

## **An Individual Mandate For Health Insurance: Unwise, Unwarranted, Unworkable**

### **Executive Summary**

An individual mandate for health care is a proposal to require each individual to have health insurance, just as drivers are required to have auto insurance.

An individual mandate puts the risk and responsibility on each individual, undermining the existing system of care and coverage, which relies on two pillars of groups coverage: employer-based coverage for more than half of all Californians, and public insurance programs such as Medicare, Medi-Cal and Healthy Families for another 10 million or 28%.

An individual mandate invites employers to drop coverage for everyone below the threshold for subsidies. And in Massachusetts and in most proposals, the threshold for subsidies is at or near the median income.

An individual mandate assumes that health insurance is available to all who wish to buy it: it's not – whether because of health or financial status.

An individual mandate assumes that a family of four living on \$61,000 a year in Oakland or Glendale can afford to spend \$12,000 -- 20% of their income -- on health insurance and still pay the rent. They can't.

An individual mandate assumes that someone who is unemployed can afford to pay for their own health insurance. Most cannot.

An individual mandates assumes that people “choose” not to have health insurance: but 80% of the uninsured make less than 300% of poverty. Is somebody who lives on \$1000 a month “choosing” not to buy health insurance?

Only 2% of the uninsured, who are making more than 300% of poverty (\$60,000 for a family of four), choose to turn down the employer-based coverage when given the option. The remaining 18% are unemployed or not eligible for coverage through their employer – therefore having no choice. Is it fair to punish people for not having choices?

### **Introduction**

Some policymakers have proposed requiring every Californian to have health insurance.

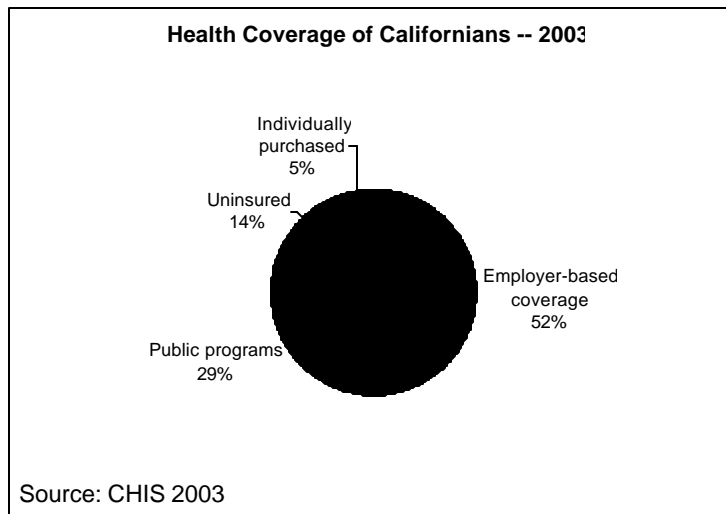
This proposal is not just unfair or unworkable but unwise: it is destructive of the current underlying social structure that supports health benefits and coverage for more than 30 million Californians today.

## I. Individual Mandate Undermines the Social Basis of Health Insurance

By definition, an individual mandate places the risk and responsibility for obtaining health coverage on each individual. It relieves both employers and government of that risk and responsibility, exposing each individual to the gale forces of the market place without the shelter of a larger purchaser.

Yet in our current system, health coverage works best when people are grouped together to share the risk and cost of health care, through employment-based coverage or public programs. As shown in Figure 1, of 35 million Californians, more than half get their health insurance from an employer, either their own or that of a family member, and over 10 million are covered by public programs such as Medicare, Medi-Cal and Healthy Families. In contrast, fewer than two million Californians buy their health coverage on their own, in the individual insurance market.

Figure 1



While too many Californians have been asked to pay a greater and greater share of their health care costs, most Californians still get their health coverage through a larger purchaser, either an employer or a government program.

An individual mandate is not about “shared responsibility”: it’s about shifting risk and responsibility from employers and government to the individual.

Employers are already shifting costs to individuals, either through scaled-back benefits or higher out-of-pocket costs. An individual mandate does more than shift costs: it puts all of the risk and the responsibility on the individual. Each of us is told: you’re on your own: If you don’t buy insurance, you will be punished.

We have been down this road before with pensions and retirement security: it begins with the shift from defined benefit plans to defined contribution plans and it ends with the Bush proposal to create private accounts in Social Security.

