Do Individual Mandates Matter?

Timely Analysis of Immediate Health Policy Issues
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Summary

How necessary are individual mandates for ensuring that all Americans have health coverage?

Many reform proposals being discussed at the state level and in the presidential campaigns include mandates that individuals must obtain health insurance. The Massachusetts reforms, for example, include an individual mandate for adults, conditional on there being an available policy that meets the affordability standards set by the state. Others would make participation in insurance programs voluntary, but create new ways to encourage people to obtain insurance.

In this brief, we delineate the reasons why an individual mandate is essential to achieving universal coverage. In so doing, we discuss why it is critical that individual mandate proposals specifically address the affordability of adequate health insurance coverage and develop fair and effective ways to enforce the mandate.

Why does an individual mandate matter?

Our contention that an individual mandate is critical to achieving universal coverage rests upon three points. First, many individuals will not choose to obtain coverage under a purely voluntary system. Second, adverse selection will occur under a voluntary insurance system. Third, it is politically difficult to redirect current government spending on care for the uninsured to offset the costs associated with new broad-based reforms unless the full population is insured.

Evidence on Voluntary Participation. There is abundant evidence that without an individual mandate a health reform would fall well short of achieving universal coverage. As part of the work that we did early in the debate over universal coverage in Massachusetts, we showed that voluntary approaches without an employer or individual mandate would only cover about 40 percent of the uninsured; adding an employer mandate would still leave about 50 percent of the uninsured without coverage.[1] We found that Massachusetts could achieve universal coverage only with an individual mandate, even when we assumed relatively generous subsidies provided to those with incomes up to 400 percent of the FPL, government-sponsored reinsurance for high-cost cases in the private nongroup and small-group (fewer than 100 workers) markets, and an organized purchasing pool.

Other analysts have reached similar conclusions. In a study that analyzed health reform options for the state of New York, the Lewin Group found that voluntary measures including a public expansion and subsidized buy-in to a state health plan reduced the number of uninsured by 29 percent. Adding an employer mandate (but not an individual mandate) to these voluntary measures reduced the number of uninsured by 36 percent.[2] In an analysis extending the Massachusetts type plan to the United States, Jon Gruber found that voluntary measures, including income-related subsidies and a purchasing arrangement, would reduce the number of uninsured by about 50 percent.[3]

Opponents of an individual mandate argue that they can come close to universal coverage with a combination of income-related subsidies, more options for purchasing affordable coverage (e.g., through purchasing pools), and administrative mechanisms for facilitating enrollment in insurance. The most recent data indicate that there are 47 million uninsured people in the United States.[4] Even if subsidies, benefits, and administrative simplifications are sufficient to reach two-thirds of the uninsured (a reach beyond what any study to date has shown for a voluntary system), this would still leave 15.5 million people uninsured. This would be admirable, but would be considerably less than full coverage, and, as health care costs and insurance premiums increase, these numbers could easily erode unless further government dollars were injected into the system.

The Implications of Adverse Selection. Under a voluntary system, the individuals who are most likely to enroll in a new subsidized insurance option or even in a new unsubsidized option that is open to all individuals regardless of health status, are those who are older and who are less healthy than average.[5] People who expect to use more medical services will value health insurance coverage more than those who do not, making them more likely to participate. And for some individuals with high medical needs who do not have access to employer-

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based insurance and who are not currently eligible for public programs, such new sources of coverage may be the only insurance option they have, given that most states do not have guaranteed issue of private non-group insurance. This will also tend to increase the average health care risk profile of those voluntarily enrolling in a new program.

Disproportionate enrollment of higher-cost individuals will increase expected average expenditures in the new plan. Because premiums are traditionally set based upon the expected health expenditures of those choosing to enroll in a particular plan, higher expected average expenditures will translate into higher premiums unless the government intervenes and either explicitly subsidizes the above-average costs in the plan or redistributes them across a broader population through another mechanism. Absent such government intervention, higher premiums would further dissuade enrollment by younger adults and the healthy, accelerating the increase in premiums. Insurance companies are also likely to be wary of participating in insurance markets where the likelihood of adverse selection is high, and low participation by insurers may dissuade participation by individuals further due to limitations on available choices.

Government financing could be used to offset all or a portion of the high costs associated with enrolling more expensive individuals in a new purchasing pool, but this would raise the public costs associated with the reform.[6] Alternatively, federal regulations of private insurance markets could be implemented that forced broader-based risk pooling across those purchasing private insurance outside of the new purchasing pool and those purchasing inside of the new pool. However, this would increase premiums for many of those remaining with their current source of health insurance coverage, creating a disincentive for the young and healthy to purchase insurance coverage from any private source, potentially causing further increases in premiums.

Conversely, if all individuals were required to purchase health insurance, policies could be put in place that spread the excess costs associated with high medical needs across the entire population. Because most individuals are healthy, each person's share of these costs would be modest. Additionally, there would be no concerns that doing so would lead to declines in insurance coverage among the healthy or that average premiums would escalate as the insured population declined over time. Voluntary measures alone provide no such protections and may lead to continued increases in financial burdens being placed upon those with the greatest health care needs.

