Women and Individual Mandates

Health care reform plans may include an "individual mandate," or a requirement that individuals obtain acceptable health insurance.[1] Some policymakers and health economists believe that an individual mandate is necessary to achieve universal coverage, whereby all residents in a state or nation have health insurance.[2] Though various state and federal proposals for health reform have included an individual mandate, to date, only Massachusetts has enacted a health reform plan with this feature.

While proposals that include an individual mandate will increase the number of people with health coverage, women's advocates should approach this type of health reform with some caution. Unless and until an individual mandate policy is combined with reforms that make comprehensive health insurance more available and affordable, a requirement to obtain coverage will do little to benefit—and may even unfairly penalize—some women and their families.

What Is an Individual Mandate?

An individual mandate requires all residents within a state or nation to obtain health insurance coverage at least to the minimum benefit level set by the mandate. Typically, those who fail to buy insurance must pay a penalty unless they have arranged for a special exemption from the requirement.

An individual mandate attempts to correct the problem of "adverse selection" in health insurance markets; that is, if low-risk, healthy individuals choose not to buy insurance, that leaves an insured group of high-risk, sicker individuals with more expensive health care costs. The smaller an insured group, the fewer people among whom to spread the costs. When health insurance is required for all, costs are spread across a larger number of people and low-risk individuals help share the burden of insuring high-risk individuals.

Why Should Women's Advocates Approach an Individual Mandate Policy With Some Caution?

Proponents of individual mandates reason that obtaining coverage must be a requirement because otherwise, some (healthy) people will forgo purchasing insurance until they are sick enough to need it, making coverage more unaffordable for everyone. But opponents of this type of reform counter that individual mandates—and their associated penalties—will harm residents who cannot find or afford health coverage that fits their needs. At a minimum, individual mandate policies must adhere to principles of affordability, adequacy, and availability.

An individual mandate should not require women to spend more than they can afford on health insurance. Many cost-related barriers exist in the current health care system—especially for women. Compared to men, women have more trouble affording health care since they are generally poorer and they need and use more health services.[3] Health reform plans must establish mechanisms to ensure the affordability of health insurance before imposing any requirement to purchase coverage under an individual mandate. These mechanisms include tax credits for the purchase of health insurance,[4] annual limits on the amount an individual spends on healthcare costs (including premiums and all other forms

of out-of-pocket spending), and government subsidies for those whose healthcare spending exceeds the established limits.

An individual mandate reform should include exemptions for people who cannot find affordable coverage, and the exemptions themselves should be easy to apply for and obtain. However, while exemptions are necessary to avoid unfairly penalizing some individuals, they offer no solution to the underlying problems of affordability or uninsurance, since exempt residents will remain uninsured even after the reform has been implemented.

An individual mandate should not require women to purchase insurance that does not adequately meet their needs. To hold down costs, some women (especially those living in financially-strained households) might purchase policies for catastrophic health insurance coverage only, or obtain other types of coverage that do not adequately protect their health. While these kinds of policies may be less expensive, they do not cover many of the health services that women need on a regular basis, such as preventive care and immunizations, maternity care, chronic disease management, and family planning services. It is important that, as part of any mandate policy, an adequate standardized minimum benefit set is established. Individuals should only be required to buy coverage that will meet their needs and will not leave them "underinsured" (i.e. insured under a plan with unaffordable deductibles or very limited benefits that leaves women vulnerable to financial risk and unmet health needs). Moreover, public dollars should not be used to subsidize inadequate private insurance products.

An individual mandate should be combined with health reforms that will increase the availability of coverage for all women. Some women cannot obtain health insurance simply because there are no coverage options available to them. Women who are not eligible for public or employer-sponsored health insurance, for example, must look for coverage in the individual insurance market, where—in an overwhelming majority of states—it is legal for insurers to deny coverage to a woman with a pre-existing health condition or to sell her a policy that explicitly excludes coverage for the condition. Individual market insurers are also usually allowed to charge more for health premiums depending on a person's gender, age, health status, or occupation. Women seeking coverage in the individual market may not be able to find an insurer who is willing to offer them coverage, or they may be offered coverage that is cost-prohibitive. In many states, ensuring that virtually all residents can obtain adequate health insurance will likely require changes within the individual insurance market—such as adoption of guaranteed issue policies—to make sure that insurance companies are not allowed to deny coverage based on someone's health status or other factors.[5]

Reform plans can also establish new insurance options for people who are not eligible for public or employer-sponsored health coverage. This includes those who work part-time and are not offered employer fringe benefits—in 2005, nearly a quarter of all uninsured women worked part-time.[6] To create new coverage options for women, states may propose to merge the small group insurance market (where small businesses purchase coverage for their workers) with the individual insurance market, which spreads health care risks and costs among more people. Some states, such as Massachusetts, have also established new "Connector" entities to serve as a type of marketplace that makes it easier for individuals and small businesses to compare and purchase insurance policies.