An individual mandate is an invitation to employers to drop coverage for everyone below the threshold for subsidies. Earlier literature on expansions of public programs provides

little guidance: in most instances, most employees were not eligible for these public programs. For example, Medicaid (Medi-Cal in California) does not cover adults without children under 18 at home, no matter how low the worker's income. So a Medicaid expansion did not affect employer behavior significantly. But an individual mandate proposal would affect every single employee. And the subsidy level would be widely known: most proposals have subsidies for workers at or below the median income.

If an individual mandate was accompanied by subsidies for low and moderate income families, employers could shed employer-based coverage for workers making less than \$60,000 a year by reclassifying positions or otherwise re-organizing work. An employer currently providing coverage would find it cheaper to drop coverage and increase wages by an amount less than the cost of coverage to the employer but more than the (initial) cost of coverage to the employee net of any subsidy. Taxpayers lose and in the longer run workers would be on the hook for increasing premiums but in the short run it would look like a win-win for employers and workers.

The very concept of an "individual mandate" takes us in the wrong direction, undermining the existing systems of coverage and care.

## **II. A Wrong Solution: The Myth of the Young Invincibles and The Reality Of Low-Income Working Families**

The individual mandate is premised on the notion that some uninsured "choose" not to buy coverage or to accept employment-based coverage.

The facts are otherwise: only a fraction of the uninsured have incomes sufficient to buy individual coverage and an even tinier fraction are employed and turn down employer-based coverage for which they are otherwise eligible.

### **a. Skin in the Game and Life on the Line Already: The Reality of Working Families**

A frequent refrain from some quarters is that consumers need to have more "skin in the game" in our health care system, and need to contribute more. In reality, individual health care consumers have their lives and livelihoods on the line already.

The penalties for being uninsured are numerous: the uninsured live sicker, die younger, and are one emergency away from financial ruin. They have worse health outcomes and more like to take on medical debt and file for bankruptcy. With these severe health and financial consequences, piling on additional financial and legal penalties is Dickensian in its consequences: instead of debtors' prisons and Bleak House, an individual mandate drives people without health insurance further into financial ruin.

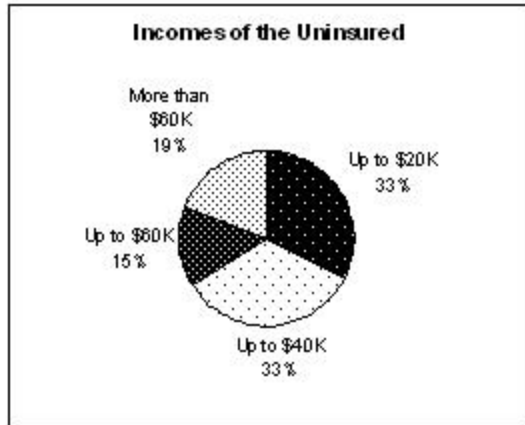
The insured are already paying more and getting less in terms of health benefits. Over the last five years, employers have shifted a greater share of the increases in premiums to those covered through job-based coverage, increasing the share of premium,

deductibles, and co-payments, imposing tiered benefits for prescription drugs. Individual Californians feel that they are paying more and getting less in terms of health care—and they are right. The point of health care reform is to help people, not to penalize them.

**b. Most of the Uninsured Are Low or Moderate Income**

Of the more than six million Californians without health insurance, it is estimated that less than half a million make more than \$70,000 for a family of four.

Figure 2



Based on 2006 Federal Poverty Guidelines for a family of four.  
Source: CHS 2003

As shown in figure 2, of the more than six million Californians without health insurance, almost five million, make less than 300% of federal poverty. That's less than \$60,000 for a family of four. Asking a family of four living on \$60,000 a year to pay up to \$12,000 per year for health insurance is not reasonable or wise. Punishing them for failing to dedicate 20 percent of their income for health insurance is Dickensian.

