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Individual Mandate: A Background Report

*By Lucien Wulsin, Jr.
and Adam Dougherty*



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TABLE OF CONTENTS

I. INTRODUCTION AND PROFILE OF THE UNINSURED.....	1
II. THE ISSUES AND PERCEIVED BENEFITS	3
III. HOW IT WOULD WORK.....	7
IV. POTENTIAL COSTS	11
V. OTHER CRITICISM	13
VI. RECENT PROPOSALS	15
VII. HISTORY AND EFFECTIVENESS OF MANDATES	17
VIII. MASSACHUSETTS.....	21
IX. INTERNATIONAL PERSPECTIVE.....	23
X. CONCLUDING THOUGHTS	25
XI. ENDNOTES	27

I. INTRODUCTION AND PROFILE OF THE UNINSURED

Key issues in achieving universal healthcare coverage are the affordability of and lack of enrollment in health insurance. A recent report from the Commonwealth Fund's Commission on a High Performance Health System concludes "the failure to provide continuous, affordable coverage that ensures access and financial protection to everyone in the United States contributes to the poor performance of the health system."¹

The health consequences of being uninsured are well documented and contribute to higher economic costs from serious health problems, longer hospital stays, lost productivity from absenteeism, and higher premature mortality rates.^{2,3} Over 46 million Americans are without healthcare coverage. The number of uninsured is increasing with the growth of unemployment and stagnation of employer-based coverage. Healthcare cost growth continues to outpace growth in wages.⁴

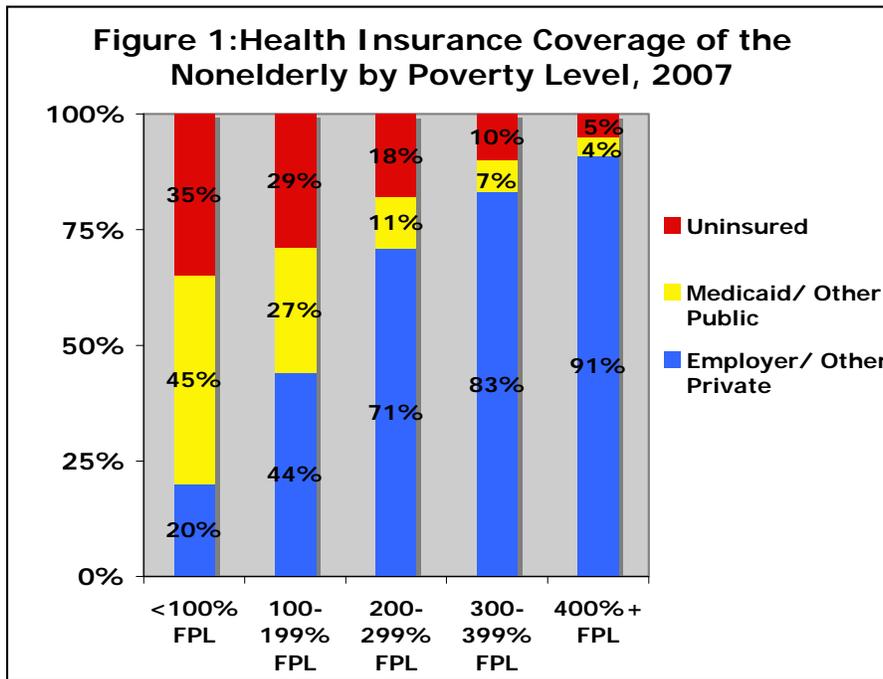
The individual mandate is a policy option that could significantly reduce the number of uninsured in the United States. An individual mandate would require every citizen to obtain health insurance, be it through an employer, an individual plan, a purchasing pool, or a public plan.⁵ Proponents argue that universal coverage is impossible without a mandate, though skeptics believe even with a mandate there would still be people without health insurance. The mandate has been discussed in the presidential debates of 2008, in state reform efforts, and internationally. This report will discuss how such a mandate could work, what it would cost, examples of other mandates, as well as the arguments in opposition to the reform. Today there are examples of the individual mandate in action; this report will look specifically at its implementation in Massachusetts, Switzerland, and The Netherlands.

To apply an individual mandate in California would mean that at least 6.5 million uninsured Californians (over the course of the year) would be required to enroll in or purchase coverage.⁶ Compliance might be relatively easy for the nearly 370,000 children eligible but not enrolled in Medi-Cal or Healthy Families and for the estimated 270,000 adults eligible but not enrolled in Medi-Cal.⁷ Compliance might be somewhat more affordable for the 1.5 million uninsured with incomes over 300 percent of the Federal Poverty Level (FPL), depending on their age and family composition, and less affordable for the five million uninsured with incomes under 300 percent of the FPL (\$60,000 for a family of four, \$30,000 for an individual).⁸ Coverage may not be available for the 200,000 currently uninsured Californians with serious medical conditions.⁹ This background report will review the pros and cons of the individual mandate as well as the availability, affordability and enforcement that would come from such a mandate.

