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Individual Mandates in Health Insurance Reform

American College of Physicians
A Policy Monograph
2009

Individual Mandates in Health Insurance Reform

A Policy Monograph of the
American College of Physicians

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How to cite this paper:

American College of Physicians. Individual Mandates in Health Insurance Reform. Philadelphia: American College of Physicians; 2009: Policy Monograph. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

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Executive Summary

The American College of Physicians is the largest medical specialty society in the United States, with over 129,000 physician and medical student members. The College strongly supports universal health care coverage and a reformed delivery system that is patient-centered and focused on preventive care. Specifically, the College has recommended that Medicaid be expanded to include all Americans with incomes below the Federal Poverty Level, that tax-based subsidies be made available for the uninsured who are not eligible for public coverage, and that new options be made available to small businesses to purchase coverage for their employees, among others. The College has also recommended that once health coverage is made affordable and available, individual participation should be ensured by applying an individual mandate, an employer mandate, automatic enrollment in publicly funded plans, or some combination of these approaches (1).

Several recent health reform proposals have called for individual mandates to ensure that all Americans have coverage, including those of Senate Finance Committee Chairman Max Baucus (D-MT) and the Healthy Americans Act sponsored by Senators Ron Wyden (D-OR) and Robert Bennett (R-UT). In this policy monograph, the College considers establishing an individual mandate as part of a broader health care reform proposal. To be successful, an individual mandate cannot exist on its own—it must be established along with comprehensive health insurance reforms that include subsidies to make coverage affordable for the uninsured, reforms to stabilize costs and ensure access, and an enforcement mechanism to guarantee compliance. ACP offers the following recommendations on implementing an individual mandate:

Recommendation 1: An individual mandate should be established only in connection with reforms that ensure that any legal resident will have access to coverage that is affordable, accessible, portable, and guaranteed, with sufficient federal funding to subsidize purchase of qualified private health insurance plans or for eligible persons to enroll in applicable public programs.

Recommendation 2: An individual mandate should be linked to requirements that all participating health plans offer a core package of essential benefits, including preventive services. ACP recommends that an expert advisory panel, including primary care physicians, be created to recommend a core set of benefits.

Recommendation 3: Individual mandates will be most effective, and less likely to result in a hidden tax on individuals and families, if combined with a requirement that employers provide health insurance coverage or pay into a fund to provide such coverage.

Recommendation 4: Federal and/or state stakeholders should monitor and enforce an individual mandate through a comprehensive mix of methods, such as review of personal income tax records, random audits, data matching, and database review. Fines for noncompliance should be fair and effective to encourage participation, but compliance should not be enforced by denying access to care.

Recommendation 5: Reforms to the insurance market, including guaranteed issue and renewability, modified community rate setting, portability safeguards, and no exclusions or limitations of coverage for preexisting conditions, are needed to ensure access to affordable coverage.

Recommendation 6: In conjunction with efforts to achieve universal health coverage and reform the nation's health care delivery system, efforts to expand and strengthen the long-term viability of the primary care physician workforce must be undertaken to ensure that individuals with coverage are able to access health care when needed.

Introduction

In this policy monograph, the American College of Physicians considers implementation of an individual mandate as a means to ensure universal health coverage. An individual mandate in a health care system is a requirement that all people have health care coverage, whether provided by their employer, purchased by the individual, or obtained from government programs or other sources. Individual mandates are established to spread risk, reduce adverse selection, and to achieve universal health insurance coverage. It should be stressed that an individual mandate is only one part of a greater health care reform effort. To be effective and fair, an individual mandate can only exist if health coverage is made affordable, if the insurance market is reformed so insurance is accessible, and enforcement mechanisms are in place to ensure compliance. ACP has previously expressed support for an individual mandate, as well as other methods to increase participation, on the condition that health insurance is made affordable and available. In the ACP position paper, *Achieving Affordable Health Insurance Coverage for All Within Seven Years*, the ACP provided a framework for expansion of coverage and stated that:

> Once coverage is affordable and available, national and/or state-based health plans should ensure that all individuals participate in the coverage plan by applying individual mandates, employer mandates, automatic enrollment in publicly funded plans, or some combination of these approaches (2).

