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The Case for the Individual Mandate in Health Care Reform

A Comprehensive Review of the Evidence

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Introduction and summary

Until all Americans have access to health insurance in 2014 under the Affordable Care Act, 50 million people lack health insurance. Before the legislation is fully phased in, Americans can be charged higher premiums when they are sick, and adults can be denied coverage because of a pre-existing condition. Oftentimes, all it takes is one illness or injury to send a family into bankruptcy. Illness or medical bills cause 62 percent of all personal bankruptcies, and a significant portion of medically bankrupted families lacked health insurance or experienced a recent lapse in coverage.[1]

In short, health insurance does not provide security to those who need it the most.

Moreover, caring for the uninsured when they show up at emergency rooms exacts high costs on our society. The uninsured still receive health care—much of which is not paid for—at a cost of $57.4 billion in 2008, the last year for which data is available.[2] That uncompensated care is paid for by taxpayers through public programs, by health care providers through lost profits, and by providers shifting costs to private insurers. In turn, private insurers may increase premiums. According to one estimate this cost shifting increases family premiums by more than $1,000 per year on average.[3]

While the uninsured still receive health care, they use much fewer health care services and do not receive all of the health care they need, which harms their health. The poorer health and shorter lifespans of the uninsured are estimated to cost the economy $207 billion a year.[4]

Those who do have health insurance are at risk of losing it if they lose their job. Moreover, this risk may discourage employees from starting their own business or moving to a job in which they would be more productive—causing so-called "job lock."

All of these problems have plagued the health care system for decades. If we want to solve them—but continue to rely on private health insurance markets—then

the most effective solution involves a requirement to maintain health insurance coverage, known as an "individual mandate." That is the approach taken by the national health reform legislation signed into law in 2010, the Affordable Care Act.

In this report we will examine why the individual mandate is an essential pillar of comprehensive health care reform. In states that tried market reforms without a mandate, premiums increased significantly and enrollment declined. By contrast, the Massachusetts health reform law enacted in 2006 included a mandate with the result that coverage is now near universal. Independent analyses of the Affordable Care Act indicate that the mandate will be instrumental in achieving near-universal coverage, and that it will reduce premiums. Significantly, there is no evidence that any alternatives to the mandate would be nearly as effective.

The problem of adverse selection

To guarantee access to health insurance at a premium rate that is affordable, the law must prohibit discrimination based on health status. That means requiring an insurer to enroll all individuals who apply for coverage even if they are sick or have a pre-existing condition—known as "guaranteed issue." It also means prohibiting an insurer from charging higher premiums for that coverage if an individual is sick or injured and regulating how much premiums can vary based on age—known as "modified community rating." Otherwise, older, less healthy individuals would be priced out of the market, and the guarantee to enroll in coverage would do them no good. Finally, it means prohibiting an insurer from excluding coverage of pre-existing conditions.

If all of these reforms were implemented by themselves, then many individuals would wait to get health insurance until they need care—knowing that coverage will be guaranteed at a premium rate that will not rise because they are sick or injured. Less healthy, more costly individuals would be more likely to enroll in coverage and would largely make up the insurance risk pool.[5] This "adverse selection" would drive up premiums, which in turn would cause even more healthy individuals to drop coverage—possibly leading to a so-called "death spiral." Higher premiums would also significantly increase the cost to taxpayers of providing premium tax credits to make coverage affordable.

This adverse selection in the absence of an individual mandate is not theoretical. There is substantial evidence from the experience of several states. A classic example is New Jersey.[6] In 1993 the state implemented guaranteed insurance issuance and community rating in its direct-purchase market—where individuals buy health insurance directly from an insurer, not through their employer. Older, more costly individuals enrolled in coverage, and premiums rose by up to 155 percent from 1996 to 2000. Even the premium of the state's Health Maintenance Organization plan—which more aggressively manages costs—rose by 48 percent over this period. As a result, overall enrollment declined by 41 percent in the same period—consistent with a death spiral caused by adverse selection.

New Jersey was not the only laboratory for this experiment. Kentucky, Maine, New Hampshire, New York, Vermont, and Washington all enacted laws designed to guarantee access to health insurance without an individual mandate. In every state these laws destabilized the direct-purchase market—increasing premiums, reducing enrollment, or causing insurers to exit the market. Some of these states, such as Kentucky, were ultimately forced to repeal these laws. As could be expected, in states where community rating is currently in effect, premiums in the direct-purchase market are among the highest in the country.[7]

Options to maximize participation

To address the problem of adverse selection—which can be exacerbated by regulations that guarantee access—reform must maximize participation in the system to ensure a broad insurance risk pool that includes young and healthy individuals. Of course, one way to ensure universal participation—common throughout the industrialized world—would be to adopt a so-called "single-payer system." In these systems, premiums are, in effect, collected by governments through the tax system, making participation mandatory.

