⁶⁴ The Massachusetts Department of Revenue has also expanded their role significantly to enforce the individual mandate through the state tax system.⁶⁵

Enforcement costs of an individual mandate are high for state government, but costs to businesses are also considerable. For example, businesses must determine if the coverage offered to employees meets state standards and provide employees with certificates to that status. The certificates are needed to demonstrate at tax time that the employees have complied with the individual mandate. Millions of Massachusetts workers were given certificates of creditable coverage last year by their employers to include with their state tax return. Many did not recognize that certificate as important and did not retain it. As April approached, human resource departments were swamped with calls from workers needing replacement certificates.⁶⁶

Beyond the direct costs of enforcement and subsidies, future liability of those costs, the costs of expanding primary care capacity to meet the increased demand, necessary increases in Connecticut's bureaucracy to regulate insurance and the on-going need for a safety net are likely to be significant and well beyond Connecticut's means.

An individual mandate would be difficult to enforce.

Designing a fair penalty in Connecticut for not buying health insurance would involve many difficult decisions. Options include fees, higher taxes, garnishing wages, denying health care and even jailing offenders. All the options carry risks and costs.

How would non-compliant citizens be identified - at tax time, in random audits of households, by their employer? Tracking consumers through their workplace and garnishing wages would place significant administrative burdens on Connecticut businesses. Connecticut is a compassionate state and it is unlikely that policymakers would approve denying needed health treatment to people who've not bought insurance. Is Connecticut willing to jail people over this, and to pay for their incarceration which would, ironically, get them health coverage without paying for it?

Enforcement through taxes, as in Massachusetts, is retroactive and is less effective as a deterrent, assessing the penalty months or even a year after the

"crime". In April, when a consumer has to find the money to pay a tax penalty for being without coverage the previous year, he has no incentive or funds to start buying insurance then. Enforcement through taxes would also leave out the thousands of Connecticut residents who do not pay state income taxes. And if unlucky enough to be audited, how would low income uninsured Connecticut families pay a lump sum tax penalty?

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Mental illness and homelessness are just two of the barriers that would make it difficult to hold people accountable for complex health insurance decisions required by a mandate. States have been successful in enforcing child support for only 41% of children awarded support.⁶⁷

An individual mandate is not the best way to improve overall health.

Twenty two thousand Americans die each year due to uninsurance,⁶⁸ however between 44,000 and 98,000 die annually due to medical errors just in hospitals.⁶⁹ There are many public health issues plaguing the well-being of Connecticut residents that would not be addressed by an individual mandate including obesity, environmental hazards, access to healthy food, safe opportunities to stay active, and youth campaigns to counter unhealthy behaviors, among others. Fifteen percent of Connecticut adults smoke cigarettes.⁷⁰ A 2007 state Department of Public Health program offering no-cost nicotine replacement therapy was overwhelmed with demand from 8,000 applicants and ran out of funding in three weeks.⁷¹ If Connecticut is considering an individual mandate as a means to improve our health, there is an abundance of more effective, less expensive, and more just tools readily available and desperately needed.

An individual mandate would invite legal challenges.

Requiring people to buy a product from a private company just for the right to reside in Connecticut would be an unprecedented restriction to personal freedom. Drivers are required to purchase auto insurance, but you don't have to own a car. Children have to go to school, but there is a free, public option and parents can opt out and home school their children. As the Congressional Budget Office stated, "A mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action. The government has never required people to buy any good or service as a condition of lawful residence."⁷² According to a prominent consumer rights attorney, "Forcing citizens to buy an expensive, unregulated private product is nothing less than taxation without representation."⁷³

Who benefits from an individual mandate?

Obviously insurers stand to benefit from a mandate that everyone must purchase their product and their national organization has endorsed the individual mandate.⁷⁴ Hospitals and other health care providers are also likely

to benefit since more patients with insurance, especially better paying privately insured patients, will increase demand and profits. Other winners include pharmaceutical companies and employers.⁷⁵ An individual mandate could also bring needed revenue to banks and other failing financial institutions, as consumers are forced into health savings account-based plans and accumulate medical debt from high deductibles and other cost sharing.⁷⁶

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– Congressional Budget Office

How is Massachusetts' individual mandate working? Are other states looking at mandates?

It is too early to say whether Massachusetts's individual mandate is working. In its first year (2007), Massachusetts' health care reforms cut the percentage of uninsured state residents in half. However 62,000 state residents had incomes too low to be subject to the mandate but too high for subsidies, and were still uninsured. Another 86,000 uninsured chose to pay the modest \$219 tax penalty.⁷⁷ This April tax penalties for residents without insurance coverage will rise to \$912 per individual.⁷⁸ Even though many more residents have insurance coverage and Massachusetts has impressive consumer protection standards in place, a recent survey found that 13% of residents with insurance reported that they were not able to pay for some health services in the past year, 35% of those with less comprehensive insurance and 40% of the uninsured had trouble paying bills. Not surprisingly, lower income Massachusetts residents and adults with health problems were more likely to report difficulty paying medical bills and not getting needed care due to cost.⁷⁹

Maine and Vermont both recently passed comprehensive health reforms but decided not to include individual mandates.⁸⁰ Vermont's law includes a provision that if less than 96% of state residents are insured in 2010, the state will consider an individual mandate.⁸¹

California's health care reform proposal this year included an individual mandate similar to Massachusetts'. Those reforms failed in large part because of the mandate. One Senator remarked, "I just came to the conclusion that the working people are going to end up paying for it. There's control for everybody else - the employers are protected and the insurance industry. The only group that's vulnerable is the working people."⁸²

But isn't an individual mandate critical to reforming the system?

In fact, an individual mandate does nothing to address the main problems in the current health care system. Other countries pay half or less on health care per capita than the US and get more for their money.⁸³ Requiring people to buy insurance products in our inefficient, poorly regulated insurance market does nothing to reduce costs and may make matters worse by supporting an inefficient, opaque system that hides cost drivers and incentives. An individual mandate does nothing to address the unfairness of tax breaks enjoyed by Americans who are lucky enough to have employer-sponsored health benefits.

“I just came to the conclusion that the working people are going to end up paying for it. There’s control for everybody else – the employers are protected and the insurance industry. The only group that’s vulnerable is the working people.”

– A CA Senator on his decision to vote against the reform proposal

The costs of employer sponsored health benefits are tax-deductible for both employers and workers. These tax breaks cost government about \$200 billion each year.⁸⁴ An individual mandate does nothing to realign incentives to reward quality over quantity, to reward prevention and management of chronic illness over excess utilization. An individual mandate does not support quality initiatives such as pay-for-performance or evidence based medicine. An individual mandate does nothing to promote the efficiencies of health information technology or better use of information. An individual mandate does nothing to support patient-centered care or shared decision making which not only improve outcomes but also improves compliance and personal responsibility, making us all healthier. An individual mandate does nothing to reduce medical errors or to ensure efficiency in health insurance markets. An individual mandate does nothing to promote cost benefit analysis of new, questionable treatments or to promote research to find better treatments from the lab or the field.

In fact, the considerable difficulties in implementing an individual mandate will doubtless divert attention and precious resources away from these critical reforms.

Conclusion

An individual health insurance mandate for Connecticut residents would be counterproductive. It would place people who cannot afford expensive health benefits in legal jeopardy in addition to the health care and financial risks they already face. It would be difficult and expensive to enforce. It would not further the goals of health care reform - reducing costs, improving health, enhancing value and quality of care, and promoting fairness. It would drain important attention and funding away from those improvements. Connecticut residents would be better served by attending to those critical reforms and not establishing an individual health insurance mandate.

Notes

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