This monograph will discuss issues related to individual mandates and present recommendations on effective implementation of an individual mandate.

Background

The United States' health care system is characterized by a framework of public and private insurance sources funded largely by employers and federal and state governments. Unlike other industrialized nations with compulsory or mandated health coverage, most Americans are not required by law to have health insurance. In 2007, the number of uninsured persons was a staggering 45.7 million (3). Without changes to current policy, the number of uninsured could rise to 54 million in 2014, according to the Congressional Budget Office (4). The characteristics of the uninsured vary widely by socioeconomic status, age, and employment status. Although over 53% of Americans are insured through their employer, 80% of uninsured children and adults live in working families (5, 6). Not surprisingly, lower-income families are more likely to be uninsured and for longer periods than moderate-income families (7). However, 22.3% of the uninsured are people in households with annual incomes above $50,000 (8). The primary reason for remaining uninsured is lack of affordability (9). A survey published in *Health Affairs* found that the uninsured can be divided into three groups: those who are eligible for public programs, such as Medicaid, but are not enrolled, those who are ineligible for public programs and cannot afford insurance because it is not offered through their employer, and those who can probably afford insurance but have not purchased it. The survey finds that most uninsured people fall into the second group and cannot purchase health insurance without some financial support (10).

The idea of an individual mandate in health care has been considered at least since the early 1990s, when the Heritage Foundation, a conservative think tank, suggested such a route during the health care reform efforts of President Clinton (11). Stakeholders from around the ideological spectrum have endorsed

individual mandates as a means for achieving universal health coverage. The health care reform proposals of former Senate Majority Leader Tom Daschle (D-SD), Senate Finance Committee Chairman Max Baucus, California Governor Arnold Schwarzenegger, the Commonwealth Fund, the Mayo Clinic, and others include a requirement that individuals have health coverage. President Obama's health reform proposal would require that children have coverage. During the 2008 presidential campaign, Senator Obama expressed concern that an individual mandate would penalize those who would be unable to afford health coverage and that if insurance was made affordable, people would buy it (12, 13).

Effect on Coverage

In 2006, Massachusetts enacted a sweeping health care reform law that featured a phased-in individual mandate. Since implementing the health reform initiative, the Commonwealth has had one of the lowest rates of the uninsured. In the fall of 2006, before wide implementation of the reform initiative, 13% of Massachusetts residents had no health coverage (14). According to the *Commonwealth Connector*, 97.4% of Massachusetts residents now have health insurance (15).

Numerous studies have asserted that establishing an insurance mandate is vital to achieving the goal of universal coverage. According to an Urban Institute study that outlined health care reform options for Massachusetts, an individual mandate was the only way to reach 100% insurance levels (16). The study reported that a strictly voluntary program with subsidized coverage would cover about 40% of the uninsured. With an employer mandate added to the voluntary program, the level of coverage rose to 50%. A report by the United Hospital Fund and the Commonwealth Fund reviewed options for health care reform in New York and reached similar conclusions (17). A RAND microsimulation that tested a health care proposal that featured an income-related subsidy, an individual mandate, and a noncompliance penalty of 50% of the premium cost, found that such a plan would result in 15 to 26 million more people with health coverage, depending on the level of the subsidy.

Supporters argue that an individual mandate, paired with subsidies or other inducements, would reduce the number of people who are otherwise unwilling or unable to have health care and rely on uncompensated charity care when needed, the costs of which are ultimately borne by the public in higher taxes and in higher insurance premiums from cost shifting to those with insurance. Individual mandates would force everyone to pay their fair share (18). Finally, proponents state that an individual mandate will provoke a kind of social change, leading the public to consider compulsory health insurance the norm (19).