From the Experts: Which Consumer Protections Are Necessary Under an Individual Mandate?

Policy analysts at Community Catalyst, a national health advocacy organization that has closely monitored the implementation of the Massachusetts individual mandate, released a report in early 2008 which details "Ten Ways to Make Individual Mandates Work for Consumers":

1. Establish a right to purchase insurance ("guaranteed issue").
2. Prohibit insurers from charging people different premiums based on factors such as health status ("community rating").
3. Encourage efficiency in health insurance.
4. Establish an affordability scale.
5. Create adequate subsidies to help people afford insurance.
6. Set minimum benefit standards to guard against underinsurance.
7. Protect lower income populations from harsh penalties.
8. Create a robust and easy-to-use waiver and appeals process.
9. Encourage equal responsibility by all stakeholders.
10. Consider a phased-in approach.

For more information about this set of recommendations, the report titled *A Guide to Protecting Consumers under an Individual Mandate* (March 2008, authored by Christine Barber and Michael Miller), is available on the Community Catalyst website at: www.communitycatalyst.org.

What Is "Shared Responsibility," and What Does an Individual Mandate Have to Do With It?

Reform proposals often include both an individual and an employer mandate[7] (a requirement that employers contribute to the cost of workers' health care) along with efforts to expand publicly-sponsored insurance options funded by the government. The term "shared responsibility" refers to these types of policy combinations, since employers, individuals, and the government all share the duty of providing or obtaining health coverage; each plays a significant role in increasing the number of people with health insurance.

If implemented together with sufficient safeguards, employer and individual mandates can result in a major reduction in the number of uninsured people. Alone, however, each type of mandate presents a problem in achieving universal coverage:

- An individual mandate places responsibility for obtaining coverage on an individual. It does not address whether health insurance is available to that individual or whether the coverage is affordable. If employer participation in the health insurance marketplace is not also mandatory and the cost of coverage continues to grow, employers will continue to shift the burden of cost increases to their workers or could decide to forgo offering employee health benefits altogether. This would make it more difficult for individuals to meet the mandatory insurance coverage requirement, since fewer workers would be able to obtain affordable coverage through their jobs and more individuals would bear the entire cost of their coverage.
- Without additional reforms, an employer mandate has the potential to leave many individuals uninsured, such as non-workers, workers who are eligible for employer plans but choose not to enroll, workers who do not fulfill the minimum "full-time" requirements, and employees at small or low-revenue firms that may be exempt from

the mandate. This point is particularly relevant for women, since they are more likely to be among those potentially "left-out" of an employer mandate; when compared to men, women are more likely to be non-workers or to work part-time (i.e. fewer than 35 hours per week),[8] and they also hold the majority of low-wage jobs.[9]

Moreover, while an employer mandate may exempt small and low-revenue businesses from compliance, it does not address the challenges these firms face in finding affordable health coverage for their workers; in 2007 nearly three-quarters of small firms that did not offer employee health benefits cited high premiums as a "very important" reason for not doing so.[10]

Additionally, for individual and employer mandate reforms to be successful, they must be appropriately enforced. Governments must set up efficient systems for determining whether individuals and employers are in compliance with the mandate and there must be appropriate penalties for those who do not comply. The goals of shared responsibility will never be met if mandates are not properly enforced.

Lessons from the States:

Massachusetts Adopts an Individual Mandate as Part of a Comprehensive Health Reform Plan

Massachusetts enacted health reform in April 2006 which included shared responsibility between the Massachusetts government, employers, and individuals. In addition to expansions of public programs and premium subsidies for low-income families, the state adopted an individual mandate that required all adults in the state to purchase a minimum level of health insurance by the end of 2007. Residents may be exempt if they can demonstrate that they cannot afford coverage. Those who failed to obtain health insurance by the deadline lost their personal income tax exemption (about $217 for an individual or $437 for a family in 2007[11]).

