

# The Individual Mandate in Perspective

## Timely Analysis of Immediate Health Policy Issues

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*Researchers find small number of people will be affected by mandate, but large benefit for population and stability of insurance markets.*

The “individual mandate”—the requirement that individuals either have health insurance coverage or pay a fine—is both the best known and the least popular component of the Affordable Care Act (ACA).<sup>1</sup> That people know about the mandate—and may even worry about it—is not surprising, given both the heated political controversy and the constitutional challenge surrounding this provision of the law. What may be surprising, however, is that if the ACA were in effect today, 94 percent of the total population (93 percent of the nonelderly population) or 250.3 million people out of 268.8 million nonelderly people—would not face a requirement to *newly purchase* insurance or pay a fine.

In this brief we use the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM) to estimate the number and share of Americans potentially subject to the mandate, identify their insurance status absent the ACA, and simulate eligibility for Medicaid and exchange-based premium and cost-sharing subsidies.<sup>2</sup> To allow the most direct comparison of postreform coverage with coverage absent reform, our analysis treats the provisions of the ACA as if fully implemented in 2011. The table presents the results of this analysis—with estimates of the population exempt from the mandate; the population potentially affected by the mandate, but already covered by insurance of some type; and the remaining population required to newly purchase coverage or pay a fine.

Starting from the top, our analysis

shows that if the ACA were fully in effect in 2011, 87.4 million nonelderly Americans—33 percent of the population under age 65 would be explicitly exempt from the individual responsibility requirement. These are people whose incomes fall below the tax filing threshold, those for whom the direct premium of the lowest cost available plan exceeds 8 percent of family income,<sup>3</sup> and undocumented immigrants. (Also exempt from the mandate, but beyond our capacity to estimate, are people found to have other economic hardship or religious objections, Native Americans, those without coverage for less than three months, and incarcerated individuals.) Almost three-quarters of the exempt population already have health insurance coverage of some type today; a little more than one-quarter is uninsured.

Of the remaining 181 million Americans under the age of 65 who are subject to the mandate, 86 percent are estimated to have health insurance without reform. HIPSM simulates that 95 percent of those with some type of insurance coverage (employer, nongroup, public) without reform will have the same type of coverage under the ACA (data not shown). Virtually all of the remaining 5 percent will obtain coverage through a different route under reform than they do today (e.g., some of those with nongroup coverage today will get an employer offer of coverage under reform, and will take that up instead of buying nongroup, and vice versa). In short, the vast majority of those potentially subject to the individual mandate have coverage

today and will not obtain a different type of coverage postreform.

Forty-three percent of the population potentially subject to the individual responsibility requirement receive coverage through large employers; 12 percent receive coverage through small employers; and 7 percent have employer-based coverage from an unobserved source (most commonly a family member living in another household or a previous employer); almost all of these people will continue to obtain their coverage through the same route once the reforms are fully in place. Five percent purchase coverage in the nongroup market, and 17 percent have coverage through a public program (e.g., Medicaid, Children’s Health Insurance Program (CHIP), military); again, almost all will continue to do so once the reforms are fully in place. Although those already covered by nongroup or small group coverage will not be newly purchasing coverage under the reforms, some will have their coverage broadened somewhat so that it satisfies the ACA’s minimum or “essential health benefits” requirements.

About 26.3 million Americans who are currently uninsured will be required to newly obtain coverage or pay a fine. In this group, 8.1 million people will be eligible to receive free or close-to-free insurance through Medicaid or CHIP and can avoid the mandate penalties if they do so; hence our finding that 18.2 million Americans (6 percent of the total population, 7 percent of the nonelderly population) will be required to newly



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purchase coverage or face a penalty. Of that 18.2 million, 10.9 million people will be eligible to receive subsidies toward private insurance premiums in the newly established health insurance exchanges, but will have to make partial contributions toward their coverage. About 7.3 million people—2 percent of the total population (3 percent of the population under age 65)—are not offered any financial assistance under the ACA and will be subject to penalties if they do not obtain coverage.

