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ISSUE BRIEF



**THE INDIVIDUAL MANDATE IS
UNNECESSARY AND UNFAIR**

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Executive Summary

The importance of the individual mandate to the Affordable Care Act's exchanges has been greatly exaggerated. It has done little to increase enrollment, to reduce insurance premiums, or to alleviate the burden of uncompensated care. Rather, the main effect of the provision has been to concentrate more of the expense of covering the chronically ill on the relatively small cohort of working Americans who lack employer-sponsored coverage. By doing so, the mandate has served to obscure the total cost of the entitlement.

This issue brief examines the intent of the individual mandate, investigates why it was implemented in its present form, and demonstrates that its poorly distributed penalties have done little to enhance the affordability of health insurance or the stability of the individual market.

THE INDIVIDUAL MANDATE IS UNNECESSARY AND UNFAIR

The Intent of the Mandate

By itself, the ACA's individual mandate has never been popular, but many of its advocates have seen it as essential to achieving the goals of the legislation that are. Among the most popular provisions of the ACA's reforms to the individual market have been "guaranteed issue" and "community rating" regulations—which require insurers to cover people with major preexisting conditions on the same terms as they do healthy individuals of a similar age.

But if premiums faced by relatively healthy individuals vastly exceed the value of health-care services that they expect to consume, many of them may forgo insurance. The premiums paid by the rest of the people in the risk pool will rise, leading more relatively healthy people to drop out and sending premiums higher, with more dropouts—what the insurance industry calls a "death spiral."

This is no hypothetical concern. When New York State instituted regulations similar to the ACA's guaranteed issue and community rating in the early 1990s, enrollment in its individual market collapsed from 752,000 to 34,000.¹ Maine, New Jersey, and Washington were forced to roll back their own similar regulations as insurers fled the market, while Kentucky and New Hampshire abandoned them altogether.² Massachusetts took a different course—subsidizing individuals' purchase of insurance and imposing a penalty on those without coverage, in an attempt to prevent the flight of low-cost individuals from the insurance pool.³

The ACA sought to follow Massachusetts's example. Its advocates have argued that the legislation's insurance reforms are a package deal—with the mandate necessary to prop up guaranteed-issue and community-rating protections for individuals with preexisting conditions—and the subsidies necessary to make mandated coverage affordable.⁴

Nonetheless, Barack Obama was initially opposed to the individual mandate. In the 2008 Democratic presidential primary, Senator Obama argued that "the main difference between Senator Clinton's plan and mine is the fact that she would force in some fashion individuals to purchase health care."⁵ The Obama campaign's TV ads attacked the Clinton plan, suggesting: "It forces everyone to buy insurance, even if you can't afford it, and you pay a penalty if you don't."⁶ Obama went on to argue: "If a mandate was the solution, we could try that to solve homelessness by mandating everybody buy a house."⁷

But as the ACA worked its way through Congress, House and Senate bills both included versions of the individual mandate, and President Obama changed his position.⁸ Congressional staff believed that if the cost of the bill "went over \$1 trillion that that would just be too big to be able to achieve the 60 vote threshold [in the Senate] necessary to win."⁹ The Obama administration anticipated that without an individual mandate, the Congressional Budget Office (CBO) would

score the bill as costing \$270 billion more, and leave 28 million of the projected 56 million (who were projected to be uninsured without the ACA) still uninsured in 2014.¹⁰

Trying to get the bill into law, Obama argued that the cost of caring for individuals without insurance was shifted to those who did. “Each time an uninsured American steps foot into an emergency room with no way to reimburse the hospital for care,” he asserted in a June 2009 speech to the American Medical Association, “the cost is handed over to every American family as a bill of about \$1,000 that is reflected in higher taxes, higher premiums, and higher health-care costs; a hidden tax that will be cut as we insure all Americans.”¹¹

The Mandate as Implemented

In *NFIB v. Sebelius* (2012), the Supreme Court interpreted the individual mandate as technically a tax imposed by the federal government on individuals who fail to maintain “minimum essential coverage,” as defined by the Affordable Care Act.¹² In short, the penalty (tax) applies to all those without employer-sponsored insurance, health insurance purchased on the individual market, or major government health-care entitlements.¹³

