



# The New Bipartisan Consensus for an Individual Mandate

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## In Brief

The individual responsibility requirement, most often referred to as the individual mandate, included in the Affordable Care Act (ACA) has perhaps been the most controversial feature of the law since its passage. It requires most Americans to maintain minimum essential coverage (as defined in the ACA) or pay a tax penalty. The ACA includes the individual mandate to avoid the consequences of individuals waiting until they are sick or injured to obtain coverage, because the act also prohibits insurers from discriminating against those with health problems. If people did not enroll in coverage until they knew they would need care, premiums would increase tremendously and health insurance markets could become unstable. Although those opposing the ACA have decried the burdensome nature of such a mandate, a recent proposal (the Patient Choice, Affordability, Responsibility, and Empowerment Act, or PCARE) developed by Republican Senators Orrin Hatch and Richard Burr and Representative Fred Upton seeks to address the same problem as the ACA's mandate and would impose strong penalties on the uninsured. Specifically, if individuals fail to maintain continuous coverage, they can be medically underwritten or effectively denied insurance in the nongroup market. Medicare Parts B and D also have provisions that penalize individuals for failing to promptly enroll in coverage for the same reason, yet this approach to an individual mandate has not been controversial. With the PCARE proposal, there now seems to be at least some agreement across the political spectrum that insurance markets cannot effectively operate while simultaneously treating individuals equitably regardless of health status (e.g., covering pre-existing conditions, no medical underwriting) if the healthy can obtain coverage whenever they choose. The consensus also appears to be that strong incentives to obtain and maintain insurance are required, although the details differ across the ACA, PCARE, and Medicare Parts B and D. Only the ACA is popularly referred to as an individual mandate, although that is, in fact, what all of them include.

## Introduction

With the Patient Choice, Affordability, Responsibility, and Empowerment Act (PCARE) introduced by Republican Senators Orrin Hatch and Richard Burr, together with Congressman Fred Upton, it is now clear

that there is at least some bipartisan agreement on the need for an individual mandate for health insurance. Although the official description of the PCARE proposal includes language indicating strong objection to the individual responsibility requirement of the Affordable Care Act (ACA), the proposal uses different types of penalties intended to bring most Americans into the health insurance pool and keep them there.<sup>1</sup> According to the authors, “Unlike the individual mandate which unfairly forces Americans to buy insurance or face financial penalties, these alternative provisions strike the right balance between strongly encouraging individuals to become insured, while ensuring greater regulatory predictability and market stability, which in turn helps to keep health care costs down.” The individual mandate referenced is the ACA’s requirement that individuals be enrolled in minimum essential coverage during a given year or pay a tax penalty if they are uninsured for more than three months and do not qualify for an exemption.<sup>2</sup> However, PCARE’s approach imposes financial penalties on uninsured people as well; the method for imposing the penalties, their size, and the types of people exempt are where the differences in its individual mandate lie as compared to the ACA’s. The Medicare program has also created a type of individual mandate in Parts B and D, again with the same intent as the ACA and PCARE, but differing in the particulars of the mechanism, size, and exemptions.

## Patient Choice, Affordability, Responsibility, and Empowerment Act

PCARE would provide a one-time open enrollment period. After that it would require individuals to have continuous private coverage for at least 18 months in order to have guaranteed issue of private insurance *without* being medically underwritten. For those who have a gap in coverage (the document suggests that a permissible length of a gap in insurance would be defined consistent with the Health Insurance Portability and Accountability Act, which is 63 days), the penalty is that insurers can use medical underwriting to set premiums as a function of current or past health experience; outright denials would also be allowed, at least between annual open enrollment periods.<sup>3</sup> Although the wording is unclear, it seems that the approach would require insurers to offer a policy to all applicants during the open enrollment period; however, the proposal would not limit the premiums that could be charged to those not having 18 months of continuous coverage prior to applying, and thus insurers would be allowed to effectively deny coverage by setting prices prohibitively high.

