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Administering Health Insurance Mandates

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SUMMARY

Mandates form an integral part of many state and national proposals to expand health insurance coverage. Often, however, too little attention is paid to how and whether they can be administered. In general, we find that a mandate will be easier to administer when some or all of the following conditions are met:

- It emphasizes facilitating compliance rather than penalizing noncompliance;
- It operates as a simple play-or-play arrangement;
- It can accurately take advantage of regular withholding for most workers;
- It involves penalties that are moderate and collectable;
- It is coordinated with any subsidies and other public programs, including Medicaid;
- It is based upon other government payments that can be denied, such as tax benefits;
- It is applied only to those with more than low incomes, unless the penalty is denial of other benefits;
- Its size does not vary greatly with fluctuations in income, so any penalty can be collected currently and accurately.

Many current proposals to promote more universal health insurance coverage contain mandates that would require individuals to buy health insurance. Language is important here: some who oppose an individual mandate do not object to modest penalties for those who fail to purchase insurance. Other proposals would impose requirements on employers to provide or pay for coverage in addition to or instead of an individual mandate. "The general theoretical conclusion from economics," writes Mark Pauly, "is that there is likely to be very little difference, in the long run, between an individual and an employer mandate" (Pauly 1994). This argument rests largely on the notion that if the same ultimate tax or mandate is imposed on exactly the same activity, the ultimate economic incidence doesn't depend on who initially pays. People will eventually react to the same net incentives in the same way. In practice, however, significant differences arise between what can be implemented through charges on employers and on employees, often guided by practical issues of administration and how people respond to alternative administrative structures.

While well grounded in principle, mandates to pay for or purchase health insurance must confront important administrative challenges. Most important, for many people a mandate to purchase health insurance requires that they receive subsidies adequate to make the insurance affordable. At the same time, given the long history of less than full participation in means-tested benefit programs, administration of mandates and subsidies needs to be carefully coordinated and thought out. Both are difficult. In addition, since sizable penalties are hard to collect after the fact or at the end of the year, payments should be kept current and penalties modest. Among the available techniques are withholding, automatic enrollment, and relating the penalty to some other tax or transfer benefit that can be denied through simple administrative means.

This paper identifies ways to structure health insurance mandates, if adopted at the federal level, so that they are more likely to be administered fairly and effectively. In doing so, it draws on information about the administrative arrangements used in existing health insurance mandates in Hawaii, Massachusetts, the Netherlands, and Switzerland, as well as the administration of mandates proposed by California Governor Arnold Schwarzenegger, the New America Foundation, and Senators Ron Wyden (D-OR) and Robert Bennett (R-UT). The appendix to this paper provides detailed information about the administrative features of these existing and proposed mandates.

INITIAL CONSIDERATIONS

Employer and individual mandates provide financing for expanded health coverage without being labeled as tax increases. Unlike taxes, mandated premiums would not necessarily be recorded in the federal budget (Seiler 1994). Like taxes, mandates pose issues of equal justice for those equally situated (sometimes called horizontal equity), not merely progressivity for people at different income levels (sometimes called vertical equity). Progressivity can be achieved through a variety of redistributive means. Health insurance mandates require both universal participation in payment systems for health insurance *and* that money be spent on health insurance.

Mandates attempt to prevent people from being "free riders" who depend upon others to support the insurance, often implicit and insufficient, that they receive from society. If free or subsidized access to health care is provided to those without adequate resources at time of illness, then most people without private insurance can be considered to have a backup, if unstated, public health insurance policy. For instance, even some currently middle- or high-income uninsured are potentially eligible for Medicaid if their future health costs are high enough. Without a mandate or more universal insurance, those who could have paid for insurance or saved to cover their costs, but did not, can shift their burdens onto others. Mandates require that at least some payment is made up-front on a nearly universal basis—thus preventing people from shifting their health care burdens onto others who are no more capable of paying for their insurance.

Mandates also aim to assure that everyone who is in good health shares in helping those who face large health-care costs, even when the health status of the individuals is known before the purchase of the insurance. Here, progressivity comes back into play. "Mandates greatly reduce insurers' legitimate fears that they may otherwise be forced to provide coverage for disproportionate numbers of individuals with high health costs," says Len Nichols. Mandates might also reduce administrative costs, depending upon how designed. "Getting everybody into the market will lead to significant reductions in administrative and marketing costs that can be passed on to consumers and payers" (Nichols 2007).

Any employer or individual mandate must specify the nature and size of the health insurance policy that must be purchased, either by listing specific benefits or establishing a required actuarial value. At one extreme, the required insurance might cover a very wide range of services with generous payment rates to providers and limited cost-sharing by beneficiaries. At the other extreme, if few restrictions are imposed, individuals might get by with a policy that covered only catastrophic events, and only up to a specified dollar limit. The more extensive the requirements, the greater will be the cost of the required insurance and the greater the burden of the mandate. Moreover, as the costs of health care rise, each year's increase in the cost of the mandated policy may increase the gap between the cost of insurance and the cost of paying a fine or penalty for not meeting the mandate. Thus, depending upon how the fine or penalty evolves, paying the fine may become increasingly easier than complying with the mandate.

EMPLOYER MANDATES

Employers can be required both to administer a mandate on individuals in their employ and to contribute directly to the purchase of health insurance for their employees. For our purposes, when we speak of an "employer mandate," we are referring to the latter. When we turn to an individual mandate below, we will further examine the potential role of the employer in administering and enforcing that mandate.

Almost all states require health insurers doing business in their states to cover specific types of health care services, such as mammography screening and minimum maternity stays. The federal government also imposes several requirements on health insurance plans, including self-insured employer-sponsored plans (Jost 2008). Although often referred to as "mandates,"

these requirements are not discussed here, since they apply only to employers that elect to provide health benefits to their employees.

An employer mandate alone cannot ensure universal health insurance coverage, since many uninsured people do not have a current connection to the workforce, but it can strengthen the system of employer-sponsored insurance, which is the primary source of coverage for nonelderly Americans. Eighty percent or more of the uninsured are estimated to come from working families. Employer mandates may apply not only to current workers, but to those who have left employment. For example, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires that employers with 20 or more employees that provide employer-sponsored insurance offer access to continuing health insurance temporarily to some who have left employment or otherwise lost coverage.

In the United States, only Hawaii and Massachusetts currently impose mandates on employers to provide or pay for health insurance, although employer mandates have been proposed in other states and at the federal level. The limited use of employer mandates is partly a consequence of the federal Employee Retirement Income Security Act (ERISA) of 1974, which frees self-insured employment-based health plans from state regulation. ERISA prevents states from requiring employers to provide health coverage or to spend any particular amount on health coverage (Jost 2008). Hawaii has a limited exemption from ERISA, but other states—including Massachusetts—do not.

Types of Employer Mandates

Employer mandates can take one of two forms. In one, as in Hawaii, employers must provide most employees with health insurance and must make a prescribed contribution to that insurance. In another, often called play-or-pay, employers have the option of paying a tax instead of providing health insurance coverage. Massachusetts requires that employers make a "fair and reasonable" premium contribution toward a health insurance plan for their employees or pay the state a Fair Share Contribution of up to $295 annually per employee. The size of the required contribution reflects the extent to which government depends upon employers to help achieve more universal insurance. Massachusetts kept the Fair Share Contribution modest partly to avoid an ERISA-based legal challenge, which remains a possible threat (Butler 2006).

Employer mandates may, but need not, exempt small businesses. In Hawaii, the mandate applies to all nongovernmental employers except sole proprietors with no other employees. In Massachusetts, the mandates generally apply to firms with 11 or more full-time-equivalent employees. Some proposals set a cut-off at larger firm sizes. The extent of the required employer contribution may also vary by firm size or by a firm's average wage. Small business exceptions raise a variety of administrative issues. Closely held businesses might easily split into several different legal entities. Larger businesses might contract out more to smaller firms and independent contractors; indeed, this is already a way that employers can effectively avoid anti-discrimination rules that apply to retirement plans. Note that this evolution doesn't have to be planned by the firm's owners or managers; firms with fewer mandates may simply be more

competitive and grow faster than others—thereby gradually extending an exemption to larger portions of the employer community.

Proposals for employer mandates, at least so far in the states, often do not require covering dependents. The mandate in Hawaii does not apply to dependents, nor does the Fair Share Contribution requirement in Massachusetts. Nonetheless, firms that offer coverage for workers generally offer coverage for dependents as well, even if they do not contribute (or contribute less) to the cost of that coverage.