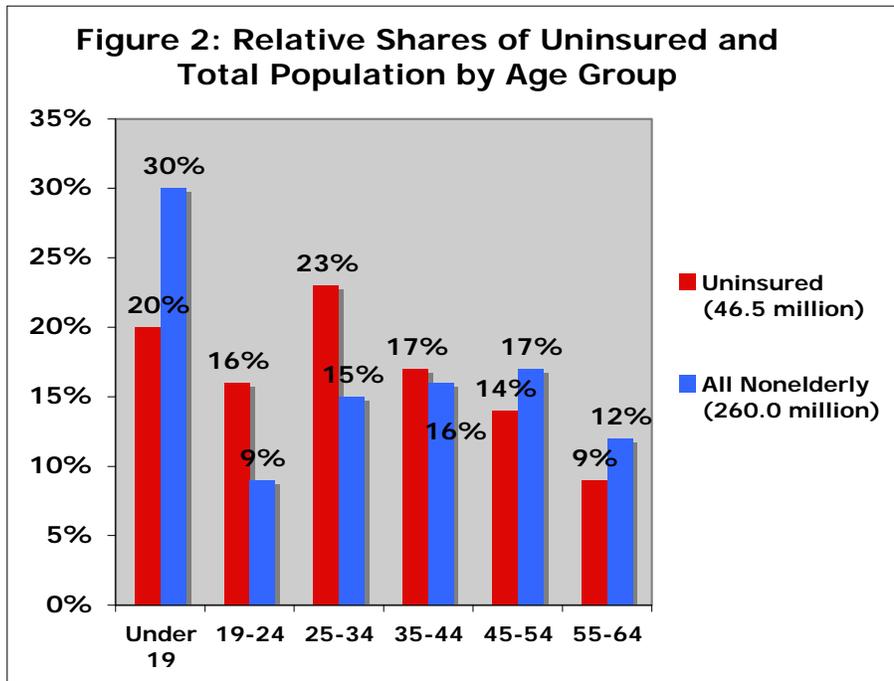
Profile of the Uninsured

Americans left out of the insurance pool typically belong to one of two groups:

1) Low-wage workers who are not offered employer-sponsored plans



2) Healthy young people unwilling to purchase insurance at prevailing prices



Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of March 2007 CPS

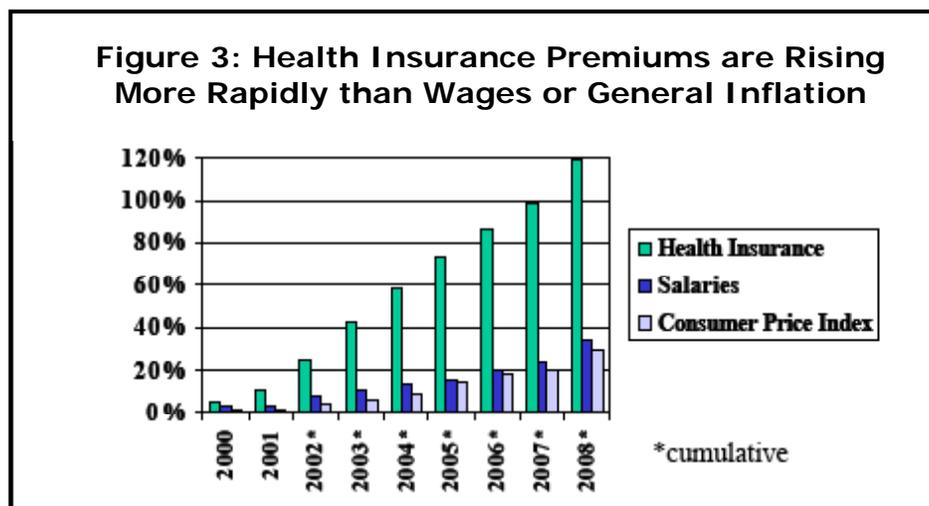
II. THE ISSUES AND PERCEIVED BENEFITS

Adverse Selection

The basic concept of insurance is to spread individual risk across a broad range of enrollees. In health insurance, this equates to a large number of healthy individuals covering the costs of a few very unexpectedly sick and costly individuals at any one time. Roughly 70 percent of health-system costs in a given year are associated with ten percent of the population.

In a voluntary system, individuals who tend to enroll in a health plan are those who expect to use more services and tend to be less healthy. Those with substantial incomes enroll and pay the premiums to protect assets in the event of catastrophic illness. They see the greater value of health insurance, and will benefit most from being enrolled. On the other hand, healthy persons who are voluntarily uninsured may not perceive a benefit to enroll based on their health risks and the price of coverage. The ability of persons to opt in and out of risk pools can create a disproportionate enrollment of high-cost individuals. This is termed adverse selection.

An Urban Institute study found that individuals with incomes between 200 percent and 300 percent of the Federal Poverty Level would have to spend 17 to 21 percent of their income on premiums and out-of-pocket expenses for a standardized benefit package in the non-group market.¹⁰ Without a significant subsidy or markedly lower prices, only a small percentage of this population could actually purchase coverage. Rising health costs result in higher premiums that price individuals out of the pool while others become underinsured, thereby causing a downward spiral that could topple the insurance market.¹¹ This may now be occurring as the number of uninsured continues to rise (particularly among the young and healthy) while premiums have outpaced wages three-fold since 2000 (see Figure 3).



Source: Kaiser Family Foundation, 2008 Employer Health Benefits Survey

Proponents of an individual mandate argue that the measure would increase the number of young healthy persons in the risk pool, thus spreading risk and lowering premiums. Income-linked subsidies would need to be available for low-income individuals.