The primary impact of a mandate will be to increase the financing burdens of younger and healthier individuals. All will find their access to health insurance and necessary medical care more stable and secure, however. This approach will tend to provide benefits for all individuals over time as they age or otherwise find themselves with substantial medical needs. In addition, young people with modest incomes can be protected from significant adverse financial consequences of this broader risk-sharing approach via income-related subsidies.

Sources of Financing for Health Reforms. Another reason for favoring an individual mandate is that it would free up current public spending that could then be used to finance expensive health care reforms. The financing for universal coverage could include funds that currently support safety net hospitals and others that provide care to the uninsured. However, voluntary measures will also be costly because, while fewer of the uninsured will be covered, those who will voluntarily participate and who will take advantage of new subsidized programs tend to be older and less healthy than average. Thus, the cost of a major voluntary expansion with generous subsidies would not be substantially lower than a plan that provides universal coverage.[7] At the same time, without universal coverage, a voluntary reform effort will have a much more limited ability to make use of the large amount of funds currently flowing from Medicare, Medicaid and other public programs to safety net providers. Safety net hospitals and clinics and other providers of care to the poor would make strong political claims that they cannot afford to give up their direct subsidies when such a large number of people would remain uncovered and thus be potential users of charity care.

The incremental cost of bringing in the additional people that would be enrolled through an individual mandate would be relatively low because these reluctant enrollees would tend to be younger and healthier than the voluntary enrollees. But the new program's political claim on existing safety net dollars that support the currently uninsured would be substantially strengthened by their incorporation.

Affordability and enforcement

As we argued above, an individual mandate to have health insurance coverage is necessary for achieving universal coverage and has important implications for average premiums and the financing of reforms. There are, however, two issues with an individual mandate that require further discussion. Initial negative reactions to an individual mandate often hinge on the notion that individuals would be required to purchase insurance coverage that they cannot afford, and that failing to do so, draconian enforcement mechanisms and penalties would be imposed. Here we address these two related concerns of affordability and enforcement.

Affordability. No individual mandate would be morally or politically acceptable if required premiums exceed an individual or family's ability to pay. Defining what is affordable for families of different economic circumstances is inherently a value judgment, however, and as of now, there is no established social consensus on what that should be. None of the candidates has yet to delineate their

perspectives on this issue. In our work, we have demonstrated the importance of taking both premiums and out-of-pocket liability into account when assessing affordability of health insurance.[8] For example, a health insurance plan may have a low premium and seem affordable to a person of modest income; however, if the low premium reflects a deductible of thousands of dollars and limited covered benefits, it would not provide affordable access to medical care for that individual when they needed it.

After considerable deliberation, Massachusetts adopted a health insurance affordability schedule that seems quite reasonable, particularly given the generosity of the benefit packages offered through their Medicaid, SCHIP, and Commonwealth Care programs to the population with incomes below 300 percent of the FPL. Children with incomes below 300 percent of the FPL can obtain comprehensive coverage at no or little cost through the state's Medicaid and SCHIP programs (MassHealth). Commonwealth Care is available to adults in the same income group who have not had access to employer-sponsored insurance in the preceding 6 months. Those below 150 percent of the FPL are not required to pay any premium; those below 100 percent of the FPL would face virtually no cost-sharing requirements, and those between 100 and 150 percent of the FPL would face very modest co-payments. Covered benefits are comprehensive and no Commonwealth Care plan includes deductibles. Premiums are charged for enrollees between 150 and 300 percent of FPL, with premiums and co-payments somewhat higher for those between 200 and 300 percent of the FPL. Those at 250 to 300 percent of the FPL would face premiums of 4 to 5 percent of income.[9]

We have shown elsewhere that, nationally, those with incomes between 200 and 300 percent of the FPL who buy their insurance through the private non-group market already spend an average of 12 to 14 percent of their incomes on premiums, or 17 to 21 percent of income when also taking into account out-of-pocket medical costs.[10] Reflecting these high financial burdens and lack of guaranteed issue of these policies, only a small percentage of people in this income range without access to other sources of insurance actually purchase coverage in the non-group market. Thus, the subsidy schedule that has been adopted in Massachusetts provides a broadly accessible insurance plan at considerably lower financial burden than is found in the nongroup market in Massachusetts as well as in the United States today. Moreover, the Massachusetts experience shows that an individual mandate with a generous definition of affordability and corresponding subsidy schedule can actually be quite progressive; that is, low-income individuals spend less as a percentage of income than higher-income individuals.

Enforcement. Enforcement is necessary in order to achieve universal coverage under an individual mandate, but it is also important as a matter of fairness to the overwhelming majority of those who already have coverage or who voluntarily comply. The first and most important step to enforcing an individual mandate is to make it easy for people to comply with it and to enroll in qualifying insurance coverage. Substantial amounts need to be spent on outreach and education. Many avenues through which people can obtain coverage will be necessary. For example, employers could be required to facilitate the enrollment of their workers even if they do not contribute to that coverage.[11] Public schools can provide assistance in enrolling families, and health care providers can provide assistance in enrolling those seeking medical care.