Effect on Workforce

ACP is deeply concerned about the nation's shortage of primary care physicians. Currently, an estimated 36 million Americans lack access to a primary care physician and 16,261 primary care physicians are needed to meet the demand (20, 21). By 2025, the physician shortfall will reach 124,000 (22). Evidence suggests that implementing an individual mandate and dramatically increasing coverage would further strain the health care system. Universal health coverage could increase the physician shortfall by 25% (23). Following implementation of the Massachusetts program, problems of access to primary care services were exacerbated and patient wait times for services increased dramatically (24, 25). ACP has made extensive recommendations on how to strengthen the primary care

workforce. The College's 2009 State of the Nation's Health Care report urged Congress and the Obama Administration to enact a comprehensive plan to achieve universal coverage. The paper also requested that stakeholders address the primary care shortfall by enacting payment reforms to make primary care competitive with specialty medicine and integrate the Patient-Centered Medical Home model into an improved delivery system (26). In addition, the College issued the paper *Solutions to the Challenges Facing Primary Care Medicine*, which provided recommendations to stakeholders on how to sustain and grow the primary care workforce, improve the way health care is delivered, and create payment models that incentivize effective and efficient care (27). ACP's *Reforming Physician Payments to Achieve Greater Value in Health Care Spending* provided a thorough analysis of health care payment models and made recommendations on how innovative payment methods could strenghten primary care and improve patient health (28). Should an individual mandate be implemented, policymakers will have to address the workforce shortages that plague the health care system so the newly insured are able to receive care when needed.

Effect on Cost

A health care system with an individual mandate could be more cost-effective than one in which coverage is voluntary. A study by John Gruber assumed that in a national health care system modeled after the system in Massachusetts, the federal government could cover 97% of the uninsured population at a cost of $125 billion a year. Without an individual mandate, 40% of the uninsured would be covered at a cost of $95 billion a year (29). In a discussion on individual mandates sponsored by the National Federation of Independent Businesses, Sherry Glied stated that mandates "reduce the public cost that is necessary to get coverage nearer to universality…it takes a lot of money to get uninsured people to voluntarily take up coverage."(30) An individual mandate paired with subsidies and insurance market reform will also reduce the financial burden of the uninsured on the U.S. economy. It is estimated that in 2008, the cost of providing care to the uninsured will total about $86 billion (31).

Establishing an individual mandate would reduce the amount of uncompensated care provided by physicians and other health care professionals. A substantial amount of the uninsured currently receive nonemergency care in hospital emergency departments, which are required by law to serve all who seek care regardless of insurance status; often, this is because they lack access to primary care (32). Because care furnished in an emergency department is more expensive than office-based care, universal coverage and an improved primary care workforce could lead to substantial cost savings. Those who lack insurance have more difficulty accessing preventive care, which is crucial to maintaining health. One half of uninsured adults do not have regular access to a physician, and a similar percentage of uninsured adults do not have access to primary care. Further, 25% of uninsured adults have foregone care because of cost. This is especially problematic for persons with chronic illness, as the uninsured are less likely to follow chronic care treatment plans (33). Those without access to regular chronic care treatment, for example, are more likely to be hospitalized than those with regular access to such treatment (34). In 2006, the loss to the U.S. economy due to poorer health and preventable mortality related to lack of insurance is estimated at a startling $200 billion (35).

Lack of insurance could endanger the overall community. For instance, children without insurance are less likely to receive treatment for influenza and other communicable maladies. Similar external effects include decreased productivity due to lack of insurance (36, 37).

An individual mandate may also reduce waste in the health care system. According to RAND, an individual mandate could lead the newly insured to seek primary care in more efficient outpatient settings rather than in expensive emergency departments (38).

Opposition to Individual Mandates

Some critics of individual mandate proposals believe that such a requirement would disproportionately hurt low-income people. When California legislators and stakeholders debated a state health care reform proposal that featured an individual mandate, opponents said it would place significant financial risk on low-income people, erode employer-sponsored health insurance, and unfairly penalize those who are unable to acquire health coverage (39). The AFL-CIO opposed Massachusetts' individual mandate over similar concerns (40).

Critics of individual mandates have expressed concern that if employers are not required to provide insurance and it is unavailable through public programs, many of the currently insured will be forced to buy unaffordable insurance or face punishment. In a 1993 speech to the National Governors Union, President Clinton expressed concern that if an individual mandate was imposed, employers would drop coverage for their employees, making coverage difficult to acquire (41).

