



Individual Health Care Mandates and the Problem of Affordability

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Is an individual mandate to purchase health care insurance the solution to America's growing health insurance crisis?

More and more states are considering individual mandates as key elements of reform guaranteeing affordable health care for all families. Yet, the problem of affordability is emerging as a key barrier to the implementation and fairness of individual mandates. By examining Massachusetts' experience implementing its first-in-the-nation individual mandate and other state proposals for affordable health care, this report will: (1) consider the fairness and financial impact of individual mandates on American families and (2) present priorities for addressing the problem of affordability inherent in our health care system and health care reform.

Finally, any health care reform approach should be judged based on its financial impact on families and small businesses measured as a percentage of income.

Table of Contents

Summary.....	Page 2
Massachusetts, Is the Individual Mandate Affordable?.....	Page 2
Loopholes to the Massachusetts Individual Mandate	
Measuring Affordability – Include ALL Out of Pocket Costs.....	Page 4
Limiting Individual Mandates with Aggressive Affordability Protections.....	Page 5
State Models	
Federal Poverty Level is Falling Behind	
Ensuring Affordability of Employer Mandates.....	Page 7
Conclusion.....	Page 8
More Resources and Footnotes.....	Page 9

Summary

47 million Americans are without health care coverage and millions more are struggling to afford ever-rising premiums, deductibles and co-pays. In 2006, **Massachusetts** became the first state to require all residents to have health care coverage, known as an individual mandate, and the deadline to comply with the mandate was December 31, 2007. Non-compliance will result in significant tax penalties.

The problem with an individual mandate is that the vast majority of individuals impacted by it will be lower-income people who are working yet don't have access to employer-based coverage. A report by the [Blue Cross Blue Shield Foundation of Massachusetts](#)¹ shows that 75% of the uninsured live below 300% of poverty and [most are working](#)², yet they are not eligible for employer-sponsored coverage or can't afford what is offered to them. These numbers [mirror most states](#)³. Uninsured Americans are very cost-sensitive as health care costs eat up a significantly larger portion of their income than higher income people, potentially making an individual mandate very burdensome on low-income and many middle-income families.

This problem of affordability is the key issue for individual mandates, just as Massachusetts is currently experiencing. Despite premium subsidies and a new state insurance negotiating agency, Massachusetts is exempting over 60,000 uninsured residents from the mandate because of the lack of universally affordable health insurance options. In contrast, reforms proposed in **Wisconsin, Washington, and Maine**, present strong models for states struggling with how to ensure affordability. These proposals measure affordability by including all out of pocket costs - premiums, co-pays, and deductibles - in the calculation and limit total yearly health care costs to a percentage of an individual's or family's income. A measure for affordability must consider more than just the cost of premiums and take into account the real-world financial realities of already financially stressed Americans.

In summary, health care costs must be made proportional to a family's resources, ability to pay, and take into account other family obligations, like the cost of housing, food, clothing, transportation, education and savings.

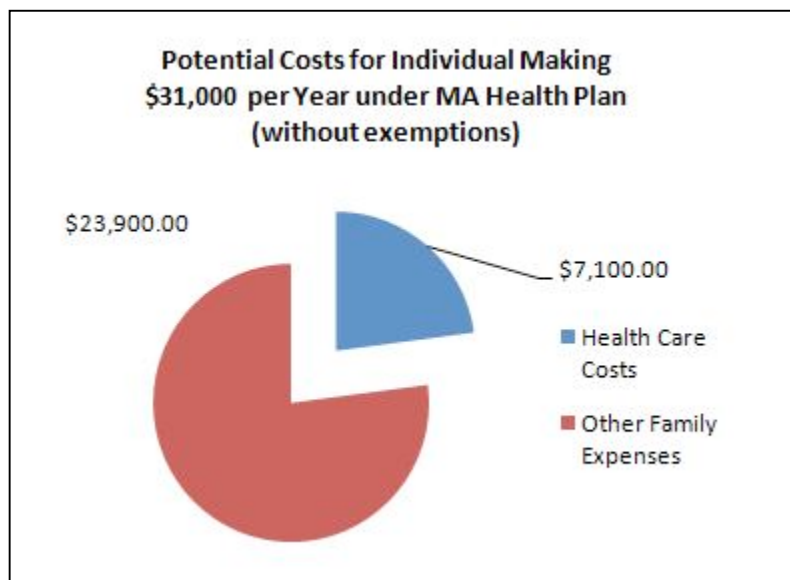
Massachusetts - Is the individual mandate affordable?