Whether or not dependents are included in an employer mandate, issues of coordinating public and private benefits arise. For instance, according to the Congressional Budget Office, expansion of the State Children's Health Insurance Program (SCHIP) will likely displace some employer-sponsored coverage. Excluding dependents from a mandate might increase the incentive for employers to drop insurance for dependents, since they could no longer drop insurance for everyone. Even if children are covered by an employer mandate, they may be eligible for some benefits under SCHIP or Medicaid that are not provided under the employer plan.

While employers may be required to contribute toward health insurance, the size of the mandate may not be adequate to cover the cost of that insurance. In Hawaii, for example, the employer must pay at least half the cost of an individual health insurance policy, and the employee may be required to contribute up to 1.5 percent of wages. In Massachusetts, the individual mandate requires all adults to obtain insurance, whatever the employer's contribution to its cost. Other arrangements, of course, are also possible.

Experience with Employer Mandates

Although only Hawaii and Massachusetts offer any U.S. experience with mandates requiring employers to provide or pay for health insurance, employers are subject to mandates in other areas, such as paying a minimum wage, providing workers' compensation, and withholding and paying taxes. These examples provide some lessons about what to expect from an employer mandate and how to make an employer mandate as effective as possible.

Health Insurance Mandates

Since 1975, Hawaii's Prepaid Health Care Act has required nearly all employers to provide health insurance to employees who work 20 hours or more a week for four consecutive weeks. The Disability Compensation Division of the state's Department of Labor and Industrial Relations, which also administers workers' compensation, enforces the mandate by responding to complaints and conducting compliance visits with randomly selected employers. Although we have not found any data on the rate of compliance, the mandate appears to be effective in expanding health coverage. After the Prepaid Health Care Act became law, the rate of uninsurance in Hawaii dropped from 30 percent to perhaps as low as 5 percent (Hawaii Uninsured Project 2003). In 2004-2006, according to the Census Bureau, it was 8.6 percent—the second lowest rate in the Nation. A 2004 analysis finds that the rate of insurance among workers

in Hawaii is 10.9 percentage points above the level that would otherwise be expected (Kronick, Gilmer, and Rice 2004).

The employer mandates in Massachusetts are less far-reaching than the mandate in Hawaii, because Massachusetts—unlike Hawaii—does not have an exemption from ERISA. By the same token, Massachusetts relies more than Hawaii on other mechanisms, including an individual mandate. Under the reforms that became effective in 2007, Massachusetts firms with 11 or more employees must make a "fair and reasonable" premium contribution toward health insurance or pay the state a Fair Share Contribution, as previously described. Firms must also offer a cafeteria plan meeting federal requirements (under section 125) that allows employees to pay for health insurance coverage on a pre-tax basis. Firms that do not comply are subject to a Free Rider Surcharge, effectively charging them for part of the care used by their employees or dependents that is financed by the state's Health Safety Net Fund. Because these requirements have gone into effect only recently, it is too soon to determine their impact on the rate of health insurance.

Minimum Wage

The federal government and all but six states require that hourly employees in most industries be paid a minimum wage. Under the federal Fair Labor Standards Act (FLSA), business must pay back wages if they fail to comply with the minimum wage, and they are subject to fines for willful violation (Glied *et al.* 2007). Estimates of compliance with the minimum wage depend upon the data and definitions employed. Using the 1973 Current Population Survey, Ashenfelter and Smith estimated an overall compliance rate of 69 percent, when compliance was measured by the fraction of covered workers earning the minimum wage or less who earned exactly the minimum wage (Ashenfelter and Smith). In a 2006 survey, the Wage and Hour Division of the U.S. Department of Labor found that 92 percent of low-wage workers in low-wage industries were paid in compliance with the FLSA (U.S. Department of Labor). Whatever data and measure are used, however, the studies agree that compliance varies considerably among industries and locations, and that vigorous enforcement and higher penalties can significantly increase compliance (Glied *et al.* 2007; Weil 2005).

One of the major economic objections to an employer mandate is that it operates very much like an increase in minimum wage, which can increase unemployment and off-the-books work among low-wage workers (Baicker and Levy 2007; Burkhauser and Simon 2007). The threat is much stronger the larger the increase in costs imposed. Enforcement and compliance problems are therefore likely to rise more than in proportion to any rise in the effective minimum wage. Introducing gradual increases in employer mandates in place of gradual increases in the minimum wage might alleviate both the economic and administrative concerns.

Unemployment Insurance and Workers' Compensation

Under the federal-state unemployment insurance (UI) program, employers must pay a payroll tax on the earnings of covered employees. In addition, every state except Texas mandates that private employers provide workers' compensation protection for almost all of their

employees. The coverage of the two programs is largely the same (Sengupta, Reno, and Burton 2007). As with the minimum wage, there are no consistent, comprehensive data on the rate of compliance with state workers' compensation laws. A recent study in New York State, however, offers evidence that employer non-compliance is a growing problem. The study cites several findings that employers frequently misclassify employees as independent contractors, thereby avoiding responsibility for both UI and workers' compensation. In addition, many fewer workers in New York appear to be covered by workers' compensation than by the UI system. The same study suggests that other states have been more effective in combating workers' compensation fraud through expanded enforcement efforts and increased penalties (Fiscal Policy Institute 2007).

A more thorough study in California finds that under-reporting for workers' compensation increased from a range of 6 to 10 percent of total private industry payroll in 1997 to 19 to 23 percent of payroll in 2002—a period when premiums rose rapidly. Employers also misclassify workers in high-risk categories as earning wages in lower risk occupations. The study estimates that, for very high risk classes, as much as 65 to 75 percent of payroll is under- or misreported (Neuhauser and Donovan 2007).

Tax Compliance

In many cases the enforcement of an employer mandate rests with the tax authorities. Most employers are required to file returns regularly, turning over periodic tax payments, reporting on pensions and payments to retirement plans, and withholding taxes on employees' earnings. Not all of this is done seamlessly. Partnerships and self-employed individuals are estimated to underreport their net incomes on average by 30 percent or more. The tax authorities also get limited information on the provision of health insurance, but it is not currently compiled in ways conducive to a mandate. For example, the Internal Revenue Service (IRS) does not match up reports on general expenses and coverage with the participation of employees in health insurance in each payment period. Rules that attempt to limit transactions undertaken only for tax purposes are difficult to enforce, in part because the transactions are difficult to find. For instance, rules requiring employers to maintain current efforts when incentives encourage them to change the way they do things are almost impossible to enforce in the long-run. As a simple example, it would be very hard to use tax penalties to restrict firms over time from splitting up into smaller entities if there are small-business exceptions to a mandate. Some of these issues arise, as well, with individual mandates enforced through employers.

Employers also face anti-discrimination rules regarding employer-provided benefits such as pensions and deposits to retirement accounts, as well as employee contributions to such plans. These rules add to compliance costs and also threaten firms with lawsuits over whether certain actions are discriminatory. A requirement that any health insurance be provided equally among employees could raise similar issues of deciding what was discriminatory and what was not, as well as force further attention to exactly who is an independent contractor. Employers operating in more than one state also seek uniformity of treatment, which is a major reason for the provision in ERISA limiting state regulation of employee benefit plans.

Administrative Considerations

Whether or not to impose an employer mandate in place of an individual mandate (in whole or in part) is likely to hinge as much on political as administrative concerns. Generally speaking, an employer mandate encourages the notion that employees are getting something for nothing. While some minimum-wage employees might gain higher total compensation—imposing a mandate is like a requirement to raise the minimum wage, at least for those employees who maintain their employment—economists generally believe that employees bear the burden of the mandate in the form of lower cash wages, at least on average over time. (Recently, Len Nichols has argued that continuing, rapid increases in the cost of health insurance prevent employers from shifting its entire burden to employees, although high profit rates cast doubt that this situation can hold for very long.) In any case, hiding the true cost of a mandate may lead to mistakes in allocating burdens across society and in determining the amount of health insurance that is mandated. For example, depending on the rules and circumstances, a mandate to participate in a community-rated health insurance pool could result in transfers from the young to the middle-aged, who are usually better off.