The tax is set at 2.5% of household income above the tax-filing threshold (\$10,350 for single adults in 2016), with an inflation-adjusted fixed floor (\$695 per adult and \$347.50 per child in 2016) and a ceiling set at the national average for bronze plans available on the exchange (\$2,676 for an adult in 2016).¹⁴ Individuals with income below the tax-filing threshold are automatically exempt (**Figure 1**).¹⁵

The ACA authorizes the Department of Health and Human Services to grant additional exemptions from the individual mandate, and the Obama administration did this for large categories of enrollees for reasons of low income, unavailability of affordable plans, or religious affiliation.¹⁶ In 2014, CBO estimated that 23 million of the 30 million uninsured would qualify for one or more of these exemptions from the individual mandate.¹⁷

The Mandate’s Effect on Coverage

Scoring the ACA, CBO initially estimated that the uninsured would decline from 50 million in 2013 to 31 million in 2014—when the insurance regulations, Medicaid expansion, and subsidies were implemented—and stabilize at about 21 million from 2016, when the mandate was fully phased in (**Figure 2**).¹⁸

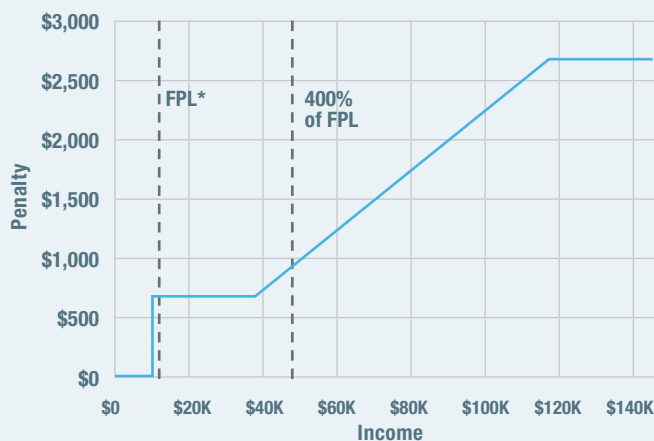
The CBO predicted that the number of uninsured would decline by 19 million in 2014 as the Medicaid expansion, insurance-market reforms, and exchange subsidies went into effect. In reality, the number of uninsured declined only by 9 million, amid the chaotic rollout of healthcare.gov and the Supreme Court ruling that made Medicaid expansion optional for states.

A 2016 examination by Molly Frean, Jonathan Gruber, and Benjamin Sommers of the ACA’s income-based penalties and of exemptions from those penalties found that the individual mandate had no significant effect on the extent of coverage in 2014. But as the mandate penalty was only 1% or \$95 in that first year, the authors suggested that this might change in subsequent years as the penalty was increased.¹⁹

Did it? To answer this question, consider the changes in individual market enrollment and the reduction of the uninsured from 2015 to 2016, when the mandate penalty’s floor rose from \$325 to \$695. CBO had predicted

FIGURE 1.