When Massachusetts enacted comprehensive health care reform, [Chapter 58](#)⁴, in 2006, it was heralded as the first state to pass universal health care coverage. Yet it still left many families unable to afford the health care they were now mandated to buy, unlike comprehensive plans enacted in [Maine](#)⁵ and [Vermont](#)⁶ which expanded coverage without an individual mandate.

Massachusetts did try to make their mandate easier to stomach; the law included several laudable measures to improve affordability of health care coverage, including subsidies to individuals and families living below 300% of the federal poverty line and combining the non-group and small group insurance markets, which is [reducing individual premiums](#)⁷ on average 15%. The plan also created a unique state clearinghouse, called a Connector, to negotiate with private insurance companies for more affordable health insurance options for the state's residents.

Although the [Connector authority](#)⁸ determined that premiums should not exceed between 5% and 10% of an individual's income, that affordability requirement did not include the costs of deductibles, co-pays and other cost-sharing. Under new plans negotiated by the Connector, deductibles [go as high](#)⁹ as \$2,000 per individual and \$4,000 per family and total out of pocket spending limits can be \$5,000 for an individual and \$10,000 for families.

Under the rules, an individual earning just over 300% of the poverty line (\$31,000) could face total health care costs of \$7,100 when you add monthly premiums to the out of pocket limit. The [cheapest option](#)¹⁰ for a middle-age resident is about \$175 per month, with a \$2,000 deductible and out of pocket limit of \$5,000. In the event of a major medical crisis, like a cancer diagnosis, a personal injury, or complications from managing a chronic disease, like diabetes, the **combined costs would amount to 23% of the individual's income** and could quickly result in a serious fiscal crisis, if not bankruptcy.



Loopholes to the Massachusetts Individual Mandate

Before other states adopt an individual mandate, they should recognize that Massachusetts itself understood the difficulty of achieving affordability and wrote into the law loopholes to prevent these costs from crushing state residents.

First, as mentioned above, there were subsidies provided through the Connector for the lowest income individuals. Premiums are scaled as follows: \$0 in premiums for individuals below 150% of poverty scaling up to \$105 for individuals between 250% and 300% of poverty. For individuals ineligible for subsidies, or reduced premiums, the [cost of plans](#)¹¹ offered through the Connector range from \$122 to more than \$800, with the cheapest option for middle-age residents starting at \$175 a month.

Second, although [300,000 previously uninsured](#)¹² residents have obtained health insurance through the end of 2007, anywhere from 150,000 to 300,000 residents had yet

to sign up with an insurance plan leading up to the December 31, 2007, deadline. After December 31st, any uninsured residents will be [penalized](#)¹³ in 2008 by losing a \$210 tax exemption. In 2009, the penalty will jump to "half the monthly cost of the least expensive plan available for each month that individual is uninsured." But officials recognize that the still-high costs of health care in Massachusetts make imposing this penalty unfair. The Connector authority is granting [waivers to 20%](#)¹⁴ of the state's uninsured residents, or roughly 65,000 individuals, exempting them from the individual mandate.

Measuring Affordability - Include ALL Out of Pocket Costs

The bottom line for consumers in the health care reform debate is the affordability of health care and coverage. The problem of affordability is especially pronounced with individual mandates. It is not enough to only consider premiums when determining the affordability of health care coverage and the feasibility of individual mandates. All out-of-pocket costs must be included when calculating the affordability of health care coverage.

As already discussed, uninsured and low-income Americans are very cost-sensitive. Health care costs take up a larger slice of their income than higher income and insured Americans. As the [Blue Cross Blue Shield of Massachusetts Foundation's](#)¹⁵ report, [Getting Ready for Reform: Insurance Coverage and Access to and Use of Care in Massachusetts in Fall 2006](#)¹⁶, points out,

An important issue to consider in assessing the quality of health care for low- and moderate-income adults is whether their health insurance coverage protects them from financial risk in the event of a major illness or surgery. Limited benefits and high cost-sharing place more of the financial risk of high health care costs on the individual.

Also documenting the cost-sensitivity of low and middle income families is a June 2007 report by [Health Access-California](#)¹⁷. The [report states](#)¹⁸ that a major medical event and a \$5,000 deductible would financially "wipe out 40% of Californians" and a \$10,000 out of pocket limit "would eliminate almost all the assets of 60% of Californians."