Free Riders and Uncompensated Care

Up to 20 percent of uninsured individuals have the financial means to purchase health insurance but choose not to, knowing they can get emergency care when they need it.¹² When this population, termed *free riders*, ends up needing expensive care the costs are shifted to others in the form of higher taxes and increased insurance premiums. It is estimated that a “hidden tax,” from 2 percent up to 10 percent of private premiums, goes for uncompensated care of the uninsured.¹³ Mandate supporters claim that compulsory insurance will reduce the average premium and create a shared responsibility.¹⁴

About three percent (\$38 billion) of total health expenditure goes to uncompensated care and is financed by the federal, state and local governments, and private cost shift.¹⁵ These payments go primarily to hospitals through patchwork subsidies that overpay some institutions and underpay others. Hadley and Holahan argue that this money could be used to subsidize insurance (coupled with the mandate), thus allowing the funds to be better targeted for care and relieving taxpayers of significant financial burden.¹⁶

Opponents of the mandate argue that this small fraction of national health expenditure is not enough to justify such an ambitious and potentially harmful change in the law.¹⁷ Those opposed to the mandate also note that there would still be free riders in the system regardless of the law, as is the case with car insurance.

Administrative Overhead – Underwriting

Sherry Glied explains that in our current health insurance system, the fundamental problem is people know much more about their own health than insurers do and use that information in making their decisions to obtain coverage and the scope of covered benefits.¹⁸ As a result, insurers discourage

enrollment of those who will be more costly (such as those with pre-existing conditions), through medical underwriting, the process of assessing whether a person is insurable based on his/her medical history. This process not only makes it harder for people to gain coverage who actually need it, but it drives up administrative costs.

Table 1: Healthcare Spending on Health Insurance Administration

	Per Capita Spending	Percent of National Health Expenditure
United States	\$486	7.2%
Netherlands	\$190	5.6%
Germany	\$184	5.4%
Switzerland	\$195	4.8%

Source: OECD Health Data, 2008

As shown in Table 1, per capita expenditures on healthcare administration is more than twice as high in the United States as in the Netherlands, Germany and Switzerland.¹⁹ Glied argues that an individual mandate and individual market reforms may diminish

these types of insurer tactics. The insurance market would move to a system where everyone is in, as opposed to one that invests significant dollars in keeping the costly out. While an individual mandate with a minimum benefits package may contribute to reduced administrative costs, many remain skeptical of the perceived savings.

III. HOW IT WOULD WORK

Many reform proposals include an individual mandate; supporters argue that fundamental components needed for a program to be effective include: affordability, availability and enforcement. These issues are discussed below.

Affordability

There is a general concurrence that premium costs under a health insurance mandate must not exceed an individual or family’s ability to pay.²⁰ To be effective, an income-related subsidy would need to be included in the legislation, most likely as a sliding-fee subsidy based on percentages of income. Some contend that both premiums and out-of-pocket expenses should be factored into the affordability equation.

Using the seven percent of income threshold for the income tax deductibility of medical expenses under federal guidelines, the basic coverage under a typical HMO plan is only affordable for those young and single at 400 percent FPL (see Table 2). Thus there is a need for extensive subsidies for most of the uninsured affected by an individual mandate.

Table 2: A Typical Individual Plan with Monthly Premiums as a Percent of Monthly Income for Two Income Brackets, 2007

	25 year-old (single)	35 year-old (single)	55 year-old (single)	25 year-old (married couple, 2 children)	35 year-old (married couple, 2 children)	55-year old (married couple, 2 children)
Kaiser Premium with \$25 Co-pay	\$216	\$264	\$439	\$786	\$943	\$1106
Percent of monthly income, 300% FPL	8%	10%	16%	14%	17%	20%
Percent of monthly income, 400% FPL	6%	7%	12%	10%	13%	15%

Source: Kaiser Permanente Quote site: <https://kaiser.healthinsurance-asp.com/expressweb/plan/QuotingInformation.action?refID=>, 2009 HHS Poverty Guidelines

Individual insurance payments are not tax deductible except for the self-employed. Tax deductibility concentrates its benefits on those in the highest income tax brackets and is not an approach to improve affordability for the low income population.²¹ A monthly or quarterly refundable tax credit or voucher administered by a purchasing pool may be a more effective approach.

Defining what is affordable for households with differing economic circumstances is a challenge. Arbitrary cutoffs can be perilous, as families have different circumstances, regions have different costs, and rising costs of healthcare would erode affordability subsidies over time.

As savings from the reform might not cover the costs of the program it has been suggested that a progressive consumption tax could be included to provide the additional revenue needed to fund the subsidies.²² Most importantly, the tax rates and subsidy levels should be revisited over time.