Mandate Penalty for Single Adults

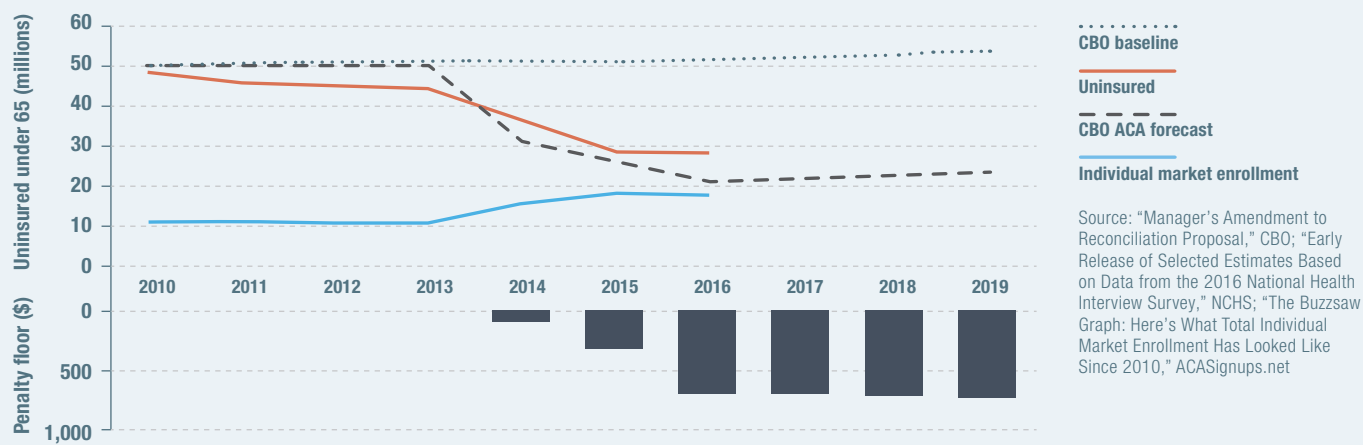


*Federal Poverty Level

Source: “Individual Shared Responsibility Provision—Reporting and Calculating the Payment,” IRS

FIGURE 2.

The Mandate Penalty and the Uninsured



that the nongroup market and exchanges would grow by 6 million from 2015 to 2016, while the uninsured would fall by an additional 5 million.²⁰ In reality, the number of uninsured fell by only 0.2 million, while total enrollment in nongroup markets even shrank by 0.2 million—a statistically insignificant shift.²¹ The 27.2 million remaining uninsured in 2016 still well exceeds the 18.0 million who chose to enroll in the individual market.²²

regardless of the existence of the mandate or the risk profile of individuals enrolled in the exchange.

Consider: In 2016, only 2% of otherwise-eligible individuals earning above the income cutoff for subsidies were enrolled in the exchanges, and over 70% of enrollees across both exchange and off-exchange individual market plans were eligible for subsidies.²⁵ Given these circumstances, McKinsey's assessment of the individual market concluded that there was

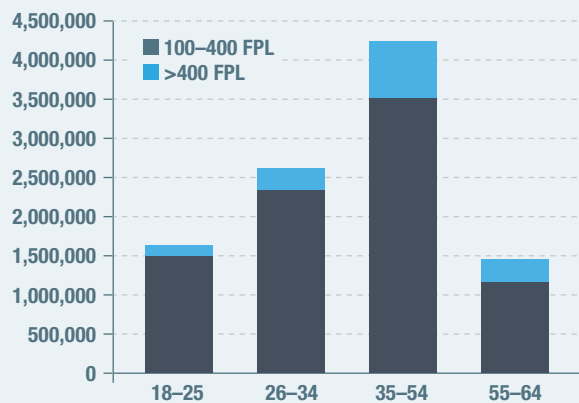
The Mandate's Effect on the Exchange Risk Pool

The repeal of the individual mandate may cause insurance premiums on the exchanges to increase as some healthy individuals drop out. But in 2010, CBO predicted that the elimination of the mandate would increase premiums for unsubsidized individuals by only 15%–20%.²³ This is because most people who buy insurance on the exchanges are eligible for subsidies that cap out-of-pocket costs as a share of income, so unsubsidized premium levels would have little effect on their decision to get coverage.²⁴

Exchange subsidies are the essence of the federal government's guarantee of affordable coverage for low-income Americans and those with preexisting conditions. They automatically expand and contract as needed to ensure a defined benefit for low-to-middle-income individuals with or without preexisting conditions,

FIGURE 3.

Exchange-Eligible Uninsured Adults by Age and Income



Source: "Health Insurance Marketplace Enrollment Projections for 2017," ASPE Issue Brief, Oct. 19, 2016

“little risk” of premiums spiraling upward, “as long as the federal government continues to offer subsidies to those with incomes below 400% of the federal poverty level.”²⁶ By paying a large share of premiums that exceed the medical costs of low-income healthy enrollees, exchange subsidies for individuals below 400% of the federal poverty level indirectly subsidize the premiums of those paying full price.