One administrative complication with an employer mandate derives from its use as a way to prevent employees from being free riders on government systems. Not all employees who opt out of an employer's own plan are free riders. Some may acquire insurance from other sources, such as a spouse, parent, or other family member. Some older workers and persons with a disability may have access to Medicare or Medicaid. Children may have access to Medicaid or SCHIP. In addition, many workers hold more than one job at a time.

All these issues raise potential administrative complications about distributing the burden of an employer mandate fairly and efficiently among families with different work histories, sizes, labor force participants, and employers. Suppose, for instance, that employers are mandated to pay for the cost of a family policy for full-time workers. Policy makers might attempt to come up with formulas for allocating that requirement across several jobs held by several members of a family, but it is highly unlikely that its cost could be easily and precisely coordinated.

Therefore, various rough-and-ready approaches to making an employer mandate administrable are almost inevitably employed, but at some cost in equity or efficiency. In Hawaii, an employee with two or more employers must designate a principal employer, who is responsible for providing health coverage, and employees may claim an exemption if they have other coverage. This provision could encourage employers to provide weaker plans (within the statutory requirement), so they can save costs by becoming less likely to be "designated." And because part-time jobs are excluded from the mandate, a person with two 15-hours-per-week jobs will lack the health insurance available to a person with one 30-hours-per week job. In Massachusetts, the requirement that employers make a "fair and reasonable" premium contribution toward health insurance applies to the firm as a whole and not to each of its employees individually.

With individual mandates (including those enforced by an employer) it is often easier to reconcile payments at the end of the year when there are several employed family members and

several employers. Today, for example, reconciliation of employee Social Security taxes collected from multiple jobs is achieved with end-of-year income tax filing by the employee. In the case of the employer mandate to pay Social Security tax, on the other hand, no such reconciliation is attempted. This simplification makes the employer-mandated tax administrable, but it also means that some employees—those with several jobs and with total earnings above the taxable maximum—have greater contributions made on their behalf by employers than other employees with the same earnings.

Firms are already subject to a wide range of federal, state, and local requirements relating to wages and hours, unemployment compensation, workers' compensation, tax withholding, workplace health and safety, environmental protection, and more. Although not all firms comply with all of these requirements, lack of compliance by some firms is not generally considered a reason to forego establishing otherwise desirable requirements. In all these areas, employer mandates often require some unique trade-offs to make them administrable.

Any health reform plan that includes an employer mandate must make provision for non-compliance. Lack of compliance with a new mandate to provide health insurance is likely to be concentrated among firms that fail to comply with existing requirements. For example, agricultural businesses have a poor record of compliance with the requirement to report an employee's taxable earnings using the correct Social Security number, and garment makers have a low rate of compliance with the minimum wage. It is reasonable to surmise that some of these same firms would also fail to provide required health insurance to their workers.

If an employer fails to comply, what penalties will apply? Fines could be levied, and law suits could issue when they are not paid. The play-or-pay option adopted in Massachusetts was likely adopted not simply as a matter of equity between employers with insurance and those without, but as a matter of administrative simplification. In effect, it provides a fairly simple penalty structure: a flat penalty per employee not covered. Of course, once penalties are put into the law, several other administrative mechanisms must be developed: reporting requirements, penalties for misreporting (not just failing to comply), judicial or administrative procedures to handle disputes, and collection agents to collect fines, penalties, and interest. Different enforcement mechanisms may be needed depending on whether the employer is a private-sector taxable entity, a nonprofit organization, or a government. In Massachusetts, the Fair Share Contribution is collected by the Division of Unemployment Assistance, which also has the responsibility to implement penalties for nonpayment.

INDIVIDUAL MANDATES

Administering an individual mandate potentially raises more issues than administering an employer mandate, but mainly because it usually covers more people. A mandate on employees, administered by employers, may be no harder and sometimes easier for the employer to administer than an outright employer mandate. Moreover, an employer mandate is often backed up by an individual mandate to reach those outside the labor force. In the discussion below, we will mainly deal with administrative issues that differ from those discussed previously for employer mandates.

When it comes to individual mandates, there are few existing U.S. models to follow. The federal government requires that draft-age men register with the Selective Service System. States require children to attend school up to a certain age and often require certain immunizations as a prerequisite. Since July 2007, the state of Massachusetts has required everyone over the age of 18 to have health insurance, as long as it is defined as "affordable." Otherwise, governmental mandates "typically apply to people as parties to economic transactions, rather than as members of society" (Seiler 1994). Social Security taxes must be paid by individuals with wages or self-employment earnings, for example, but not by those without earnings from work.

Experience with Individual Health Insurance Mandates

Limited guidance may be found in individual health insurance mandates that have applied since 1996 in Switzerland and since 2006 in the Netherlands. Both countries have achieved coverage rates of 97 to 99 percent, but in both cases coverage was almost as high under the mixed public-private arrangements that existed before imposition of the mandate. In addition, their political and cultural institutions differ from those of the U.S. in some other major respects.

In Switzerland, for example, every resident must register his or presence with the local population control office shortly after taking up a new place of residence. The enforcement of the health insurance mandate by Swiss cantons builds on this pre-existing registration requirement, which is absent in the U.S. If you don't sign up for insurance or pay your premium, an employee of your canton or commune is likely to knock on your door to obtain compliance.

In the Netherlands, several features hold down the level of premiums and thereby facilitate compliance with the mandate. The cost of health care is less than in the U.S. Half of the cost of insurance for adults is paid for by an income-related tax, and the government pays the entire cost for children. Moreover, 40 percent of the population is eligible for a premium subsidy. Even so, an estimated 1.5 percent of the legal population is estimated to be uninsured, and a similar number of people are delinquent in the payment of premiums. Since the architects of the Dutch mandate did not envision any problem with non-compliance, the initial legislation created few effective sanctions if a person does not take out insurance or pay premiums, and the government is currently developing enforcement mechanisms (Okma 2007).

Massachusetts provides an excellent illustration of a recent attempt to administer an individual mandate in the context of comprehensive health financing reform. In addition to the individual and employer mandates, the Massachusetts reform includes a restructuring of the individual and small group market for health insurance, creation of an insurance purchasing exchange (the Commonwealth Connector), and provision of subsidies for coverage to families with incomes up to 300 percent of the poverty level (Commonwealth Care). Massachusetts carefully considered the administrative arrangements before enacting legislation, relied heavily on existing state agencies to administer the new program (in addition to creating the Connector), left some significant discretion to program administrators, and provided extensive assistance to individuals and employers on how to comply with the new requirements. Although it is too early to determine the effectiveness of the Massachusetts mandate, almost all residents will be

affected: an estimated 1 percent of the state's population will not be required to obtain insurance because it is still considered unaffordable.

Experience with Other Individual Mandates

Outside of the health insurance area, governments impose individual mandates for automobile owners to purchase liability insurance, for children to be immunized before attending school, and for recipients of income to pay taxes. The government's experience in collecting benefit overpayments, student loans, and other debts also carries lessons for the enforcement of individual mandates.

Automobile Insurance

Forty-six states (and the District of Columbia) have some form of compulsory automobile insurance, and all states hold motorists accountable for bodily injury and damage to other vehicles. The Insurance Research Council (IRC) provides periodic estimates of the percentage of uninsured motorists in each state based on data from accident claims. Nationwide, 15 percent of motorists in 2004 were estimated to lack coverage. The highest rates of uninsured drivers were found in Mississippi (26 percent), Alabama (25 percent), California (25 percent), New Mexico (24 percent), and Arizona (22 percent). The states with the lowest rates were Maine (4 percent), Vermont (6 percent), Massachusetts (6 percent), New York (7 percent), and Nebraska (8 percent) (IRC 2006).

Both opponents and proponents of an individual health insurance mandate cite the experience with automobile insurance to bolster their cause. Opponents argue that requiring motorists to purchase insurance coverage and imposing penalties for violation have been ineffective at reducing the number of uninsured motorists (Kelly 2004). Proponents contend that recent efforts in California, Colorado, Georgia, and elsewhere show how data matching and information technology can be used successfully to crack down on uninsured motorists—and, by extension, to enforce an individual health insurance mandate (Harbage 2007) or to identify those to enroll in state health insurance coverage expansions (Dorn 2007). However, automobile insurance databases have sometimes proved costly, controversial, and error-prone. And for most households health insurance costs a lot more than automobile insurance.