Enforcement and Penalty Size

Blumberg and Holahan argue that the first and most important step in enforcement is to make the enrollment and compliance process as easy as possible for the individual. Outreach and education can be facilitated through multiple avenues such as employment, schools, and healthcare providers.²³

Enforcement through the income tax system is a common method to reach nearly all households. The Government Accountability Office (GAO) performed a study on income tax compliance and found that providing tax-filing support to individuals noticeably increased compliance rates.²⁴ Gruber, et al. suggest that auto-enrollment can be an effective tool to boost compliance under certain circumstances.²⁵

Electronic monitoring of insurance status may prove to be an important enforcement tool to assure initial and ongoing enrollment. Electronic data matching across a range of entities (e.g., employers, schools, providers, insurance plans) could achieve significant compliance rates.²⁶ Frequent data matching through multiple electronic databases may serve to further improve compliance rates and increase enrollment.²⁷

Penalties are used to ensure compliance with a mandate, most often as a monetary fine. The penalty must be high enough to convince people to enroll, but not excessive. If it is too small, the cost of enforcement may be greater than the funds collected. Opponents argue that the new layer of bureaucracy would be too expensive to create any revenue. The Urban Institute suggests that individuals could be subject to a tax penalty if they fail to provide proof of insurance when filing their annual tax return, and the funds could be used to partially fund the subsidy program.²⁸

Market Reform

In order for an individual mandate to function, significant insurance market reforms are needed. First, there would have to be guaranteed issuance and renewal, where insurance companies would not be able to deny or drop coverage based on patients' medical conditions. This issue is not much disputed by supporters and opponents.

There would have to be agreement on a set of benefits that every plan would offer, termed the minimum benefits package. This package would increase benefits for the underinsured. These changes would change plans' incentives from excluding sick patients to more efficiently managing care and costs.²⁹ Supporters argue that the benefits package should mirror the Federal Employee Health Benefits Package (FEHBP).

The minimum benefits package is a point of contention among those opposed to the mandate. There is a concern that creating such a package would allow provider and patient interest groups to lobby for inclusion of their services, which would increase costs and premiums with every newly included service.³⁰

Table 3: Average Monthly Premiums and Actuarial Values in the CA Small Group and Individual Markets

	2003	2006
Average Monthly Premiums: Small Group (Actuarial Value)	\$250 (83%)	\$405 (83%)
Average Monthly Premiums: Individual (Actuarial Value)	\$211 (75%)	\$392 (55%)

The individual market has high non-benefit costs and declining actuarial values, the share of medical expenses paid by insurance as opposed to patients

(see Table 3).³¹ Individual subscribers are paying more for less coverage than do large- and small- coverage

businesses. Len Nichols, of the New America Foundation, and others propose that a mandate be coupled with improvements in the individual market. More effective purchasing pools and greater transparency would need to be created to reduce administrative expenses, improve minimum loss ratios and increase affordability in the individual market. A recent report prepared by Watson Wyatt for the California HealthCare Foundation compares premiums and the actuarial values of individual health plans in California and finds that certain plans provide strong “value” for their premiums while others provide far less actuarial value for comparable premium costs.³² Nichols suggests modified community rating with an age rating component so that the ill and sick are not priced out of coverage.³³

Source: CHCF Snapshot, Health Insurance: Can California Afford It? 2007

Table 4: ITUP Comparison of Rules for Insurers in California Small Business and Individual Markets³⁴

	Guaranteed Eligibility	Guaranteed Renewal	Age Rating	Family Size	Geography	Purchasing Pool
Small Business	Yes	Yes	Yes	Yes, 4	Yes, 9 regions	Yes, but discontinued due to adverse selection
Individual	No	Yes, with rescissions	Yes	Yes, unlimited	Yes, unlimited	No

	Medical Loss Ratio	Pre-existing Condition Exclusion	Bad Risk Pool	Reinsurance	Premium Rate Variations for Bad Risks
Small Business	No	6-month exclusion period	No	Yes, not implemented	±10%
Individual	No	12-month exclusion period	Yes, MRMIP	No	Unlimited initially, no variation once insured

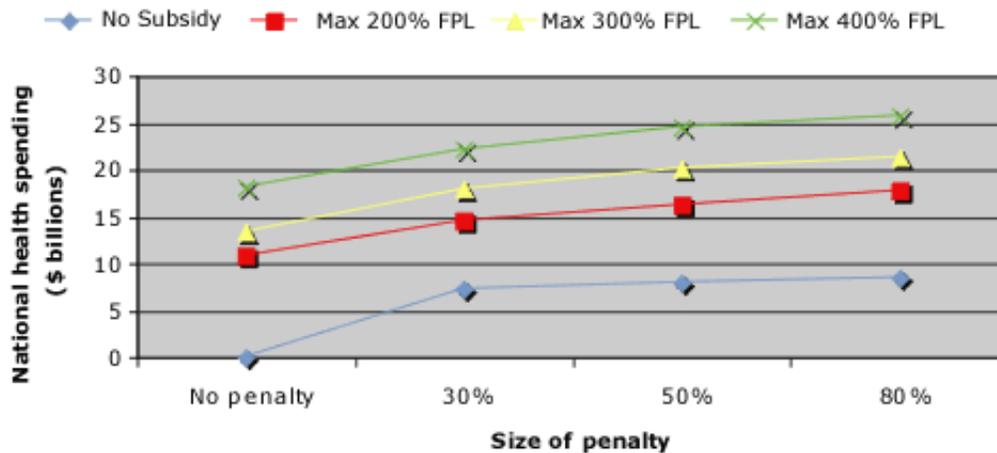
IV. POTENTIAL COSTS

RAND Corporation used a series of models to predict overall costs and spending under a national individual mandate.³⁵ The models included design features such as a national purchasing pool, mandate without a hardship exemption, age-rated premiums, and subsidy structures related to income. Penalties reflected a percentage of the premium an individual would have paid in the purchasing pool.