Studies demonstrate that the “non-poor” uninsured are poorer than the “non-poor” insured: they have fewer assets and lower

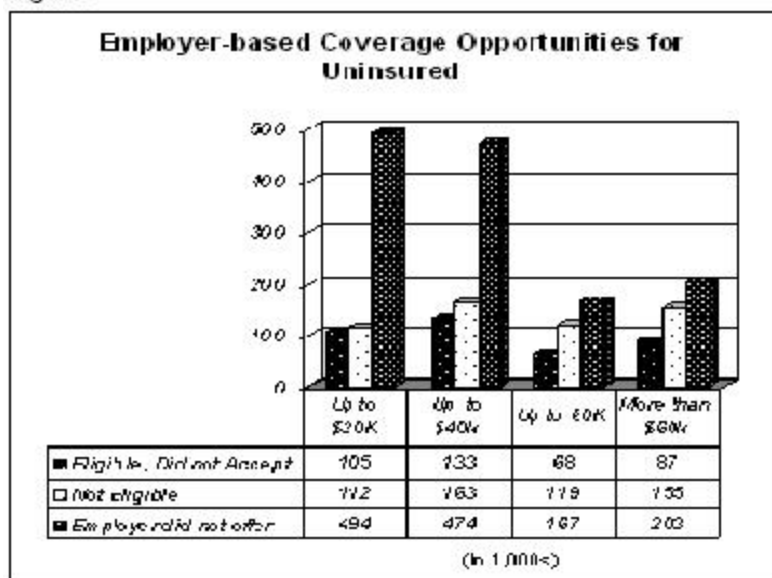
income. Their ability to afford coverage is more limited—and so is their ability to afford high deductibles.

Can a family of four making \$70,000 and living in Oakland or Glendale afford to contribute something to their health care? Perhaps the co-pays. Not deductibles of thousands of dollars. Certainly not the entire cost of coverage. Not if they want to keep paying the rent.

**c. People Take Coverage If It's Offered**

Californians who are offered health benefits on the job take that coverage. Of the six million uninsured, only 87,000, less

Figure 3



Based on 2006 Poverty Guidelines for family of four  
Source: CHS 2003

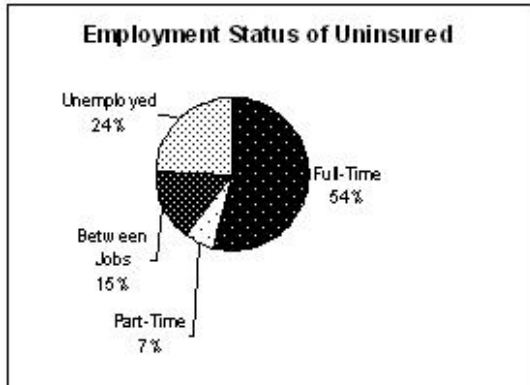
than 2% of the uninsured, make over 300%FPL and fail to take up employer-based coverage for which they are eligible.

The remaining millions of uninsured are either below 300%FPL, working and not eligible for employment-based coverage (about 350,000 people) or not employed (about 320,000 people).

Who, then, is the target of the individual mandate?

Are they among the 300,000 Californians who make more than 300%FPL and are not eligible for health insurance on the job? Or is the target the 350,000 Californians who are unemployed but made more than 300% FPL? Is the plan to require people who are unemployed to pay for their own insurance? Is that the point of the individual mandate?

Figure 4



Source: CHIS 2003

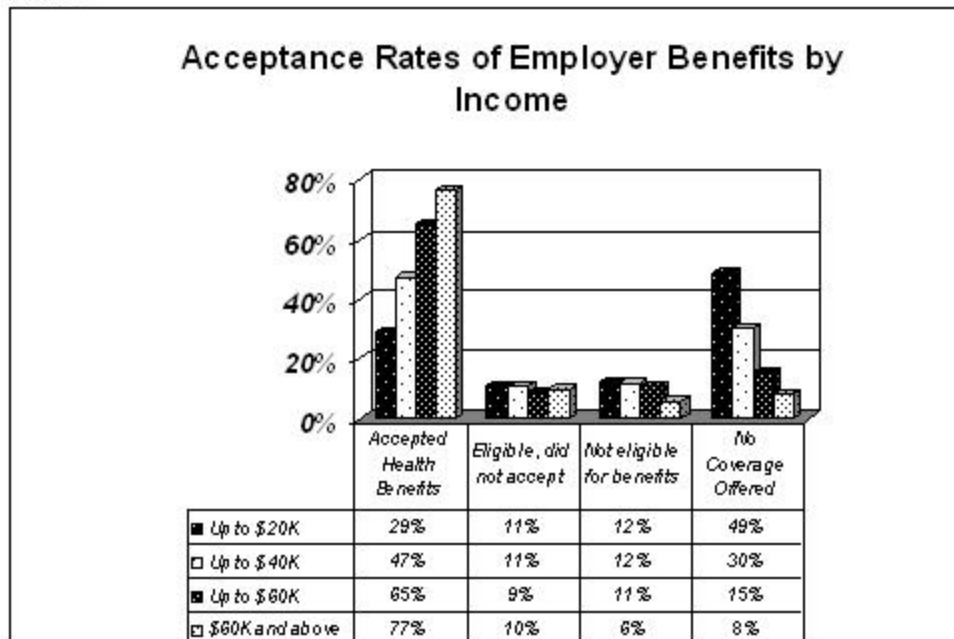
**d. The Myth of the So-Called Young Invincibles**