No time limits on medical underwriting are noted in the document describing the PCARE proposal, nor does it mention whether re-underwriting would be permitted, but it is certainly possible that the higher rates could persist until the age of Medicare eligibility (65), depending upon an individual’s circumstances. As an illustration, consider an individual with a gap in private coverage of more than 63 days who applies for nongroup insurance and is denied coverage or charged a premium so high that it is unaffordable. If that person cannot gain access to 18 months of affordable creditable coverage, where at least the last type of coverage held was employer-based insurance,<sup>4</sup> there appears to be no mechanism for him or her to eventually obtain insurance in the nongroup insurance market. Even if this person was guaranteed issue of a policy during the next annual open enrollment period or some type of special enrollment period for which he or she might be eligible, there is no provision that would limit the premium that this person could be charged, thereby denying him or her coverage for all practical purposes. Given the income fluctuations of the low- and moderate-income population and the challenging circumstances that can arise over the course of one’s life, particularly in the case of individuals facing health challenges, it is entirely possible that large numbers of people could find themselves without insurance for a few months at one time or another, and then never again have access to adequate, affordable insurance.

# The Affordable Care Act

In contrast, the consequences of going uninsured for more than three months under the Affordable Care Act is a tax penalty for that year, with guaranteed issue of coverage, including essential health benefits and meeting actuarial value standards, again available at the next annual open enrollment period without premium discrimination based on health status. The tax penalties are the greater of a flat dollar amount and a percentage of family income, prorated for the number of months uninsured (details provided in the matrix below) and not to exceed the national average cost of bronze-level coverage. Under the provisions of both the ACA and PCARE, the individual must have coverage or pay a penalty; the size of the penalty, the method of its delivery, and which individuals are exempt from it are what differ. The PCARE proposal is not being referred to as an individual mandate, but it is one in all but name.

## Medicare Parts B and D

Similar rules hold in Medicare Part B (public insurance for physician services) and Part D (public insurance for prescription drug expenses), programs available to persons age 65 and older and certain disabled persons. Individuals who do not sign up for Part B upon becoming eligible pay a penalty of 10 percent of the regular Part B premium for each 12-month delay in enrolling, with the penalty assessed for the rest of their lives while enrolled, once they do ultimately enroll.<sup>5</sup> In Part D, a penalty for late enrollment is also imposed via the premium, equal to 1 percent per month that the individual is without qualified prescription drug coverage; again, this penalty is imposed for the rest of the person's life while he or she is enrolled. Similarly, under both programs, penalties are assessed on those who enroll, disenroll, and then enroll again.

## Comparing the Alternative Types of Individual Mandate

The ACA, PCARE, and Medicare all include significant financial penalties for individuals who do not enroll in and maintain health insurance coverage, and they all do so for exactly the same reason. If individuals can enroll in coverage at the same price and with the same benefits whenever they choose, they would wait until they were sick or injured and needed medical care before obtaining coverage. Healthy individuals would have no reason to enroll, and the average health care costs of those insured would skyrocket along with premiums paid by enrollees (and/or government in the case of publicly subsidized plans). In fact, the concentration of high-cost individuals in insurance pools could accelerate and destabilize the markets, likely leading to their eventual collapse in the case of private insurance or the need for substantially more government financing per enrollee in the case of publicly subsidized insurance.

Thus, providing adequate, accessible insurance regardless of health status in the context of private insurance markets ultimately requires an approach that provides sufficiently strong incentives for individuals to enroll and remain enrolled, even when they do not expect to use medical care. PCARE recognizes this problem, as did the architects of the ACA and Medicare Parts B and D.