RAND Key Findings:

- Aggregate national health spending would increase by \$7 billion to \$26 billion, representing an increase of 0.3 percent to 1.2 percent. (See Figure 4)
- Cost per newly insured persons decreases at higher penalty levels, as these subscribers are taking fewer subsidies and/or are younger and healthier. (See Table 4)
- Medicaid expenditures would increase by about 7.5 percent (\$25 billion). Overall government spending on healthcare would increase 1.2 percent to 6.0 percent annually (\$12 to \$62 billion).

Figure 4: Effect of Subsidy Levels and Size of Penalty on Changes in Aggregate National Health Spending



Source: RAND COMPARE microsimulation model, 2008

Table 5: Government Cost per Newly Insured with Sliding Scale Subsidy

	Size of Penalty (Percentage of Premium)			
	No penalty	30%	50%	80%
Government cost per newly insured (\$)	\$2,655	\$2,284	\$2,110	\$1,835

Other researchers using similar micro simulation methods estimated substantially larger increases in spending. Gruber simulated a mandate with subsidies up to 400 percent FPL, and included a voucher program for people who are offered employer-sponsored coverage who have not obtained it.³⁶

Gruber Key Findings:

- The policy would achieve 97 percent coverage at a cost of \$2,700 per newly insured individual.
- Total government costs of \$124 billion.
- Budgetary efficiency: the government spends \$0.81 per dollar of insurance value provided. Gruber points out that the individual mandate with tightly targeted subsidies to assure affordability to those who cannot afford the full cost of coverage is a highly efficient way to increase coverage.³⁷

This total cost difference is in part due to the assumption by RAND that people with access to employer-sponsored insurance were not eligible for a subsidy, and thus their enrollment would not increase the cost to government. Gruber's analysis also includes a comparatively higher administrative cost in the new purchasing pools.

An analysis by Lambrew and Gruber estimated an increase in spending of \$56 billion to \$114 billion with a combination of an individual mandate, Medicaid expansion, tax credits, and a purchasing pool.³⁸ The range is attributed to the degree of public program expansion. Their design assumes universal coverage.

Cost to individuals is also an important factor. The RAND simulation assessed individual financial risk before and after a mandate, and found little increase in the proportion of households with high levels of healthcare spending.³⁹ However, the median proportion of income spent on healthcare by the newly uninsured did increase substantially – from about three percent of income to six percent of income, this assumed that subsidies are available up to 400 percent of FPL and there is a substantial penalty for noncompliance.⁴⁰

V. OTHER CRITICISM

Individual mandates face opposition from both the political left and right. Aside from the enforcement issues, doubts that mandates will succeed, and increased costs to government to assure affordability, many are opposed to the basic philosophy of the mandate as inconsistent with fundamental American values of freedom and liberty.⁴¹ Skeptics on the right are suspicious of government's intrusion to assure that every American has health insurance, and with increased regulation see it as a first step towards greater government control of private medicine and private health insurance.⁴² There is concern on the right that a mandate coupled with a public plan option would lead to significant "crowd-out" of the private market, as the public plan could have an unfair pricing advantage (i.e. it is assumed that it would pay at Medicare rates that are 20-30 percent below commercial rates, making it attractive to businesses and individuals struggling with the rising costs of health coverage) and this option is a back-door approach to single payer.

Mandatory employer contributions often accompany mandate proposals and are a point of common opposition for business leaders along with other opponents of the mandate. Variations on this concept include employer "pay-or-play" mechanisms. It is argued that small businesses experience an unequal burden under such a mandate, because their costs of coverage would be much higher and put them at a competitive disadvantage to larger companies.⁴³

Groups on the left such as Consumer Watchdog are skeptical of the mandate, especially as it is publicly supported by the insurance industry.⁴⁴ The mandate would undoubtedly mean more business for the industry, and Watchdog deems their support as self-serving – to increase their profits without having to control costs and offer an affordable product. Expansion in the insurance market is strongly opposed by many single-payer advocates, who believe that "all rational health insurance companies will cherry pick [the healthiest people] as much as the law allows, since it's the proven method to increase profits."⁴⁵

Thus, the left would prefer to eliminate private insurance and cover everyone with a public program while the right wants to move away from employment-based insurance and public programs, and move towards voluntary individual insurance, supported by vouchers for those who cannot afford it. Both sides maintain that their favored solution would be far less costly than today's layer cake of public and private coverage.

VI. RECENT PROPOSALS

The individual mandate has been suggested in various forms in the health reform debate. Below is a sample of proposals that have some form of a mandate.

Barack Obama Presidential Campaign Proposal

President Obama did not support an individual mandate during the presidential campaign; instead he limited his proposal to a parental mandate to assure coverage for children. This was the biggest difference between the Obama and Clinton camps (see Clinton proposal below). He believed tax subsidies, a newly established public plan, and the formation of a National Health Insurance Exchange (NHIE) would expand coverage. He expressed reluctance to support a mandate until people could afford the cost of coverage and instead, he addressed the affordability issue first.⁴⁶

Hillary Clinton Presidential Campaign Proposal

During her presidential campaign, Secretary of State Clinton proposed an individual mandate as the centerpiece of her health reform plan. She focused on the need to include young and healthy individuals in the pool, thereby tackling the adverse selection and free rider issues. Clinton's proposal included an expansion of Medicare and the FEHBP to cover the uninsured, also it incorporated a tax subsidy for small businesses and families. The plan also included a guaranteed issue provision and a pay-or-play assessment on businesses who do not offer insurance. The fee was to help pay for coverage of the uninsured.⁴⁷