Ultimately, penalties are needed to ensure compliance. However, our preferred approach is that the state deem all residents to be covered and that the tax penalty serve as a way of collecting unpaid premiums. Initially, penalties should be modest as the system is put in place, initial implementation difficulties are resolved, and educational and outreach efforts take effect. Later, those not complying with the mandate could be required to pay the premium that they would have paid had they enrolled in coverage. Low-income individuals who would have been eligible for fully subsidized premiums would therefore incur no penalty, and those who would have been eligible for partially subsidized coverage would have only modest penalties.

Penalties could be assessed when people pay taxes. Insurers could be required to provide information on the insurance that people had and the dates they were covered during the year, in the same way that mortgage companies now provide information on interest payments. Failure to provide evidence of coverage would result in the imposition of a tax penalty. Massachusetts chose to make the penalty (in the second year after implementation) half of the cost of the premium, on the theory that individuals would find this an onerous burden given that they would not be provided with health insurance.

Discussion

We conclude that, absent a single payer system, it is not possible to achieve universal coverage without an individual mandate. The evidence is strong that voluntary measures themselves would leave the nation with large numbers of people still uninsured. Moreover, voluntary measures would tend to enroll disproportionate numbers of individuals with higher-cost health problems, creating high premiums and instability in the health insurance pools in which they are enrolled, unless further significant government subsidization is provided. Leaving a large number of uninsured would also mean that the government would have difficulty laying claim to the substantial amounts of current public health care funding that could be used under a mandate to offset some of the cost associated with a new program. Covering the remaining uninsured through a mandate would add healthier, lower-cost people and under a reform and allow the government to lay claim to the funds already in the system.

Notes

[1] Blumberg, L. J., J. Holahan, et al. 2006. "Toward Universal Coverage in Massachusetts." *Inquiry* 43(2): 102–21.

[2] Holahan, D., E. Hubert, and C. Schoen. 2006. "A Blueprint for Universal Health Insurance Coverage in New York." The United Hospital Fund and the Commonwealth Fund.

[3] Gruber, J. 2007. "Taking Massachusetts National: Incremental Universalism for the U.S." Paper prepared for the Hamilton Project Conference on Universal Coverage, November.

[4] Holahan, J., and A. Cook. 2007. "What Happened to the Insurance Coverage of Children and Adults in 2006?" Kaiser Commission on Medicaid and the Uninsured Issue Paper, http://www.kff.org/uninsured/upload/7694.pdf

[5] Blumberg, L. J., et al. 2006. "Towards Universal Coverage in Massachusetts." *Inquiry*, 43(2): 102-121; Holahan, J. 2001. "Health Status and the Cost of Expanding Insurance Coverage" *Health Affairs* 20(6): 279-86; Blumberg, L. J., L. M. Nichols, and J. Banthin. 2001. "Worker Decisions to Purchase Health Insurance." *International Journal of Health Care Finance and Economics* 1(3/4): 305–26.

[6] For an example of how this might be done, see Holahan, J., L. M. Nichols, and L. J. Blumberg. 2001. "Expanding Health Insurance Coverage: A New Federal/State Approach," in JA Meyer and EK Wicks, eds., *Covering America: Real Remedies for the Uninsured*, Economic and Social Research Institute, Washington, DC.

[7] Blumberg, L. J. et al. 2006. "Towards Universal Coverage in Massachusetts." *Inquiry* 43(2): 102–21.

[8] Blumberg, L. J., Holahan J, J Hadley, and K. Nordahl. 2007. "Setting a Standard Of Affordability For Health Insurance Coverage," *Health Affairs*, 26(4): w463–73.

[9] For those with incomes above 300 percent of the FPL, Massachusetts would exempt from the mandate those for whom available premiums exceed a specified share of income. Our preferred approach is for the government to pay the difference between a benchmark premium and a specified percentage of income, thus avoiding the need for exemptions from the mandate. In addition, as noted above, eligibility for Commonwealth Care is denied to those with recent employer-sponsored insurance offers, where the employer offered to contribute at least 33 percent of the cost of a single policy and 20 percent of the cost of a family policy. This type of restriction has the potential to create significantly greater financial burdens for low-income workers with employer offers than their similarly situated counterparts without such offers. Our preference is that all individuals of similar economic circumstances be treated similarly for affordability and eligibility purposes.

[10] Blumberg, L.J., Holahan J, Hadley J, and K. Nordahl. 2007. "Setting a Standard of Affordability for Health Insurance Coverage." *Health Affairs* 26(4): w463-73.

[11] See a discussion of this issue in Blumberg L.J., R. Bovbjerg, and J. Holahan. 2005. "Enforcing Health Insurance Mandates," Roadmap to Coverage Project Report, Blue Cross Blue Shield of Massachusetts Foundation, www.roadmaptocoverage.org