Individual Mandates: What are they, do they matter, and how do we make them work?

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What is an individual mandate?

A requirement that all individuals in a defined population (e.g., children, adults, all permanent residents) obtain health insurance coverage (public or private) that satisfies a minimum standard.

Mandated level of coverage must be made available to all.

- Currently, no guaranteed source for purchasing coverage.
- Implementation requires that all have access to coverage that meets the minimum standards.
- Likely to require changes to market regulations and/or creation of new purchasing options/entities.

Mandated level of coverage must be made affordable.

- Public insurance coverage and/or subsidized private insurance plans can be used to provide affordable coverage.
- Affordability standards must be set for individuals at different socio-economic levels.
- Complete mandates require subsidizing up to those affordability standards, otherwise exceptions to the mandate will be necessary.

Coverage should be adequate to provide effective access to necessary care.

- Minimum coverage standards sufficient for the high-income may not provide the low-income with adequate access;
- Subsidies for different income groups would ideally be pegged to coverage that would provide them with effective access to care at an affordable level.
  - Must take premium **and** out-of-pocket liability into account.

Why does an individual mandate matter?

- Universal coverage can't be achieved without one;
- Adverse selection will occur under a voluntary system;
- Necessary to redirect current spending on the uninsured to finance reforms.

Evidence on voluntary participation

- Abundant evidence that voluntary options will leave many uninsured;
- Depending upon the generosity of subsidies and associated market reforms, researchers find the uninsured can be reduced by 30-50% with voluntary measures;
- As prices increase over time, uninsured would grow.

Implications of Adverse Selection

- Voluntary participants in a new subsidized, more accessible insurance option are those who are older & less healthy than average.
- This selection will increase average costs of new plan.
  - Higher premiums for enrollees unless government intervenes by subsidizing risk or redistributing costs in another way.
  - Further dissuades healthy from participating;
  - Dissuades insurers from participating.

Implications of Adverse Selection, continued

- Spreading risk with a mandate is much easier:
  - Costs of high need can be spread broadly, at low marginal cost to the healthy;
  - No dissuading coverage among the healthy,
  - Pool wouldn't get more expensive due to insured population decreasing over time.
- Primary impact of mandate: increased financing burden on the younger and healthier. However,
  - Their access to health insurance and medical care is more stable and secure;
  - Young with modest incomes can be protected via income-related subsidies.

Insurance reforms and mandates

- No risk selection in and out of insurance market means:
  - no need for coverage denials;
  - no need to medically underwrite policies;
  - could allow limited age rating or not;
    - Age rating will require subsidies to apply to higher incomes to keep coverage affordable for near elderly;
    - Pure community rating in near term would be more disruptive in terms of price changes. If want this, can consider phasing into it.
  - depending upon insurance options, may need some risk adjustment across plans.

Insurance exchanges can plan useful role in:

- Risk spreading;
- Cost containment;
- Delivering subsidies;
- Facilitating & ensuring enrollment;
- Ensuring meaningful coverage;
- Promoting health insurance transparency;
- Promoting health insurance accountability.

Sources of Financing for Health Reform

- Individual mandate frees up current public spending.
  - Safety net hospital support from Mcaid/Mcare;
  - Other spending on the uninsured;
- Voluntary reform still expensive as it attracts the higher need, but politically tough to redirect $.
  - Reluctant enrollees relatively inexpensive but greatly increases claim to public funding.

Long-run financing issues

- Long-run costs issues are same as the ones we face today without a mandate:
  - Increased chronic illness;
  - Growth in health technology;
  - Prescription drug cost growth;
  - Market imperfections –
    - Insurer consolidation + Provider consolidation ⟹ lack of competition

Options to address long-run costs, increasing in power

- Managed competition;
- Public insurance plan option;
- Exchange as provider rate negotiator;
- All-payer rate setting.

Mandate Enforcement

- Necessary to reach universal coverage and matter of fairness;
- Primary focus –
  - Make it easy to enroll in qualifying coverage.
    - Outreach and education investment;
    - Easy enrollment options
      - Learn from best public programs (short applications, on-line, mail, wide array of in-person options including schools);
      - Provider involvement
      - Employer involvement

Mandate enforcement, continued

- Secondarily, will need penalties.
  - Initially small, as bugs worked out;
  - My preferred approach is to deem people as covered and enroll them, using penalties primarily to collect unpaid premiums.
    - Back premiums paid to insurers;
    - Penalty add-on goes to state coffers;
    - Back premiums owed take subsidy eligibility into account.
- Penalties assessed at tax time;
  - Insurers required to provide form with info on coverage during year;
  - Failure to report leads to tax penalties.

Summary

- Absent single payer, no universal coverage without a mandate;
- Voluntary measures will enroll the higher cost, creating high premiums and instability in insurance pools without large addt'l gov't subsidies.
- Can't lay claim to current gov't dollars without full coverage.
- Long-run financing issues are central, regardless of mandate or not.
- Enforcement can be designed to feel more like enrollment than punishment.