POLICY MEMO

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An Individual Mandate With More Teeth But Less Bite

By David B. Kendall and Anne Kim

The requirement that every American obtain health insurance (the "individual mandate") is the linchpin to successful health reform. However, it has also become both a lightning rod for opponents of comprehensive reform and a concern for progressive members who want to ensure the affordability of coverage. This memo proposes four ideas for how progressives can defend a strong individual mandate while also minimizing its burden on the middle class.

Perhaps the best-known and most-popular aspect of President Obama's health reforms now moving through Congress is health insurance reform. These reforms would, for example, ban lifetime and annual benefits caps and bar insurance companies from denying coverage or charging higher premiums due to preexisting conditions, such as diabetes or a heart condition.

But the viability of these popular and historic reforms rests in turn on a critical component of health reform—the individual mandate. Without the addition of the millions of young and healthy Americans who now choose to forego coverage, health insurance reform is impossible. Without the mandate, the requirement that insurers insure all comers ("guaranteed issue") would actually backfire—resulting in higher premiums and more instability for the middle class.[1]

Moreover, the coverage requirement will ultimately ease the burden on middle-class Americans with insurance who are now footing the bill for the uninsured. The cost of expensive emergency-room visits by the uninsured is eventually passed on in the form of higher premiums, roughly an extra $1,000 in premiums per family according to Families USA.[2] Bringing everyone into the system will help control those costs.

Nevertheless, the coverage requirement has come under attack from opponents of reform, who have called the penalty for non-compliance a "tax on the

middle class." It has also raised concerns among some progressives, who fear that an overly restrictive mandate would be unaffordable for many people.

To weaken the mandate is not an option. However, the following four changes related to the coverage requirement could help minimize its burden on the middle class while still maintaining a mandate robust enough to make insurance reforms work:

OPTION #1

Instead of assessing a penalty, eliminate or reduce tax breaks for people who don't buy insurance

Instead of imposing an unfamiliar tax, one alternative is to reduce or eliminate tax breaks for people who don't comply with the personal coverage requirement. For example, one option might be to require non-compliers to forfeit the personal exemption, which under current law automatically entitles all taxpayers to take a set deduction from their income (equal to $3,650 in tax year 2009) for themselves, a spouse and each dependent.

For a taxpayer whose effective income tax rate is 20 percent, the loss of one personal exemption would be equal to a penalty of $730. In comparison, the Senate HELP and Finance Committee bills would levy a tax of $750, and the House bill uses a tax penalty of 2.5% of income, which for a median income household would be about $1,250. (This penalty would be higher for higher-income people in higher tax brackets and lower for lower-income people in lower brackets.) This approach has several advantages:

- **It's not a tax.** The personal exemption is essentially an entitlement in the tax code—an automatic tax break intended to shelter a portion of every taxpayer's income from federal income tax liability. This proposal would simply modify the personal exemption so that it is no longer automatic but available to those who qualify—in the same way that the child tax credit is available only to taxpayers with "dependent" children as defined by the tax code.
- **It will be an effective enforcement mechanism because it could reach all Americans.** In 2007, income tax returns included claims for 283 million exemptions for either taxpayers or their dependents.[3] The U.S. population in 2007 was 301 million residents.
- **It would have teeth.** Structured in the right way, the forfeiture of the personal exemption would result in higher tax liability for non-compliers even if that taxpayer is entitled to other credits and deductions that reduce or eliminate their tax liability.[4]

- **It has precedent.** Under Massachusetts law, individuals who do not comply with the personal coverage requirement do not qualify for a state tax exemption during the first year of the requirement. However, because losing the state tax exemption was worth only about $218 for individuals ($437 for families), the penalties were increased for subsequent years.[5]

This proposal would *not,* however, affect taxpayers entitled to refundable credits such as the EITC or the refundable portion of the child tax credit. The two Senate bills currently under consideration exempt low-income households from the coverage requirement (under 133% of poverty in Finance Committee bill and under 150% in the HELP Committee bill), which means that they would not be subject to any penalty for non-compliance, including under this proposal.