Health Access shows that middle income families have few resources to withstand the potential costs of an individual mandate without strong protections for affordability that reflect a family's "real-world" ability to pay. Middle income families, earning as much as \$70,000 a year, are struggling with higher everyday costs to afford a home, put money away in savings, and pay down credit card debt, tying up as much as one-third of their income.

The only true and fair way to ensure affordability of health care coverage for all families, those insured and those uninsured, is to limit ALL yearly out-of-pocket expenses - premiums, deductibles and co-pays - to a percentage of a family's or individual's income. This ensures that health care expenses do not exceed financial resources. Percentage-of-income limits on all yearly health care expenses should allow for other expenses, including housing, food, clothing, transportation, and the ability to accrue savings for family and education. More and more states are pursuing this model.

Limiting Individual Mandates with Aggressive Affordability Protections

With an eye towards Massachusetts, states are developing concrete proposals to ensure affordability of individual mandates and other programs that would cover all residents. Examples include **California, Illinois, Maine**, and most notably, **Wisconsin**. Although these have not been enacted, they are promising models for achieving affordability of health care and expansion programs.

Wisconsin

A promising affordability measure for individuals and employers is being pursued by legislators and health care advocates in Wisconsin, as we [profiled](#)¹⁹ this past summer. [Healthy Wisconsin](#)²⁰ would preserve choice of providers while guaranteeing all residents comprehensive health care coverage equal to legislators' own health plans. The initiative would ensure shared responsibility by instituting a payroll-based fee paid by all employees, individuals, and employers. The payroll deduction would replace all premiums in the current system and co-pays and deductibles would be minimal.

The fees would be capped at 4% of social security wages for employees and 12% for employers (estimates placed the initial employer fee at 10.5% of wages). The virtue of a payroll-based payment system is that it ensures shared responsibility for health care and, importantly, each employee's and employer's payments are directly proportional to their income, or wages, and ability to pay.

A [study](#)²¹ by the Lewin Group found that Healthy Wisconsin would [save](#)²² the state \$13.8 billion over ten years, the average family \$750 per year and employers that currently provide coverage an average 15% from their current costs. Healthy Wisconsin was passed by the State Senate but blocked by the conservative Assembly. However, progressives, led by State Sen. Jon Erpenbach, [vow to bring Healthy Wisconsin back](#)²³ as its own separate piece of legislation in 2008.

A [similar](#)²⁴ reform package has been proposed in Washington by State Senator Karen Keiser, called the [Washington Health Partnership](#)²⁵.

California

The 2007 comprehensive California health care reform package negotiated by Governor Schwarzenegger and Legislative leaders, called [ABX1 1](#)²⁶, was rejected by a Senate committee after passing the Assembly last December. Despite this defeat, the measure included strong affordability protections that serve as a model for any lawmaker considering mandates, or a similar participation requirement, as part of a comprehensive reform package.²⁷

The California measure included an individual mandate. To help families afford coverage, it employed several measures put forth by the Massachusetts law, including an insurance connector to bring more affordable options to market, robust Medicaid expansions, premium subsidies to help families afford coverage and an employer "pay or play" requirement. Yet, the affordability protections went a few steps further than Massachusetts. Subsidies in the form of a [refundable tax credit](#) would have been provided to families with incomes up to 400% of poverty if premiums exceeded 5.5% of income, versus sliding scale premium subsidies up to 300% in Massachusetts. A downside to this measure, like Massachusetts, is that there were no specific caps on

potential out-of-pocket expenses, a major concern to some health care advocates who opposed the individual mandate.

Additionally, a hardship exemption to the California mandate would be available to families based on the impact of all health care costs on a families' budget.

Illinois

Governor Rod Blagojevich's [Illinois Covered](#)²⁸ initiative offered strong measures to ensure affordability of health care premiums, although it did not include deductibles and other insurance costs in the affordability measure. The [proposal](#)²⁹, which did not include an individual mandate, was similar to many comprehensive reform packages that rely on a combination of public and private efforts to expand access to quality coverage. To help ensure affordability, Illinois Covered would have provided premium subsidies to residents with incomes up to 400% of poverty, or \$80,000 for a family of four, a level significantly higher than Massachusetts. While the legislation would limit premium payments to a percentage of annual income, it did not cap out-of-pocket expenses, so many families might be able to afford the insurance but not be able to afford deductibles in the case of serious illness. Illinois Covered [stalled](#)³⁰ in 2007 but the Governor has signaled his intent to [push](#)³¹ for the reform package in 2008, picking up support along the way the AFL-CIO, SEIU and Teamsters.

