

A Guide to Protecting Consumers under an Individual Mandate

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Individual mandates have become increasingly popular in health care proposals; they are now viewed by many as one of the “building blocks” of comprehensive health reform. While consumer groups are rightly wary of policies that mandate individuals to purchase insurance, we also realize that if they are done well, individual mandates are an important tool to get to universal coverage. In that vein, this paper examines the policies that can help make an individual mandate work best for consumers.

Introduction

Individual mandates are gaining popularity as a way to cover the uninsured. In 2006, Massachusetts became the first state to require residents to obtain health insurance, if it is affordable to them, as part of the state’s comprehensive health reform package. Although this policy has only recently gone into effect, other states including Maine, California and Maryland are already considering an individual mandate, or a law that requires all residents to enroll in health insurance.¹ Many policymakers now believe that the only way to get to universal coverage is through an individual mandate. While there are potential harmful effects of a mandate, there are ways to mitigate these—through consumer protections and tenets of shared responsibility among stakeholders.

What is an Individual Mandate?

An individual mandate is simply a policy that requires individuals to obtain health insurance. To date, we have seen two principal types of individual mandates, in Massachusetts and California. Individuals in Massachusetts must either acquire an available health plan if it is affordable or pay a penalty. However, the penalty, while significant, is much less than the cost of insurance. So the Massachusetts law creates a financial incentive, but not an absolute requirement to purchase coverage. The other approach, proposed in California, is an outright mandate to purchase.² In this case, the penalty for not purchasing coverage would *equal* the cost of the premium. Therefore, there would be no real choice but to purchase coverage.

The Presidential debate

Once limited to conversations among policy wonks, individual mandates recently hit prime time in the Presidential debates. Senator Hillary Clinton’s health care proposal includes an individual mandate, which she maintains is the only way to achieve universal coverage. Sen. Barack Obama’s proposal mandates coverage only for people under age 25. The two candidates have largely similar health plans—both would expand public coverage, make changes to increase access to private insurance, and increase cost containment measures. The big difference, which has been a heavy focus of the debates, is the individual mandate. (For more information, see health08.org)

For consumers, individual mandates have two major risks: the possibility of forcing people to spend more than they can afford on coverage, and the prospect that the insurance does not provide good benefit value, as with many health plans now sold on the individual market. If insurance is unaffordable, a mandate will impose undue financial

¹ Although the Massachusetts health reform law passed in April 2006, the mandate that individuals have insurance only recently began on December 31, 2007.

² Throughout this paper, we refer to the recent California proposal for an individual mandate in ABx1-1, the bill supported by the Assembly and Governor. This proposal was rejected by the Senate in late January.

burdens. If benefits are inadequate, a person may be left with cost-sharing requirements that expose them to financial hardship in the event of a major or chronic illness.

There are a few arguments for imposing an individual mandate. One, individual mandates are favored by health economists who worry about adverse selection, or when people with the greatest health needs become the majority of people enrolled in an insurance plan. A mandate addresses adverse selection by compelling all people with different health risks—young, old, sick, healthy—into the insurance pool.³ In addition, research demonstrates that even with robust subsidies and private insurance reform, health reform without an individual mandate would not reach full universal coverage.⁴

Alternatively, a common argument for an individual mandate is to place more responsibility for health costs on consumers. Consumer groups are rightly wary of this intent, but it is an important concept to recognize to engage stakeholder groups around an individual mandate. Agreeing to an individual mandate may be necessary to secure a larger reform package that also requires shared responsibility by employers, insurers and providers. Community Catalyst does not necessarily endorse individual mandates, but we think it is reasonable to consider a mandate, if there are certain consumer protections in place, as part of a larger reform package. This paper briefly describes some of the policies that advocacy groups and policymakers can use to make individual mandates work best for consumers. These are not mutually exclusive options; rather, a number of these ideas work well in concert.

An alternative to an individual mandate:

One goal of an individual mandate is to ensure that everyone obtains health coverage and that people don't wait until they are sick to seek insurance. There may be other ways to achieve these ends. For example, a state could create an auto-enrollment system that would require people to opt *out* of, rather than *into* insurance coverage, and would include automatic premium withholding. This is a comparable system to the management of employer-sponsored insurance (ESI), which has a higher participation rate than most public programs even when premium costs are similar.

