



# Health Policy Brief

September 29, 2009

## **Individual Responsibility:** Should Congress require that most Americans have health insurance — and that they be subject to penalties if they don't?

### What's the issue?

The leading health reform bills in Congress would impose a national individual mandate requiring most Americans to have health insurance. New standards would be set to determine “acceptable” minimum coverage and spell out how much people needed to contribute out of their own pockets. Coverage could be obtained in various ways, including through employers, through government health programs, or through new federal or state health insurance exchanges. Subsidies would make coverage more affordable for low- and moderate-income people, and insurance market reforms would make coverage more reliable. Penalties, most likely in the form of a tax, would be imposed on individuals who had not obtained coverage or who were not exempted from the requirement for various reasons.

For supporters, including President Barack Obama — who explicitly endorsed the individual mandate in a speech to a joint session of Congress on September 9, 2009 — the individual mandate

is an essential part of national health reform. Requiring everyone to have or to contribute toward health insurance is viewed as central to reducing the number of uninsured people. Health insurers also regard an individual mandate as a critical element of a package of reforms that would require them to abandon some practices and meet new requirements.

Opponents of an individual mandate object for different reasons. Some who are or lean libertarian consider the proposal a coercive move by government. Others object to the fact that the mandate would force many people to spend a sizable portion of their incomes on health insurance — perhaps for coverage that is not especially generous. Still others consider an individual mandate unenforceable.

As described below, a number of technical aspects of a mandate would be critical to determining how well it would either accomplish supporters' goals for coverage or feed opponents' fears about the cost burden that will be imposed on many.

**“In 2006, Massachusetts became the first state in the nation to require all residents 18 and older to have health insurance.”**

### What's the background?

This is not the first time an individual mandate has been proposed at the national level in the United States. The concept was put forward in 1993 as part of the Health Security Act, the national health reform legislation proposed by then-President Bill Clinton. It was also the centerpiece of alternative reform proposals, such as that proposed by Rep. Jim Cooper, then representing Tennessee's 4th District.

The concept died with the collapse of health reform efforts in 1994, but it surfaced again during the 2008 presidential campaign, when it was a subject of debate among Democratic candidates. Then-New York Senator Hillary Clinton proposed an individual mandate as part of her plan. Then-candidate Obama proposed a mandate requiring parents to make certain their children were covered, but said an individual mandate was not part of his initial plan. However, he said an individual mandate could be considered following implementation of major health reform if it were deemed necessary to expand coverage.

In 2006, Massachusetts became the first state in the nation to require all residents age 18 and older to have health insurance. The state also enacted several other measures to expand coverage in other ways and to facilitate compliance with the mandate.

The mandate, which took effect in 2007, includes these key provisions:

- Residents must confirm on their state income tax forms that they have insurance, unless their incomes, or other factors including access to employer coverage, are such that they are deemed unable to obtain “affordable” coverage. The affordability levels are set each year by a newly created, independent, quasi-governmental agency called the Commonwealth Health Insurance Connector. Hardship waivers are also available for people who arguably have access to affordable coverage but can't afford it for particular reasons.
- The Connector also serves as an intermediary, helping individuals and small businesses acquire health coverage. The coverage must meet certain benefit standards that, among other things, specify the types of benefits that must be included in policies. Through the Connector, individuals, depending on their income

level, can qualify for state-subsidized health coverage or purchase private health insurance products certified as providing high-quality health coverage. These offerings include new low-cost plans for 18-to-26-year-olds, with lower benefits, cost sharing, and benefit maximums as low as \$50,000.

- Individuals who are subject to the requirement but do not comply must pay penalties equivalent to a portion of the costs of health insurance. In 2009, the maximum penalty is \$624 for 18-to-26 year-olds and \$1,068 for those age 27 and older.

The Massachusetts law has other features, including a requirement that employers with 11 or more workers either contribute to employees' health insurance or pay a penalty. It is widely agreed that the individual mandate has been a key reason that the uninsurance rate among non-elderly Massachusetts adults has fallen from 7 percent in 2007 to an estimated 2.6 percent, according to an Urban Institute study conducted for the Massachusetts Division of Health Care Finance and Policy. In part, the mandate appears to have prompted more workers eligible for employer coverage to enroll in the coverage offered to them.