Still, compulsory automobile insurance raises some of the same issues as a health insurance mandate. States may determine the extent of the required automobile liability insurance, but people may fail to purchase coverage because the cost is deemed too high or their income is too low. The availability and cost of automobile insurance also depends on the driver's perceived risk. Most states which require automobile insurance have some sort of assigned risk plan to assure that a driver can get coverage. The cost of insuring drivers under an assigned risk plan is typically high, but insurers must accept their share of those who cannot obtain insurance in the regular market. States generally do not provide subsidies for low-income drivers, although California in 2004 created the California Low Cost Automobile Insurance Program to offer insurance at subsidized rates to people meeting a "good driver" standard (Harbage 2007).

Automobile insurance also illustrates the relationship between mandatory coverage and the pricing of insurance. Low-risk drivers often pay slightly higher premiums because their insurance companies are required to participate in the assigned risk pools; correspondingly, high-risk drivers pay lower rates than required to fully reflect their risk. However, automobile insurers still offer lower prices to individuals they perceive as belonging to lower-risk groups. In the case of health insurance, such pricing would favor younger people; with automobile insurance, the young are disfavored. The point here is simply that automobile insurance shows how an individual mandate is likely to be accompanied by requirements on insurers to accept high-risk policy holders—and these must be administered as well.

Federal Debt Collection

The federal government has faced significant difficulties in collecting nontax debts owed to it by members of the public. At the end of fiscal year 2006, delinquent nontax debt totaled $65 billion, of which $44 billion had been delinquent for more than 180 days. Federal loan programs, primarily direct student loans, comprised 78 percent of total delinquencies (U.S. Department of the Treasury 2007).

Excluding loans, the largest amount of delinquent debt ($3.3 billion) is owed to the Social Security Administration (SSA). Debts to SSA arise when the agency pays an individual too much in benefits—for example, when someone receives excess Supplemental Security Income benefits because he fails to report an increase in income, or when a family member fails to report a Social Security recipient's death. The agency finds it relatively easy to collect overpayments when the debtor is still eligible for monthly benefits; in such cases, the overpayment is gradually recovered through the reduction of subsequent monthly payments. When the debtor is no longer on the benefit rolls, however, debt recovery is more difficult. Despite the use of increasingly aggressive debt collection tools, the amount of SSA's delinquent debt has increased by more than half in the last four years (U.S. Social Security Administration 2006).

Tax Compliance

The tax authorities are often turned to as the enforcing authority when mandates are applied. As with the collection of excess benefits, however, tax officials rely, where possible, on receiving payments over the course of the year so that fewer liabilities are owed with year-end filing. Withholding on wages and periodic estimated taxes are examples of the methods used. Also, IRS benefits from modest amounts of over-withholding during the year to help with enforcement, as those who are over-withheld tend to be more compliant than those who are under-withheld.

In general, IRS estimates that when there is withholding on wages, there is just under 99 percent compliance with the tax laws. With information reporting from third parties (for example, banks reporting to IRS the interest payments paid to individuals), but no withholding, compliance is on the order of 95 percent. Finally, where there is neither information reporting nor withholding, compliance is often less than 50 percent (Toder 2007).

The earned income tax credit (EITC) provides a variety of lessons for enforcement by tax authorities. Noncompliance with the EITC is fairly high, recently estimated to be between 27 and 32 percent (U.S. Department of the Treasury 2002). One major complication derives from determining in whose household or tax unit a child resides. Rules vary widely across welfare and tax programs, and children are often claimed for one tax unit when they fit into another, as in multi-generational households or when parents are present for only part of the year.

Although the EITC is technically available, at least in part, throughout the year, few employees take advantage of this option. One of the major problems is that the amount of subsidy is generally unknown at the start of the year because the amount varies widely with moderate changes in income. Also, many families gain or lose members throughout the year due to marriage, divorce, and births; these changes also affect considerably the size of subsidy.

Administrative Considerations

Individual mandates to obtain health insurance pose several administrative questions: how to encourage voluntary compliance with the mandate, what mechanisms to establish to enforce compliance, what agency or agencies should administer the mandate, and how extensive the mandate should be. Administration of a mandate must also be coordinated with the administration of subsidies to purchase insurance, as well as with other public insurance programs such as Medicaid and SCHIP.

Encouraging Voluntary Compliance

An individual mandate to purchase health insurance presumes that most of those affected can purchase insurance at an affordable price. Thus, proposals for individual mandates often also provide for guaranteed issue of insurance, an insurance exchange or other arrangement to make insurance universally available, and some form of subsidies for low-income people. Clearly, in these cases achieving compliance with an individual mandate runs in parallel with efforts to make it easy for people to enroll for insurance and obtain available subsidies. A mandate also may apply more selectively, as when it is confined to those who pay income taxes, which excludes many lower-income individuals.

Although the term “play-or-pay” is typically applied only to employer mandates, it can describe an individual mandate as well, to the extent that individuals face a choice between obtaining insurance and paying a penalty. Indeed, a subsidy contains an implicit a play-or-pay mandate: the recipient must spend the subsidy on insurance (play) or lose it (pay).

Just like some play-or-pay provisions applying to employers, individual mandates may serve two purposes that fall short of universal health insurance. First, they can serve as a way of charging those without insurance for their implicit coverage under Medicaid or other public arrangements should they fall on hard times. Second, they can reduce the net difference in cost between buying and not buying insurance and thus serve as an inducement to buy.

Many individuals simply hate paying penalties, regardless of how mild they are; the incentive effect of a mandate may therefore be higher than the economic cost it imposes for not buying insurance. Thus, a mandate can be used as a tool toward achieving more universal insurance, even when administrative or equity issues prevent assessing a large penalty for not meeting the mandate and even when subsidies themselves may be inadequate for many people.

The cost of complying with the mandate will depend on the coverage of the required insurance policy, the rules governing the pricing of policies, other aspects of the health care financing system, and the overall cost of the health care delivery system. In the Netherlands, the average premium in 2007 is about $1,650 a year. In Switzerland, the premium varies by canton and averages about $3,100 a year for an adult. In Massachusetts, the cost of minimum creditable coverage can reach $4,920 for a person age 50 or over in the most expensive region of the state.

The lower the insurance premium, the easier it will be to get people to comply with a mandate. In the Netherlands, for example, half of the cost of insurance is paid for by an income-related contribution (tax), so that the premium covers—at most—the remaining half. Some proposals hold down premiums by providing for government reinsurance of high-cost cases. Of course, it is possible to shift rather than remove administrative problems simply by moving them from the mandate side of health policy to the subsidy side; in aggregate, they likely rise together with the cost of insurance.

Enforcement and Penalties

What penalties might apply with an individual mandate? In Massachusetts, where individuals are required to provide information about their health insurance status on their state income tax form, individuals can lose their personal income tax exemption for 2007 and will be subject to a monthly penalty starting in 2008. Massachusetts thus adopted the type of mandate first suggested by Steuerle—denial of certain tax preferences such as the personal exemption (Steuerle 1994). However, Steuerle suggested this at the federal level; at the state level, this exemption is of fairly limited value, and Massachusetts had to accept a variety of exceptions to make the provision administrable—such as exclusion of temporary residents.

Massachusetts (starting in 2008), the Netherlands, and Switzerland all impose monthly penalties for failure to comply with their individual mandates. In each case, the penalty is equal to some fraction or multiple of the unpaid insurance premiums. Each jurisdiction also provides for waiving the penalty for certain people, such as those eligible for premium subsidies or those experiencing financial hardship. In the Netherland and Switzerland, the penalties are imposed by insurers when the person subsequently applies for insurance or is automatically enrolled.

Even at the federal level, year-end filing may not provide an adequate means of enforcing a mandate if the penalty is large. As noted, the tax authorities have significant problems collecting from those with liabilities that are large relative to their income. Many households have little or no savings from which to draw.

Mark Pauly has proposed that an individual mandate be enforced through employers (Pauly 1994). In his plan, "The employer would be required to ascertain whether or not the employee had obtained insurance (including as a member of an employment-related group) and, if not, to withhold from the employee's wages enough to pay for insurance from a government-contracted or government-run insurer of last resort." This idea has much to recommend it, since contemporaneous enforcement is likely to be more effective than retrospective enforcement. By the time a person has gone months without insurance, or has incurred uninsured medical bills, the prospect of recovering back premiums and charges, let alone penalties, is likely to be remote. Similarly, it seems infeasible, or unreasonable, to enforce a mandate by hitting uninsured people with large costs when they need care. However, as noted earlier, employers' compliance with mandates has also been less than complete, and not everyone is connected to an employer.