While the number of people who will be required to newly purchase coverage or pay a penalty is small compared with the total population, the individual responsibility requirement will still make an important difference in the premium

levels and long-term stability of the nongroup and small group insurance markets under the ACA. Almost 11 million people uninsured without reform and subject to the mandate will be eligible to purchase subsidized nongroup coverage in order to comply with the coverage requirement; and many of the 7 million not eligible for subsidies will also comply by purchasing coverage in the nongroup market, because they will not have access to employer-sponsored insurance (ESI). The nongroup market now covers about 14 million people, so several million additional enrollees brought in by the coverage requirement will change premiums in the market noticeably. In addition, the consumer protections introduced by

the ACA, which will guarantee issue of insurance products and prohibit premium variations due to health status and claims experience, could lead some of those currently healthy and insured in these markets to leave them in the absence of the coverage requirement. By encouraging the currently insured healthier individuals to stay in these markets and attracting newly insured healthy individuals into them as well, the individual responsibility requirement leads to lower premiums and more stable insurance markets than would be the case without it. We find that premiums in the nongroup market would be 10 to 20 percent higher on average without the individual coverage requirement.<sup>4</sup>

## The Individual Responsibility Requirement\*

	Number of People (millions)	% of Subgroup	% of Nonelderly	% of Total Population
Total Nonelderly	268.8	–	100%	87%
<b>Number Exempt from Individual Responsibility Requirement, Regardless of Postreform Coverage Decision</b>	<b>87.4</b>	<b>100%</b>	<b>33%</b>	<b>28%</b>
<b>Coverage in Baseline</b>	<b>63.4</b>	<b>73%</b>	<b>24%</b>	<b>20%</b>
Large Firm ESI	20.4	23%	8%	7%
Small Firm ESI	5.3	6%	2%	2%
Unknown Firm Size ESI	10.9	12%	4%	4%
Non-Group	4.9	6%	2%	2%
Public	22.0	25%	8%	7%
<b>Uninsured</b>	<b>24.0</b>	<b>27%</b>	<b>9%</b>	<b>8%</b>
Undocumented Immigrants	7.3	8%	3%	2%
Income Below Tax Filing Threshold	14.3	16%	5%	5%
No Access to Affordable Coverage	2.4	3%	1%	1%
<b>Number Potentially Subject to Individual Responsibility Requirement if Uninsured</b>	<b>181.4</b>	<b>100%</b>	<b>67%</b>	<b>59%</b>
<b>Coverage in Baseline</b>	<b>155.1</b>	<b>86%</b>	<b>58%</b>	<b>50%</b>
Large Firm ESI	78.3	43%	29%	25%
Small Firm ESI	22.6	12%	8%	7%
Unknown Firm Size ESI	13.0	7%	5%	4%
Non-Group	9.6	5%	4%	3%
Public	31.6	17%	12%	10%
<b>Uninsured</b>	<b>26.3</b>	<b>14%</b>	<b>10%</b>	<b>8%</b>
Eligible for Medicaid Under Reform	8.1	4%	3%	3%
Eligible for Exchange Subsidies Under Reform	10.9	6%	4%	4%
Access to Affordable Unsubsidized Coverage	7.3	4%	3%	2%

Source: Urban Institute analysis, HIPSIM 2011.

\*Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

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## Endnotes

- 1 Kaiser Family Foundation. Health Tracking Poll, March 2012. <http://www.kff.org/kaiserpolls/upload/8285-E.pdf>.
- 2 HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. For more information on HIPSM and a list of recent publications using the model, see <http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf>.
- 3 Here we assume that dependents without access to a family premium (either through employer-based coverage or the exchange) whose direct cost to the family is less than or equal to 8 percent of income will not be subject to a penalty for being uninsured. This is an interpretation consistent with the spirit of the Notice of Proposed Rulemaking. See: US Department of the Treasury, "Health insurance tax credit," Federal Register 2011; 76(159):50931-49.
- 4 For a discussion of these results and other effects of eliminating the coverage requirement, see Matthew Buettgens and Caitlin Carroll, "Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care" (Washington, DC: The Urban Institute, 2012), [http://www.urban.org/health\\_policy/url.cfm?ID=412480](http://www.urban.org/health_policy/url.cfm?ID=412480).

*The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees or its funders.*

## About the Authors and Acknowledgments

Linda J. Blumberg is a senior fellow, Matthew Buettgens is a senior research associate, and Judy Feder is an Urban Institute Fellow in the Urban Institute's Health Policy Center. This research was funded by the Robert Wood Johnson Foundation. The authors would like to thank Jeremy Roth for research assistance and John Holahan for helpful comments and suggestions.

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