Maine

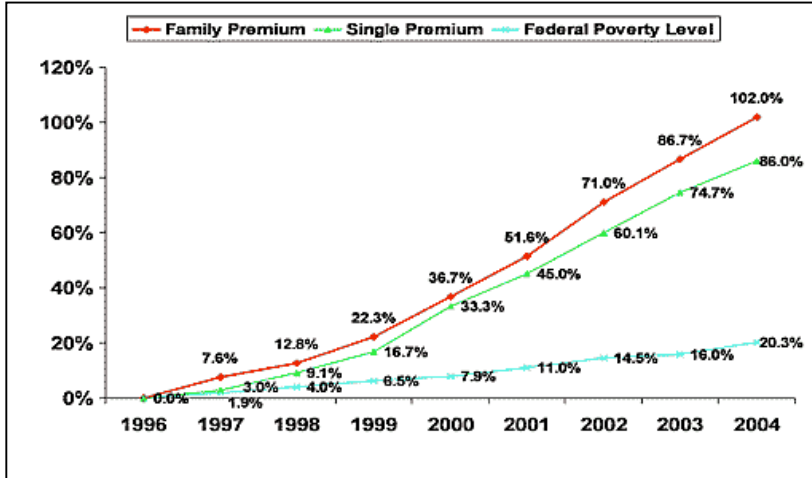
A stronger measure of affordability was [proposed](#)³² in Maine in 2007. To ensure the state's public/private insurance program for individuals and small businesses, called [DirigoChoice](#)³³, is more broadly affordable, legislators sought to tie all insurance costs to an aggressive income scale through [LD 1716](#)³⁴. Subsidies for DirigoChoice are currently offered to enrollees with incomes up to 300% of poverty, but, again, the subsidy scale does not directly limit an enrollee's total exposure to health care costs. Under LD 1716, DirigoChoice enrollees with incomes up to 250% of poverty would receive full coverage at no charge. Those between 251% and 300% of poverty would spend no more than 0.5% of their taxable income on coverage, including deductibles and co-pays. From 301% to 350% of poverty, enrollees would pay no more than 1% of their taxable income. The scale would increase similarly up to a maximum of no more than 10% of taxable incomes being spent for coverage under the program. Although the legislation failed, it presents a strong model for ensuring affordability of health care coverage.

Pennsylvania

Advocates for a [single-payer health care system](#)³⁵ in Pennsylvania are steadily signing up co-sponsors in the State Senate and House of Representatives. Funding for the plan would be a combination of state and federal dollars and a 10% payroll tax paid by employers and a 3% income tax paid by residents. Again, the strength of tax-based funding is that an individual's and employer's health care costs are directly proportional to their financial resources and income. The measure would guarantee comprehensive health care for all residents, including documented immigrants. It would establish a system of medical malpractice coverage for providers and residents would not face any premiums, deductibles, or co-pays under the system. 37 members of the 203-seat House of Representatives have co-sponsored the plan and 6 members of the 50-seat Senate are [co-sponsors](#).³⁶ And, although he is pushing his own package of reforms, Governor Rendell is on record indicating that if a single-payer bill got to his desk it would receive his [signature](#).³⁷

Federal Poverty Level is Falling Behind

Payroll-based funding systems keep up with the times better than affordability measures which use the federal poverty level to determine eligibility for subsidies. As a [Kaiser Family Foundation](#)³⁸ report shows, the value of the federal poverty level has not kept pace with health care costs.



And so, subsidies to purchase health insurance coverage, as in Massachusetts, Vermont, and Maine, based on the federal poverty level lose value over time as health care costs rise precipitously. Therefore, the family share of premiums, even with a subsidy, will increase overtime and consume more and more of the family income. The report says,

As long as health insurance premiums continue to rise more quickly than the costs of other goods and services, eligibility thresholds tied to FPL (or a multiple of FPL) will not maintain a consistent level of financial protection against rising health insurance costs.

Ensuring Affordability of Employer Mandates

As polling by the Herndon Alliance shows, Americans strongly [identify with small businesses](#)³⁹ and are very concerned that reform not hurt small firms. Yet, employers play a vital role in US health care, providing health care coverage for more than [158 million Americans](#)⁴⁰, and ensuring continued employer participation is a key priority for health care reform. In fact, a recent [survey](#)⁴¹ of small business owners in California found that 80% believe employers should pay something to provide health care to their employees and 75% ranked the availability of affordable health care as extremely or very important.