Ten Ways to Make Individual Mandates Work for Consumers

1. Establish a right to purchase insurance (“guaranteed issue”)
2. Condition the mandate on affordability
3. Create adequate subsidies to help people afford insurance
4. Protect lower income populations from harsh penalties
5. Create a robust and easy-to-use waiver and appeals process
6. Prohibit insurers from charging people different premiums based on factors such as health status (“community rating”)
7. Set minimum benefit standards to guard against underinsurance
8. Encourage efficiency in health insurance
9. Promote equal responsibility by all stakeholders
10. Consider a phased-in approach

³ Blumberg, Linda and John Holahan, *Do Individual Mandates Matter? Timely Analysis of Immediate Health Policy Issues*, Urban Institute, January 2008.

⁴ Ibid.

1. Establish a right to purchase insurance (“guaranteed issue”)

Being able to purchase insurance is a fundamental precondition to any requirement to do so. To ensure that every person is able to acquire health insurance under an individual mandate, policymakers may need to make changes to private insurance rules.

“Guaranteed issue” requires insurers to allow all people to purchase insurance, regardless of age, health status or claims history. Nearly all states have guaranteed issue in the small group insurance market, but only a few have this protection in the individual (non-group) market.⁵

Some states that do not have guaranteed issue instead have high-risk pools for people who have been denied insurance in the standard market. In nearly all cases, high risk pools charge exceedingly high premiums and may cap enrollment. If people are not able to access insurance, or if that insurance is prohibitively expensive to them due to a health condition, an individual mandate cannot be implemented fairly.

2. Condition the mandate on affordability

If people do not have an affordable offer of insurance, through either their employer or a public program, they should not be subject to an individual mandate. This affordability protection could be established in a few different ways. A state could exempt all people earning under a certain income level, as is being discussed in Maine (for instance exempting people below 200% of the federal poverty level [FPL]). Alternatively, a state could determine at what price health coverage is affordable at different income levels. For instance, Massachusetts has created a schedule of affordability of health insurance for people up to about 500% FPL.⁶ These approaches can also be combined.

An affordability schedule should take into account out-of-pocket costs such as copayments, coinsurance, and deductibles. Inevitably, a good affordability scale will exempt many low- and moderate-income people, unless there is a very robust subsidy program (see #3). However, determining affordability is not an exact science; there is a degree of subjectivity in creating economic judgments about how much is affordable to households. For a greater discussion of determining affordability in the context of an individual mandate, see Community Catalyst’s *Affordable Health Care for All: What Does Affordable Really Mean?*⁷

3. Create adequate subsidies to help people afford insurance

A separate, but related, affordability protection under an individual mandate is the creation of subsidies for coverage. Because the goal of an individual mandate is to insure all people, imposing this requirement may be a good opportunity to push for insurance subsidies or expansions of public coverage programs for people with lower incomes.

⁵ States with guaranteed issue in the individual market: ME, MA, NJ, NY, VT.

⁶ Beyond about 500% FPL individuals must purchase insurance, no matter the cost. See Massachusetts Affordability Schedule, Health Insurance Connector, www.mahealthconnector.org

⁷ Paper available online at

http://www.communitycatalyst.org/doc_store/publications/affordable_health_care_for_all_apr07.pdf

For instance, policymakers may set an affordability scale for health coverage and then realize, through analysis and real-life budgets, that there is a large gap between what is affordable and what insurance is available on the market. Therefore, a good strategy may be to advocate for state-sponsored subsidies (or Medicaid expansions) to aid people with lower incomes to obtain insurance and be able to comply with the mandate.

4. Protect lower income populations from harsh penalties

There are options for enforcement of an individual mandate that can protect low-income people from burdensome penalties. If penalties are imposed on many people, it is sign that people do not consider available insurance options to be affordable or a good value. Because there is little experience with the impact of individual mandates, care should be taken not to add financial distress to low- and moderate-income families.

