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The Role of Individual Mandates in Health Care Reform

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In April 2006 Massachusetts became the first state in the nation to mandate that all adults purchase health insurance (subject to some limitations discussed below). This development set off a fierce debate over the role of individual mandates in health reform, particularly between leading Presidential candidates. The Massachusetts experience is being carefully watched, and interest in individual mandates continues to be high. Several national reform proposals include an individual mandate, and a number of states have considered moving in this direction as well.

Yet much of the discussion of mandates has occurred without a careful consideration of the evidence supporting arguments for and against them, without discussion of their nuances in practice, and without a review of the available evidence on their effectiveness. In this essay I review all three of these topics.

Why Mandate?

There are four primary arguments in favor of an individual mandate. The first is that it is impossible to achieve universal health insurance coverage without such a requirement since many uninsured are already offered subsidized coverage or could afford to pay full cost, yet opt not to obtain coverage. Recent estimates suggest that a plan without a mandate would be unlikely to cover more than half of the uninsured.¹

Second, individuals who choose to remain uninsured impose major costs on the rest of society since these individuals generate about \$30 billion per year in unpaid hospital bills and those costs are passed on to the insured.² This “free riding” on the system uses funds that could be more efficiently devoted to covering the uninsured before they are sick.

Third, the ability of those in better health to opt out of risk pools in the absence of mandates means that insurance prices rise for those in

poorer health, leading to an “adverse selection” spiral that destabilizes the market. This consequence is particularly important in the context of proposals that attempt to improve access to health insurance by restricting the ability of insurers to price discriminate on the basis of health. Such community rating necessarily leads to higher prices for the healthy. Without a mandate the healthy may choose to not participate in insurance markets, rendering the reform ineffective.

Finally, there is a simple paternalism argument: many of these “voluntarily uninsured” may not appreciate the health risks they face and the value of holding at least catastrophic insurance coverage. A mandate for a minimum level of insurance coverage can make these individuals better off.

Why Not Mandate?

Opposition to a mandate is also based on four grounds. First, from the perspective of individual liberties, opponents argue that the government does not have the right to force individuals to purchase insurance. Second, many young and healthy consumers today obtain low prices in the individual health insurance market, and a mandate may significantly increase their prices if they are forced into an insurance pool with older, less healthy people. That is, in some respects a mandate is a “tax on the healthy” to cross-subsidize the costs of the sick.

Third, a mandate may end up being unfair and very difficult to administer. In particular, requiring individuals to purchase insurance will be unworkable without sufficient subsidies to make insurance affordable for lower-income Americans. The typical group insurance policy in the U.S. for a family costs roughly \$12,000 per year; for a family at two times the federal poverty level (about \$40,000), this is 30 percent of their family income for the premiums alone. Many are concerned that an individual mandate

will put pressure on families to pay more than they can reasonably afford.

Finally, we have no long-run experience with a health insurance mandate in the U.S., so concerns remain that it will not be nearly as effective as proponents suggest. Indeed, the mandate in Massachusetts is still not universal. If we will end up far away from universal coverage even with a mandate, then the political battle over the mandate may not be worthwhile.

The Practical Nuances: Design and Implementation Challenges

Any effort to establish an individual mandate will face four critical design and implementation decisions (Figure 1): (1) defining affordability; (2) defining the mandated minimum benefit package; (3) determining eligibility for subsidized coverage; and (4) establishing enforcement mechanisms. Here I describe how Massachusetts has dealt with each challenge.

Defining Affordability. The task of defining affordability was left to the Connector Board, the expert board in charge of implementing the legislation (of which I am a member). After considerable debate, it was decided that coverage will be fully subsidized through the state’s “Commonwealth Care” program for those with incomes below 150 percent of the federal poverty level (FPL) and not having access to employer-sponsored insurance (ESI), and would be heavily subsidized for those with incomes between 150-300 percent of FPL. The mandate applies to all individuals in this subsidized range and to all individuals above median income in the state (about \$50,000, or five times the poverty line, for an individual). For individuals between 300 to about 500 percent of FPL, an affordability schedule dictates the maximum amount that they would have to pay for insurance before being exempted on affordability grounds. Since

insurance is age rated above three times poverty, this provision means that most young persons in this income range are mandated, but few older persons are. Roughly 15 percent of the uninsured are estimated to be exempt from the mandate due to this schedule. Whether this affordability standard is sufficiently (or too) generous is subject to debate.³

Defining the Mandated Minimum Benefit Package. There is an important tradeoff in deciding what minimum level of insurance will be mandated. A minimum must provide “real insurance” or the mandate will be meaningless, but a minimum that is too generous can be very expensive for individuals and raise resistance to the mandate. Moreover, defining a generous minimum may mean dictating that some existing policies are inadequate, creating opposition to the mandate among holders of those policies.