Including affordability protections for small businesses as part of employer mandates can help engage small business owners and advocacy organizations as strong allies for reform.

Massachusetts and **Vermont** were early leaders in requiring employers to provide health coverage for employees or pay a penalty to the state. The penalties, however, at \$295 and \$365 per worker per year respectively, are pittance compared to the cost of

health care coverage. The **City of San Francisco** has gone several steps further by requiring employers with 20 or more employees to either provide health care or contribute \$1.17 to \$1.76 per hour (depending on firm size) to a city program providing health care for uninsured city residents.

As with San Francisco, states are considering sliding scale employer mandates that take into account firm size and other financial factors. For example, although the California measure previously discussed, ABX1 1, was defeated it proposed a sliding scale employer mandate. The measure proposed that employers either provide health care coverage or make payments at increments of 2% and 4% for payrolls less than \$250,000 and the full 6.5% fee for employers with annual payroll above \$250,000.

Conclusion

As a means to achieving quality and affordable health care for all, individual mandates are problematic absent strong affordability protections for consumers. As long as families are not protected from resource-depleting health care costs in the event of a medical crisis, individual mandates will only exacerbate the lack of affordable access to health care coverage that pervades our health care system.

Several states in addition to Massachusetts and California are actively considering individual mandates to obtain health care insurance as key elements of comprehensive health care reform proposals, including [Colorado](#)⁴², [New Mexico](#)⁴³, and [Iowa](#)⁴⁴. The health care debate in these and other states must include affordability protections that limit total health insurance costs to a percentage of family income; a percentage that allows for other family expenses like food, clothing, transportation, housing, and the ability to accrue savings.

Lastly, it is important to note that despite the affordability challenges faced by Massachusetts and its individual mandate, the state's health care reform law has achieved significant and measurable success. The Connector authority, as an agent negotiating with insurance companies on behalf of consumers, is a strong model for bringing more affordable options to the market. Combining the individual and small group markets is a smart and practical way to create economies of scale and provide consumers with stronger negotiating power against insurance companies. Importantly, almost 140,000 residents have [enrolled](#)⁴⁵ in subsidized coverage through the [Connector](#)⁴⁶, which is the level officials had expected by next July. And, [55,000](#)⁴⁷ residents have newly enrolled in MassHealth, the state Medicaid program. However, through September, only [8,306 residents](#)⁴⁸ had signed up for unsubsidized health care coverage through the Connector and anywhere from 150,000 to 300,000 residents remain [uninsured](#)⁴⁹.

More Resources

This report is adapted from the November 19, 2007, Stateside Dispatch [*Individual Health Care Mandates and the Problem of Affordability*](#)⁵⁰.

Kaiser Family Foundation - *States Moving Toward Comprehensive Health Care Reform*

- <http://www.kff.org/uninsured/upload/State%20Health%20Reform.pdf>

Kaiser Family Foundation - *Effect of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level*

- <http://www.kff.org/insurance/snapshot/chcm021507oth.cfm>

Health Access-California - *Health Access Weblog, Tracking California Health Care Reform*

- <http://www.health-access.org/blogger.html>

Citizen Action of Wisconsin - *Healthy Wisconsin Resource Center*

- http://citizenactionwi.org/index.php?option=com_content&task=view&id=122&Itemid=92

Commonwealth Fund - *A Roadmap to Health Insurance for All: Principles for Reform*

- http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=553840

Massachusetts Commonwealth Connector - *Affordability Tool and Certificate of Exemption*

- <http://tinyurl.com/ynnorm>

Progressive States Network - *Wringing Costs Out of the Health Care System*

- <http://www.progressivestates.org/content/541/health-care-in-2007>

Progressive States Network - *Health Care in 2007*

- <http://www.progressivestates.org/content/541/health-care-in-2007#1>

Progressive States Network – *Healthy Wisconsin: Model Policy and Advocacy*

- <http://www.progressivestates.org/content/649>

Footnotes/Links

¹ http://www.bcbsmafoundation.org/foundationroot/en_US/documents/664-006Mass_Report_SUMMARY.pdf

² <http://www.statehealthfacts.org/comparebar.jsp?ind=135&cat=3>

³ <http://www.statehealthfacts.org/comparebar.jsp?ind=136&cat=3>

⁴ <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>

⁵ <http://www.dirigohealth.maine.gov/>

⁶ <http://hcr.vermont.gov/>

⁷ <http://www.hcfama.org/uploads/documents/live/Market%20Merger%20Commissioner%20CoverLetter%2020061229.pdf>