S.334: Healthy Americans Act (Senators Wyden and Bennett)

The Healthy Americans Act is a comprehensive bipartisan reform plan that includes an individual mandate. Under this bill, employers would no longer provide health insurance and would convert those costs into salary increases for their employees. Individuals would then use this money to buy individual insurance. Guaranteed issue and a minimum benefits package equal to the Blue Cross "standard" package would be required, and subsidies up to 400 percent FPL would be offered. The bill anticipates that \$200 billion would be saved by eliminating the employer tax deduction and that could be used to pay for the subsidies. The Lewin Group estimates a cumulative savings of \$1.5 trillion over ten years. It also would achieve federal budget neutrality.⁴⁸

Call to Action: Health Reform 2009 (Senator Baucus)

The white paper proposal released by Senator Baucus includes an individual mandate, with subsidies for individuals under 400 percent FPL. It proposes a new public plan

option. It would expand public programs for low-income individuals and provide for a Medicare buy-in program for the 55-64 age group. The proposal calls for an employer “pay-or-play” model based on size and includes a small business tax credit to help employers provide coverage.⁴⁹

AMA Proposal for Reform

The American Medical Association proposes an initial mandate on individuals above 500 percent FPL. Though only 11 percent of the uninsured are in this category, the AMA believes this group clearly passes a threshold of financial affordability and responsibility. Focusing on a small segment of the population could facilitate the development of enforcement procedures. The AMA anticipates that this action would establish an important precedent for future expansion of the concept. In its view, an expanded mandate would depend on the system of tax credits and subsidies proposed.⁵⁰

Table 6: Select Proposal Comparisons

	Obama Campaign Proposal	Clinton Campaign Proposal	S.334: Healthy Americans Act (Wyden, Bennett)	Baucus White paper
Individual Mandate	Children only	Yes	Yes	Yes
New Public Plan	Yes	No	No	Yes
Public Insurance Expansion	Yes	Yes	Converted to “wrap-around” supplemental coverage	Yes, plus Medicare buy-in for 55-64 age group
New purchasing pool	National Health Insurance Exchange (NHIE)	Not specified	State-based pools	Health Insurance Exchange
Minimum Benefits Package	FEHBP	FEHBP	Blue Cross “Standard” Package	Established by Health Coverage Council
Employer Role	Pay-or-play	Pay-or-play	Effectively removed	Pay-or-play
Tax credits	Individual and small business	Individual and small business	Individual only	Individual and small business

VII. HISTORY AND EFFECTIVENESS OF MANDATES

Looking more broadly, mandates appear in many policy contexts. It may be useful to review the experiences of other mandates and evidence of their successes (or lack thereof) across a range of issues.

Automobile Insurance

The most commonly discussed example of a mandate is the requirement for drivers to purchase liability insurance. Compulsory auto insurance was first introduced in Massachusetts in 1927 for bodily injury and property damage. By 2006, 47 states and the District of Columbia had enacted the mandate. Though compulsory, state comparisons show a wide range of compliance. According to the Property Casualty Insurance Bureau, the percentage of uninsured motorists by state varied from 4 percent to 43 percent of motorists, with the national average around 15 percent. The variation is attributed mostly to differences in penalties and enforcement.⁵¹

Enforcement measures to reduce noncompliance are central to the individual mandate debate, and a common point of contention in regard to auto insurance. Penalties for non-compliance range from no penalty at all to fines of \$5,000, revocation/suspension of vehicle registration and licenses, impounding of vehicles, and jail time. States with higher penalties tend to have higher compliance rates.⁵² The enforcement mechanisms in place vary; some states require proof of insurance when drivers register their automobile, while others rely on random spot checks.

The opposition to the individual health insurance mandate refers to studies showing that states with compulsory auto insurance have no lower rates of uninsurance than states without the law. A major loophole cited by some critics is the situation where drivers purchase insurance before renewing their registration and then cancel the policy shortly afterward unbeknownst to the state Department of Motor Vehicles (DMV).⁵³

Some states rely on electronic matching, where insurers must transmit insurance verifications to the DMV. The data is tracked in a database and allows the DMV to suspend uninsured motorist's car registration. Georgia implemented its Electronic Insurance Compliance System in 2001 and in less than two years witnessed a cut in the uninsured motorist rate from 20 percent to 2 percent. California implemented a similar reform in 2006 designed to track and improve compliance.⁵⁴

Other efforts to improve compliance in California include the California Low Cost Automobile (CLCA) Insurance Program.⁵⁵ The Program is meant to help low-income automobile owners meet the mandate by offering less coverage at lower rates since motorists' compliance is dictated primarily by affordability. Subsidies would be a necessary component of an individual mandate, and some would argue for a reduced benefits package as well, such as catastrophic coverage.

The auto insurance experience in states shows varying levels of effectiveness, and some states have been successful at improving compliance. Using the lessons learned with automobile insurance, affordability and routine tracking of coverage status may make a similar mandate of health insurance possible.

Enforcement Issues: Income Tax, Child Support, Minimum Wage

A mandate must be enforceable in order to achieve effective levels of compliance. This includes routine and systematic monitoring systems coupled with collectable penalties. Below are several examples of mandates that have had difficulty with enforcement.