A number of other states, including California, Maryland, Maine, and Washington, have also considered individual mandates but not adopted them. And several European countries have also enacted individual mandates, often in the context of major health reforms. Switzerland adopted an individual mandate in 1996. Strict penalties enforced by the Swiss cantons, or provinces, are imposed on those who do not purchase health insurance for infants within three months of birth or after moving to Switzerland. The Swiss mandate has helped achieve a 99 percent compliance rate. The Netherlands in 2006 mandated that individuals purchase health insurance or face a penalty of 130 percent of premiums. Early reports from the first year of implementation suggest that 98.9 percent of residents enrolled in health insurance.

### What's proposed?

An individual mandate is a key component of all three major legislative health reform proposals now under consideration in Congress. But at the same time, a mandate is only one part of complex reform plans in which the various pieces are to a large extent interdependent.

For example, if policymakers decide there should be an individual mandate, they must also decide what type or amount of coverage people must have. Another issue is whether an individual mandate applies to adults only or also to children — and who can be exempted from the requirement for religious or other reasons.

What's more, since not everyone will be able to afford the full costs of coverage, policymakers must decide what, if any, financial or other assistance will be available to help people buy it. There are also questions about what the penalties for not obtaining coverage will be, as well as the method of enforcement. If penalties are imposed through the tax system, for example, people who don't file taxes could in effect escape the requirement.

Each of the leading congressional proposals addresses these questions in somewhat different ways, as described below.

### The House bill

As this brief is being published, the majority in the House of Representatives is finalizing its version of the House bill, the America's Affordable Health Choices Act of 2009 (HR 3200). Three different versions were approved by three House committees during the summer of 2009.

All versions of the Tri-Committee bill, as it is known, would have an individual mandate — a requirement that individuals and their dependents have so-called acceptable coverage. This would include coverage under Medicare, Medicaid, military health insurance, or the Veterans

Health Administration; an employment-based plan; a new public health insurance plan, as set forth in the bill; or any other “qualified health benefits plan” that includes at least an “essential benefits package.” The legislation lists broad categories of benefits that would have to be included, such as physician and hospital services, but the specifics would be determined by the secretary of health and human services (HHS).

The House bill includes a number of measures designed to help people obtain coverage. Large employers would be required to offer coverage (see Health Policy Brief, “[Shared Responsibility](#),” August 13, 2009). New tax credits would go to small, low-wage businesses to help them pay for workers' coverage. The bill would also provide Medicaid coverage to anyone with incomes under 133 percent of the federal poverty level, which in 2009 is equal to \$14,404 for an individual and \$29,327 for a family of four. (For more, plus a table showing incomes at different multiples of the federal poverty level, see Health Policy Brief, “[Coverage for Low-Income People](#),” July 24, 2009.)

The bill would also provide subsidies for those with incomes too high to receive Medicaid but under 400 percent of the federal poverty level (in 2009, this is \$43,420 for an individual and \$88,200 for a family of four). These subsidies would help people purchasing private health insurance coverage or the new public option through the proposed new national Health Insurance Exchange. Employers would also be required to offer coverage to their employees or pay a penalty. If the employment-based insurance costs workers more

#### EXHIBIT 1

## Key Features of Individual Mandate Proposals

Provision	House bill	Senate HELP Committee bill	Senate Finance Committee bill
Exemptions	Those demonstrating financial hardship; Native Americans; those with religious objections (e.g., Christian Science).	Same as House bill, except Native Americans would only be exempt if states don't establish a separate exchange for them. Also, if coverage is unaffordable because lowest premium available exceeds 12.5% of income. Those without coverage for fewer than 90 days.	Same as House bill. Also, if coverage is unaffordable because lowest premium available exceeds 10% of income.
Penalties	Maximum is 2.5% tax on income, not to exceed average national premium for basic coverage.	\$750 annual tax penalty.	Annual tax penalty of \$750 for individuals at 100%–300% of federal poverty level (\$1,500 maximum per family); \$950 (\$1,900 per family) for those with higher incomes.

**“Marketplace reforms and consumer protection provisions would make it easier for individuals to obtain coverage.”**

than 12 percent of their income in the second year of the mandate, they could qualify for tax credits to buy coverage through the exchange instead.

The bill’s marketplace reforms and consumer protection provisions would also make it easier for individuals to obtain coverage. For example, insurance companies could not reject applicants because of their pre-existing health conditions. Limits would be placed on how much companies could vary the premiums charged to policy holders based on age, family size, and location.

Certain people could claim and obtain exemptions from the mandate — for example, on religious grounds or financial hardship — and Native Americans would be automatically exempt. People could also claim and obtain exemptions because insurance was unaffordable, although the legislation is silent on specifics of how this exemption would work.