In the United States, Medicare Part A—which pays for hospital care—is a good example. During their working years, individuals make contributions through a payroll tax, which pays for "free" insurance for hospital care after age 65. Signing up isn't necessary because participation in this financing arrangement is mandatory.

Short of this approach, individuals could be required to pay premiums for their health insurance through an individual mandate. Indeed, the individual mandate was originally a conservative idea born as a private-sector alternative to a single-payer system or an employer mandate.

The Heritage Foundation, a conservative think tank, first proposed an individual mandate in 1989.[8] Conservative economists also proposed a mandate as part of a plan that "supports and makes use of competitive markets" and "avoids relying on the public tax or expenditure systems whenever possible."[9] In 1993, Sen. John Chafee (R-RI)—along with 18 Republican co-sponsors—introduced legislation that included a mandate as an alternative to the Clinton health reform plan.[10]

These conservatives also recognized that individuals have a responsibility to pay for their own health care when they can afford to do so. An individual mandate was necessary to prevent individuals from becoming free-riders who impose their costs on others. Thus, as the Heritage Foundation put it, "each household has the obligation, to the extent it is able, to avoid placing demands on society by protecting itself."[11]

Short of a single-payer system, it is not possible to achieve near-universal coverage in the absence of an individual mandate. Premium subsidies alone would increase participation but would not come close to achieving universal coverage. Even generous premium subsidies would cover only 40 percent to 50 percent of the uninsured.[12] The nonpartisan Congressional Budget Office estimates that in the absence of the mandate, the Affordable Care Act would cover only half as many people.[13] This is consistent with other estimates.[14]

According to the American Academy of Actuaries, an individual mandate would be more effective than other types of incentives to increase participation such as penalties for delayed enrollment or automatic enrollment.[15] Medicare Part B (for physician services) and Part D (for prescription drugs) use late enrollment penalties and achieve high participation. But all enrollees are heavily subsidized, and seniors would likely enroll anyway because they know that they will need care. Available estimates indicate that such alternatives would cover substantially fewer people while increasing premiums in the direct-purchase market as a result of adverse selection.[16]

Evidence of the effectiveness of an individual mandate

While the effectiveness of alternatives to an individual mandate is purely theoretical, there is substantial evidence from actual experience—both internationally and in the United States—that mandates are effective.

Both Switzerland and the Netherlands achieve near-universal coverage through an individual mandate.[17] Both countries require insurers to enroll all individuals who apply for coverage, and both countries prohibit insurers from charging higher premiums based on health status.

In Switzerland, which implemented a mandate in 1996, regional estimates indicate that the rate of uninsured is now below 1 percent, and 1.6 percent of the population are enrolled in coverage but do not pay their premiums. In the Netherlands, which implemented a mandate in 2006, the rate of uninsured is about 1.5 percent, and 1.5 percent of the population are enrolled in coverage but do not pay their premiums. Of those who remain uninsured in the Netherlands, 54 percent are immigrants or their children.

The experience in Massachusetts

In the United States, health reform in Massachusetts contained the same basic building blocks as national health reform: regulations prohibiting discrimination based on health status, premium subsidies, a health insurance exchange, and an individual mandate. But the program in Massachusetts started almost a year before the mandate went into effect. As a result, the least healthy individuals were the first to enroll in coverage—as could be expected.[18] Those individuals were almost four years older, were almost 50 percent more likely to be chronically ill, and had about 45 percent higher health care costs than those who enrolled after the mandate was fully implemented.[19]

Once the individual mandate was fully effective, it worked as designed to bring healthy individuals into the insurance risk pool, and the program achieved near-universal coverage. Since 2006, more than 411,000 individuals have enrolled, reducing the share of uninsured individuals to only 1.9 percent in 2010.[20]

In Massachusetts, the individual mandate, combined with other reforms, has also strengthened employer-based coverage. If employees are obligated to have insurance, they increase their demand for their employers to offer it. Since 2005, the percentage of employers that offer coverage has actually increased in Massachusetts from 70 percent to 77 percent.[21]

The individual mandate in Massachusetts is broadly comparable in scope and magnitude to the mandate under the Affordable Care Act. Both mandates exempt low-income individuals. The mandate in Massachusetts exempts those with income below 150 percent of the federal poverty level, whereas the federal mandate exempts those with income below the federal income tax filing threshold (roughly 90 percent of the federal poverty level).

Both mandates also exempt individuals who cannot afford coverage. The mandate in Massachusetts exempts those for whom the premium of the lowest-cost plan exceeds an affordability threshold. The federal mandate exempts those for whom the premium of the lowest-cost plan exceeds 8 percent of income.