Individual Income Tax

Some proposals recommend enforcement through the income tax system, which is a mandate. The IRS enforces compliance with the tax code through random, systematic audits of high-wage earners and suspicious returns. Penalties are based on severity of offense, ranging from a modest fine for underreporting to five-year prison terms for fraud. These penalties are not regularly enforced, which significantly reduces the effectiveness of the mandate. The IRS estimates that 84.5 percent of people paid taxes on time in 1998, with \$232 billion in uncollected taxes.⁵⁶ Studies have shown that increasing the audit rate promotes improved compliance.⁵⁷

Child Support

Noncustodial parents are required to provide financial support under state laws. The Social Security Act's enforcement of these provisions operates through the Child Support Enforcement (CSE) Program, a federal, state, and local partnership that operates a computerized State and Federal Parent Locator Service (FPLS). The system gathers a wide range of information from public and private records including employer new-hires and financial institutions. Noncompliance can trigger penalties through the tax system, frozen bank accounts, liens, or even jail time. Despite this structure, compliance is quite low. Only 30 percent of mothers who are owed support actually receive it.⁵⁸ Enforcement, a significant cost to states, is an obstacle for such laws, as well as the affordability of the underlying support order.

Minimum Wage

The federal minimum wage mandate is part of the Fair Labor Standards Act (FLSA), which is enforced by the Wage and Hour Division of the United State Department of Labor. Businesses that fail to comply are required to pay back wages. Businesses are required to maintain records on wages, though there is no penalty for incomplete records, which hinders enforcement.⁵⁹ States also have the option of imposing their own minimum wage, and some require third parties to monitor high-violation sectors (agriculture, garment production, etc.). National compliance rates range from 65 percent to 75 percent

and are highest in states with the most comprehensive monitoring, suggesting that surveillance is central to the mandate's effectiveness.⁶⁰

Effective Penalties: Childhood Immunizations

Vaccines for certain diseases have been required for entrance into schools since the 1960s. The costs of compliance are modest. The noncompliance penalty is most often exclusion from school. There are also varying exemptions, such as medical reasons or religious grounds, though less than one percent of students have any type of exemption.⁶¹ Overall, states with mandates show significantly higher immunization rates compared to states without the mandate, suggesting that a penalty for noncompliance improves compliance.⁶²

Hawaii Employer Mandate

An employer mandate is commonly associated with the individual mandate. The Prepaid Health Care Act in 1972 mandated that certain Hawaiian employers purchase health insurance for their employees. Though Hawaii's relatively low rate of uninsurance can partly be attributed to the demography and economy, the mandate effectively reduced the uninsurance rate by an estimated five percent to eight percent.⁶³ The mandate is enforced through random and routine audits, reports, and data matches. The penalty for non-compliance is a daily fee per employee for those employers who are not in compliance. To avoid the mandate, employment appears to have shifted toward those economic sectors and working arrangements exempt from the mandate, such as self-employment, part time, seasonal and other flex workforce arrangements.⁶⁴

VIII. MASSACHUSETTS

The Massachusetts Health Reform of 2006 was the first state expansion designed to achieve universal healthcare coverage. An important feature of the plan is the individual mandate. The plan began with Medicaid expansion in July 2006. By July 1st of the following year, all adults were required to have coverage and all employers with 11+ employees were required to offer a Section 125 health plan so that their employees could pay their premiums with pretax dollars. Employers with 11+ workers who did not offer a plan were subject to a “fair share” contribution of \$295 per employee. Enforcement of the individual mandate did not go into effect until January 1, 2008, when individuals were required to provide evidence of coverage or risk losing their personal state income tax deduction, and receive a fine monthly.

Each year an “affordability schedule” is developed which takes into account income levels and family sizes. A small percentage of the population is exempt from the mandate if the cost of insurance is not affordable or because of religious beliefs.⁶⁵

Commonwealth Care is the new program offering subsidized health insurance to those who do not qualify for public plans. Subsidies are provided, on a sliding scale basis, to those earning less than 300 percent of the FPL. Adults with incomes less than 150 percent to the FPL receive fully subsidized insurance. Adults with less than 300 percent FPL and children receive subsidized insurance (from the State Children’s Health Insurance Program (SCHIP)). A new state health entity, the Commonwealth Health Insurance Connector Authority facilitated the creation of a purchasing arrangement called Commonwealth Choice (CommChoice). The six private nonprofit plans in CommChoice operate through competitive bidding and represent 90 percent of the commercial market. A special low-priced Young Adults Plan is offered for individuals between the ages of 18 and 26. Effective 2009, health plans must offer minimum credible coverage (MCC), defined by the Connector.

The state experienced faster-than-anticipated enrollment of the uninsured. Original estimates of total uninsured ranged from 400,000 to 650,000. More than 430,000 individuals became insured: 187,000 in private commercial insurance, 165,000 in CommCare (with 50,000 partially contributing towards premiums), and 76,000 in MassHealth (Medicaid). The latest insurance rate for Massachusetts is estimated at 97.4 percent. There is no evidence of crowd-out of employer coverage for low-income adults, and the offering rate for firms with 3+ employees increased from 73 percent to 79 percent.⁶⁶

Table 7: Newly Insured Residents to Date Since Reform

Private Insurance	187,000
CommCare	165,000 (with 50,000 partially contributing towards premiums)
MassHealth (Medicaid)	76,000
Total	430,000

Source: Massachusetts Health Connector Data, 2009

The FY08 Commonwealth Care budget was \$472 million, though final spending came to \$628 million due to an unexpected increase in numbers of uninsured eligible for subsidies and their speed of enrollment. The Connector data shows that the cost per covered life is actually below budget.