For everyone else who could not prove having “acceptable coverage,” there would be penalties. These would consist of a 2.5 percent income surtax, not to exceed the cost of the average national premium for individual or family basic coverage.

To facilitate enforcement of the mandate, all entities that provided “acceptable” coverage to any individual or family would have to report that information annually to the U.S. Treasury Department. This is similar to current law requiring companies to file W-2 forms with the IRS indicating how much they have paid to employees in wages, salaries, and any taxable benefits.

#### **The Senate HELP Committee bill**

In July 2009, the Senate Health, Education, Labor, and Pensions (HELP) Committee approved the Affordable Health Choices Act. This proposed legislation would also require all individuals to have health insurance described as “minimum qualifying health coverage.” The HHS secretary would determine what constitutes this coverage, but the bill says that basic benefits would be covered, such as physician and hospital services as well as services for mental health and substance abuse.

As with the House bill, exceptions would be allowed. People for whom minimum qualifying health coverage was not deemed affordable, or who were suffering financial hardship, would

not have to comply. Coverage would be considered unaffordable if it cost more than 12.5 percent of the individual’s adjusted gross income; definitions of what constitutes financial hardship would be drawn up by the HHS secretary with input from a newly created Medical Advisory Council. Also initially exempted would be people in states that are not “participating” in a new national Health Insurance Exchange, or “gateway,” or that had not yet established their own state exchange. Native Americans would be exempted from the mandate, as would those who were without coverage for any reason for fewer than 90 days.

Those subject to the mandate, but who neglected to comply, would have to pay a tax penalty. The legislation doesn’t offer a detailed description of how this penalty would be determined but says that it could be no more than \$750 a year.

Like the House bill, the HELP Committee bill includes measures to encourage people to obtain coverage and, in many instances, to make it more affordable for them. It would require employers to provide coverage to their employees or pay a penalty. And it would also offer subsidies for individuals and families with incomes up to 400 percent of the federal poverty level for plans purchased through the new national gateway or state gateways. The HELP Committee bill would also make it easier to obtain coverage by providing consumer protection measures limiting how much health insurance premiums could vary based on age, location, family size, and tobacco use. It would also forbid variations in pricing because of sex, type of employment, or past medical claims.

#### **The Senate Finance Committee bill**

As of publication of this brief, this bill is being finalized by the committee. It includes a “personal responsibility requirement” for obtaining health insurance, either on one’s own or through an employer or government program. Language in the proposal would allow the mandate to be waived in a state if it meets certain coverage levels and achieves certain cost containment goals.

As in the House and Senate HELP Committee bills, the individual mandate in the Finance Committee bill would work in tandem with other provisions to spread coverage. Medicaid would be expanded to anyone with income under 133 percent of the federal poverty level. Tax credits would

**“Refundable and ‘advanceable’ affordability credits would help people with low and moderate incomes.”**

encourage small, low-wage businesses to provide coverage, while other incentives would encourage large employers to offer coverage as well.

For other people who are uninsured, coverage could be purchased through national or state health insurance exchanges. The draft unveiled by Senate Finance Committee chairman Max Baucus (D-MT) would establish four types of health plans that insurers could offer, with benefit levels ranging from low to high. These plans would have to provide at least a basic set of services, with no limit on annual or lifetime benefits. There would be no copays or other cost sharing for most preventive care. In addition to the four plan types, adults ages 18–25 could purchase a plan that would cost less and cover only catastrophic health expenses, with cost sharing for preventive care.

Other rules similar to those in the House bill would also make it easier to get and keep private health insurance coverage. Insurers offering coverage in the individual market could not impose pre-existing condition restrictions. Coverage would have to be offered to all interested buyers; coverage could not be rescinded after the policy holder became ill. Companies could raise premiums only up to certain limits because of a member’s age, tobacco use, family size, or location.

**Subsidies:** To help ensure that individuals can afford to comply with the mandate, the Senate Finance Committee bill also provides subsidies. These so-called affordability credits, or tax credits, would go to people with low and moderate incomes who did not have employment-based coverage and who bought insurance through an exchange. The credits would be refundable, so that those who didn’t owe taxes would still get assistance; they would also be “advanceable,” so that people could obtain them at the time coverage was purchased rather than after the fact.

Starting in 2013, the tax credits would be available on a sliding-scale basis to offset the cost of premiums for individuals and families with incomes of 134–300 percent of the federal poverty level. People with the lowest incomes would be eligible for the largest credits, based on the percentage of income that the cost of insurance represents, from 2 percent up to 12 percent. As of 2014, the credits would also be available to people with incomes of 100–133 percent of poverty, so that they could opt out of Medicaid coverage and into private health coverage if they chose.

