COMMUNITY CATALYST

Individual Mandates: Critical Consumer Protections

Congress is considering an individual mandate – a requirement that people obtain health insurance – as part of an overall health reform strategy. Many analysts believe a mandate is necessary to reach quality, affordable health care for all.

However, a mandate that all people have insurance poses significant risks if not implemented carefully with consideration for families' budgets. An individual mandate should not compel people to spend more on coverage than they can afford or to purchase inadequate insurance, which can leave them unable to access care or facing major financial liabilities.

A poorly-designed individual mandate could also undermine political support for health care reform. Evidence shows support for an individual mandate hinges on perception that the amount people will be required to pay is affordable. For instance, a 2008 poll shows 67% of Americans surveyed support a requirement that all Americans have health insurance; support drops to 19% if the plan is too expensive.[1] Adequate protections, such as an affordability scale, are necessary for an individual mandate to function properly and be acceptable to the public.

Recommendations for an Individual Mandate

To guard against harmful effects on families:

- Insurance must be guaranteed-issue and should be community rated, with very limited variation in premium rating.
- People who cannot obtain an adequate health plan for an affordable price should be explicitly exempted from the mandate.
- Affordability protections should include a scale that accounts for both premiums and out-of-pocket expenses, as well as people's ability to pay.
- A mandate should protect against underinsurance. Minimum coverage must not leave people at financial risk in the event of a major or chronic illness.
- An individual mandate, or penalties for a mandate, should be phased-in to allow time for public education and enrollment.
- A waiver and appeals process should be easy to use and allow for people's financial circumstances.

Private insurance protections

To ensure that every person is able to obtain health insurance under an individual mandate, policymakers must amend private insurance rules to establish guaranteed issue and community rating, with strong limitations on premium rating.

Even under modified community rating, premiums can vary considerably, requiring some people to pay substantially higher premiums than others. For instance, Massachusetts allows insurers to charge higher premiums based on age. Older people must pay more—in some cases twice as much—as young people to purchase required coverage.

In a system where people are penalized for not obtaining insurance, it is critical that individuals are not required to spend up to 5 times more in premiums due to their age. Larger variation in premiums may force people to either go without insurance or face serious financial burdens.

The importance of affordability

Defining affordability for health insurance is critical to successful implementation of an individual mandate.

An affordability scale 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 robust subsidy program or people have sufficient offers of employer-sponsored insurance. In Massachusetts many people just above eligibility levels for subsidies (300% FPL) who do not have an offer of employer-sponsored coverage are not subject to mandate penalties, since no affordable plan is available.[2]

Protections against underinsurance

An individual mandate should require people to have adequate coverage, not plans with limited benefits that create financial traps when people need health care. A standardized "floor" would provide people the security that their health care plans allow them to access care without incurring substantial debt. This floor should include all major elements of comprehensive coverage—inpatient and outpatient services, mental health care and prescription drugs. Also, limitations on all cost-sharing (copayments, deductibles and coinsurance) and benefit maximums will help prevent medical debt.[3]

Additional protections may be necessary for people with low incomes. As part of its reform plan, Massachusetts expanded its Medicaid program and also provided comprehensive subsidized insurance with no deductibles and limited cost-sharing for people up to 300% FPL.

Enforcing the mandate

There are different approaches to enforcing a mandate. In Massachusetts, people must either acquire insurance if it is affordable, or pay a penalty. The penalty, while significant, is much less than the cost of insurance, and is the same for all people at a given income level; it does not vary based on factors that can affect insurance premiums in Massachusetts such as age or geography.[4] If many people pay penalties instead of getting coverage under this type of mandate, it is a sign that the available insurance options are not affordable or a good value. This situation should trigger a reassessment of the affordability scale or subsidies.

Another approach, proposed in California in 2008, is an outright mandate to purchase insurance.[5] In that case, penalties would have *equaled* the cost of the premium, giving people no choice but to purchase coverage. This penalty system could only be fairly implemented under pure community rating; otherwise, people at the same income level with different rating factors would

pay very different penalties. Tying penalties directly to premiums would also require a more generous affordability scale or greater premium subsidies, due to the significant cost. It is also possible, and may be preferable, to not tie any penalty amount directly to premiums. (This is the approach used for employer penalties in Massachusetts and Vermont.)

Regardless of the approach, people with the same income and family size should be charged the same amount, and people with lower incomes should be charged less. People with the lowest incomes should be exempt from any penalty.

Phase-in options

There are a number of approaches to implementing a mandate that can greatly shape public support. Private insurance changes and other reforms will take time to implement. This is likely to be more complicated on a national scale than in Massachusetts, which already had both an expanded Medicaid program and significant insurance reforms prior to implementation.

People need time to learn about their insurance options, responsibilities, and subsidies available to them. Delaying the start of a mandate means fewer people will feel they have been compelled to purchase insurance. An individual mandate may also be implemented immediately, but penalties could be phased-in by income (e.g. apply the mandate to higher income people first) and/or by penalty (e.g. lower initial penalties that ramp up over time.)

Waiver and appeals process

Beyond an affordability scale, the government should create a fair and easy process to waive individual mandate requirements or appeal penalties for certain circumstances. An appeals process should consider situations that may prevent people from buying insurance, including disproportionately high housing or utility costs; significant medical debt; loss of employment due to illness; financial hardship; or an emergency.[6] Waivers could be provided prospectively, with appeals available after penalties are assessed. There should be adequate public information about the waiver process and reasonable ease in seeking a waiver or appealing a penalty.

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1 Kaiser Family Foundation and Harvard School of Public Health. January 2009. The Public's Health Care Agenda for the New President and Congress.

2 The Massachusetts individual mandate exempted about 144,000 people from penalties in 2007, its first year (including people with low incomes who do not have to pay taxes). About 60,000 people paid penalties for not purchasing an affordable offer of insurance. Massachusetts Department of Revenue. 2008. Data on the Individual Mandate and Uninsured Tax Filers: Tax Year 2007.

3 In Massachusetts, "minimum creditable coverage" includes preventive and primary care, hospitalization, mental health coverage, and prescription drugs. MCC caps deductibles at $2,000 ($4,000 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 a deductible of up to $250 ($500 for families).

4 The 2009 Massachusetts penalties: $0 under 150% FPL; $204/yr between 150-200% FPL; $420 between 200-250% FPL; $624 between 250-300% FPL; and $1,068 for all other income levels.

5 This refers to the 2007 California comprehensive health care proposal, ABx1-1.

6 For example, see Massachusetts regulation 956 CMR 6.08.