Health Care Reform and the Individual Mandate

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Why institute an individual mandate?

- Some of the most prominent shortcomings of the US system are rooted in its voluntary nature:
  - People prefer to obtain insurance when they know they'll need services → adverse selection;
  - Insurers construct, and regulators allow, structured barriers to the sick behaving in this way to protect carriers, but this means those in bad health are often unable to obtain adequate coverage.

Why, continued

- Institute an individual mandate, you eliminate adverse selection, and the barriers become unnecessary, in fact, indefensible.
- Risk segmentation focus has distracted insurers from developing mechanisms for efficiently managing health care costs –
  - savings from excluding the high cost swamp savings from effectively managing care.
- Once uninsured are essentially eliminated, can redirect public dollars spent on uncompensated care to help finance the reforms.

Main focus for a successful mandate

- Most people want to comply with the laws;
- Make voluntary enrollment as easy as possible –
  - Easily accessible routes of enrollment;
  - Ensure enrollment process is as simple as is feasible.
- Focus in early years is educate and enroll those not doing so on their own.

Applicable individuals must ensure that they and their *applicable* dependents have minimum essential coverage after 2013

- For those who don't comply, a financial penalty is imposed.
- Applicable individuals are people who are not:
  - Holding a religious conscience exemption;
  - A member of a health care sharing ministry;
  - Residing in the US illegally;
  - Incarcerated.

Applicable people who are exempt from penalties under the requirement:

- Individuals who cannot afford coverage;
  - Required contribution > 8% of household income;
    - ESI single coverage, if eligible, or
    - Lowest cost bronze plan in exchange, less any applicable subsidies.
    - 8% indexed to account for future premium growth over income growth.
  - Some lack of clarity over whether the family premium relative to family income can be considered in determining affordability. Regulations to clarify.

Exemptions, continued

- Taxpayers with income below the tax filing threshold;
- Members of Indian tribes;
- One gap in coverage during a year that lasts less than 3 months;
- Hardship cases defined at discretion of Sec'y of DHHS;
- Individuals outside the US.

What qualifies as *minimum essential coverage*?

Government sponsored programs:

- Medicare;
- Medicaid;
- CHIP;
- TRICARE, VA, or Peace Corps plan;

- Employer-sponsored plan;
- Non-group market plan;
- Grandfathered plans;
- Others at discretion of Sec'y of DHHS.

How will health insurance coverage information be reported in order to satisfy the requirement?

- Those providing min. essential coverage to an individual during the year must file a return which includes:
  - Name, address, taxpayer ID# of those obtaining coverage under policy;
  - Dates of coverage during year;
  - Info on whether exchange-based, and if so, any advance premium or cost-sharing reductions paid out;
  - If employer based, info on employer, portion of premium paid by the employer.

Amount of the penalty

- Penalty for the year never exceeds the national average premium for bronze level coverage.
- Calculation – the *greater* of:
  - Applicable flat dollar amount;
  - Applicable percentage of income.

Penalties, continued

- Flat dollar amount per person:
  - $95 in 2014;
  - $325 in 2015;
  - $695 in 2016;
  - Thereafter increased by inflation. For those < 18 years old, amount is halved. Family total cannot be > 300% of dollar amount.
- Percentage of income (in excess of tax filing threshold):
  - 1.0% in 2014;
  - 2.0% in 2015;
  - 2.5% thereafter.

Three suggested areas of focus for successful mandate implementation

- Access points to the enrollment process should be numerous;
- Employer's should be involved, even if they don't offer coverage to their workers;
- Exchange coverage options should be simplified.

Enrollment access points

- Exchange as one-stop shopping source;
- Applications available and submit-able on-line or via regular mail;
- In-person enrollment options also necessary:
  - Trained counselors;
  - School staff/volunteers;
  - Enrollment drives;
  - Medicaid agency staff;
  - Providers;
  - Private insurance agents/brokers.

Employer involvement

- Nearly 90 percent of the uninsured nationally are in working families;
- Employer involvement would greatly increase voluntary compliance with mandate;
- Want to keep employer burden low, but they could:
  - Remind workers annually of requirements;
  - Provide info on exchange & Medicaid options;
  - Provide web-based tools for exchange coverage;
  - Premium withholding electronically remitted to exchange.

Simplification of exchange decisions

- Decisions required in choosing among multiple insurance options can be overwhelming;
- Straightforward choices reduce enrollment time burden and stress, increasing voluntary participation.
- Actuarial value standard v. standardized benefits
  - Want focus to be comparison of prices and networks – adding in considerable benefit variation creates much greater complexity.
  - Plan “nutrition labels” are another useful option.
- Easily accessible info on provider networks, post-subsidy costs, insurer operations/practices.

Enforcement through the tax system

- Enforcement will be necessary only for the minority of the population not voluntarily complying;
- Insurers required to send out a 1099-type form annually with names of those with insurance and dates of coverage;
- This info then must be reported on income tax returns;
- Questions on tax form will identify those subject to the mandate;
- Those subject to the mandate but without sufficient coverage will be assessed penalties via the tax form;
- Forms will also compute final value of tax credits to which the tax filing unit might be have been entitled and compute any additional amount owing or owed to the unit.

Massachusetts is the only state with a currently operating individual mandate

- Reforms, first implemented in 2006, are quite similar in nature, if not detail, to federal law.
- IM fully implemented in 2007.
- Applies only to adults, own affordability schedule, exemptions, and subsidized coverage provided under separate program.

Basic coverage facts in MA, 2010

- 98% of MA residents had health insurance coverage during survey period, up from 97% in 2009, increase, largely among children;
- ESI most common type of insurance, coverage, 65%;
- Employer offer rate 62% in 2009 compared to 55% nationally, according to MEPS-IC. 7th highest rate in nation.
- Uninsured rates for non-elderly adults is 2.9%, .2% for kids, .4% for elderly;
- 4% of those <= 150% of FPL uninsured, compared to 1.5% of 300%+ of FPL .

How has the individual mandate worked?

- Most recent complete data is from tax year 2008.
- 97% of tax filers required to file schedule HC complied;
- Of those complying, 95% reported being insured for full year, <2% were uninsured for part of the year, 3.7% were uninsured for full year.

Of the part-year insured

- 65% had incomes less than 150% of the FPL, and were exempt from penalty;
- 35% were in the affordability range and were assessed a penalty;
- Small number couldn’t afford coverage, had religious exemptions, appealed, or had short coverage gaps so weren’t assessed penalty,

Of the 3.7% uninsured for full year:

- 17% were assessed a penalty;
- 2.7% appealed a penalty;
- 61% were exempt due to low income;
- 15% didn't have affordable coverage available to them, so exempt;
- 3.5% had a religious exemption.

Of 4.8 million tax filers

- 85% filed the schedule HC;
- 12% were not required to file schedule HC;
- 2.5% should have filed it but didn't, or filed an incomplete one. These filers were assessed penalties for non-compliance.
- By 12/09, 80% of 2008 penalties assessed had been collected. Remainder were in processing, under payment agreements, or late. Haven't found 2010 update yet.

Massachusetts system working effectively, but some ACA issues remain to be worked out.

- Income fluctuations and end-of-year reconciliation
  - Uncertainty of final credit may inhibit enrollment for some;
  - Those moving from <400% of the FPL to 400%+ during year could have large reconciliation amounts.
- Affordability over time linked to cost-containment success, but not everyone has taste for serious cost containment.