Administrative Agencies for Mandates and Subsidies

The administration of individual mandates is closely connected to the administration of premium subsidies. The attempt by states to use both mandates and subsidies together reflects the very high cost of even a modest health insurance policy today. Subsidies by themselves could prove very expensive for taxpayers, but mandates by themselves will place heavy burdens on some individuals. Together, however, subsidies and mandates may succeed in creating a much larger wedge between buying and not buying insurance, especially for many middle-income families. A crucial administrative issue, then, is whether both subsidies and mandates can or should be handled by the same or a different agency.

The prime candidates for administering subsidies are the Internal Revenue Service (or comparable tax authorities, as in the Netherlands and Switzerland), the Social Security Administration (as in the Medicare low-income drug subsidy), state Medicaid agencies (as in Massachusetts), or a new federal or state agency. Whatever agency administers the subsidy, basing eligibility on assets as well as on income would greatly complicate the process. Data on assets are not readily available, and asset tests have proved to be difficult to administer and to discourage program participation (Ebeler and Van de Water 2006).

If the IRS is the administrative agency—at least for taxpayers—then a more complete reconciliation report might be filed once at the end of the year with the IRS. But if the cost of the mandate and the size of the subsidy is to be calculated by the employer and reflected in withholding with each paycheck, then more regular reports may be required. The great advantage of reflecting both the mandate and subsidy in withholding (and effectively using the IRS as an enforcement agency) is twofold: people would see more immediately the consequence of not buying insurance; and regular calculations, reflected in withholding, reduce the likelihood that government will have to collect much, if anything, at the end of the year.

An alternative approach that avoids an end-of-year reconciliation is to base eligibility for the subsidy, in most cases, on recent rather than current income. In the case of the low-income subsidy under Part D of Medicare, for example, the Social Security Administration determines eligibility for the subsidy for the upcoming year using the most recent available data from the IRS. Thus, in late 2007 SSA determines eligibility for the subsidy for 2008 using tax data for

2006. SSA generally reviews changes in income, resources, household composition, or other factors only once a year (Ebeler and Van de Water 2006). In Switzerland, most eligible people receive their health insurance subsidy automatically, without need for an application, based on their taxable income in the year before last. The subsidies are paid directly to health insurers and are deducted from the premium owed by the individual. Under arrangements like these, of course, provision may need to be made to assist those who experience a major change in circumstances, such as the birth of a child or loss of a job.

Pauly suggests that "the credit that would pay the subsidy need be no more difficult to administer than (and could even be merged with) the earned income credit. Finally, persons already receiving welfare payments could have their credit incorporated with their other government payment." Here, Pauly may be too sanguine, especially about using a heavily income-related design for either a mandate or a subsidy. Although individuals may arrange for monthly payment of the earned income credit, most still do not receive their credit until they file their tax return. Also, the government would still need a back up system to handle those who do not have sufficient earnings. (The EITC is based upon largely on earnings, so the IRS has some advantages in administering that provision, since it has fairly good annual records on earnings. It is not the administrative agency for welfare programs that include many people with limited attachment to the labor force.)

Health mandates and subsidies administered by the IRS raise some but not all of the same type of problems that occur in the EITC. When mandates and subsidies vary widely with annual income, the employer has trouble knowing how much to reflect in withholding, and the individual has trouble knowing for how much he qualifies.

Ways are available to minimize this last set of administrative problems. For instance, if the subsidy is essentially flat or equal per person, then it is fairly easy to know what the subsidy is for each pay period. With a mandate, a flat amount would also be easy to reflect in withholding if the mandate is to apply at low and moderate-income levels. Another route to simplicity is for the mandate simply to deny some tax benefits already reflected in withholding—the standard deduction, the child credit, etc. Withholding tables are already set up to reflect the presence or absence of these items. If the penalty for lack of health insurance extended to denial of some of the EITC, it probably would be administrable as well, to the extent that the EITC is paid to most people only at the end of the year.

The child credit —now $1,000 per child—is not indexed for inflation, so that it is declining in value over time. Steuerle has suggested at various stages that the child credit, or at least increases in the child credit, could be made contingent on maintaining insurance for the child. Because the credit is a relatively flat amount throughout much of the income distribution, this type of approach would also be fairly easy to administer. The credit is only partially refundable, however, so that separate administration would be required if the child credit were extended much lower in the income distribution and made fully refundable. In all likelihood, a separate agency would probably be required for that population. Also, at that point, the credit would probably be integrated into Medicaid and SCHIP.

When the amount of the mandate and credit are known with reasonable certainty, insurance companies very likely would get into the business of finding uninsured people, as they could more immediately sell them on making use of their subsidies and avoiding penalties associated with mandates. Indeed, with a flat or equal subsidy, it would be possible to let insurance companies file directly with an administrative agency, and skip individual filing for the subsidy almost altogether. As noted earlier, Switzerland provides for largely automatic payment of subsidies to insurance companies by basing the subsidy amount on income from a prior year.

In 1990, the Congress provided a limited individual health insurance tax credit for children as an addition to the EITC. A subsequent Congressional investigation found that, in response to the credit, some insurance companies marketed policies with very limited benefits to unsuspecting low-income families (Lav and Friedman 2001). The credit came to be viewed as unwieldy and subject to abuse and was repealed in 1993. Although many problems were related to its limited scope, the experience warns us that issues of consumer protection can easily arise.

Family structure creates further complications for a mandate. A mandate on adults in a household raises issues of coverage for spouses, persons living together but not married, persons claiming to have common law marriages, and multi-generational households such as parents living with adult children. Also, various programs employ various definitions of a household, so complications could arise if the health mandate chose a different definition than that used by the administrative agency or agencies enforcing a mandate or subsidy.

An added administrative issue is the interaction between new income-conditioned subsidies and existing means-tested programs. Instability of insurance coverage is already a serious problem for public insurance programs, chiefly Medicaid and SCHIP (Summer and Mann 2006). Coordination of old and new programs will obviously be required, and rules will be needed to determine what happens to a person who moves from one to another. In Massachusetts, for example, determinations of eligibility for the new subsidized Commonwealth Care program are made by the state Medicaid agency.

Another decision related to the choice of administrative agency is whether an individual mandate should be enforced through multiple channels. In the New America Foundation's proposal, for example, employers, tax authorities, health care providers, schools, and automobile insurers would all be required to ask for documented proof of health insurance coverage and to inform a new "insurance market administrator" of individuals who lacked coverage (Nichols 2007). More ways of enforcement would make a mandate more effective, but also more intrusive. At the same time, more immediate identification of the uninsured would allow for earlier efforts to overcome inertia, which can be a strong factor over and above economic incentives in determining why some fail to insure, and reduces the size of any penalties.

Extent of Mandates and Subsidies

These administrative issues become much more difficult when the objective is to provide very large subsidies and mandates. Health insurance for a family often runs as much as $12,000 a year. These high costs pose significant challenges for implementing health insurance mandates

and subsidies. The larger the subsidy, the more income conditioning is likely to save on costs. Depending on how it is structured, income conditioning of large subsidies and mandates can significantly increase marginal tax rates on additional earnings, as well as exacerbate marriage penalties. Similarly, the more costly the mandate, the more difficult it becomes to set penalties that would be large enough to assure substantial compliance yet could be enforced or collected.

As two supporters of an individual mandate write, "Make no mistake: an individual mandate, whether to obtain automobile liability insurance, vaccinate your children before sending them to school, or pay your income taxes both encounters evasion and sometimes entails intrusive enforcement. This is a public 'bad' that must be weighed against the public 'goods' of universal health insurance protection and a fair distribution of the costs of coverage" (Graetz and Mashaw 1999).

AUTOMATIC ENROLLMENT

In recent years, behavioral economists have become increasingly aware of the power of inertia in individual behavior and have developed innovative approaches to harness that inertia in beneficial ways. They have found, for example, that more people contribute to retirement savings plans if they are enrolled automatically at work (but can opt out) than if they must take active steps to enroll. This finding has led to proposals that most firms be required to enroll new workers automatically in a retirement savings plan.