Other critics oppose the individual mandate because they feel it would lead to less personal liberty and more government influence in the lives of individuals. They maintain that individuals should be free to choose whether they have health insurance. The libertarian Cato Institute has stated that an individual mandate would take the nation one step closer to a government-run health care system (42).

The College has considered these concerns but concluded that an individual mandate, if designed correctly as part of a broader health reform effort to make coverage available and affordable, could be an effective means of ensuring that all Americans have health insurance coverage. The College offers the following recommendations to policy makers as they consider use of individual mandates in efforts to reform health care in the United States:

Recommendation 1: An individual mandate should be established only in connection with reforms that ensure that any legal resident will have access to coverage that is affordable, accessible, portable, and guaranteed, with sufficient federal funding to subsidize purchase of qualified private health insurance plans or for eligible persons to enroll in applicable public programs.

ACP believes that affordable health coverage must be made available to all Americans. The College has recommended a framework for universal coverage that includes an expansion of public health coverage programs, tax-based subsidies, and delivery system reform that emphasizes quality care (43). The proposal also states that once coverage is made affordable, an individual mandate should be implemented.

To achieve success, an individual mandate should only be established along with appropriate subsidies to help people purchase coverage.

According to the Institute of Medicine's *Insuring America's Health* report, inability to afford coverage is the primary reason people are uninsured (44). Further, the cost of insurance is why most small businesses do not purchase health coverage for their employees. Targeted efforts in the 1980s and 1990s to

improve portability and renewability of employer-sponsored insurance, such as the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Health Insurance Portability and Accountability Act of 1996, have done little to increase the number of insured persons because they do not address the issue of affordability (45).

The IOM report states that most uninsured families would not have the financial means to purchase insurance without significant premium subsidies. Additionally, Senate Finance Chairman Max Baucus's "Call to Action" plan cautions that health coverage must be made accessible before a mandate can be applied.

In a 1994 *Health Affairs* article, economists Krueger and Reinhardt propose that an individual mandate could result in lower-income families seeing a significant drop in their disposable income as wages rise. Particularly, individuals and families would see a dramatic increase in their out-of-pocket costs if their income rose to an amount that would disqualify them from receiving a subsidy. Unless formulated properly, the individual mandate could act like a significant tax increase on those families who earn just enough income to disqualify them from financial support, potentially forcing such families out of the workforce (46, 47). An individual mandate without adequate subsidies could increase the level of medical debt, especially if premiums and cost-sharing levels are punitive (48).

The rate of employer-sponsored insurance has declined significantly in the past decade, and many who are unable to find coverage at work are forced to purchase coverage directly from insurance companies in the individual market. As stated in Recommendation 4, consumer protections are needed to ensure that affordable health insurance is accessible to those who need it most, particularly people with preexisting conditions. The individual health insurance market is notorious for underwriting practices that dramatically increase premiums or deny coverage to the sick and aged. For instance, in 2005 the average premium for a single plan in the individual market was $4,288 for individuals aged 55–64. Those under the age of 40 paid an average premium of $1,580 (49). According to one study, 58% of individuals who considered purchasing individual coverage had difficulty finding affordable coverage and 21% of individuals faced significantly higher premiums, had certain conditions excluded, or were denied coverage because of a preexisting condition (50). Safeguards, such as guaranteed issue and renewability, will make affordable health coverage accessible and constant for those who would otherwise be denied access to insurance because of complicated health care needs.

In an effort to ensure affordability (and likelihood of mandate compliance), Massachusetts expanded eligibility to Medicaid, SCHIP, and the Commonwealth Care program; reduced or eliminated cost-sharing requirements for low-income people; and required employers to provide insurance to their employees or face a penalty (51). The Commonwealth also established an affordability schedule that defines the maximum amount of premiums families and individuals should pay for health coverage (52). Regardless, insurance remains too expensive for about 60,000 in Massachusetts; penalties for this population are being waived (53). This "hardship exemption" has been criticized as undermining the effectiveness of the overall mandate, because it permits some level of uninsurance (54). The Netherlands health insurance mandate has a high compliance rate, chiefly because health insurance is made affordable through a combination of premiums subsidies, fully subsidized health care for children, and partial payment by an income-related tax. However, the government is developing an enforcement mechanism because about 1.5% of the legal population remains uninsured (55).