⁸ <https://www.macommonwealthcare.com/goalmind/login/external/intro.jsp>

⁹ <http://www.kff.org/uninsured/upload/State%20Health%20Reform.pdf>

¹⁰ http://www.usatoday.com/money/industries/health/2007-04-13-mass-usat_N.htm

¹¹ http://www.usatoday.com/money/industries/health/2007-04-13-mass-usat_N.htm

12 http://www.denverpost.com/ci_8152526?source=rss

13 http://www.mass.gov/Qhic/docs/CC_ProgramUpdate_MayJune2.ppt#500_30.What%20is%20the%20penalty?

14 http://www.usatoday.com/money/industries/health/2007-04-13-mass-usat_N.htm

15 <http://www.bcbsmafoundation.org/foundationroot/index.jsp>

16 http://www.bcbsmafoundation.org/foundationroot/en_US/documents/664-006Mass_Report_SUMMARY.pdf

17 <http://www.health-access.org/>

18 http://www.health-access.org/Assets_Debt07.pdf

19 <http://www.progressivestates.org/content/629/nations-most-comprehensive-health-plan-approved-in-wisconsin-senate#1>

20 http://citizenactionwi.org/images/stories/Documents/healthy_wis_summary.pdf

21 http://citizenactionwi.org/images/stories/healthywi_cost_coveragerpt.pdf

22 http://citizenactionwi.org/images/stories/Documents/coalition_healthy_wisconsin_frequently_asked_questions_iii_6-26-07_pdf_2.pdf

23 <http://www.wrn.com/gestalt/go.cfm?objectid=380295CC-D977-65D1-D65C81CD2B86A262>

24 <http://www.senatedemocrats.wa.gov/2008/releases/Keiser/partnership.htm>

25 <http://apps.leg.wa.gov/documents/billdocs/2007-08/Pdf/Bills/Senate%20Bills/6221.pdf>

26 http://www.leginfo.ca.gov/cgi-bin/postquery?bill_number=abx1_1&sess=CUR&house=A&search_type=bill_update

27 <http://www.progressivestates.org/content/763/low-income-tax-relief-california-health-care-and-public-financing-in-washington#2>

28 <http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=5755>

29 <http://www.progressivestates.org/content/579/universal-health-cares-next-steps-pa-il-plans#1>

30 <http://www.sj-r.com/News/stories/20212.asp>

31 <http://www.illinois.gov/PressReleases/PressReleasesListShow.cfm?RecNum=6397>

32 <http://www.progressivestates.org/content/595/wringing-costs-out-of-the-health-care-system#6>

33 <http://www.dirigohealth.maine.gov/dhlp02.html>

34 <http://janus.state.me.us/legis/LawMakerWeb/externalsiteframe.asp?ID=280024593&LD=1716&Type=1&SessionID=7>

35 <http://www.healthcare4allpa.org/powerpoint/SENATE%20BILL%20300%20P.N.%20336.pdf>

36 <http://www.healthcare4allpa.org/legis.htm#QS>

37 <http://youtube.com/watch?v=dAfwIRY-RYA>

38 <http://www.kff.org/insurance/snapshot/chcm021507oth.cfm>

39 http://www.kaisernetwork.org/health_cast/uploaded_files/110207_herndon_script.pdf

40 <http://www.statehealthfacts.org/comparebar.jsp?ind=125&cat=3>

41 http://www.smallbusinessforhealthcare.org/2007_california_healthcare_survey_report.php

42 <http://www.colorado.gov/208commission/>

43 http://insurenemexico.state.nm.us/documents/INM_HCNM_Comm_Final_Report_20070809.pdf

44 http://www.legis.state.ia.us/scripts/docmgr/docmgr_comdocs.dll/showtypeinterim?id=true&type=ih&com=208

45 http://www.boston.com/news/local/articles/2007/11/05/health_plan_help_line_swamped_with_calls/

46 <http://www.macommonwealthcare.com/goalmind/login/external/intro.jsp>

47 http://www.lowellsun.com/front/ci_7394923

48 http://www.berkshireagle.com/headlines/ci_7401731

49 http://www.lowellsun.com/front/ci_7394923

50 <http://www.progressivestates.org/content/719/individual-mandates-and-the-problem-of-affordability>