When some look and see that a high percentage of the uninsured are younger, in their 20s, some mistakenly assume that young uninsured people are being irresponsible.

In fact, the young are more likely to be low-income, more likely to work at the type of

jobs—like those at McDonald’s or Wal-Mart—that don’t provide health coverage, less likely to qualify for coverage at a workplace because of longevity requirements, and less likely to qualify for public programs because of lack of a child.

Figure 5



Based on 2006 Federal Poverty Guidelines for a family of four.  
Source: CHIS 2003

Young workers, age 19 through 30, are two to

five times less likely to be eligible or offered health benefits, resulting in more than half of workers in this age group being uninsured. Those who are under age 30 are just as likely to accept coverage for which they are eligible as those over 50. The statistics indicate that controlling for income and coverage eligibility, young people are just as likely to take up employment-based coverage as those who are older.

While it might be possible to find a young, high-income person who chooses not to have health insurance, that's not the majority, or even a significant percentage of the uninsured. Instead, it's a sliver of the uninsured.

The individual mandate proposes to create an entire social policy—one that erodes the foundations of health coverage for 80% of Californians—based on a problem that scarcely exists.

### **III. Who are the Uninsured? What Can They Afford?**

Four out of five of the uninsured are below 300% federal poverty level. Almost nine of ten of the uninsured are below 350%FPL.

What does that mean in terms of what people can afford? Can an individual who makes \$15,000 or \$20,000 or even \$25,000 afford \$4,000 a year for individual coverage? Can a family that makes \$50,000 or \$60,000 afford \$10,000-\$12,000 a year for family coverage?

#### **a. Affordability of Coverage: \$10 Billion**

Health insurance coverage costs about \$4,000 for an individual and \$10,000-\$12,000 for a family.

Most proposals for an individual mandate assume that those making less than 300% of federal poverty would need financial assistance to buy health insurance. That means subsidies or public program expansions for about five million people.

Assuming the cost of public coverage is about half the cost of private insurance, expanding public programs to cover the almost five million uninsured Californians under 300% FPL would cost about \$8-\$10 billion. Subsidizing private coverage for the five million uninsured Californians is trickier to estimate: simply buying private coverage would cost about \$20 billion. If individuals and employers were required to contribute, subsidizing an individual mandate would cost perhaps half that.

This cost can be reduced if an employer obligation is one part of the proposal.

### **IV. Lack of Availability of Health Insurance for Individuals**

Under existing law, consumers find it *nearly impossible* to obtain insurance if they've ever experienced seemingly innocuous ailments such as ear infections, bladder

infections, or more than three doctor visits in the last year. It's even harder to find coverage – at all -- for individuals with serious conditions such as asthma, diabetes or heart disease.

Under an individual mandate, consumers who are rejected from coverage by insurers would be breaking the law – but not of their own volition.

Guaranteed issue alone does not correct this problem: not if insurers can use medical underwriting to price coverage. With guaranteed issue with unlimited medical underwriting, insurers are required to issue coverage but are allowed to price coverage with no limits on premiums.

### **b. Existing California Law Does Little to Help Consumers**

Under California law,

- No requirement that every individual who wants to buy a policy can do so (called “guaranteed issue” in insurance parlance).
- No protection against being denied coverage because of pre-existing medical conditions (unless someone has previously had coverage and pays to continue).
- No regulation of premiums or rates.
- No regulation on out of pocket maximums.
- No requirement that insurance cover a specific package of benefits. Health insurers can offer just hospital care or just cancer coverage or any other combination. (Under Knox-Keene, HMOs must cover a standard package of benefits, putting HMOs at a competitive disadvantage to health insurers.)
- No regulation of insurance company practices in selecting for the lowest risk customers

Here is the extent of the regulation of the individual market in California: insurers must be financially solvent and any policy is guaranteed renewable. That's it.