- An individual mandate should include clauses about both affordability and type of insurance (see #7). People who cannot obtain adequate insurance for an affordable price should be exempt. For example, in Massachusetts the mandate applies to all people who have an *affordable* offer of insurance per the state's guidelines. Maine's Governor has proposed an individual mandate that would apply only to people with income above 400% FPL.⁸ In addition, California's proposal for a mandate did not contain an affordability schedule, but exempted low-income residents from the individual mandate if premium costs exceed 5% of their income and they were not eligible for public subsidy programs.⁹ Alternatively, policymakers could apply the mandate to certain groups of people, or mandate coverage only for children.¹⁰
- What is the penalty for not purchasing insurance? If a state is developing a penalty schedule separate from the full cost of purchasing insurance (as is the case in Massachusetts), it is important to create a penalty schedule that is fair and equitable, and not overly burdensome for low-income families. This scale should also be progressive and take into account the real-life budgets of people with low-incomes.¹¹

5. Create a robust and easy-to-use waiver and appeals process

There should be a fair and easy process to waive the individual mandate or appeal a penalty for people with certain circumstances. An appeals process should be set for events or conditions in people's lives that may prevent people from purchasing health insurance, including: disproportionately high rent or utility costs, significant medical

⁸ See Report of the Blue Ribbon Commission on Dirigo Health, January 2007.

⁹ <http://www.dirigohealth.maine.gov/BRC%20Final%20Report.pdf>. In April 2007, Governor Baldacci made recommendations for changes to Dirigo, including an individual mandate.

⁹ See Mike Zapler, "Most in California favor health care overhaul," The San Jose Mercury News, December 21, 2007.

¹⁰ The latter is being proposed by Presidential candidate Barack Obama. See www.Health08.org

¹¹ In Massachusetts the 2008 penalties are: \$0 for people under 150% FPL; \$210/yr for people between 150-200% FPL; \$420 between 200-250% FPL; \$630 between 250-300% FPL; and \$912 per individual for all other income levels. See Massachusetts Department of Revenue, www.mass.gov/dor.

debt, loss of employment due to illness, financial hardship, or an emergency situation.¹² Waivers should be made available prospectively, while appeals should be available at the time penalties are assessed. In addition, people must be informed of the waiver process and given reasonable opportunities to seek a waiver or appeal a penalty.

6. Protect against inequitable insurance premiums (“community rating”)

“Community rating” requires insurers to set the same premiums for each person buying a health plan, regardless of age, health, gender or other factors. Most states have “modified” or “adjusted” community rating in their small group insurance market, which means that although insurers cannot charge different premiums based upon health status, variation is permitted for other factors, such as age, gender, geography and type of business. As with guaranteed issue, only a few states have this protection in the individual market.¹³ An individual mandate can be a good opportunity to address problems of accessing insurance without community rating.

Even with modified community rating, premiums can vary considerably. An individual may be required to pay more substantial amounts of her/his income toward health insurance due to certain factors. For instance, Massachusetts allows insurers to charge higher premiums based on age. Therefore, people subject to the individual mandate who are older must pay more to purchase insurance, in some cases twice as much, as young people. There are two arguments for allowing premiums to vary by age: one, younger people typically use less health care and are less inclined to purchase insurance if the premium is based on average costs of the whole population; two, young people often have less money and therefore are less able to afford insurance. In the context of an individual mandate, the first argument no longer holds. People will not have a choice about purchasing insurance—therefore there would no longer be a reason to manipulate premiums to induce the purchase of insurance. While there would still be a question of affordability for young people (see #2 and #3), there are methods to make insurance less of a financial burden.

7. Set minimum benefit standards to guard against underinsurance

An individual mandate should require actual health insurance, not weak coverage that creates financial traps for people who need health care. A standardized “floor” of what constitutes insurance should be set to allow people to access care without fear of incurring serious medical debt.¹⁴ This floor should ideally include all of the major elements of comprehensive health coverage—inpatient and outpatient services, mental health care and prescription drugs. Also, consideration of cost-sharing (copayments, deductibles and coinsurance) and benefit maximums is important to prevent medical debt.

Massachusetts’s determination of “minimum creditable coverage,” or MCC, includes comprehensive benefits, such as preventative and primary care, hospitalization, mental

¹² For an example, see Massachusetts regulation 956 CMR 6.08.

¹³ States with community rating or *modified* community rating in the individual market: ME, MA, NJ, NY, OR, VT, WA.