Under both individual mandates, even if a penalty would usually apply to an individual, the individual may claim an exemption due to financial hardship. In addition, both mandates exempt those who refuse to obtain health insurance because of their religious beliefs. While the mandate in Massachusetts only applies to adults, the federal mandate applies to taxpayers and their dependents, requiring taxpayers to pay reduced penalties on behalf of their dependents.

In Massachusetts the penalty for not having qualified insurance is 50 percent of the amount that an individual would pay for the lowest-cost plan after taking into account any premium subsidy. Under the Affordable Care Act, the fully phased-in penalty in 2016 will be the greater of $695 per adult (half of that for children) or 2.5 percent of the amount of income that exceeds the federal income tax filing threshold. But the penalty may not exceed an overall cap equal to the national average premium of the lowest-cost plan.

Differences in design mean that the individual mandate under the Affordable Care Act will be stronger for some individuals and weaker for others.[22] Fewer people with income below 300 percent of the federal poverty level will be exempt under the federal mandate. Moreover, the federal penalties will be higher for people with income below 250 percent of the federal poverty level. On average, the federal penalties, once fully phased in (in 2016), will be slightly higher than the penalties in Massachusetts—about $674 per person under the federal law compared to $537 per person in Massachusetts.[23]

Given the experience in Massachusetts, there is reason to believe that the individual mandate will be effective nationally. Since the premium subsidies are smaller under the Affordable Care Act than under the Massachusetts law, the federal mandate is that much more critical to bringing healthy individuals into the insurance risk pool.

Independent analyses of the Affordable Care Act

The experience in Massachusetts has informed analyses of the Affordable Care Act.[24] According to the most recent estimates of the nonpartisan Congressional Budget Office, the new law will cover and additional 34 million people, a coverage rate of 95 percent.[25] Other independent analyses have produced similar results.[26] In particular, the RAND Corporation found that the individual mandate by itself is the provision that contributes the most to increasing coverage.[27] Of those who will remain uninsured, one-third will be undocumented immigrants, and one-quarter will be eligible for Medicaid.[28]

Given this significant reduction in the number of the uninsured, it is not surprising that the individual mandate will also significantly reduce the cost of uncompensated care. With the mandate, the Affordable Care Act will reduce the cost of uncompensated care by $39 billion, compared a reduction of only $19 billion with the Affordable Care Act structure without a mandate.[29] This indicates that the uninsured do shift costs to taxpayers, health care providers, and private health insurance—and that a reduction in this cost shifting will save taxpayers money, increase provider revenue, and lower private health insurance premiums.

Moreover, estimates indicate that the individual mandate will work as intended to counter adverse selection. The CBO concluded that the mandate will "encourage a broad range of people to take up coverage in the exchanges."[30] As a result, the CBO estimates that the influx of healthier enrollees will reduce average premiums by up

to 10 percent in the direct-purchase market. Conversely, eliminating the mandate would result in adverse selection, increasing premiums by up to 20 percent in the direct-purchase market.[31] This is consistent with other estimates.[32]

Similarly, in the market for employer-based coverage, the CBO concluded that the individual mandate will induce "younger and relatively healthy workers who might otherwise not enroll in their employers' plans to do so."[33] In addition the mandate will increase the percentage of small-business employers that offer coverage—and those employers that newly offer coverage will be more likely to have healthier employees. Both effects will reduce average premiums slightly. Overall the CBO estimates that premiums for employer-based coverage will remain stable.

As in Massachusetts, the individual mandate will also bolster private health insurance coverage. The CBO estimates that in the absence of the mandate, about 4 million to 5 million fewer people would be enrolled in employer-based coverage.[34] The share of people covered by private health insurance would decline—and would actually be lower than under current law.[35]

Importantly, the individual mandate yields the most "bang for the buck"—increasing coverage by as much as possible for the least possible cost. By bringing healthy individuals into the insurance risk pool, the mandate will lower the average cost per person, reducing the cost of premium tax credits. With the mandate, many of the newly insured will gain private coverage, which also lowers the cost to the government. The CBO estimates indicate that inclusion of the mandate will increase coverage by 100 percent at a cost increase of only 31 percent.[36] With the mandate, government spending for each newly insured person will be slightly more than half of what it would be without a mandate.[37]

In short, the individual mandate is essential to making health care reform cost-effective.