This same approach—termed "automatic enrollment" or "default enrollment"—could be employed as a backstop, or as an alternative, to a mandate to purchase health insurance. In Switzerland, for example, cantons (states) automatically enroll in a private health plan everyone who fails to comply with the individual mandate. In this case, the insured person does not have a choice of an insurer; he or she is billed by the insurance plan and is liable for payment of the premium. In the U.S., enrollment in Medicare's Supplementary Medical Insurance (SMI) is voluntary, but nearly universal, because applicants for Hospital Insurance are enrolled automatically in SMI unless they opt out. At the start of Medicare Part D in January 2006, beneficiaries dually eligible for Medicare and Medicaid were automatically enrolled in a low-cost prescription drug plan, although they could still select a plan of their own choosing. In addition, many low-income people were automatically enrolled in the low-income prescription drug subsidy.

As part of a plan for achieving near-universal health coverage, those without insurance could be automatically enrolled either in a private plan available through an insurance exchange (as in Switzerland or Medicare Part D) or in an existing or new public program (as in SMI or as proposed by some Presidential candidates). Blumberg and Holahan propose that "the state deem all residents to be covered and that the tax penalty serve as a way of collecting unpaid premiums" (Blumberg and Holahan 2008). Either way, enrolling people automatically in a health plan would encounter some of the same administrative issues as enforcing an individual mandate (Dorn 2007). Automatic enrollment might prove more successful in the end, however, if it were viewed as simpler and less punitive than an individual mandate.

CONCLUSION

Individual or employer mandates comprise part of the latest health care initiatives or laws in several states, as well as in countries such as the Netherlands and Switzerland. They also have been proposed by an increasing number of elected officials and candidates for elective office. Strong equity and efficiency arguments can be made in favor of mandates in a world where the public provides some back-up public insurance for almost any household that does not buy insurance on its own. To work effectively, however, mandates must be administered well.

Mandates can be administered effectively if not too much is demanded of them—that is, if the size of the insurance requirement is not too high and the size of the related penalty is not so large that compliance and enforcement are threatened. Among the more administrable types of penalties are denying tax benefits to individuals who do not buy insurance and engaging employers in a play-or-pay mandate that requires some contribution to government when they do not separately pay toward an employee's insurance.

A mandate can stand alone, but it generally forms part of a system of regulations and subsidies that aim to make health insurance more available and affordable. Even at a moderate level of penalty and mandate, however, many administrative issues arise: which household members to include, what constitutes qualified insurance, how to deal with multiple employers for the same family, and whether to extend a mandate below tax thresholds for individuals.

If these administrative considerations are given adequate weight, it is possible to set up effective incentives to buy at least a low-cost insurance policy through a combination of subsidies and mandates. This arrangement might go a long way toward encouraging people to buy insurance even when together a subsidy and mandate do not together make it more expensive to be uninsured than insured.

If administrative issues are only lightly considered, however, then more can be asked of mandates than they might be able to deliver. With employer mandates, there is an ever-present danger of using health insurance as a *de facto* minimum-wage policy, which may increase unemployment and almost certainly reduces cash wages. Inequities can also arise for families with multiple employers. With individual mandates, experience with the EITC warns us about varying the size of the mandate and the subsidy too much with current income and family circumstances. Such efforts make it much harder to reflect the right amount in withholding, and the IRS often has great difficulty collecting substantial liabilities suddenly owed at the end of the year. Inability to know the size of one's subsidy or mandate up front also makes it harder for insurance companies to identify those eligible for subsidies and sell policies to them, perhaps even doing the administrative work that could remove the need for individual filing.

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APPENDIX—FEATURES OF IMPLEMENTED OR PROPOSED MANDATES

Implemented Mandates

Hawaii

Since 1975, Hawaii's Prepaid Health Care Act has required nearly all employers to provide health insurance to employees who work 20 hours or more a week for four consecutive weeks. This mandate is made possible by an exemption from the federal Employee Retirement Income Security Act (ERISA). After the Prepaid Health Care Act became law, the rate of uninsurance in Hawaii dropped from 30 percent to 5 percent (Hawaii Uninsured Project). In 2004-2006, according to the Census Bureau, it was 8.6 percent—the second lowest rate in the Nation. A recent analysis finds that the rate of insurance among workers in Hawaii is 10.9 percentage points above the level that would otherwise be expected (Kronick, Gilmer, and Rice).

I. Individual mandate
None

II. Employer mandate

A. Scope of mandate
The mandate applies to all nongovernmental employers. Workers excluded from coverage include those working less than 20 hours a week, seasonal agricultural workers, insurance or real estate salespersons paid solely by commission, and sole proprietors with no employees. Employees may claim an exemption if they have other health coverage. An employee with two or more employers must designate a principal employer.

B. Nature of mandate
Employers must provide health care coverage for eligible workers by purchasing an approved health care plan or adopting an approved self-insured health care plan. All plans must be approved by the Department of Labor and Industrial Relations (DLIR) as meeting prescribed minimum standards. Coverage begins after four consecutive weeks of employment, or at the beginning of the following month. Employers may pay at least half of the premium, but the employee's contribution cannot exceed 1.5 percent of wages.

C. Locus and method of enforcement
The Disability Compensation Division of DLIR administers the law. (DLIR also administers Hawaii's unemployment compensation, workers' compensation, temporary disability insurance, and workforce development programs, as well as regulations on wages and hours, occupational safety and health, and collective bargaining,) The division's Investigation Section responds to complaints and conducts compliance visits with randomly selected employers. Employers are penalized if it is determined that they knowingly failed to provide coverage as required by law.

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Massachusetts

I. Individual mandate

A. Scope and nature of mandate

People age 18 and over must have "minimum creditable coverage," as defined by the Commonwealth Health Insurance Connector Authority, so long as it is deemed affordable under the schedule set by the Connector (Chapter 58, section 12). The affordability of insurance depends on premiums (which vary by age and place of residence), family income, and family size. An estimated 60,000 people (10-20 percent of the previously uninsured and 1 percent of the state's population) will not be required to obtain insurance because it is considered unaffordable (Belluck).

B. Role of employers

Employers must collect an Employee Health Insurance Responsibility Disclosure Form from an employee who declines to use a section 125 plan or enroll in employer-sponsored health insurance. Employers must retain the form for three years and make it available upon request to the Division of Health Care Finance and Policy and the Department of Revenue.

C. Role of tax authorities

The individual mandate is enforced by the Massachusetts Department of Revenue through the process of collecting state personal income taxes. Individuals must provide information about their health insurance status on their tax form.

D. Role of insurers

The Health Care Access Bureau in the Division of Insurance will maintain a database of members of health insurance plans. Insurance carriers and the Office of Medicaid must provide a monthly list of residents for whom they provide creditable coverage. The Division of Insurance may share the database with the Department of Revenue for purposes of implementing the mandate (Chapter 58, section 6A).

E. Role of health care providers

Hospitals must begin collecting copayments and deductibles from certain patients seeking free care. Hospitals must report to the Division of Health Care Finance and Policy the names and addresses of employers whose employees receive free care.

F. Relationship to subsidies

The Commonwealth Care program, administered by the Connector, provides subsidies on a sliding scale to families with incomes up to 300% of poverty. MassHealth (the state Medicaid agency) processes all applications. The Connector may also reduce or waive premiums for extreme financial hardship. Persons receiving subsidies are limited to health plans with low cost-sharing.

G. *Other enforcement mechanisms*

H. Penalties for noncompliance

Adults who do not obtain insurance by December 31, 2007, and who are not exempt from the mandate, will lose their 2007 state personal income tax exemption (Chapter 58, section 12). In 2008, uninsured adults will pay a monthly fine equal to half of the cost of the most affordable health plan available to them, as certified by the Connector (Chapter 58, section 13).The Connector will establish standards to waive the penalty if its imposition would create extreme hardship (Chapter 58, section 101).

If an enrollee in Commonwealth Care does not pay premiums for two months, coverage will be cancelled. An enrollee who has been disenrolled for failure to pay premiums may not re-enroll unless he pays at least two months of the overdue premiums or has made all payments due under an approved payment plan (Connector *Administrative Information Bulletin 01-07).*

I. Providing and financing care to those without insurance

The Commonwealth of Massachusetts maintained an Uncompensated Care Trust Fund to pay for care provided by hospitals and health centers to persons without health insurance. This pool is replaced by a Health Safety Net Trust Fund, administered by a new Health Safety Net Office in the Office of Medicaid.