In Massachusetts the minimum benefit package features (a) no allowable limits on care per visit or per year (although lifetime limits remain), (b) coverage for inpatient and outpatient services and prescription drugs, (c) a maximum deductible of \$2000 per individual, and (d) a maximum out-of-pocket limit of \$5000 per individual. Since Massachusetts originally had very generous insurance coverage, this minimum ruled out only a small share of existing policies. Nonetheless, it is still viewed as too generous by many, in particular with respect to required coverage for prescription drugs. Defining the minimum benefit package is even more difficult in a state like California, where high deductible coverage is already much more widespread; in that case Governor Schwarzenegger’s proposal of a minimum policy with a \$5000 deductible was widely criticized as being too limited, but a more generous policy would have ruled out a very large number of policies already being sold in the state, further raising opposition to the reform.

Regulating Access to Subsidized Coverage. In Massachusetts those with access to employer coverage are not eligible for state subsidized coverage through Commonwealth Care, which leaves many low-income individuals required to make contributions for their employer’s coverage that greatly exceed what they would pay for Commonwealth Care. There are four potential solutions to this problem in the mandate context: (i) waive these individuals from the mandate (but don’t help them with any subsidies); (ii) permit all low-income people to access Commonwealth Care, even if they are offered ESI; (iii) require these people to stay in the employer system, but subsidize their ESI premiums so they equal the cost of coverage through

Figure 1. Critical Design and Implementation Decisions

Defining Affordability

- What subsidy structure will be used to assist low-income persons?
- Will any groups be exempt from the mandate on affordability grounds?

Regulating Access to Subsidized Coverage

- Will low-income workers with access to “unaffordable” employer coverage be permitted to access state-subsidized coverage?
- If not, are they still subject to the mandate?

Defining the Mandated Minimum Benefit Package

- How will the desire to provide meaningful coverage be balanced against concerns about costs of generous benefit packages and worries about deeming some existing policies unacceptable?

Enforcing the Mandate

- What penalties will be imposed?
- What administrative mechanisms will be used to facilitate compliance and verify coverage?

Commonwealth Care; or (iv) allow those with ESI into Commonwealth Care, but only if they bring their employer contribution as a “voucher” to offset state costs. For now, Massachusetts has chosen the first of these options, which has resulted in an estimated 30,000 individuals being waived from the mandate. The Connector Board is debating a move to the “voucher” option, but the additional costs have so far been a barrier to implementation.

Enforcing the Mandate. Starting in 2008 individuals who are without qualified coverage are subject to a penalty of one-half the cost of the least expensive policy in the state. For those in Commonwealth Care, this penalty represents a modest charge; for those outside the public system, this amounts to at most \$912 per year. The mandate is enforced through a tax penalty due to the Department of Revenue, and lack of payment is penalized as tax evasion. The size of the penalty was subject to some debate, and it is unclear if it is large enough to enforce compliance.

Do Individual Mandates Work?

The early returns from Massachusetts on the effectiveness of the mandate (coupled with the other components of the state’s reform package) are very promising. As of the middle of 2008, 440,000 individuals have gained insurance coverage in Massachusetts, which is at least two-thirds of the ex-ante base of uninsured. Forty percent of those are in the heavily subsidized Commonwealth Care program, but another 44 percent are new purchasers of private insurance, mostly obtained through employer-sponsored coverage, which has risen by 160,000 persons. This “crowd-in” of employer-sponsored insurance stands in stark contrast to predictions of “crowd-out” for the newly subsidized public program, and credit clearly lies with the individual mandate that has caused individu-

als to enroll in employer insurance. Use of uncompensated care has fallen by almost half in the state, and public support remains high and growing.⁴ Early evidence clearly suggests that the mandate “works.”⁴

The Massachusetts experience also illustrates, however, that we cannot cover the uninsured for free. The costs of this program have been high, with a budgeted \$869 million for FY 2009. This amounts to costs of only \$2000 per person, which is quite low compared to typical estimates of the cost of expanding insurance coverage.¹ Yet this figure is large relative to the state budget, and cost pressures will be a key consideration for the state going forward.

Conclusions

The one thing that is certain about the debate over individual mandates is that the issue is not going away. There are very strong feelings and very strong positions on both sides of the debate, and little long-term evidence that can be brought to bear to close the gap between the sides. Continued attention to evidence generated by the ongoing experiment in Massachusetts will be important as the nation considers a mandate at a national level. ■

1 See, for example, Gruber J. “Covering the Uninsured in the U.S.,” *Journal of Economic Literature*, 46(3), September 2008, 571-606.

2 Gruber J and D Rodriguez, “How Much Uncompensated Care Do Doctors Provide?” *Journal of Health Economics*, 26, December 2007, 1151-69.

3 See, for example, Greater Boston Interfaith Organization (2007). “Mandating Health Care Insurance: What is Truly Affordable for Massachusetts Families?,” mimeo, GBIO and Gruber J. (2007). “Evidence on Affordability From Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance,” mimeo, MIT.

4 All facts on Massachusetts’ implementation are from a presentation to state stakeholders by Jon Kingsdale, Executive Director of the Massachusetts Health Insurance Connector, on September 15, 2008.