



Health Policy Brief

January 13, 2010

Individual Mandate: Congress is now weighing different versions of a requirement that individuals obtain health insurance.

What's the issue?

The separate versions of health reform legislation passed by the two houses of Congress would impose a national individual mandate requiring most Americans to have health insurance. New standards would be set to determine “acceptable” minimum coverage and spell out how much people needed to contribute out of their own pockets. Depending on an individual’s circumstances, coverage could be obtained in various ways, including through employers, through government health programs, or through new federal or state health insurance exchanges. Subsidies would make coverage more affordable for low- and moderate-income people, and insurance market reforms would make coverage more accessible and reliable. Penalties would be imposed on individuals who did not obtain coverage and who were not exempted from the requirement for various reasons.

For supporters, including President Barack Obama, the individual mandate is an essential part of national health reform. Requiring everyone to have or to contribute toward health insurance is viewed as central to reducing the number of uninsured people. Health insurers also regard an

individual mandate as a critical element of a package of reforms that would require them to abandon some practices and meet new requirements.

Opponents of an individual mandate object for different reasons. Some who are or lean libertarian consider the proposal a coercive move by government. Others object to the fact that the mandate would force many people to spend a sizable portion of their incomes on health insurance — perhaps for coverage that is not especially generous. Still others consider an individual mandate unenforceable.

As described below, a number of technical aspects of a mandate would be critical to determining how well it would either accomplish supporters’ goals for coverage or feed opponents’ fears about the cost burden that would be imposed on many.

What's the background?

This is not the first time an individual mandate has been proposed at the national level in the United States. The concept was put forward in 1993 as part of the Health Security Act, the national health reform legislation proposed by then-

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President Bill Clinton. It was also the centerpiece of alternative reform proposals, such as that proposed by Rep. Jim Cooper, then representing Tennessee’s 4th District.

The concept died with the collapse of health reform efforts in 1994, but it surfaced again during the 2008 presidential campaign, when it was a subject of debate among Democratic candidates. Then — New York Senator Hillary Clinton proposed an individual mandate as part of her plan. Then-candidate Obama proposed a mandate requiring parents to make certain their children were covered, but said an individual mandate was not part of his initial plan. However, he said an individual mandate could be considered following implementation of major health reform if it were deemed necessary to expand coverage.

In 2006, Massachusetts became the first state in the nation to require all residents age 18 and older to have health insurance. The state also enacted several other measures to expand coverage in other ways and to facilitate compliance with the mandate.

The mandate, which took effect in 2007, includes these key provisions:

- Residents must confirm on their state income tax forms that they have insurance, unless their incomes are such that they are deemed unable to obtain “affordable” coverage. The affordability levels are set each year by a newly created, independent, quasi-governmental agency called the Commonwealth Health Insurance Connector. People with incomes below 150 percent of the federal poverty guideline (FPG), or \$16,245 for a single individual in 2010, are considered to be unable to contribute anything towards premiums, so no penalty is imposed if they do not obtain coverage. A person whose income is 450 percent of poverty, or \$54,600, is deemed to be able to afford an annual premium of \$4,104 — about 8 percent of income. Hardship waivers are available for people whose income is sufficient to pay for coverage but who have other pressing financial needs.
- The Connector also serves as an intermediary, helping individuals and small businesses acquire health coverage. The coverage must meet certain standards that, among other things, specify the types of benefits that must be included in policies. Through the Connector,

individuals can qualify for state-subsidized health coverage or purchase private health insurance; eligibility for subsidies, however, depends on their income levels, whether or not they have employer-sponsored coverage and their immigration status (at present, neither legal or illegal immigrants qualify for subsidies). Offerings available through the Connector include new low-cost plans for 18-to-26-year-olds, with lower benefits, significant cost sharing, and annual benefit maximums as low as \$50,000.

- Individuals who are subject to the requirement but do not comply must pay penalties equivalent to a portion of the costs of health insurance. In 2009, the maximum penalty is \$624 for 18-to-26 year-olds and \$1,068 for those aged 27 and older.

The Massachusetts law has other features, including a requirement that employers with 11 or more workers either contribute to employees’ health insurance or pay a penalty. The individual mandate has been one reason that the uninsurance rate among nonelderly Massachusetts adults has fallen from an estimated 13 percent in 2006 to 3.5 percent in 2009. (Overall, the insurance rate for the state is estimated to have risen to 97.4 percent in 2009). In part, the mandate appears to have prompted more workers eligible for employer coverage to enroll in the coverage offered to them. In the second year of the mandate, 2008, 1.1 percent of taxpayers paid a penalty rather than buy coverage.