Recommendation 2: An individual mandate should be linked to requirements that all participating health plans offer a core package of essential benefits, including preventive services. ACP recommends that an expert advisory panel, including primary care physicians, be created to recommend a core set of benefits.

Another issue to consider is the definition of a reasonable benefit package. If individuals are required to have insurance, there should be a core set of benefits included in each product to ensure meaningful and effective coverage. In the ACP paper *Achieving Affordable Health Insurance Coverage for All Within Seven Years*, the College recommends the establishment of an expert advisory commission authorized to, among other things, determine and make periodic recommendations about health coverage benefits for various groups, including children and people with disabilities, as well as coverage related to disease management and preventive care (56). In Massachusetts, the Commonwealth requires that insurance be comprehensive and include prescription drug coverage. Deductibles are limited to $2,000 for an individual and $4,000 for a family (57). If a benefits package is not comprehensive and requires significant out-of-pocket expense once treatment is needed, the mandated coverage may prove unaffordable. Similarly, if the minimum benefits package is too generous, premiums may make the package too costly. Of course, this outcome can be avoided with adequate subsidies (58).

Recommendation 3: Individual mandates will be most effective and less likely to result in a hidden tax on individuals and families if combined with a requirement that employers provide health insurance coverage or pay into a fund to provide such coverage.

To further ensure access to insurance and prevent crowd-out, many health care reform proposals that include an individual mandate also require employers, at least those who have more than a certain number of employees, to provide coverage to their employees, usually with credits or subsidies for small businesses. The Massachusetts program features a "pay or play" requirement, where employers have to either provide coverage or pay into a general health coverage fund. Evidence suggests that employers may be more likely to offer coverage to their employees if an individual mandate is established in an effort to retain staff (59). As noted above, ACP has also expressed support for an employer mandate as a way to achieve universal coverage.

Recommendation 4: Federal and/or state stakeholders should monitor and enforce an individual mandate through a comprehensive mix of methods, such as review of personal income tax records, random audits, data matching, and database review. Fines for noncompliance should be fair and effective to encourage participation, but compliance should not be enforced by denying access to care.

"A mandate is only as good as its enforcement mechanisms," according to economist C. Eugene Steuerle (60). Ensuring compliance is an important consideration in implementing an individual mandate. Potential enrollees may be wary of acquiring insurance, depending on the cost of coverage, the enrollment process, personal values, and penalties associated with noncompliance, among other things. Evidence shows that proper enforcement may be the primary factor in determining whether a mandate succeeds or fails. RAND

simulated a health care proposal that included income-based subsidies but did not penalize those who did not purchase coverage. The study estimated that without penalties, only 8.9 to 10.5 million people would purchase insurance, even when subsidies for people with incomes ranging from 100% to 400% of the federal poverty level (FPL) were provided. A reform proposal with no subsidy and a noncompliance penalty of 80% of average premium costs would increase the number of newly insured by over 21 million. According to the study, a high subsidy was less effective than a high penalty for noncompliance in increasing the number of insured, although for lower income people, "penalty and subsidy are good substitutes for one another."(61)

Although the federal government does not have experience with implementing and enforcing an individual mandate related to health care, the CBO reviewed automobile insurance, vaccination mandates, and others to find that compliance ranged from 60% to 90% (62). Other efforts to enforce behavior have been less successful; for instance, child support payment mandate compliance is around 30% (63).

Research shows that mandate enforcement is most successful when a combination of methods is used. Switzerland established annual open enrollment periods and data matching at various points of contact to monitor coverage. Some states have used data matching and information technology to ensure adherence to auto insurance requirements. In California, insurers are required to submit verification to an electronic database maintained by the Department of Motor Vehicles (DMV) when a driver purchases auto insurance and when a policy is dropped. The DMV sends warning notices to those who are not listed in the database and suspends vehicle registration if the person fails to comply. (64) Georgia established a similar system and saw noncompliance rates drop from 20 to 2%. Insurers and Medicaid officials in Massachusetts are required to send monthly reports to the state Department of Insurance, listing who is provided creditable coverage (65). However, the comparison of a health insurance mandate and an auto insurance mandate may be tenuous. Persons applying for a driver's license who do not have the required insurance are denied the right to operate a vehicle–those who do not comply with a health insurance mandate are not and should not be denied health care.

