



Insight

Alternative Policy Options to the Individual Mandate

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As Congress continues working to repeal and replace the Affordable Care Act (ACA), lawmakers are considering various alternatives to the ACA's individual mandate. The individual mandate requires everyone to purchase health insurance, with a few exceptions. The intent of such a provision is to broaden the risk-pool as much as possible, ensuring that individuals of all ages and health status are insured, not just those who are higher-risk or costlier to insure. It is also important that individuals remain insured throughout the year, rather than waiting to sign-up until they are sick. Having an unbalanced risk pool leads to higher premiums and an unstable insurance market, increasing the likelihood that the market will collapse on itself in a so-called "death spiral". The ACA's mandate, though, has been both ineffective—28.6 million Americans remain uninsured^[1]—and unpopular—66 percent of Americans oppose the individual mandate.^[2]

The House-passed American Health Care Act (AHCA) included a [continuous coverage incentive](#) as an alternative to the mandate. It has been suggested, though, that the structure of this provision will preclude it from being included in any legislation that moves through the Senate under the budget [reconciliation](#) process and the corresponding "Byrd rules" to which such legislation will be subject. This paper examines other potential alternative policies designed to encourage individuals to remain insured.

Premium Surcharge

The AHCA, as passed by the House, encourages individuals to remain continuously insured by providing premium cost protections to anyone who does so. Beginning in plan year 2019 (or 2018 if an individual enrolls during a Special Enrollment Period in that year), an insurer may impose a surcharge of 30 percent of what the individual's premium would otherwise be for up to one year if an individual is uninsured for more than 63 days in the 12 months prior to enrollment; after that year, the penalty would cease. Besides providing an incentive to individuals to remain insured, the surcharge should help insurers cover the costs of insuring an individual who may have pent-up demand for additional health care services to address needs that went unmet during that uninsured period. Though, there is uncertainty as to how much the surcharge would need to be to achieve this goal. The surcharge may also make the premiums unaffordable for some, resulting in their inability to gain insurance, perpetuating the problem.

There are two ways the surcharge may be modified—either by duration or amount. One option would be to apply the surcharge for an equal number of months that the individual had a gap in coverage. The other option is to vary the amount of the surcharge by the number of months the individual was uninsured. For instance, if the individual was uninsured for only six months, rather than a full year, the surcharge would be reduced by half to 15 percent, rather than 30 percent.

Variations of a premium surcharge are currently used in all parts of Medicare for enrollees who fail to sign up during their initial open enrollment period. Under Part A, the late enrollment penalty is ten percent and charged for twice the number of months the individual was not enrolled.^[3] Failing to sign-up upon eligibility for Part B results in a 10 percent premium surcharge for each full 12-month period the beneficiary was not enrolled for the

entire length of an individual's enrollment.[4] Part D charges one percent of the national base premium for each of the months the beneficiary was not enrolled for the entire length of enrollment, and because the base premium typically increases each year, the beneficiary's penalty will likely increase each year.[5]

Waiting Period

Requiring individuals who have not remained continuously insured to face a waiting period, during which they will not be able to access benefits through their health insurance coverage, is another option for discouraging gaps in coverage. The individual would be required to begin paying monthly premiums, but coverage would not go into effect until the waiting period is over. This type of policy was common prior to the ACA, and a typical waiting period was often twelve months or more.[6] However, this option typically faces strong criticism, as someone suddenly enrolling after a gap in coverage is likely in need of immediate care, resulting in denial of services for a sick individual.. Conversely, it is for the same reasons that such a provision could particularly be effective at driving continuous coverage.

Limited Plan Choice

Restricting the number or types of plans available to an individual enrolling after a gap in coverage for some length of time is also likely to encourage continuous coverage. The individual may be limited in their plan choice up until the next open enrollment period, or for some other length of time, say 6 or 12 months. If the period ended outside the normal open enrollment period, a Special Enrollment Period allowance would be needed to then allow the individual to enroll in the full range of products available.

Plan choice may be limited to catastrophic plans or those with low actuarial value, similar to the ACA's "bronze level" plans. Under this option, it would likely be necessary to couple such a provision with an inability for the individual to simultaneously receive a tax credit, as the amount of the tax credit would likely cover the entire cost of such a plan, mitigating any incentive to maintain coverage and making such a policy less effective.

Combination of Waiting Period and Limited Plan Choice

It would also be possible to combine the waiting period with a variation of the limited plan choice, such that an individual could enroll in any of the plans, but during the waiting period they would only receive catastrophic level coverage. Once the waiting period was over, the beneficiary would then receive the full level of coverage corresponding with the plan they selected. This option lessens the severity of the strict waiting period option, while maintaining an incentive to maintain continuous coverage.

Tax Credit Eligibility Modification

The amount of the tax credit for which an individual is eligible could be adjusted based on the number of months they were uninsured. Under this provision, the amount of the tax credit available would be proportionally reduced by the number of uninsured months. For example, if an individual had a gap in coverage of three months (a fourth of the year), the tax credit would be reduced by 25 percent. This option could save the federal government money without denying an individual immediate access to the full-range of coverage options available, though—like the premium surcharge—may have the effect of making coverage unaffordable for some.

Excise Tax

An excise tax on one's premiums could be imposed for the same number of months the individual was uninsured in the past year. The revenues from this tax could be used to help fund the health insurance tax credits or the Patient and State Stability Fund. Some may view this option as being highly similar to the individual mandate and its associated penalty.

Pre-Funded HSA

Providing positive incentives, rather than punitive disincentives, could also incentive people to maintain continuous coverage. One such option is to provide enrollees who maintain coverage with a credit towards a health savings account. While HSAs are highly popular and a great tool to encourage patients to seek high-value care, this option could have significant costs to the federal government.

Auto-Enrollment

One final option that has been discussed is auto-enrolling any uninsured individuals into an insurance plan, and then providing them the option to opt out of such coverage. While this policy is likely to be effective in decreasing the number of uninsured individuals, it will be difficult to administer and may be objectionable on privacy grounds. The federal and/or state government would have to know who was uninsured in each state and whether they had an offer of insurance coverage from their employer or were eligible for some other health care program. Assuming the government can successfully make such determinations, if an individual was found to be eligible, they would then be automatically enrolled in a plan. This may either be a randomly selected plan available to all individuals in that state, or perhaps a default plan the state selects that would ideally have a premium equal to the amount of the tax credit available. The individual must then be notified of the plan placement; if one opted out or failed to pay any premium due, they would be disenrolled.

There will be significant costs, effort, and data-sharing required to administer auto-enrollment programs in each of the 50 states. Congress is already concerned with the amount of money being spent by the federal government to provide health care, and the government has a [history of data breaches](#). Individuals enrolled may not appreciate the government acting in such a way on their behalf, and it may not be the best use of federal funds.

[1] <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf>

[2] <https://today.yougov.com/news/2017/02/27/public-wants-Obamacare-minus-individual-mandate/>

[3] <https://www.medicare.gov/your-medicare-costs/part-a-costs/penalty/part-a-late-enrollment-penalty.html>

[4] <https://www.medicare.gov/your-medicare-costs/part-b-costs/penalty/part-b-late-enrollment-penalty.html>

[5] <https://www.medicare.gov/part-d/costs/penalty/part-d-late-enrollment-penalty.html>

[6] <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8356.pdf>