A number of other states, including California, Maryland, Maine, and Washington, have also considered individual mandates but not adopted them. And several European countries have also enacted individual mandates, often in the context of major health reforms. Switzerland adopted an individual mandate in 1996. Strict penalties enforced by the Swiss cantons, or provinces, are imposed on those who do not purchase health insurance for infants within three months of birth or after moving to Switzerland. The Swiss mandate has helped achieve a 99 percent compliance rate. The Netherlands in 2006 mandated that individuals purchase health insurance or face a penalty of 130 percent of premiums. Early reports from the first year of implementation suggest that 98.9 percent of residents enrolled in health insurance.

What's proposed?

An individual mandate is a key component of legislative health reform proposals that have passed the House of Representatives and the Senate as this brief is published. But at the same time, a mandate is only one part of complex reform plans in which the various pieces are to a large extent interdependent.

For example, if policymakers decide there should be an individual mandate, they must also decide what type or amount of coverage people must have and must assure that this coverage is available to everyone subject to the mandate. What's more, since not everyone will be able to afford the full costs of coverage, policymakers must decide what, if any, financial or other assistance will be available to help people buy it. There are also questions about what the penalties for not obtaining coverage will be, who will be exempt for financial or other reasons, and how the rules will be enforced. If penalties are imposed through the tax system, for example, people who don't file taxes could in effect escape the requirement.

The following is a description of how these issues are addressed in the House bill, the Affordable Health Care for America Act (H.R. 3962), and the Senate bill, the Patient Protection and Affordable Care Act. (The Senate proposal was passed as an amendment to an unrelated House-passed tax bill, H.R. 3590.)

Basic requirement and definition of acceptable coverage: The two bills require all legal residents — with exceptions to be described below — to have coverage meeting minimum standards. The two bills include broad definitions of “essential benefits” for individual insurance coverage, with details to be set by the Secretary of Health and Human Services. The House-defined minimum policy would cover 70% of costs for these benefits, compared to 60% in the Senate bill. Remaining costs would be paid by enrollees in the form of deductibles, copayments, or coinsurance.

People would comply with the mandate by buying coverage on their own or through an insurance exchange; by enrolling in Medicare, Medicaid, or another government program for which they qualified; or by enrolling in an employment-based plan. A “grandfather” clause would let people who already have individual or employer

coverage continue that coverage, even though it might not meet the new benefit standards. (In the House bill, employers would have to meet the standards within five years.) The mandate would take effect in 2013 in the House bill, and in 2014 in the Senate bill.

Exemptions: Both bills would exempt certain people from penalties for failing to comply with the mandate. These would include people for whom buying coverage would be a “financial hardship,” as explained more fully below; people with religious objections to health coverage; people not legally resident in the United States; and those who only went without insurance coverage for short periods of time (3 months in the House bill but for an unspecified period in the Senate bill). The Senate bill also exempts anyone with income below 100% of the federal poverty level, although for the vast majority of such persons, coverage would be available through Medicaid. Unlike the Massachusetts plan, neither bill would exempt children.

A key difference in the bills is the way that “hardship” is defined. The House leaves the definition to be set by the Secretary of Health and Human Services and a new Health Choices Commissioner. This is similar to the approach adopted in Massachusetts, where the Massachusetts Connector Authority sets affordability standards each year. The Senate bill specifies that people would be exempt from the mandate if their required contribution for basic coverage was more than 8% of income. (The required contribution is the amount a worker would have to pay for his or her employer's plan, or the net premium after tax subsidies for the least expensive basic plan offered through an exchange.) This percentage limit would increase if basic premiums grew faster than average personal income.

Penalty and enforcement: For people failing to obtain required coverage, the House bill would impose a tax equal to 2.5% of the amount by which a person or family's modified adjusted gross income exceeds the income tax filing threshold (currently \$9,350 for singles and \$18,700 for couples filing jointly). If the rule were in effect today, a single person with income of \$25,000 who failed to obtain coverage would pay a penalty of \$391; someone with \$50,000 in income would pay a penalty of \$1,016. The penalty could not exceed

“Health insurance markets work best when everyone is insured.”

the national average premium for basic benefits in the insurance exchange.

The Senate bill would impose a penalty equal to the greater of a flat dollar amount for each person not covered in any family or a percentage of household income. The flat dollar penalty would begin at \$95 in 2014, would rise to \$750 in 2016, and then would be indexed for inflation using the Consumer Price Index. For uncovered children, half of the penalty would be imposed, and no family would pay more than three times the level of the individual penalty, or \$2,250 in 2016. The income-based penalty would begin at 0.5 percent of income in 2014 and rise to 2 percent in 2016. As in the House bill, this income-based penalty could not exceed the national average premium for the minimum benefit package available through insurance exchanges. In both bills, the penalties would be prorated for people without coverage only for part of the year.