Other components of the Affordable Care Act

To be sure, several components of the Affordable Care Act are also important in achieving near-universal health insurance coverage and mitigating adverse selection. The new law:

- Expands Medicaid coverage to all individuals with income below 138 percent of

the federal poverty level, which will increase enrollment by 17 million people[38]
- Creates state-based health insurance exchanges—online marketplaces where individuals and small businesses can easily shop for and enroll in quality plans
- Provides premium tax credits to individuals, structured to guarantee that premiums will never exceed a certain percentage of income
- Provides tax credits to small businesses for up to 50 percent of their health insurance costs
- Collects payments from plans that have healthier enrollees and makes payments to plans that have less healthy enrollees, on average—known as "risk adjustment"
- Provides insurers with insurance against high-cost enrollees—known as "reinsurance"

To reinforce the individual mandate, several reforms also help ensure broad participation among young people. As of September 2010, young adults can remain on their parents' plans until age 26. This reform has already had a significant impact, covering an additional 2.5 million young adults.[39] In 2014, more than 90 percent of young people enrolling through exchanges will be eligible for premium tax credits.[40] In addition, young adults under the age of 30 will be able to enroll in a low-cost catastrophic plan.[41]

Conclusion

The individual mandate is the most controversial aspect of health care reform. If Americans are prepared to accept a system in which those who are sick or have a pre-existing condition can be denied coverage or charged exorbitant premiums and can shift their costs to others, then a mandate is not necessary. But if Americans want a health care system that eliminates discrimination based on health status, then a mandate is essential to making the system work effectively. All known empirical evidence—both evidence of failure in several states, and evidence of success in Massachusetts—supports this conclusion.

Moreover, there is no evidence that any alternatives would achieve anywhere close to universal coverage. In every health care system that has achieved near-universal coverage, health insurance is mandatory. Some systems—such as Canada, Great Britain, Germany, and France—make it mandatory through the tax system. Others—Switzerland, the Netherlands, and Massachusetts—simply obligate individuals to maintain health insurance. As an alternative to a single-payer system, conservative economists and Republicans originally endorsed this latter approach.

Research and analysis indicate that the individual mandate will not just achieve near-universal coverage. The mandate will also:

- Significantly reduce the cost of uncompensated care
- Lower premiums in both the direct-purchase market and the market for employer-based coverage
- Increase the percentage of small businesses that offer coverage
- Increase enrollment in employer-based coverage
- Increase the cost-effectiveness of reform—its "bang for the buck"

All independent analyses consistently reach these results.

The individual mandate—and the participation that it encourages—affirms the nature of insurance. Insurance is protection against risks that are unknown and involves the sharing of risk. At any given point in time, some individuals will have higher costs, and others will have lower costs—and they will balance each other out. But over the course of a lifetime, the premiums that an individual pays should roughly reflect that individual's costs. Young and healthy individuals may not need health care at a given point in time, but insurance protects them and society against the financial catastrophe of an illness or accident. Moreover, their participation enables their continued participation over time as they age—and enables the sharing of risk, which is what makes insurance work in the first place.

About the authors

Neera Tanden is President of the Center for American Progress and one of our nation's leading experts on comprehensive health care. She previously served as senior advisor for health reform at the Department of Health and Human Services, advising Secretary Kathleen Sebelius and working on President Barack Obama's health reform team in the White House to pass the Affordable Care Act. In that role she developed policies around reform and worked with Congress on particular provisions of the legislation.

Prior to that, Tanden was the director of domestic policy for the Obama-Biden presidential campaign, where she managed all domestic policy proposals. She also served as policy director for the Hillary Clinton presidential campaign where she directed all policy work. Before the presidential campaign Tanden was Senior Vice President for Academic Affairs at CAP. She was one of the first senior staff members at the Center, joining as Senior Vice President for Domestic Policy when CAP first opened its doors. Prior to joining CAP Tanden was Hillary Clinton's deputy campaign manager and issues director for her Senate campaign in New York. Tanden also served as associate director for domestic policy in the Clinton White House and senior policy advisor to the first lady.

Topher Spiro is the Managing Director of Health Policy at the Center for American Progress, where he has primary responsibility for developing and managing all aspects of CAP's work across a broad range of issues, including implementation of the Affordable Care Act and cost containment. Prior to joining CAP Spiro worked on health care reform at both the federal and state levels. He served as deputy staff director for health policy for the U.S. Senate Committee on Health, Education, Labor, and Pensions under Sen. Edward M. Kennedy (D-MA) and Sen. Tom Harkin (D-IA).

At the committee Spiro was a member of the team that drafted the Affordable Care Act of 2010. He has also served in other senior roles in the Senate, as senior policy advisor for Sen. Jack Reed (D-RI) and for the Senate Special Committee on Aging. In addition to his Senate service, Spiro served as health policy director for the Rhode Island Healthcare Reform Commission, where he coordinated implementation of health reform and led the stakeholder consultation process for the Rhode Island Health Benefits Exchange.

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