Some have suggested that the mandate penalty should be increased in order to reduce premiums on the exchange.²⁷ But as American Enterprise Institute analyst Thomas Miller has noted, “the space separating the floor and ceiling for the individual mandate is narrow.” Almost twice as many taxpayers (12.7 million) were exempt from the mandate in 2015 as paid any penalty at all (6.5 million).²⁸ The remaining nonelderly uninsured are mostly low-income. Only 11% of the nonelderly uninsured would be ineligible for premium subsidies as a consequence of earning above 400% of the poverty level.²⁹ Indeed, only 1.2 million taxpayers above this subsidy cutoff were expected to have to pay the mandate penalty in 2016.³⁰ A disproportionately small share of these were in the younger and healthier age groups (**Figure 3**).³¹ Forcing more young and healthy individuals to purchase insurance would likely increase federal spending on exchange subsidies rather than getting them to bear costs currently carried by others currently in the risk pool.

The vast majority of the 126 million Americans in households earning more than 400% of the federal poverty level are currently covered by ACA-compliant, employer-sponsored insurance or Medicare. Employer-sponsored insurance plans operate as distinct risk pools, and there is no risk adjustment between them and the individual market. Increasing the penalty for being uninsured would therefore do little to herd healthy middle-to-upper-income earners into the exchange risk pool if it encourages their take-up of employer-sponsored plans.³²

John McDonough, a former senior congressional staffer who was influential in the construction of the ACA, was therefore correct to argue that “the issue is far less the magnitude of the individual mandate penalties and much more the size of the subsidies to make the purchase of insurance genuinely affordable for people who need to buy it.”³³

The Mandate’s Effect on Uncompensated Care

In 2012, before the ACA was fully implemented, the Urban Institute projected that the law would halve the cost of providing uncompensated care and that the individual mandate was particularly crucial to this outcome.³⁴ The reality has fallen well short of this hope. According to the American Hospital Association, the \$46 billion in uncompensated hospital care provided in 2013 fell to \$36 billion in 2015.³⁵ This followed a 30% reduction in the unemployment rate and a \$79 billion increase in federal spending on the insurance coverage provisions of the ACA.³⁶

A recent study examining charity care and bad debt reported by hospitals found that uncompensated care costs fell by 24% as a share of operating costs in states that expanded Medicaid. In states that did not expand their Medicaid rolls under the ACA, uncompensated care increased slightly as a proportion of hospital spending, despite the improvement of the economy and the ACA’s regulatory reforms.³⁷ Which is to say that the ACA’s reforms to the individual market by themselves, including the mandate and its subsidies, failed to significantly reduce the cost of providing uncompensated care.

This should not be a surprise. Federal law requires hospitals to stabilize the condition of patients turning up in the emergency room; it does not prevent facilities from billing them afterward. Those above the income cutoff for Medicaid coverage, and newly eligible for subsidized insurance on the exchange, would likely not have been given a free pass by hospital debt-collection agencies before (or after) the ACA.

Conclusion

The ACA has achieved some success in guaranteeing a defined benefit as a safety net for low-to-medium-income individuals and those with preexisting conditions. But by attempting to herd the rest of the population into the exchange as a one-size-fits-all arrangement, it has inflicted unnecessary pain, expense, and anxiety—including rising premiums, narrowing networks of providers, and soaring deductibles.

Insurers participating in the exchange may like the legal requirement that individuals purchase their

products, but what is good for insurance-industry incumbents is not necessarily good for consumers. It is not just that healthy individuals might prefer slimmer benefit packages; most just want coverage that insures them well at a price in reasonably fair proportion to their likely health-care utilization needs.

The mandate is largely a tax on individuals in precarious circumstances—those lacking coverage through their employers—such as owners of small businesses,

recent immigrants, or those trying to patch together a middle-class income by working several part-time jobs. This is an inappropriate and inequitable way to subsidize insurance for individuals with costly preexisting conditions. A desire to provide further assistance to currently unsubsidized higher-earning individuals with preexisting conditions would justify extending subsidies to this group, not additional penalties levied on those who already find health insurance unaffordable.



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