Critics argue that even though the reform decreased the uninsurance rate, it has not contained health costs, and the mandate is merely a tax on the uninsured. Sidney Wolfe, MD of Public Citizen and Rachel Nardin, President of the Massachusetts chapter of Physicians for National Health Reform claim that the private insurers are driving up costs, rather than restraining them, and safety-net providers like public hospitals and community clinics are being damaged.⁶⁷

Table 8: Comparing California and Massachusetts

	California	Massachusetts
Medicaid/SCHIP eligibility for kids	250%	300%
Medicaid/SCHIP eligibility for infants	300%	300%
Eligibility for Parents (FPL)	100%	300%
Eligibility for MIA	No	Yes
Population <100% FPL	19%	16%
Population 100-199% FPL	21%	15%
Median Household Income	\$55,864	\$58,286
Unemployment rate, January 2009	10%	7%
Uninsured Rate	20%	2.6%

Source: www.statehealthfacts.org

IX. INTERNATIONAL PERSPECTIVE

The following countries use individual mandates, which may provide insight for consideration in the United States. Though these countries are small and homogeneous compared to United States or California's demography, the core policies, concepts, and experiences may be useful for comparison.

The Netherlands

The 2006 Health Insurance Act set into place a privatized structure "as a way to realize a neoliberal, entrepreneurial, business-oriented, private sector health insurance system."⁶⁸ The Dutch system includes an individual mandate with guaranteed issue, basic benefits package, and community-rated premiums combined with a sliding-scale subsidy that assists about 38 percent of the population. Voluntary supplemental plans that cover extended services are offered; about 90 percent of citizens purchase a supplementary plan.

A percentage of plan premiums is withheld and paid into a risk equalization fund to reduce risk gaming by health insurers. Risk adjustment funds are paid to those insurance companies who have a disproportionate share of costly enrollees (determined through a complex formula), and conversely those with healthier individuals must pay into the fund. There is concern that the fund may undermine efforts towards cost-effective care as it rewards those plans who are least successful in controlling costs, and economists are urging the government to modify the system so it is more future-oriented, encourages efficiency and rewards subscribers' improved health outcomes, as opposed to retrospectively rewarding those companies with high expenses due, for example, to poor management of patients' care.

An estimated 1.5 percent of the population is uninsured, and the government is tracking these individuals. If nonenrollment persists, these persons may be auto-enrolled with an insurer. Another 1.5 percent of the population is enrolled but neglects to pay their premiums. Officials intend to create an automatic wage deduction to enforce compliance.⁶⁹

Switzerland

The Swiss model embraces market competition, coupled with an individual mandate that achieves over 99 percent compliance rate. Switzerland operates a risk equalization scheme to discourage cherry picking; the formula is comparatively simpler than the Dutch model; it accounts only for age and gender. Due to widespread agreement that this approach fails to adjust risk adequately, the formula will be modified substantially in 2012.⁷⁰

Enforcement of the mandate is done by the 26 Swiss cantons. Compliance is monitored through data matches and is facilitated by a yearly open enrollment period. Plans operate and compete at the canton level, and offer supplementary coverage that is obtained by most. Consequences of such a decentralized system include higher degrees of inefficiency and duplication of services.

X. CONCLUDING THOUGHTS

Many believe an individual mandate is necessary to achieve universal healthcare coverage. It is believed the mandate could be implemented within the existing system of public and private coverage. It introduces new challenges to assure affordability and availability of coverage, improved efficiency of the individual market and citizens' compliance with the mandate. Opponents critique the greater involvement of government in our individual lives that a mandate demands, and raises concerns about the reform's ability to restrain rising health costs.

Single payer was not a part of this report, nor was cost containment; however the California health reform debate has focused on the choice between the single payer and shared responsibility with an individual mandate component. Single-payer and shared responsibility models are two, among many, ways to get to universal coverage, there are three key differences between these systems:

1. The single-payer system would eliminate most private health insurance, while a shared responsibility mandate seeks to reform it;
2. The single-payer system relies on the government to pay the medical bills and control spending, whereas the shared responsibility model retains the mixed public/private system; and
3. The single-payer system introduces increased regulation to control rising health costs, as opposed to greater reliance on market and competitive incentives in the shared responsibility model.

Solving the conundrum of dependence on employer-based healthcare coverage and increases in healthcare costs has been problematic for many years. Healthcare insurance coverage is increasingly unaffordable for both the public and private payers, and California's residents are becoming either uninsured or underinsured. The "shared responsibility" approach, with its reliance upon an individual mandate, offers a promise to achieve universal healthcare coverage. The experience of California in its attempt to achieve a "shared responsibility" approach to universal healthcare coverage may provide important insights for enacting a federal program.

Related Reading:

- Blumberg, L., Holahan, J., Do Individual Mandates Matter? (Urban Institute, January 29, 2008) at <http://www.urban.org/publications/411603.html>
- Glied, S., Hartz, J., Giori, G., Consider it Done? The Likely Efficacy of Mandates for Health Insurance, *Health Affairs*, 26:6:1612-1621
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- Ask the Experts: Individual Mandate, Kaiser Network HealthCast, Washington, D.C., January 31, 2008 at http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2486
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XI. ENDNOTES

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