The bills would require health insurers, employers, and government insurance programs to report to the Internal Revenue Service each year on each person covered by an “acceptable” plan during the year, and on the period of time that this person was covered. The information would be used to determine which taxpayers were uncovered long enough to incur a penalty and whether the taxpayer appropriately calculated the penalty on his or her income tax return. People failing to pay the penalty would be subject to the usual procedures for collecting unpaid taxes, except that the Senate bill specifies that liens or criminal sanctions for tax evasion would not apply to the health insurance assessment.

Helping people meet the requirement: Both bills include measures intended to make health insurance available and affordable to more people. Insurers selling coverage to individuals and small groups, whether that coverage were sold through or outside of an exchange, would be required to accept all applicants. They also could not limit benefits on the basis of pre-existing conditions; could not vary premium rates according to enrollees’ health status; and could vary premiums by age by only a specified amount. More low-income people would be eligible for Medicaid; tax credits would be provided for the purchase of insurance through an exchange; and most larger employers would be required to provide coverage or make payments on behalf of their workers,

while smaller employers would receive assistance with the cost of providing coverage. (These measures are described in detail in other Health Policy Briefs, including [Coverage for Low-Income People](#), July 24, 2009; and [“Shared Responsibility,”](#) August 13, 2009.)

What’s the argument?

In favor of an individual mandate: Supporters make two primary sets of arguments in favor of requiring most Americans to have health insurance. One set of arguments is primarily economic and market-oriented; the other is primarily ethical and moral.

In the first category, supporters argue that an individual mandate is key to having America’s hybrid public-private system of health coverage function as effectively as possible. Health insurance markets work best, they say, when everyone is insured. This is because the risk of high medical expenses for a relative few is spread among a large and diverse group of healthy people. These healthier individuals pay premiums regularly and may or may not be filing claims, in contrast to sicker enrollees who are filing claims regularly. In effect, premium dollars are shared across the healthy and sick alike. This is considered fair because, no matter what one’s health status is at a given moment, many if not most people will ultimately need some form of medical treatment.

Free riding and adverse selection: In the absence of a requirement to buy coverage, some healthy people tend not to buy it, believing that they won’t need it if they are not sick. This is a phenomenon known as “free riding.” Because many of these people become ill and are treated anyway, the costs of their care are often shifted to insured populations in the form of higher charges by providers, which in turn lead to higher premiums.

As evidence of at least some population of “free riders,” some analysts point to the fact that according to the Census Bureau’s Current Population Survey, about 9.1 million people in households with incomes of \$75,000 or more did not have coverage during 2007. Presumably, many of these people could have found affordable coverage but had other priorities.

Other people may seek to buy coverage only after they become sick and expect to incur large medical expenses. This problem is known as

“With nearly all individuals in the pool, many insurance company practices would be banned.”

“adverse selection.” If sick people are more likely to enroll, insurers must raise premiums to cover costs. Premium increases can in turn lead healthier people to drop coverage. In extreme cases, an insurer could fall into a “death spiral,” covering a steadily shrinking pool of very high-cost enrollees. Concern about adverse selection is one of the key reasons that insurers have adopted many of the restrictions that can close off coverage to people with medical problems.

With nearly everybody, sick and healthy alike, in the health insurance “pool,” insurers could eliminate such practices as “medical underwriting” that denies coverage or leads to dramatically higher premiums for sicker individuals; “rescissions,” or cancellations of coverage, which sometimes occur after enrollees submit claims for previously undisclosed illness; or specific exemptions written into some insurance policies that exclude coverage for treatment of “pre-existing” medical conditions.

In fact, the leading health insurance trade group, America’s Health Insurance Plans (AHIP), has told both Congress and the White House that it will agree to new regulations barring these practices if the legislation also includes an individual mandate with a strict penalty. AHIP objected to the version of the penalties in the original Senate leadership proposal as insufficiently strict to induce many people to become insured. Citing a study by PriceWaterhouseCoopers, the group argued that the lenient penalties might lead people to delay getting coverage until they need services and that the resulting adverse selection could make the overall package of market reforms far less workable. AHIP has not yet commented on whether these concerns have been addressed by the more stringent penalties included in the final bill passed by the Senate.

Supporters further contend that an individual mandate would be reasonable because it would be accompanied by resources that would help individuals comply with it. Health insurance exchanges would make it easy for people to shop for coverage. Subsidies would be provided to millions to make coverage more affordable. Medicaid would be expanded to cover more low-income people who don’t currently qualify for the program. Many of those newly eligible would be exempt from the mandate because their income was

below poverty (under the Senate bill) or the tax filing threshold (under the House bill).

Finally, supporters expect that the individual mandate would affect only a minority of Americans who currently lack health insurance. Nearly three in five Americans under age 65 are already covered by employment-based health insurance; senior citizens and the disabled already have Medicare; and, as noted above, Medicaid expansion would cover many of the remaining uninsured people.