II. Employer mandate

A. Scope of mandate

The major mandates apply to firms with 11 or more full-time-equivalent employees (as defined in regulations).

B. Nature of mandate

1. Fair Share Contribution
   Employers must make a "fair and reasonable" premium contribution toward a health insurance plan for their employees or pay the state up to $295 per employee. The primary test is that at least 25% of full-time employees (those working at least 35 hours a week) are enrolled in the employer's health insurance plan and that the employer is making a financial contribution to the plan.

2. Section 125 plans and Free Rider Surcharge
   Employers must adopt and maintain a section 125 plan (except for certain categories of employees) or be subject to a Free Rider Surcharge for part of the care used by their employees or dependents that is financed by the state's Health Safety Net Fund (replacing the Uncompensated Care Trust Fund). If an employer pays the full monthly cost of medical coverage for all its employees, it is not required to adopt a section 125 plan. The surcharge will be triggered when one employee receives free care more than three times, or when a company's employees in total receive free care five or more times in a year. The surcharge will range from 10% to 100% of the state's cost of services, with the first $50,000 per employer exempted.

3. Health insurance responsibility disclosure
   Employers must report whether they offer a section 125 plan and health benefits. Employers must also collect an Employee Health Insurance Responsibility Disclosure Form from an employee who declines to use a section 125 plan or enroll in employer-sponsored health insurance.

C. Locus and method of enforcement

1. Fair Share Contribution
   The amount will be determined by the Director of Workforce Development and the Division of Health Care Finance and Policy. It will be collected by the Division of Unemployment Assistance.

2. Section 125 plans and Free Rider Surcharge
   Employers must submit a copy of their plan documents upon request of the Commonwealth Health Insurance Connector Authority. The amount of the Free Rider Surcharge will be calculated by the Division of Health Care Finance and Policy, which will notify affected employers after September 30 of each year.

3. Health insurance responsibility disclosure
   The Employer Health Insurance Responsibility Disclosure Form is being developed by the Division of Unemployment Assistance. The Employee Health Insurance Responsibility Disclosure Form must be made available upon request to the Division of Health Care Finance and Policy and the Division of Revenue.

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Netherlands

The new Dutch system of health insurance contains many of the elements of managed competition—a defined basic benefit, choice of private insurance plans (including plans with different deductibles), open enrollment, a single premium for each plan (irrespective of age or health status), risk-adjustment (equalization) of payments to insurers, dissemination of comparative information about plans, and government regulation and supervision of the markets for providing and insuring care.

I. Individual mandate

A. Scope and nature of mandate

Starting on January 1, 2006, the Health Insurance Act requires everyone who resides or pays payroll tax in the Netherlands (with few exceptions) to take out health insurance for essential care. A person must take out insurance within four months of establishment of the obligation. Supplementary insurance may be purchased to cover such items as glasses, dental care for adults, contraceptives, complementary medicine, and other services not covered by the standard package.

An insured person pays a "nominal premium" to the health insurer. Premiums may differ between health insurance policies and insurers. Every insurer must accept anyone who applies for insurance and must charge everyone the same premium for the same health policy. The nominal premium of approximately €1,150 (about $1,650) per year in 2007 covers 45 percent of the total costs. The government pays the premiums of children up to age 18, which amounts to 5 percent of expenditures. The remaining 50 percent of costs is covered by an income-related contribution, which is divided through a risk-equalization scheme (see item II.B).

B. Role of employers

Insurers may offer group insurance contracts to employers, unions, and patient organizations. Under these contracts, insurers may offer a premium discount of up to 10 percent. In 2007, 57 percent of people were covered by a collective contract, up from 44 percent in 2006. (Maarse 2007)

C. Role of tax authorities

The Tax and Customs Administration levies the income-related contribution.

D. Role of insurers

An insured person pays the nominal premium directly to the insurer, but in case of group contracts alternatives can be arranged. The insurer must issue a policy every year to every insured person as proof of the insurance agreement. Most insurers provide services and offer insurance throughout the Netherlands; small insurers (with fewer than 850,000 policyholders) may cover a smaller area, but must cover at least one or more whole provinces.

E. Role of health care providers

F. Relationship to subsidies

Under the Health Care Allowance Act, people who take out health insurance qualify for a health care allowance if the nominal premium is excessive compared with their income. The Tax and Customs Administration pays out the allowance in monthly installments based on an estimate of income for the coming year. If necessary, an adjustment is made later to reflect actual income. People may authorize that the allowance be paid directly to the insurer. To maintain cost consciousness, the allowance is based on the average nominal premium (called the "standard premium"), not the actual premium for the chosen plan. (VWS 2005)

G. Other enforcement mechanisms

Initially, the Health Insurance Act did not include mechanisms to seek out individuals who fail to take out health insurance. (Greß, Manougian, and Wasem 2007). However, due to concerns over the number of uninsured in general, and more specifically the people who don't pay their nominal premiums, the Dutch parliament requested the government in June 2007 to introduce other enforcement mechanisms.

H. Penalties for noncompliance

If a person fails to meet the insurance obligation or to meet it on time, the individual care insurers will impose a fine on behalf of the Health Insurance Board if the person subsequently applies for insurance. The fine equals 130 percent of the premium, payable over the number of months that the person was not insured (up to a maximum of five years). During the period of non-insurance, a person has no entitlement to reimbursement of costs incurred for care. (VWS 2005)

I. Providing and financing care to those without insurance

J. Other

The number of uninsured is estimated at about 241,000 (1.5% of the population). (Statistics Netherlands 2007a) It is expected to rise further after July 2007 because health insurers will remove those who have not paid their premiums from their list of insured. (Maarse 2007) As of December 31, 2006, 190,000 registered adults had not paid their premiums for at least six months (Statistics Netherlands 2007b). These figures do not include illegal immigrants, who are not eligible for health insurance.

II. Employer mandate

A. Scope of mandate

Employers must withhold the income-related contribution from the wages of employees.

B. Nature of mandate

In addition to the nominal premium, the insured pays an income-related contribution on his income or social allowance through income tax (6.5 percent of earnings up to

€30,623 in 2007[1]). The individual's employer (or benefits office) is required by law to reimburse the income–related contribution to the insured person. However, the individual (employee) pays payroll tax on this amount. In this way the insured person has a full overview through his payroll of the costs of health care, whereas in the former situation income-related costs were 'hidden' in general taxes. In all, income-related contributions cover approximately 50 percent of expenditures of health insurers and is divided through a risk equalization scheme.

C. *Locus and method of enforcement*
The Tax and Customs Administration levies the income-related contribution.

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[1] 4.4 percent in case the benefits office does not reimburse the contribution or in case of self-employment.

Switzerland

I. Individual mandate

A. Scope and nature of mandate

Since January 1996, all permanent residents (with minor exceptions) are required to obtain basic health insurance within three months of taking residence in Switzerland (RS 832.10, art. 3). Parents must insure newborns within three months of their birth.

Previously, four cantons had required mandatory insurance for their entire population. In some other cantons, it was required for certain categories of people, notably those with limited incomes (Swiss Confederation 1991).

B. Role of employers

Employers are not involved in providing health insurance to workers. Before implementation of the individual mandate, in 1995, 22 percent of the population received health insurance through their employer (Noble 2007).

C. Role of tax authorities

D. Role of insurers

Compulsory basic health insurance can be purchased from a limited number of insurance companies, both public and private, which are regulated by the Federal Office of Public Health within the Federal Department of Home Affairs. Premiums for basic insurance differ by canton and age bracket (children, young people, and adults), and insurers must accept all individuals living in the canton. In 2007, the average monthly premium for an adult is CHF311 (about $260). A risk-adjustment scheme attempts to compensate insurers for differences in costs resulting from variations in their insured populations. Supplementary health insurance is also available.

With three months notice, an insured person can change insurers at the end of June or December. To assure that a change of insurer does not result in a gap in coverage, affiliation with the former insurer cannot end until the new insurer has informed it that there will be no interruption in the person's coverage (RS 832.10, art. 7).

E. Role of health care providers

F. Relationship to subsidies

Low-income people are eligible for premium subsidies. Cantons define the criteria for assistance and administer the subsidy. In 2005, subsidies were provided to 30 percent of the population at a cost of 3.2 billion Swiss francs, of which the cantons paid 36 percent.