¹⁴ For more information on the problems of limited health coverage and medical debt, see The Access Project, “The Illusion of Coverage: How Health Insurance Fails People When They Get Sick,” 2007.

health coverage, and prescription drugs. MCC caps deductibles at \$2000 (\$4000 for families) and requires three primary care visits (6 for families) pre-deductible. Maximum out-of-pocket costs are capped at \$5,000 (\$10,000 for families) and prescription drugs carry a separate deductible of up to \$250 (\$500 for families).¹⁵

California did not delineate benefits in the legislation, but would have a state board decide minimum benefits and cost-sharing.

8. Encourage efficiency in health insurance

If state policymakers decide to require all people to purchase insurance, they have an obligation to ensure that people getting good value for their money. Options to make insurance more efficient include:

- Setting medical loss ratios

A medical loss ratio, or a limit on the proportion that insurance carriers may spend on administration, marketing, profit and expenses other than medical costs, can potentially reduce insurer spending. A few states impose medical loss ratios on the small group market currently, with varying degrees of success.¹⁶ In recent years, some researchers have questioned the effectiveness of medical loss ratios in an insurance marketplace where carriers can creatively account for medical care and administrative services. However, this may be a method of holding insurers to a spending limit.¹⁷

- Requiring rate reviews

Rate reviews allow an entity, usually the insurance regulator, to set allowable premium increases each year. For instance, policymakers may require that the insurance commissioner review (and may deny) any premium increases exceeding 10% per year. Alternatively, a state could require public hearings to discuss health premium rate increases each year. For example, Hawaii implemented rate regulation in 2003, with some success: the state has denied six insurer premium increase requests since then.¹⁸

9. Encourage equal responsibility by all stakeholders

If policymakers in your state decide to adopt an individual mandate, the most equitable way to do so is to require proportional costs and certain conduct of other stakeholders in the health market. Individuals should not be the only ones with “responsibility” for health insurance—an individual mandate should be paired with adequate and equitable employer responsibility for assisting with the costs of health insurance.

¹⁵ The Board of the Connector delayed enforcement of MCC rules until January 2009 to allow consumers and employers time to acquire adequate coverage. For more information, see [Hwww.mahealthconnector.org](http://www.mahealthconnector.org)

¹⁶ At least 9 states impose medical loss ratios in the individual market. For more information, see A Consumer Guide to State Health Reform, [Hhttp://communitycatalyst.org/projects/schap/links?id=0025](http://communitycatalyst.org/projects/schap/links?id=0025)

¹⁷ See for instance James Robinson, *Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance*, *Health Affairs* (16) 4: 176, 1997.

¹⁸ Greg Wiles, “No more oversight of health plan rates,” *The Honolulu Advertiser*, May 4, 2006. Hawaii re-instated this law in 2008, after the original law sunsetted last year.

For instance, a state may limit penalties for individuals to no more than those for employers—especially important in the case of states that follow Massachusetts and Vermont, which imposed relatively low penalties on employers not providing insurance.¹⁹ There is concern in these states that individuals are shouldering more of the burden than employers. Policymakers could also require providers and insurers to adhere to certain standards, such as pay-for-performance, quality and cost control measures, or rate regulation.

10. Consider a phased-in approach

The manner in which an individual mandate is phased-in can greatly impact its effects on consumers. Here are some options and possible repercussions:

- “Soft-launch”: An individual mandate may not be implemented immediately. Rather, a certain date or benchmark may be set to consider a mandate. For example, if a coverage benchmark is not met in Vermont, the recent health reform law authorizes a commission to revisit an individual mandate.²⁰ Another is for an administrative or legislative body to request a study of the impact of a mandate. This approach requires legislation to create a mandate, allowing health reform policies to be fully implemented.
- “Intermediate-launch”: Policymakers may decide to grant the administration authority to implement an individual mandate if certain benchmarks are not met. This option is similar to a soft-launch, but no legislative action is necessary—it is an administrative decision.
- “Hard-launch”: A state may consider setting a certain coverage benchmark and authorizing an individual mandate to go into effect automatically, without a vote by the legislature, if that goal is not met. In this case, a vote is needed to stop the implementation of a mandate. This option creates greater pressure to meet coverage benchmarks in the time allotted.
- Gradual phase-in: Alternatively, a state may decide to implement an individual mandate immediately, but phase-in enforcement by income. For instance, people above 600% FPL may be required to purchase insurance, while people with lower incomes are given time to acquire coverage. This option allows greater opportunity for outreach and enrollment in public programs.
- Immediate mandate: If policymakers believe appropriate protections and structures are in place, they may choose to mandate insurance immediately but still phase-in penalties. This option may not provide adequate time for public information about the mandate and appeals system. Massachusetts chose to

¹⁹ In Massachusetts and Vermont, the penalty for employers not providing insurance is \$295 and \$365, respectively, per uninsured worker per year.