Some proponents of an individual mandate have recommended using the individual income tax system to monitor and/or enforce the coverage requirement. The Internal Revenue Service could be enabled to review a person's tax records to ensure that they have acquired coverage. The IRS could then issue penalties for noncompliance and could increase the number of audits it conducts to further review compliance. The Healthy Americans Act sponsored by Senators Ron Wyden and Bob Bennett, which would establish a universal health insurance program, proposes that health care premiums be automatically collected through personal income tax filings regardless of whether a person is signed up for the health coverage provided in the Act. (66) Although this legislation proposes using the IRS's existing tax enforcement activities to ensure coverage, it would be a new role for the IRS that could require substantial additional resources. In Massachusetts, individuals are required to indicate on their state income tax form that they have acquired coverage. In 2007, those who were financially able to comply with the mandate yet refused to acquire coverage lost their personal income tax exemption. Subsequent monthly financial penalties equal to half of the lowest cost insurance premium available were issued beginning in 2008 (67). Other tax-based methods include establishing a surtax for persons who do not purchase health insurance (68).

The level of penalty is also a major consideration. Compliance increases with the amount of penalty but may level off if the penalty is too high (69). If a penalty is too low, an individual might forego insurance because that is the financially attractive option. If revenue from fines is a component of the enforcement agency's budget, modest financial penalties may not be enough of an incentive for the agency to properly enforce the requirement (70). Further, the rate of compliance increases with the likelihood that offenders will be caught. In Switzerland, officials often visit people "to obtain compliance" and offenders can receive substantial fines and/or prison time for failing to acquire insurance (71). In a proposal on how to achieve universal health coverage in California, the New America Foundation suggests an income-based sliding-scale fee for those who are able to purchase health insurance but have not done so (72). To help finance an overhaul of the health care system, any funds derived from individual or employer mandate penalties should be directed toward efforts to improve access to health coverage. Potential funding recipients could be state insurance pools authorized to provide subsidies to the uninsured or community health clinics in medically underserved areas.

Studies show that enforcing compliance of a national insurance mandate will probably be a difficult and costly endeavor. Electronic databases and other enforcement infrastructure would require a substantial investment to fulfill a coverage mandate (73). A comprehensive enforcement structure that includes tough but fair penalties, shared databases, and frequent compliance checks would increase the potential for success.

Recommendation 5: Reforms to the insurance market, including guaranteed issue and renewability, modified community rate setting, portability safeguards, and no exclusions or limitations of coverage for preexisting conditions, are needed to ensure access to affordable coverage.

If an individual mandate is established, insurers must be required to accept all applicants, regardless of preexisting conditions (i.e., guaranteed issue). Without such a requirement, insurers would be more likely to aggressively pursue healthy people, making it difficult or expensive for sicker people to find coverage. An individual mandate could help push the insurance industry away from a business model based on risk selection to one where insurers compete by offering quality plans at affordable prices (74). In addition, an individual mandate paired with guaranteed issue and community rating would reduce premium variability and further ensure market stability (75). Requiring community rating of insurance premiums (particularly when a pooling mechanism is used) could also potentially reduce costs because insurers would no longer be able to engage in the costly practice of medical underwriting insurance products. Medical underwriting, a practice found in the individual insurance market, allows insurers to price policies on the basis of an individual's health status or claims experience. It leads to high premium prices for vulnerable consumers and higher administrative costs (76). If medical underwriting results in premiums that are too high for some people, they may be unable to afford coverage and would probably incur a penalty for not having insurance. Community rating, on the other hand, establishes a single premium for a group of insured people, which spreads risks and lowers premiums for older and sicker individuals. Insurance portability safeguards, which protect those who transition to new employment or to the individual insurance market, should also be established to maintain continuity of coverage. Establishing a health insurance connector for those who need to purchase insurance, similar to the Massachusetts model,

would facilitate portability of coverage from job to job (77). As mentioned elsewhere in this paper, guaranteed renewability should be established so those who are required to maintain insurance are not dropped by their insurance plan.

