

Individual Health Insurance Mandates: A Basis for National Health Reform?

Much attention has been paid to the idea of mandating health insurance coverage. During the 2008 presidential campaign, both Barack Obama and Hillary Clinton proposed mandated coverage; he advocated covering all children, she advocated covering everyone. Many states, tired of waiting for the federal government to act, are in the process of planning or implementing their own versions of health reform. To date, only one state – Massachusetts – has actually mandated that its residents obtain health insurance or face fines and penalties.

Policymakers are carefully watching this scenario unfold. Its success could be a harbinger of things to come in their own states, or even on a national scale. Its failure could mean starting from square one again. Can making people buy health insurance actually work? If it is coupled with improvements in cost containment and access to care, an individual mandate will meet the key goals of health care reform. However, like a three-legged stool, one cannot function without the support of the other two.

The Problems of the Uninsured

A recent report by the Kaiser Commission on Medicaid and the Uninsured noted “there were 45 million people under the age of 65, including nine million children, who did not have health insurance in 2007” (Hoffman, 2008, p.1), or roughly one in every six Americans. The working poor, minorities, as well as healthier young people were most frequently noted as lacking coverage. According to the Kaiser report, only one percent of the uninsured have no connection to the workforce – most are from working families,

either full or part-time; some two-thirds are poor or near poor, and four-fifths are adults between ages 19 and 54 (p. 4). “Young adults comprise a disproportionately large share of the uninsured, mostly because of their low incomes,” (p. 5).

The uninsured face more health problems, tend to delay or go without medical care for longer periods of time, and report problems with getting care when they do need it compared to those with health insurance. They often miss treatments, skip medication, have many unmet medical needs, often lack any assets to pay for care when they do get it, or deplete their savings to pay medical bills. The uninsured are less likely than those with insurance to have a regular source of care and more liable to have avoidable hospital or emergency room visits. (Hoffman, 2008).

Non-elderly with health insurance spent an average of \$4,463 on care in 2008; the uninsured spent \$1,686. The costs of care do not go away – they filter into “uncompensated care costs,” which amounted to some \$57 billion last year – most of which was paid for by federal state, and local governments. (Hoffman, pp. 9-12). The majority of uncompensated care is provided by hospitals because patients often turn up in later stages of illnesses and their needs require more in-patient stays and tests. That adds to the cost burden for payers, and this cost in turn, is passed on to taxpayers, as it is primarily funded by public dollars or via “pass-throughs” in health insurance premiums.

State-Level Reform

To address this growing financial burden, policymakers are finding ways to expand Medicaid and State Children’s Health Insurance Program (SCHIP) eligibility to cover more poor/near-poor adults and children. Many states are developing plans for

covering more individuals through state-sponsored health insurance programs or subsidizing individual insurance purchases. The most progressive of these, “comprehensive reforms in Massachusetts, Vermont and Maine go further toward helping low-income families purchase health insurance than in any other states” (Burton, 2007, p. v).

While several states rely on private insurers to deliver services paid for with Medicaid funds, the majority of successful of these plans also rely on shared financial responsibility. “These newest reforms are more promising than their predecessors...they are all based on some common, hard won lessons: some are beginning to recognize the need for mandatory participation; [that] voluntary purchasing pools, as a stand-alone strategy, are not likely to be sufficient to expand coverage, and address cost and quality in addition to health insurance coverage” (p. vi).

Massachusetts is unique in that it is currently the only state to have an insurance mandate. This mandate has been in place since 2006 – and policymakers are watching carefully for successes and pitfalls in the program in the hopes of modeling future state, or perhaps national reform on this model.

Starting in the mid-1980s, Massachusetts passed a number of laws related to health care reform. Key actors and stakeholders participated in the planning process, including Blue Cross/Blue Shield, consumer, and employer representatives. Planners developed several approaches to ensuring universal coverage. The state had impetus to act, as they were in danger of losing major federal funding from expiration of Medicaid waivers. In 2006, they enacted a reform plan “with the goal of covering 95 percent of uninsured residents by 2009,” (Kaye, 2007, p. 6). The plan expanded coverage but also

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