OPTION #2

Allow young people to pay lower premiums

Another option would be to maintain the ability of younger people to pay less in premiums for coverage—something that could change under many of the current proposals.

Under current law, insurance companies are allowed to charge people the full amount of the extra cost of their health care as they age. While some states have limitations on discounts for the cost of insurance for younger people, most states do not.[6] As a consequence, premiums for an older person can be six or seven times more expensive (or even more) than what a younger person would pay.[7]

The original Chairman's Mark for the Senate Finance Committee bill would have limited insurance premiums for older Americans to no more than five times what younger people pay (a "5-to-1 age band"). This was later amended to a ratio of 4-to-1. In combination with other reforms, such as guaranteed issue and community rating, this reform will deliver significant benefits to many older Americans.

Some policymakers, however, believe that the differential in premiums between older and younger Americans should be even more limited. And while that would indeed help older Americans, it would also make the individual mandate requirement much less politically palatable by significantly *raising* premiums for younger people.

- **Higher premiums for younger Americans would make the coverage requirement more onerous.** Under a 4-to-1 age band (and ideally a 5-to-1 age band), premiums can become lower for older people while holding younger people's premiums more or less constant. But if the age band is

further squeezed (e.g., to 3-to-1 or 2-to-1), younger Americans' premiums would have to increase significantly to subsidize the reduction in premiums for older Americans. In fact, under a 2-to-1 age band, premiums for 25 to 29-year-olds would increase by 69 percent over a 5-to-1 band; for 18 to 24-year-olds, premiums would be 90 percent higher.[8]

- **Younger people are already more likely to be uninsured because they can't afford coverage.** The uninsured rate for young adults ages 18 to 24 is 29%.[9] In contrast, the uninsured rate for older Americans ages 55 to 64 is 12%. Higher premiums for the young would only exacerbate this problem and also very likely increase the problem of non-compliance as well.

For these reasons, further age rating restrictions could make the coverage requirement an even higher political hurdle, while at the same time making the mandate more difficult to enforce. With fewer younger people in the insurance pool, everyone's insurance premiums will be higher.

OPTION #3

Ease the minimum benefit requirement

A third option would be to allow people to satisfy the coverage mandate with more affordable coverage than what is being required under the current proposals.

Under the bills now on the table, a person can satisfy the coverage requirement only if he or she buys a policy that meets a defined minimum standard of benefits ("minimum creditable coverage").

In the Senate Finance Committee bill, for example, the cheapest plan available through the exchange—the so-called "bronze benefit package"—would cover 65 percent of the total average cost of health care services as defined in law. In the House bill, that requirement is 70 percent.

Reducing the 65 percent requirement to 60 percent would reduce the insurance premium costs by roughly 8 percent, or $1,000 per family.[10] Massachusetts, by comparison, has a 56% requirement.[11] This change would not affect financial assistance for low and middle income families. Instead, it would primarily affect middle to upper income families who would have more financial exposure to high health care costs in a given year.

Allowing too lean a benefit package would undermine the goal of preventing bankruptcies among people who are underinsured. A minimum benefit requirement prevents insurers from offering coverage with out-of-pocket costs that can overwhelm a family's budget when someone gets very sick. If a family can't pay

its bills, then providers shift those costs to everyone else, and everyone has to pay higher insurance premiums. But setting the minimum coverage requirement at 60 percent would leave most families with significantly less financial risk than the levels that are typically seen in medical bankruptcies.[12]

OPTION #4

Allow more people to buy catastrophic coverage

Finally, a fourth option would be to allow more people to satisfy the personal coverage requirement with catastrophic coverage if they meet certain requirements.

Under the Senate Finance Committee bill, people ages 25 and younger (the so-called "young invincibles") are permitted to satisfy the coverage requirement with a catastrophic only policy in which the catastrophic coverage level is set at the HSA current law limit. The theory is that while younger people are healthier, they also have lower incomes, and the availability of cheaper catastrophic coverage would make it more likely that younger people would both comply with the coverage requirement and be able to afford it. Indeed, this Finance Committee provision could be extended up to age 29.