The verdict is not in on how the 2006 Massachusetts health reforms are impacting women and their families. Although health insurance coverage rates are increasing (as of March 2008, over 350,000 of the estimated 450,000 uninsured had obtained health care coverage[12]), over 60,000 people have received exemptions from the individual mandate.[13] These individuals remain uninsured and are presumably not getting the health care that they need. An additional 86,000 uninsured residents were deemed "able to afford" coverage but elected to pay the penalty (i.e. forgo their personal tax exemption) instead—it is not clear whether those people had problems accessing health insurance due to affordability or whether they will be any more willing to purchase insurance in subsequent years. During the reform plan's first year, it was widely acknowledged that paying the penalty cost less than purchasing health coverage; state officials have raised the penalty for 2008, which may prompt more people to purchase coverage.

What Can Women's Advocates Do to Ensure That Individual Mandates Work for Women?

Women's advocates can make certain that before any individual mandate is adopted, there are adequate consumer protections in place to ensure affordability, availability, and adequacy of health coverage.

The individual mandate policy alone does not address whether health insurance is available to women or whether the coverage is affordable. To truly improve women's access to health care, individual mandate policies must adhere to principles of affordability, adequacy, and availability.

Women's advocates can insist that an individual mandate policy include a simplified process for obtaining an exemption from the mandate when appropriate.
An individual mandate reform should include exemptions for people who cannot find affordable coverage. Exemptions are necessary to avoid unfairly penalizing some individuals.

Women's advocates can promote concepts of "Shared Responsibility" between government, employers, and individuals.
Health reform plans that require these three entities to share the duty of providing or obtaining health coverage build on the existing system of health financing.

For further reading, see:

Christine Barber and Michael Miller, Community Catalyst, *A Guide to Protecting Consumers under an Individual Mandate* (March 2008), http://www.communitycatalyst.org/doc_store/publications/im_paper_final_draft.pdf.

Linda J. Blumberg and John Holahan, The Urban Institute, *Do Individual Mandates Matter?* (January 2008), http://www.urban.org/UploadedPDF/411603_individual_mandates.pdf.

Sherry A. Glied et al., *Consider It Done? The Likely Efficacy Of Mandates For Health Insurance*, Health Affairs, 26(6):1612-1621 (November/December 2007), www.healthaffairs.org (subscription required).

References

1 Mandate is a commonly-used word in the debate about health care reform. It is important to note the difference between a mandate to purchase or offer health insurance (the individual and employer mandates) and a mandate that requires health insurers to provide specific benefits to policyholders ("mandated benefits"). See: "Mandated Insurance Benefits: Important Health Protections for Women and Their Families" section of the *Reform Matters Toolkit* for detailed information on mandated benefits.

2 Linda Blumberg and John Holahan, The Urban Institute, *Do Individual Mandates Matter?* (Jan. 28, 2008), http://www.urban.org/url.cfm?ID=411603.

3 National Women's Law Center calculations based on U.S. Census Bureau, *Table POV01: Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race: 2005, Below 100% of Poverty—All Races* (Aug. 2006), http://pubdb3.census.gov/macro/032006/pov/new01_100_01.htm.

4 See: "Women, Tax Policy, and Health Reform" section of the *Reform Matters Toolkit* for further discussion on tax credits.

5 See: "Women and the Individual Health Insurance Market" section of the *Reform Matters Toolkit* for further discussion.

6 Elizabeth M. Patchias and Judy Waxman, National Women's Law Center and The Commonwealth Fund, *Women and Health Coverage: The Affordability Gap* (Apr. 2007), http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf.

7 See: "Mandated Insurance Benefits: Important Health Protections for Women and Their Families" section of the *Reform Matters Toolkit* for detailed information on mandated benefits.

8 In 2006, about 25 percent of employed women were part-time workers, compared with 11 percent of employed men. See: US Department of Labor, Bureau of Labor Statistics, *Charting the US Labor Market in 2006* (Sept. 28, 2007), http://www.bls.gov/cps/labor2006/.

9 Marlene Kim, *Women paid low wages: Who they are and where they work*, Monthly Labor Review Online, 123 (9): (Sept. 2000), http://www.bls.gov/opub/mlr/2000/09/art3exc.htm.

10 The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey* (2007), http://www.kff.org/insurance/7672/upload/76723.pdf.

11 FamiliesUSA, *Massachusetts Health Reform of 2006* (Aug. 2007), http://www.familiesusa.org/assets/pdfs/state-expansions-ma.pdf.

12 The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *States Moving Toward Comprehensive Health Care Reform* (Apr. 3, 2008), http://www.kff.org/uninsured/statehealthreform/ma.cfm.

13 Massachusetts Department of Revenue, *Preliminary Data on the Individual Mandate, Tax Year 2007* (as of June 2, 2008), http://www.mass.gov/Ador/docs/dor/News/PressReleases/2008/HC_Data_Report_FINAL.pdf.

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