Supporters of an individual mandate argue that requiring everyone to have coverage would make the market work as it is intended (78). Given that it would require healthy and sick people to have health insurance, a health system with an individual mandate could better spread risk and potentially reduce aggressive underwriting practices, ensuring that all people have affordable coverage. A voluntary system could lead to adverse selection, where a disproportionate number of sick people purchase coverage, resulting in high out-of-pocket costs that may dissuade healthy people from purchasing coverage. The Urban Institute states that, "the primary impact of a mandate will be to increase the financial burdens of younger and healthier individuals. All will find their access to health insurance and necessary medical care more stable and secure, however." (79) Blue Cross Blue Shield of America and America's Health Insurance Plans, the health insurance trade group, have stated that they would support a guaranteed issue policy if it were paired with an individual mandate (80, 81).

Recommendation 6: In conjunction with efforts to achieve universal health coverage and reform the nation's health care delivery system, efforts to expand and strengthen the long-term viability of the primary care physician workforce must be undertaken to ensure individuals with coverage are able to access health care when needed.

ACP believes that expanding health care coverage to all should be a national priority; however, it is also vital that health care reform initiatives address the crisis in primary care. Without a sufficient primary care infrastructure, those with insurance may find it difficult to access health care services. Primary care physicians are a vital part of the health care delivery system. Evidence shows that when a mandate to acquire health insurance is established without appropriate efforts to strengthen the primary care infrastructure, patient access to care can suffer. Although the number of uninsured has decreased substantially since Massachusetts initiated its health care reform effort, many patients have reported difficulty accessing practitioners, especially those providing primary care (82, 83). A dramatic expansion in coverage may result in significant wait times for patients seeking care from both primary care and specialty care providers (84).

The nation's primary care system is in a crisis. Physicians currently practicing and students considering a career in primary care face daunting challenges, such as high levels of educational debt; lifestyle concerns due to administrative hassles and practice design; and payment issues, including the disparity in salaries between primary care physicians and specialists and payment policies that do not appropriately recognize the care that primary care physicians provide (85). As mentioned elsewhere in this paper, the primary care system faces significant workforce shortfalls unless comprehensive action is taken to improve interest in the field. ACP has outlined recommendations on how to establish a national workforce policy designed to ensure an adequate supply of primary care physicians and sufficient health care access for patients. In *Solutions to the Challenges Facing Primary Care Medicine*, the College recommends the establishment of a permanent national commission on the health care workforce charged with determining ways to improve primary care physician training; improvements in loan repayment and financial incentive programs for primary care physicians who practice in areas and health care settings that are under-

served; efforts to relieve primary care practices of administrative burdens; and the promotion of such innovative delivery models as the patient-centered medical home, among others (86). Additionally, ACP has offered extensive recommendations on how the reimbursement structure can be reformed to establish primary care at the core of our nation's health care system.

Conclusion

Individual mandates require that all people have health insurance. Evidence suggests that, absent of establishing a single-payer system sponsored by a federal or state government, such a mandate is necessary to reach universal or near-universal coverage; however, efforts must be made to ensure affordability and compliance. An individual mandate can also stabilize the insurance market by spreading risk and reducing adverse selection. Studies have shown that implementing an individual mandate is more efficient than a voluntary system (87, 88). The College believes that every American deserves access to quality health care and supports individual mandates in efforts to reform health care in the United States when coverage is made fair, accessible, and affordable. While individual mandates are a way to reform the health care system and achieve universal coverage, they can only be implemented in a way that will not make such a requirement punitive, especially to low-income Americans.

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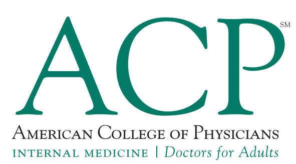

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