In addition to tax credits, subsidies to defray out-of-pocket expenses would be available for those with incomes of 100–300 percent of poverty. Out-of-pocket spending for those with incomes of 200–300 percent of poverty would also be limited and subsidized. In 2010, individuals and families in that category would have to pay no more than \$3,987 out of pocket for individuals, or \$7,973 for families.

The draft Finance Committee bill contains penalties for those who do not comply with the individual mandate. With some exceptions, most people who do not have health coverage would pay an excise tax starting in 2013, based on their income. For taxpayers with incomes of 100–300 percent of the federal poverty level, the penalty could be no more than \$750 for individuals and \$1,500 for families. For taxpayers with incomes above 300 percent of the federal poverty level, penalties would be capped at \$950 for individuals and \$1,900 for families.

The mandate would be waived for individuals under certain circumstances. These include situations in which the lowest-cost plan exceeded 10 percent of an individual’s or a family’s income or when an individual’s or family’s income was below 100 percent of the federal poverty level. Also exempt would be people with certain religious beliefs, undocumented workers, or people experiencing some level of financial hardship.

### What’s the argument?

**In favor of an individual mandate:** Supporters make two primary sets of arguments in favor of requiring most Americans to have health insurance. One set of arguments is primarily economic and market-oriented; the other is primarily ethical and moral.

In the first category, supporters argue that an individual mandate is key to having America’s hybrid public-private system of health coverage function as effectively as possible. Health insurance markets work best, they say, when everyone is insured. This is because the risk of high medical expenses for a relative few is spread among a large and diverse group of healthy people. These healthier individuals pay premiums regularly and may or may not be filing claims, in contrast to sicker enrollees who are filing claims regularly. In effect, premium dollars are shared across the healthy and sick alike. This is considered fair because, no mat-

ter what one's health status is at a given moment, many if not most people will ultimately need some form of medical treatment.

**Free riding and adverse selection:** In the absence of a requirement to buy coverage, some healthy people tend not to buy it, believing that they won't need it if they are not sick. This is a phenomenon known as "free riding." Because many of these people become ill and are treated anyway, the costs of their care are often shifted to insured populations in the form of higher premiums. By contrast, the sick may be more inclined to try to obtain coverage because of greater confidence that they'll use it — a phenomenon known as "adverse selection." Both of these phenomena can conspire to force insurers to raise premiums drastically or cancel coverage. That's because, with primarily sick people enrolled, insurers would need to charge exorbitant premiums to cover costs. Otherwise, an insurer would end up paying so much in the way of claims that it would eventually become insolvent.

These are not theoretical propositions; both phenomena have actually occurred. As evidence of at least some population of "free riders," some analysts point to the fact that according to the Census Bureau's Current Population Survey, about 9.1 million people in households with incomes of \$75,000 or more did not have coverage during 2007. Presumably many of them could have afforded insurance, although the coverage may not have been especially generous and may have cost a sizable share of their incomes. Similarly, there have been documented instances in which adverse selection was leading to "death spirals," forcing health insurers to close entire books of business.

An individual mandate would eliminate these problems of adverse selection and free riding, supporters say. With nearly everybody, sick and healthy alike, in the health insurance "pool," insurers could also eliminate practices that many find reprehensible. These include "rescissions," cancellations of coverage after enrollees submit claims for illness; "medical underwriting" that leads to dramatically higher premiums for sicker individuals; or specific exemptions written into some insurance policies that exclude coverage for treatment of "pre-existing" medical conditions.

In fact, the leading health insurance trade group, America's Health Insurance Plans (AHIP), has told both Congress and the White House

that it will agree to new regulations barring these practices if the legislation also includes an individual mandate. That way, people couldn't wait until they got sick to sign up for coverage. Not only would such changes be desirable from the standpoint of creating a functional insurance market, supporters argue; they are also required by social justice and moral fairness.

Supporters further contend that an individual mandate would be reasonable because it would be accompanied by resources that would help individuals comply with it. Health insurance exchanges would make it easy for people to shop for coverage. Subsidies would be provided to millions to make coverage more affordable. Medicaid would be expanded to cover more low-income people who don't currently qualify for the program. Under a simulation of these latter two measures — subsidies and Medicaid expansion — modeled by researchers from the Urban Institute, approximately three-quarters of the nation's uninsured people would be covered.

