NEW AMERICA FOUNDATION

HEALTH POLICY PROGRAM
ISSUE BRIEF

February 2008

MYTHS ABOUT THE INDIVIDUAL MANDATE

© New America Foundation, 2008. All rights reserved.*

By Elizabeth Carpenter and Sarah Axeen**

Requiring individuals to purchase health insurance—the so-called "individual mandate"—is the subject of much debate. This fact sheet outlines why an individual mandate, coupled with low-income subsidies and insurance market reforms, is a necessary component of any proposal that seeks to cover all Americans.

MYTHS AND FACTS

Myth: If individuals choose to be uninsured, there are no consequences to society.

Fact: The uninsured increase the price of premiums for the insured and drive uncompensated care costs that taxpayers and health care providers must absorb. They place undue strain on Emergency Departments and other sources of care that impact all of us.

In 2001, uncompensated care costs were roughly $41 billion.[1] Americans pay higher premiums or a "hidden tax" equaling roughly $700-1300 per family each year to provide health care to the uninsured.[2] When medical bills go unpaid, providers attempt to recoup the lost revenues by raising rates for services. As a result, insurers raise premiums. This vicious cycle of "cost-shifting" inextricably links the uninsured to health care costs and premium rates for the insured.

Uninsured individuals place an additional burden on already over-taxed Emergency Departments (EDs). The costs associated with uncompensated care for the uninsured and underinsured has caused many EDs to close or reduce the number of emergency beds. Between 1993 and 2003, 425 emergency departments closed nationwide.[3] Median ED waiting times increased by 36% between 1997 and 2004.[4]

Myth: An individual mandate would force families to forgo other necessities in order to buy health insurance.

Fact: All existing mandate-centered reform plans include subsidies for low-income people to ensure affordability, and insurance reforms to make health insurance markets work for all Americans.

Opinions about what constitutes affordable or fair may vary. However, policymakers who have introduced reform plans that include an individual mandate—Senators Wyden, Bennett, and other cosponsors of the Healthy Americans Act, Senator Clinton, former senator Edwards, Representatives Langevin and Shays, Governor Schwarzenegger, and former governor Mitt Romney and the Massachusetts legislature—include subsidies that reach as high as 400% of the Federal Poverty Level or $84,000 for a family of four. To date, no policymaker has proposed instituting an individual mandate without addressing affordability standards and market reforms that protect consumers.

*This paper carries a Creative Commons license, which permits non-commercial re-use when proper attribution is provided. For details, please see http://www.newamerica.net/about/copyright.
**Elizabeth Carpenter is a Senior Program Associate and Sarah Axeen is a Program Associate with the Health Policy Program at the New America Foundation.*

Myth: An individual mandate is not enforceable.

Fact: Switzerland and the Netherlands have successfully enforced an individual mandate to purchase health insurance.[5] Similarly, some American states have achieved close to 100% compliance with a mandate to purchase car insurance.[6]

Enforcement methods in a U.S. context could include:

Information sharing: Electronic information sharing between insurance agencies, insurance companies, and government agencies would allow insurance administrators to systematically review and monitor enrollment. Increased information sharing would also help identify people who are eligible for public or subsidized coverage but who are not enrolled.

Proof of insurance on tax returns: Many uninsured Americans could be identified through the tax system. While we recognize that not all low-income individuals file tax returns, this could be a useful mechanism to identify middle- and high-income uninsured Americans.

Auto-enrollment/insurance checks at point of service: Individuals who do not sign up for their own insurance (or if eligible enroll in a government program) would be automatically enrolled in a health plan by an insurance administrator. When they seek medical care from a doctor, hospital or clinic, their insurance status would be checked. If they have not paid their premiums, that will be reported to the appropriate government agency. A payment schedule would be set up, based on the uninsured person's income and ability to pay, to catch up on overdue bills. This process would not impede access to care.

When these strategies are combined and integrated effectively, considerable evidence suggests a mandate is enforceable.[7]

Myth: An individual mandate is not necessary to ensure that all Americans have health insurance coverage.

Fact: Many Americans who are eligible for public insurance at little to no cost do not enroll, while others who could afford private health insurance choose not to buy. This suggests a mandate is necessary to approach 100% enrollment.

While more Americans would buy health insurance if it were affordable, several economists have suggested that a plan that institutes generous subsidies and insurance market reforms will cover no more than half of the uninsured.[8] According to research by the Urban Institute, more than 15.5 million people would still be uninsured under a system with generous benefits, subsidies, and sufficient administrative simplification – but no mandate.[9] In addition, researchers have found that when combined with affordable insurance, a mandate that is easy to comply with and enforced appropriately is likely to be highly successful.[10]

Myth: An individual mandate will stifle market competition.

Fact: An individual mandate, coupled with insurance market reforms and subsidies, would make markets work more effectively and efficiently. By reducing the risk of adverse selection, an individual mandate would force insurers to compete based on price and quality, not underwriting and marketing.

More than half of the uninsured population is under age 34.[11] Bringing everyone into the insurance marketplace will make the risk pool healthier, reducing the incentive for insurers to charge higher rates in order to protect themselves against adverse selection. Introducing this younger population into the risk pool and reforming the marketplace so that it works for all Americans (not just the healthy and wealthy) would reward insurers for delivering high-value care. In order to reduce health care costs over time, we must encourage this type of high value per dollar health coverage.

[1] Jack Hadley and John Holohan, "The Cost of Care for the Uninsured," *Kaiser Family Foundation*, (2004).
[2] In Len Nichols and Peter Harbage, "Estimating the Hidden Tax," *New America Foundation*, (2007), the authors estimate a 6-11% hidden tax from uncompensated care. Applying this number to the cost of the average family health insurance plan yields a range of $700-$1300 in increased premiums per family. Average health insurance plan costs are from: Gary Claxton, et al., "Employer Health Benefits 2007 Annual Survey," *Kaiser Family Foundation* and *Health Research and Educational Trust*, (2007).
[3] Institute of Medicine, *Hospital-Based Emergency Care: At the Breaking Point*, (Washington, D.C.: National Academy Press, 2006).
[4] Andrew P. Wilper, et al., "Waits to See an Emergency Department Physician," *Health Affairs* 27 (2008).
[5] Sherry Glied, Jacob Hartz, and Genessa Giorgi, "Consider it Done? The likely efficacy of mandates for health insurance," *Health Affairs* 26, no. 6 (2007
[6] Peter Harbage, "What Your Car Can Teach You About Health Insurance," *New America Foundation*, (2007).
[7] Sherry Glied, Jacob Hartz, and Genessa Giorgi, "Consider it Done? The likely efficacy of mandates for health insurance," *Health Affairs* 26, no. 6 (2007) and Len M. Nichols and Peter Harbage, "Coverage without Gaps," *New America Foundation, (2007).*
[8] Jonathan Gruber, Len M. Nichols, Mark V. Pauly, „Health Debate Reality Check," *New America Foundation,* (2007).
[9] Linda J. Blumberg and John Holohan, "Do Individual Mandates Matter?" *The Urban Institute*, (2008).
[10] Sherry Glied, Jacob Hartz, and Genessa Giorgi, "Consider it Done? The likely efficacy of mandates for health insurance," *Health Affairs* 26, no. 6 (2007).
[11] Sarah Axeen and Elizabeth Carpenter, "Who are the Uninsured?" *New America Foundation* (2007).

CONTACTS

Sarah Axeen and Elizabeth Carpenter
New America Foundation
Health Policy Program
1630 Connecticut Ave, NW 7th Floor
Washington, DC 20009
202.261.6547
axeen@newamerica.net and carpenter@newamerica.net