The Congressional Budget Office (CBO) estimates that the percentage of nonelderly legal residents without insurance would drop from 17 percent in 2010 to 4 percent in 2016 under the House bill, and 6 percent under the Senate bill. The Senate bill would still leave about 23 million uninsured people, about a third of whom would be unauthorized immigrants. However, because of the exemptions for low-income people and those for whom coverage is unaffordable, only a fraction of the remaining uninsured would be subject to a tax penalty.

Against an individual mandate: A key argument against the requirement is that it would be an infringement by government on personal freedom. Opponents note that the government has never required people to buy a good or service as a condition of residence in the United States. Some also question whether Congress has the constitutional authority to impose a mandate and predict that, at minimum, a mandate would almost certainly face a legal challenge. (This assertion is disputed by others, who say that the mandate merely constitutes an exercise of the power of the federal government under the Constitution to raise taxes or to regulate interstate commerce. The Senate provision, in fact, has a lengthy preamble making the case for commerce clause authority.)

Other opponents of an individual mandate say it’s simply unreasonable to compel people to buy insurance that they clearly consider unnecessary or less important than other things they want. Others contend that a mandate would be acceptable only if individuals could choose a public option — the government-run insurance program that is included in the House bill but not in the Senate bill. In the absence of such an option, these people say, a mandate might amount to requiring people to contribute to private, for-profit entities.

Still others say that, in combination with other provisions of health reform, the mandate would be overly burdensome on many people. There are concerns that the subsidies proposed in various bills still won't be enough to make mandated health coverage affordable for many people. Under the House and Senate bills, the percentage of the premium paid by people eligible for a subsidy will stay constant in future years, but the dollar amount people must pay will rise in direct proportion to premium increases. When income growth fails to keep pace with rising premiums, people will be compelled to spend more and more of their income to comply with the mandate.

Even at the outset, requiring some moderate-income people to spend as much as 12.8 percent of their incomes on health coverage, as the bills under consideration would do, is simply unfair, these opponents of a mandate contend. (By contrast, in Massachusetts, a person earning \$54,000 would be required to spend out of pocket only 7.5 percent of his or her income on health care.) Others worry that when the required benefit package was ultimately established, it's likely the benefits would be generous and the cost of the package high. Furthermore, opponents argue that even if the mandate were initially linked to a basic, low-cost plan, there would be constant pressure to expand the scope of benefits.

There are also questions about how an individual mandate for a minimum benefit package would be implemented, since health care costs and utilization vary widely across the country. Opponents say it would not be fair to require the same amount of insurance nationwide when the cost is not the same.

Questioning the need for a mandate: Some experts don't necessarily oppose an individual mandate, but they question the need for it, depending on other provisions of health reform legislation. If insurance in a reformed system represented a "good buy" for people, they say, a mandate would not be necessary, because most people would elect to buy coverage. Whether or not insurance was such a good buy, with reasonable costs for good benefits, would depend on many other rules set forth in health reform — for example, how much insurers could charge different

groups of people based on their age, or whether or not young adults could buy just catastrophic plans. One way to proceed, these experts say, would be to reform health insurance first, then wait to see if enough people enrolled so that a mandate wasn't necessary.

Other experts who are skeptical of a mandate point to inherent tensions that could make it politically difficult to maintain and administer. In Massachusetts, for example, there are those who want a mandate, rich subsidies, and low required benefits, and on the other side, those who want a mandate, a generous benefit package, generous subsidies and a willingness to exempt more people from the mandate. These kinds of trade-offs might not be easy to resolve, and they could make an individual mandate extremely hard to maintain over the long haul.

Finally, some outright opponents of a mandate voice skepticism that it could be enforced. Auto insurance is mandatory in 47 states, although it is enforced only through license renewal and registrations, not through the tax code as an individual health insurance mandate would be. Still, the median number of uninsured drivers in those states is 12 percent.

What's next?

As this brief is published, the fate of health reform legislation is unclear — as is the fate of the individual mandate proposal. The House and Senate have passed different bills, each including a mandate. There is not likely to be formal conference on the legislation; rather, House leaders have signaled that they will work to amend the Senate bill somewhat and then pass the new version through the House. That version would then go to the Senate for its approval. It's probable that a mandate would be included in that final version. However, many other provisions affecting the mandate could change, including the size and scope of the affordability credit and the penalties for noncompliance. The conference report would then have to be passed by both houses of Congress and signed into law by the president. In short, whatever emerges from the process may in fact be different from the proposals discussed in this brief.

“It’s highly probable that an individual mandate will be part of the final health reform legislation.”

“There are concerns that the mandate would be overly burdensome or that subsidies wouldn’t make coverage affordable.”

Resources

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