Referring to the ACA's individual responsibility requirement as an "individual mandate" suggests that it requires individuals to obtain coverage, although that is not the case. Individuals can choose between enrolling in coverage and paying a penalty, a year-by-year choice under the ACA but a one-time choice under PCARE and Medicare Parts B and D. The differences, as noted earlier, are in the details of the penalties' structures, shown in the following matrix:

## Penalty Structures by Insurance Coverage Type

	Affordable Care Act	PCARE	Medicare Parts B and D
How and when is penalty delivered?	<ul style="list-style-type: none"> <li>■ Via tax system, when income taxes are filed</li> <li>■ Penalty applies to periods of uninsurance in that tax year only</li> </ul>	<ul style="list-style-type: none"> <li>■ Via medically underwritten premiums or denial of access to insurance</li> <li>■ Penalty applies indefinitely unless individual enrolls in at least 18 months of continuous creditable coverage, where at least last type held is via an employer</li> </ul>	<ul style="list-style-type: none"> <li>■ Via surcharges on premiums for these programs if the individual eventually enrolls</li> <li>■ Penalty applies for the remainder of life, unless individual disenrolls and remains disenrolled from the programs</li> </ul>
How large is penalty?	<ul style="list-style-type: none"> <li>■ Phases up to full level by 2016, then adjusted by the Consumer Price Index thereafter. Prorated for number of months uninsured</li> <li>■ Greater of a flat dollar amount or share of income. In 2016 these will be 2.5 percent of income, or \$695 per uninsured adult, \$347.50 per uninsured child, to a maximum of \$2,085 per family; penalty not to exceed national average premium for bronze coverage sold through Marketplaces</li> <li>■ Penalty is thus larger for higher incomes but does not vary by health status</li> <li>■ Individual can enroll in coverage at standard rates and face no further penalty during next open enrollment period or special enrollment period.</li> </ul>	<ul style="list-style-type: none"> <li>■ Varies by individual, based upon health and eventual coverage: smallest penalties for the healthy and those able to obtain 18 months of continuous coverage and largest for sick and injured and those without any access to employer-based insurance</li> <li>■ Amount of extra premium charged to obtain medically underwritten coverage (this amount varies by health circumstances), applied indefinitely until a period of 18 months of continuous coverage allows individual to purchase nonunderwritten coverage</li> <li>■ Effectively, penalty would range from \$0 for those who eventually enroll in coverage but who are perfectly healthy and can obtain standard rates, to a permanent inability to access coverage, due to sufficiently large premium add-on and lack of 18 months of continuous creditable coverage</li> <li>■ Penalty may also include the cost of care for excluded benefits, or, depending upon the person's financial situation, the inaccessibility of necessary medical care</li> </ul>	<ul style="list-style-type: none"> <li>■ Varies by length of time between eligibility and enrollment and length of time coverage is held upon enrollment (i.e., length of life remaining)</li> <li>■ A percentage of premium, and will therefore increase over time as premiums increase</li> <li>■ The Part B penalty is 10 percent of premium for each 12-month period that the individual could have enrolled in Part B but did not. For example, in 2015, the premium for most Medicare eligibles is \$104.90 per month. Delaying enrollment by three years would mean a 2015 penalty of \$378, with the penalty applied each year of enrollment and increasing annually with the premium.</li> <li>■ Part D penalty is an extra 1 percent of the Part D premium for each month without coverage, calculated off the national base beneficiary premium (\$397.56 in 2015). So a person who delayed enrollment by three full years would pay a penalty of \$143 in 2015, with the penalty applied each year of enrollment and increasing annually with the national base premium.</li> </ul>
Which uninsured are exempt from penalty?	Those who are uninsured for fewer than three months; with incomes below tax filing threshold; unable to obtain qualified coverage for less than or equal to 8 percent of family income; incarcerated; not legally present in the country; members of Indian tribes; with certified religious objections or membership in a health care sharing ministry; facing other hardships as determined by the Secretary.	Those who are uninsured with insurance coverage gaps shorter than 63 days; enrolled in continuous coverage for at least 18 months prior to attempting to enroll in nongroup coverage (including employer coverage as at least the last type) and not needing medical care before then; in perfect health who are thus not subject to denials or increased premiums due to medical underwriting.	Those who never purchase Part B or Part D coverage and do not face significant medical costs that they must alternatively finance out-of-pocket.

Note: PCARE = Patient Choice, Affordability, Responsibility, and Empowerment Act.