²⁰ If less than 96% of Vermont residents are uninsured in 2010, the state will consider an individual mandate. 2006 Vermont Health Care Affordability Act Frequently Asked Questions, VPIRG, http://www.vpirg.org/hc/documents/06.06.27_FINALCatamountQA.pdf.

implement its individual mandate immediately with penalties phased-in for the first year. The California proposal also had an immediate mandate.

Conclusion

There are many unknowns with regard to both the effectiveness and financial consequences of individual mandates. However, as states and the federal government grapple with ways to expand health insurance coverage, individual mandates are increasingly part of the policy mix. As with so many aspects of health policy, with a mandate, “the devil is in the details.” Under the best case scenario, an individual mandate can be a tool to expand coverage and ensure a fair measure of shared responsibility. However, if implemented without sufficient care, there could be many adverse effects, including undue financial burden on families and a shift away from group coverage. The recommendations in this guide are designed to help advocates guard against these potentially harmful effects.

Report Card for Individual Mandate Policies

Policy option	Massachusetts	California*
1. Establish a right to purchase insurance (“guaranteed issue”)	Has guaranteed issue in the merged small group and individual markets	Would move to guaranteed issue in all insurance markets
2. Condition the mandate on affordability	Mandate is conditioned on affordability. State set a sliding scale of affordability of health insurance for people earning up to about 500% FPL; affordability scale does not include cost-sharing; scale may be unaffordable for some	Mandate is conditioned on affordability, but no affordability scale; Exemption for people who earn less than 250% FPL if insurance exceeds 5% of income; For people between 250-300% FPL, tax credit to prevent insurance from costing more than 5.5% of income; lesser subsidy between 300-400% FPL; No subsidy for people earning above 400% FPL; may be unaffordable for some
3. Create adequate subsidies to help people afford insurance	Medicaid or subsidies for all adults up to 300% FPL; may not be affordable options for people between 300-400% FPL	Expand Medi-Cal (Medicaid) to adults up to 250% FPL; tax credits to subsidize insurance to 5.5% of income between 250-400% FPL; tax credit may not make affordable
4. Protect lower income populations from harsh penalties	Starting in 2008, penalties for not having insurance are equal to one-half of monthly premium for subsidized policy for low-income; not very progressive penalty	Automatic enrollment model; Individual would be enrolled in health plan and charged lowest available premium; subject to collection if unpaid; may harm people with low-

	schedule; may harm people with low-incomes	incomes
5. Create a robust and easy-to-use waiver and appeals process	Hardship waiver guidelines in regulation, but decisions based on staff; unknown impact	The legislation charges the MRMIB with developing a process for exemptions for affordability and hardship
5. Protect against inequitable premiums (“community rating”)	Has modified community rating in merged small group and individual market; allows insurers to vary premiums based on age, geography and occupation	Has modified community rating in small group market; would move to modified community rating in individual market, prohibiting premiums to vary based on health conditions, but allowing variation for other factors, such as age and geography
7. Set minimum benefit standards to guard against underinsurance	Set “minimum creditable coverage” standards as a floor of health insurance	Basic standard that minimum creditable coverage must include doctors, hospitals, preventative care, with the Managed Risk Medical Insurance Board (MRMIB) charged with creating further standards
8. Encourage efficiency in health insurance	None	Would implement medical loss ratio of 85%
9. Encourage equal responsibility by all stakeholders	Employers pay \$295 per uninsured employee per year; some pay for performance standards for providers; much lower obligation for employers than individuals	Employers pay sliding payroll assessment up to 6.5%; significant contribution from employers
10. Consider a phased-in approach	Mandate delayed 1 year; penalties phased-in	To be implemented immediately, penalties imposed only with Legislative approval

**California* refers to the recent proposal enacted by the State Assembly and supported by the Governor, but defeated by the Senate in January. Although this bill has been defeated, it serves as a model of potential policy options in designing an individual mandate. Therefore, while most of Massachusetts’s policies have been fleshed out in regulations, we only have information from California’s proposed statute.