But another group of individuals for whom catastrophic only coverage makes sense are affluent individuals. These individuals can afford most of their health care expenses out-of-pocket and may want an insurance policy to protect their wealth in the event of a major illness. While at first blush this may seem paradoxical, lower-income people actually benefit more from richer benefit packages with lower co-pays and deductibles because they may not have the resources to pay the bulk of their health care costs out-of-pocket. Affluent individuals, on the other hand, can make do or even come out ahead with more bare bones coverage.

Thus, another possibility might be to allow individuals with very high incomes to satisfy the coverage requirement with a catastrophic-only policy.

- **This proposal could benefit small business owners.** Many of them file individual income tax returns, which means that they use that return to show they are eligible to have catastrophic coverage.
- **Catastrophic only coverage is less expensive.** The invincible's catastrophic policy, which would cover about 55 percent of total average costs would cost roughly 16 percent less than a more comprehensive policy that covers 65 percent of total costs.[13]

CONCLUSION

Because the strength of insurance reform depends so critically on the strength of the individual mandate, progressives must resist the urge to give way to the mandate's critics. Alone or in combination, these four proposals can help to preserve a robust individual mandate while tempering both its substantive and political impact on the middle class.

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ENDNOTES

1 A September 2007 report by Milliman Inc. examined eight states that enacted insurance reforms (guaranteed issue and community rating) without also establishing a coverage mandate. The report found that consumers were more likely to defer buying coverage until they became sick. The result was higher premiums, little impact on the number of uninsured and in several states, the ultimate repeal of insurance reforms because of the deterioration of the individual market.

2 "Hidden Health Tax: Americans Pay a Premium," Families USA, May 2009.

3 "2007 Individual Tax Returns: Exemptions by Type and Number of Exemptions, by Size of Adjusted Gross Income," Tax Policy Center, Urban Institute and Brookings Institution, accessed October 6, 2009: http://www.taxpolicycenter.org/taxfacts/displayafact.cfm?DocID=383&Topic2id=30&Topic3id=34.

4 Nearly half of all taxpayers pay no federal income taxes because of the availability of deductions and credits in the code. Jeanne Sahadi, "47% will pay no federal income tax," October, 3, 2009, CNNMoney.com, available at http://money.cnn.com/2009/09/30/pf/taxes/who_pays_taxes/index.htm?cnn=yes.

5 John E. McDonough *et al,* "The Third Wave of Massachusetts Health Care Access Reform," *Health Affairs,* September 14, 2006.

6 "Individual Market Rate Restrictions," StateHealthFacts.org, Kaiser Family Foundation, accessed October 6, 2009: http://www.statehealthfacts.org/comparetable.jsp?ind=354&cat=7.

7 Ibid.

8 "Impact of Changing Age Rating Bands in "'America's Healthy Future Act of 2009,'" Oliver Wyman, September 28, 2009.

9 Carmen DeNavas-Walt *et al,* "Income, Poverty, and Health Insurance Coverage in the United States: 2008," U.S. Census Bureau, Sept. 2009.

10 CBO Director Doug Elmendorf speaking at the Finance Commttee mark-up on September 22, 2009 of health insurance reform suggested that 5 percent reduction in actuarial value would decrease premiums by 8 percent.

11 Chris L. Peterson, "Setting and Valuing Health Insurance Benefits," Congressional Research Service, April 6, 2009.

12 In the current health care financing system, 0ut-of-pocket medical costs averaged $17,943 for medically bankruptcies. See David Himmelstein *et al,* "Medical Bankruptcy in the United States, 2007" *American Journal of Medicine,* June 5, 2009. By comparison, the Senate Finance bill requires that coverage caps annual out-of-pocket costs up to $5,950 for individuals and $11,900 for families.

13 See note 10.