For individuals unable to access the required amount and type of continuous coverage in a timely manner and for those in less than perfect health, PCARE penalties are much harsher and longer lasting than those imposed under the ACA. The penalties can last until Medicare eligibility depending upon an individual's circumstances, and they are larger for those in worse health status. PCARE restrictions could mean denial of coverage outright or effective denial through unaffordable premiums, denial of coverage for particular benefits related to the individual's health conditions, or extra premium charges that are incurred by those who do enroll. However, given pre-ACA variation in nongroup insurance premiums, the higher premiums charged those in less-than-perfect health would, at least for some, be considerably greater than the penalties individuals are subject to under the ACA, and the ACA provides opportunities within a calendar year to obtain affordable coverage and/or end the imposition of the penalties.

Penalties in Part B and Part D also last longer than the ACA, but may be larger or smaller in size depending upon length of time prior to enrollment and length of remaining life. They apply to the Medicare population, one that is either disabled or over age 65 and thus highly conscious of the need for health coverage. As a consequence, enrollment rates are very high at the initial enrollment time. However, for those who do not enroll, the penalties are quite significant and last for the remainder of an individual's lifetime.

## Conclusion

Although there are many issues one could discuss in comparing PCARE and its implications to the ACA (e.g., affordability and accessibility of adequate health insurance benefits, financial burdens associated with health care by income group and age group, and implications for nongroup insurers' willingness to offer comprehensive coverage), what is perhaps most interesting is that PCARE acknowledges the need for an individual mandate or otherwise-named equivalent. Medicare does the same. The alternative proposals differ from the ACA regarding the appropriate size, timing, and exceptions to penalties when an individual becomes uninsured and then later seeks coverage. However, for all of the criticism of the ACA's individual mandate as being overly burdensome, it is, in fact, the least burdensome and most equitably applied of the three discussed here.

## Notes

1. "The Patient Choice, Affordability, Responsibility, and Empowerment Act," US House of Representatives, Energy and Commerce Committee, accessed March 31, 2015, <http://energycommerce.house.gov/sites/repUBLICANS.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf>.
2. Patient Protection and Affordable Care Act/Reconciliation Act of 2010. Part I, Section 1501, Requirement to Maintain Minimum Essential Coverage.
3. The description in the proposal is somewhat unclear with regard to outright denials of coverage. It reads, "Under this new protection, individuals moving from one health plan to another—regardless of whether it was in the individual, small group, or large employer markets—could not be medically underwritten and denied a plan based on a pre-existing condition if they were continuously enrolled in a health plan." This language also seems to suggest that individuals moving from public insurance coverage, such as Medicaid or CHIP, would not be afforded the same consumer protections, even if previously covered under that program continuously. In the following paragraph, however, the authors write, "So long as an individual or family in the case of a family policy, has stayed continuously covered, they could not be forced to pay a higher premium solely because of a costly health condition when switching plans." Here they do not mention outright denials of coverage, so there

is some ambiguity. However, with no limits on the higher premiums charged those being underwritten, even if outright denials are prohibited (likely during an annual open enrollment period), the premiums could be set sufficiently high to be equivalent to an outright denial.

4. Although the language in the proposal is unclear, as noted in note 3, we presume that this approach would count public insurance coverage as well as private insurance coverage as creditable coverage counting toward the 18-month total, but that portability of insurance to nongroup insurance coverage at standard rates during an open enrollment or a special enrollment period would require that the *last* type of coverage held be through an employer plan. This would be consistent with the Health Insurance Portability and Accountability Act's (HIPAA's) requirements for portability to nongroup insurance, and because the proposal references HIPAA in a number of places, we presume it would be consistent on this as well. In addition, the text of the PCARE proposal states, "Under this new protection, individuals moving from one health plan to another—regardless of whether it was in the *individual, small group, or large group markets* (emphasis added)—could not be medically underwritten and denied a plan based on a pre-existing condition if they were continuously enrolled in a health plan." There is no mention of moving to private coverage from public coverage or a high-risk pool, for example, again consistent with the provisions of HIPAA.
5. Special enrollment periods are available for those not taking Part B due to enrollment in a group health insurance plan. No penalty is assessed for those enrolling late under these provisions.

## About the Authors and Acknowledgments

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