### **c. Insurers Take Advantage of Limited Requirements**

Because insurers and HMOs must renew a policy once issued but can check for health conditions before agreeing to cover an individual, insurers and HMOs are notoriously picky about who they insure.

They can and do screen out individuals with any medical conditions that might become expensive in later years. This helps assure the financial solvency of the HMO/insurer, but does nothing to protect the consumer.

### **d. State Program for “Uninsurable” Limits Enrollment and Limits Benefits**

California has a program for medically uninsurable persons, called the Major Risk Medical Insurance Program (MRMIP) run by the MRMIB. This program has never

advertised, limits annual coverage to \$75,000 a year, and has almost always had a waiting list. It is estimated that the program only serves 10% of those who are medically uninsurable under existing California law. The very existence of a program for the medically uninsurable is testament to the failure of the existing market based system of insurance to provide coverage to all who are willing to purchase it. If the market worked to provide insurance to everyone willing to purchase it, there would be no need for a program for the medically uninsurable: instead insurers would sell to anyone who wanted to buy.

## **V. Criminalizing Care? Using the Tax System for Enforcement?**

Individual mandate proposals require an enforcement mechanism. Auto insurance is enforced when car registration is renewed: people skirt the requirement by buying coverage for a month and then canceling it or buying other kinds of substandard policies. Others fail to buy or are unable to buy insurance and drive as uninsured motorists.

Some proposals for an individual mandate would criminalize the failure to have coverage. This has the potential to turn doctors and hospitals into individual mandate cops, required to deny care for people without insurance or to turn them in for their failure to carry insurance.

Other proposals rely on the income tax. Violations of the tax code are crimes that are punished through the tax enforcement agencies.

## **VI. Earlier Legislation on Individual Mandate**

Some proposals for an individual mandate are part of larger health reform package; others propose this idea and little else. For example, several pieces of legislation were introduced by former Assemblymembers Keith Richman and Joe Nation and were defeated early in the process. Similarly, Blue Shield of California, Kaiser Permanente and the California Hospital Association sponsored a measure in 2003 that included an individual mandate along with an employer mandate.

Massachusetts has enacted a circumscribed version of an individual mandate and done so in a very different context than faced by California. Even before the 2005 legislation, Massachusetts had a smaller proportion of uninsured, a much more richly funded public health system, more extensive employer participation, more extensive insurance market regulation and more costly health insurance premiums than California. In California, health insurance is cheaper, a smaller proportion of employers buy it, public programs such as Medi-Cal are less adequately funded—and we have more uninsured Californians than Massachusetts has people. (For more, see “Massachusetts in California?” on the Health Access website, [www.health-access.org](http://www.health-access.org))

Individual mandate proposals have failed in California, opposed by a wide range of consumer, labor and other groups, because the individual mandate would unwisely undermine the social basis of health insurance. It is unwarranted, in that there is no large number of people choosing not to have insurance. It is unfair, penalizing those who find coverage either unaffordable or unavailable. It is unhealthy, as it may criminalize care, discouraging many from getting needed treatments for fear of being caught. It is unworkable and unenforceable.

## **VII. Better Models for Individual Responsibility**

Consumer groups such as Health Access California oppose individual mandates, but do not oppose the concept of individual responsibility. As stated above, individuals are already responsible for their health and finances, and face real consequences as a result.

Consumer groups have supported mandatory individual contributions to social insurance programs. Social Security, Medicare, SB2 (Burton)/Prop 72 (employer mandate) and SB840 (Kuehl) (single payer) all include mandatory individual contributions—through tax or payroll contributions. But these are contributions to social insurance programs in which an individual pays into a larger group, shares risk with others, and is assured of getting something in return (income replacement after retirement, health insurance). This isn't just forcing people into a private marketplace with no assurance of any benefit. The individual contribution helps everybody to get an even better benefit. This stands in stark contrast to the individual mandate's punitive character.

Asking a self-employed person to pay both the employer and employee share of a payroll tax is fair because the self-employed person is contributing to a larger system which in turn provides the self-employed individual with a benefit---whether it's Medicare or Social Security.

An individual mandate provides no similar guarantee: it does not guarantee that Californians will get something for what they put in. The only guarantee in an individual mandate is that each individual will bear the entire risk and responsibility for health insurance---with no assurance that anyone else, not their employer, not the government, will share the risk and responsibility as health care costs continue to climb.

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