Finally, supporters expect that the individual mandate would affect only a minority of Americans who currently lack health insurance. Nearly three in five Americans under age 65 are already covered by employment-based health insurance; senior citizens and the disabled already have Medicare; and, as noted above, Medicaid expansion would cover many of the remaining uninsured people. Arguably, the group most affected by the individual mandate would be uninsured people with incomes higher than four times the federal poverty level (in 2009, about \$88,000 for a family of four), who would receive no subsidies for coverage. The Urban Institute analysis shows that this group numbers fewer than 10 percent of the uninsured, or about 4 million people.

**Against an individual mandate:** A key argument against the requirement is that it would be an infringement by government on personal freedom and further extend the hand of government into health coverage and care. "Mandates have no place in a free society," Rep. Mike Burgess (R-TX), a member of the House Energy and Commerce Committee, said after voting against HR 3200 in committee.

Other opponents of an individual mandate say it's simply unreasonable to compel people to buy insurance that they clearly consider unnecessary or less important than other things they want.

**"Insurers could eliminate practices that many find reprehensible, including cancelling coverage after enrollees submit claims for illness."**

**“There are concerns that the mandate would be overly burdensome or that subsidies wouldn’t make coverage affordable.”**

Just because a mandate has succeeded in Massachusetts, many add, doesn’t mean that it would fly in other states with different political cultures or approaches to health reform.

Still others say that, in combination with other provisions of health reform, the mandate would be overly burdensome on many people. There are concerns that the subsidies proposed in various bills still won’t be enough to make mandated health coverage affordable for many people. Thus, millions of people could be compelled to purchase coverage with inadequate or no assistance from government to buy it. What’s more, requiring some moderate-income people to spend as much as 12 percent of their incomes on health coverage, as the bills under consideration would do, is simply unfair, these opponents of a mandate contend. Others worry that when the required benefit package was ultimately established, it’s likely the benefits would be generous and the cost of the package high. Furthermore, opponents argue that even if the mandate were initially linked to a basic, low-cost plan, there would be constant pressure to expand the scope of benefits.

There are also questions about how an individual mandate for a minimum benefit package would be implemented, since health care costs and utilization vary widely across the country. Opponents say it would not be fair to require the same amount of insurance nationwide when the cost is not the same. If states make these determinations, one could require less coverage than another, as is the case with optional Medicaid benefits, which can vary from state to state.

**Questioning the need for a mandate:** Some experts don’t necessarily oppose an individual mandate, but they question the need for it, depending on other provisions of health reform legislation. If insurance in a reformed system represented a “good buy” for people, they say, a mandate would not be necessary, because most people would elect to buy coverage. Whether or not insurance was such a good buy, with reasonable costs for good benefits, would depend on many other rules set forth in health reform — for example, how much insurers could charge different groups of people based on their age, or whether or not young adults could buy just catastrophic plans. One way to proceed, these experts say, would be to reform health insurance first, then

wait to see if enough people enrolled so that a mandate wasn’t necessary.

Other experts who are skeptical of a mandate point to inherent tensions that could make it politically difficult to maintain and administer. In Massachusetts, for example, there are those who want a mandate, rich subsidies, and low required benefits, and on the other side, those who want a mandate, a generous benefit package, and a willingness to exempt more people from the mandate. These kinds of trade-offs might not be easy to resolve, and they could make an individual mandate extremely hard to maintain over the long haul.

Finally, some outright opponents of a mandate voice skepticism that it could be enforced. Auto insurance is mandatory in 47 states, although it is enforced only through license renewal and registrations, not through the tax code as an individual health insurance mandate would be. Still, the median number of uninsured drivers in those states is 12 percent.

#### What’s next?

As this brief is published, the fate of health reform legislation is unclear — as is the fate of the individual mandate proposal. House Democrats are finalizing their version of HR 3200 that is understood to contain an individual mandate. As noted, the Senate Finance Committee bill contains an individual mandate, as does the Senate HELP Committee bill. These two bills will be blended into a final bill to be taken up by the Senate.

If legislation containing an individual mandate passes one or both houses of Congress, but in different bills, a conference committee will be appointed to craft a final compromise. It’s probable that a mandate would be included in that compromise, called a “conference report.” However, many other provisions affecting the mandate could change, including the size and scope of the affordability credit and the penalties for noncompliance. The conference report would then have to be passed by both houses of Congress and signed into law by the president. In short, whatever emerges from the process may in fact be different from the proposals discussed in this brief.

## Resources

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