In most cases, eligible people receive the subsidy automatically, without need for an application, based on their taxable income in the year before last. The subsidies are paid directly to health insurers and are deducted from the premium owed by the individual.

G. Other enforcement mechanisms

Swiss cantons and communes maintain a registry of inhabitants; people are required to register with the local population control office shortly after taking up a new place of residence. To take advantage of these existing administrative arrangements, cantons were made responsible for managing enrollment in compulsory health insurance. Cantons must periodically inform people of their obligation to obtain insurance (RS 832.102, art. 10). Cantons automatically enroll all individuals who have not enrolled themselves in a timely fashion (RS 832.10, art. 6). In this case, the insured person does not have a choice of insurer; he or she will be billed by the insurance plan and will be liable for payment of the premium. (OECD, p. 35)

H. Penalties for noncompliance

Individuals who do not obtain insurance within the required three months must pay a surcharge of 30-50% of the premium for twice the period by which the three-month limit is exceeded (RS 832.102, art. 8). People who are eligible for a premium subsidy do not pay the surcharge.

If a policy-holder does not pay his or her premiums or cost-sharing, the insurer sends notices of non-payment. If the policy-holder still does not make a payment, the debt is referred to a collection agency. Ultimately, the insurer may suspend payment for services. When full payment is received, including interest and the costs of collection, the insurer assumes responsibility for services provided during the period of suspension (RS 832.10, art. 64a). During 2005, 334,000 people (4.5 percent of the insured) were subject to the procedures for collecting overdue premiums, and 23,000 people (0.3 percent) had payment for services suspended (OFSP 2007).

People who provide false information about their insurance status are subject to fines and imprisonment (RS832.10, art. 92).

I. Providing and financing care to those without insurance

J. Other

The *Loi fédérale sur l'assurance-maladie* was enacted by the Federal Assembly on March 18, 1994, approved by a referendum on December 4, 1994, and came into force in January 1996. Before the new law, 97 percent of the population had health insurance (Noble 2007). In 2005, the number of insured persons equaled 99 percent of the resident population (OFSP 2007).

II. Employer mandate

None

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Proposed Mandates

California Proposal (Assembly Bill No. 1, 2007-08 First Extraordinary Session)

This bill was passed by the California Assembly on December 17, 2007. It was defeated in a Senate committee on January 28, 2008.

I. Individual mandate

A. Scope and nature of mandate
All Californians would be required to maintain a minimum level of health insurance for themselves and their dependents, as determined by the Managed Risk Medical Insurance Board (MRMIB). An individual would be exempt from the requirement if the board determined that insurance would not be affordable to the individual or would constitute a hardship.

B. Role of employers
None specified.

C. Role of tax authorities
None specified.

D. Role of insurers
None specified.

E. Role of health care providers
MRMIB would work with state and local agencies, health care providers, health plans, employers, consumer groups, community organizations, and others to establish point-of-service methods to facilitate enrollment.

F. Relationship to subsidies
The bill would establish a new coverage program for childless adults with incomes up to 100 percent of poverty. It would extend the Healthy Families Program (SCHIP) to children in families with incomes up to 300 percent of poverty. Health insurance subsidies would be provided for people with incomes from 100 to 250 percent of poverty who obtain insurance through a new state purchasing pool. Those with incomes from 250 to 400 percent of poverty would receive a tax credit if their cost of insurance exceeded 5 percent of income.

G. Other enforcement mechanisms
MRMIB would be directed to establish methods to ensure that uninsured individuals obtain the required coverage.

H. Penalties for noncompliance
MRMIB would pay the cost of health care coverage for a person who is enrolled by the board after having been uninsured for at least two months, and the board would be

required to establish methods to recoup the cost of health care coverage from previously uninsured individuals.

I. Providing and financing care to those without insurance
The bill would provide expanded primary care services to low-income residents who would not be eligible for other subsidized coverage. Counties and hospitals would continue to receive a portion of current funding for the uninsured, including undocumented persons. The state would also continue to fund emergency Medi-Cal.

II. Employer mandate

A. Scope of mandate
See below.

B. Nature of mandate
Employers with one or more full-time equivalent employees must establish section 125 (cafeteria) plans to allow employees to purchase health insurance on a pre-tax basis.

The bill states an intent to finance the program in part with fees paid by employers. An earlier version of the bill specified that the fees would range from 2 to 6.5 percent of Social Security wages depending on the size of the firm's payroll and would be reduced to the extent that employers incurred expenditures for health care.

C. Locus and method of enforcement
The bill would require an employer who fails to establish a cafeteria plan to pay a penalty of $100 to $500 per employee.

Source:

California, Legislature. 2007. *Assembly Bill No. 1, 2007-08 First Extraordinary Session, Amended in Assembly December 17, 2007 (The Health Care Security and Cost Reduction Act).*

New America Foundation (Nichols) Proposal

I. Individual mandate

A. Scope and nature of mandate
All U.S. citizens and legal aliens aged 19 and older would be required to purchase health insurance coverage for themselves and their dependents.

B. Role of employers
Employers will be required to ask for proof of coverage and to notify the insurance market administrator of individuals without coverage.

C. Role of tax authorities
Tax authorities will be required to ask for proof of coverage and to notify the insurance market administrator of individuals without coverage.

D. Role of insurers

E. Role of health care providers
Health care providers will be required to ask for proof of coverage and to notify the insurance market administrator of individuals without coverage.

F. Relationship to subsidies
Subsidies will be available for the low-income population.

G. Other enforcement mechanisms
Schools and automobile insurers will be required to ask for proof of coverage and to notify the insurance market administrator of individuals without coverage.

H. Penalties for noncompliance
Individuals who fail to comply with the mandate will be required to pay back premiums plus a penalty based on the length of time they have not been enrolled. The market administrator will be authorized to employ collection agencies to collect unpaid premiums and penalties. In extreme cases, wages can be garnished.

I. Providing and financing care to those without insurance
Those who fail to buy coverage will be assigned to a plan with low premiums, so that no citizen or legal alien will be without coverage. An individual's assigned default plan will be responsible for paying providers for covered services.

II. Employer mandate
None

Source:

Nichols, Len. *A Sustainable Health System for All Americans*, New America Foundation, July 2007. http://www.newamerica.net/files/NSC%20Health%20Policy%20Paper%207-12-07.pdf.

Wyden-Bennett Bill (S. 334, 110th Congress)

I. Individual mandate

A. Scope and nature of mandate
Adults age 19 and older must enroll themselves and their children in a health plan offered through a new state-wide Health Help Agency (HHA), unless they are covered through Medicare, DoD, VA, IHS, a former employer's retiree health plan, or a plan arranged under a collective bargaining agreement (section 102(a)). Individuals must enroll themselves and their children in a plan during open enrollment periods, submit documentation to determine subsidies, pay the required premium and other contributions, and inform the HHA of any changes in family status or residence (section 601).

B. Role of employers
Employers who currently sponsor health insurance will be required to convert their health care payments into higher wages that employees can use to purchase private health insurance.

C. Role of tax authorities
None

D. Role of insurers
Insurers must report to the HHA on the health insurance status of state residents (section 502(b)(5)).

E. Role of health care providers
Hospitals and other providers must report to the HHA if an individual seeks care and is uninsured or does not know his health insurance status (section 502(a)(6)).

F. Relationship to subsidies
Individuals and families with modified Adjusted Gross Income up to 400 percent of poverty will be eligible for premium subsidies (section 121).

G. Other enforcement mechanisms
Each state must establish a Health Help Agency, which will be responsible for ensuring enrollment of all individuals (sections 501 and 502). Each State shall determine mechanisms to enforce the requirement that individuals be enrolled, but the enforcement cannot be the revocation or ineligibility of coverage (section 102(b)(3)).

H. Penalties for noncompliance
An individual who does not obtain coverage must pay a penalty. The penalty equals the number of uncovered months times the average monthly premium for a plan in the person's coverage class and coverage area, plus 15 percent. Payments will be made to the HHA of the State in which the person resides. That agency also may establish a procedure to waive the penalty if the penalty poses a hardship (section 102(b)).

I. Providing and financing care to those without insurance
The HHA shall establish procedures for default enrollment of uninsured individuals into low-cost health plans (section 502(a)(5)).

II. Employer mandate
None.

Sources:

U.S. Senate. 2007. *Healthy Americans Act, S.334 (110th Congress).*