

# Why the Individual Mandate Matters

## Timely Analysis of Immediate Health Policy Issues

December 2010

Matthew Buettgens, Bowen Garrett, and John Holahan

### Summary

Few provisions of the Patient Protection and Affordable Care Act (ACA) have been as controversial as the individual mandate. Opponents of the mandate see it as a major cost to families who would rather spend their income elsewhere and a significant threat to individual freedom. Supporters view the mandate as essential to market based reform; without it, many healthy people would remain without insurance coverage, premiums for individuals and employers would escalate and insurance markets could become unstable. When the uninsured who can afford premiums do become ill, unaffordable health care costs often get shifted onto the rest of society. In this brief, we compare estimates of what costs and coverage for the nonelderly population would be under the ACA to a scenario in which the individual mandate is eliminated, but all other provisions of the ACA remain unchanged. This is what could happen, for example, if the legal challenges to the mandate were to succeed. For ease of comparison, these scenarios are simulated as if they were fully implemented in 2010.

#### *In our simulation results, we find that:*

- The ACA would leave 8.3 percent of nonelderly persons without insurance coverage. If the mandate were eliminated, 14.9 percent would be uninsured. Currently, without the main coverage reforms of the ACA being implemented, an estimated 18.6 percent are uninsured. Thus, the number of uninsured would be cut by more than half with the mandate but by only about 20 percent without the mandate.
- Government spending on acute care for the nonelderly would increase by \$69 billion under the ACA but would still rise by \$50 billion under reform if the mandate were eliminated (multiyear provisions that offset these cost increases, such as Medicare and Medicaid cost savings and other cost-containment programs, were not simulated). This occurs because the government is still covering the less healthy uninsured without the mandate.
- Government funds used to reduce the number of uninsured would be used far more efficiently with the mandate than without it. Government spending per newly insured person would be \$2,451 under the ACA, in contrast to \$4,795 without the individual mandate.
- Total health care spending by employers is largely unchanged under the ACA from what it is today and decreases by 7.2 percent under a reform with no

mandate, but this is largely because fewer people would have employer-sponsored coverage without the mandate.

- Individual spending would be somewhat higher under the ACA than with no reform, almost all because so many more people gain coverage and begin to make payments toward premiums. Some also pay individual mandate penalties. Were the mandate to be dropped, individual spending would be lower than it is without reform because fewer would be covered and there would be no penalties, but also because many would save post-reform because of lower premiums in the exchange.
- Uncompensated care would decline by \$42.4 billion under the ACA, but by \$14.7 billion under reform without a mandate because of the large number of people remaining uninsured. Reductions in uncompensated care would allow the federal and state governments to reduce spending on programs that now support the uninsured (not included in the government spending item included above) and could also result in lower private premiums and higher provider revenue.
- We estimate that overall health system spending would increase by \$53.1 billion, or 4.5 percent, under the ACA and would decrease by \$10.2 billion or 0.9 percent, if the mandate were dropped. Note that our health care spending results are single-year estimates based on 2010 costs. Multiyear provisions that would offset these costs, such as Medicare and Medicaid savings and cost-containment, were not simulated.

The bottom line is that the individual mandate is an essential component of the overall package, working with the Medicaid expansion, exchanges, premium subsidies, and market reforms to achieve the goal of greatly reducing the number of uninsured. There would be 17.8 million more people left uninsured after reform if the individual mandate were eliminated, with relatively little reduction in government spending. By requiring individuals who can afford it to contribute to the cost of the health care services they consume, the individual mandate uses government funds for reducing the number of uninsured more efficiently. The finding that uncompensated care costs are much higher without the mandate suggests that populations that would be uninsured without the mandate are essentially free riders shifting the costs of care they inevitably need onto the rest of society.



Robert Wood Johnson Foundation



## Introduction

Few provisions of the Patient Protection and Affordable Care Act (ACA) have been as controversial as the individual mandate, the legal requirement for most Americans to be covered by a health insurance plan that meets certain minimal standards. Many object to the mandate on individual liberty grounds. Supporters of the mandate, including policy experts as well as insurers, insist that it is a critical component to the effective implementation of comprehensive health care reform. Three important goals of reform are to increase health insurance coverage, to eliminate discrimination by health status in the sale and maintenance of health insurance, and to increase the affordability of coverage. Without an individual mandate, these would all be affected by the natural tendency for people to want to pay for health insurance only when they believe they will need health care services. Since those currently without insurance have significantly lower costs on average than those paying for insurance, the mandate will bring lower-cost people into the insurance risk pools. This would lower the average cost per person covered and thus lower premiums.<sup>1</sup>

In this brief, we compare the ACA to a scenario in which the individual mandate is eliminated, but other provisions of the ACA remain unchanged. This is what could happen, for example, if a legal challenge to the mandate were to succeed.<sup>2</sup> In particular, we compare the effects of each scenario on the distribution of different types of health insurance coverage, on those without health insurance, and on overall health care spending by the government, employers, and individuals.

## The Individual Mandate in the ACA

Beginning in 2014, most Americans will be required to have health insurance coverage meeting certain minimum requirements and will be subject to financial penalties if they do not comply. Undocumented immigrants, Native Americans, prisoners, and those below the tax filing threshold will be exempt

from the mandate. Exemptions will also be granted for hardships in obtaining coverage, religious conscience, situations in which no affordable insurance coverage is available.<sup>3</sup> The penalty will be assessed and collected under the tax code, except that there is no criminal prosecution or additional penalty for missing payment deadlines, and neither liens nor levies can be used. Providers of applicable insurance plans are required to report relevant information to the Internal Revenue Service and to beneficiaries.

The penalty is computed as the maximum of a flat dollar amount per person without qualifying insurance coverage and a percentage of the family's income above the tax filing threshold for those without qualifying insurance coverage. Both the flat dollar amount and the income percentage are phased in gradually from 2014 to 2016. In 2016, the flat dollar amount is \$695 for an individual, and up to three times that for a family. The income percentage in 2016 is 2.5. The penalty cannot exceed the applicable national average premium for bronze-level health insurance coverage offered through exchanges.<sup>4</sup>

## Methods

To estimate the effects of health reform and the individual mandate, we use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).<sup>5</sup> 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.<sup>6</sup>

We simulate the main coverage provisions of the ACA as if they were fully implemented in 2010 and compare results to the HIPSM baseline results for 2010 prior to implementation of these reforms. This approach differs from that of the Congressional Budget Office or the CMS actuaries who by necessity provide

10-year estimates. Our approach permits more direct comparisons of reform with the pre-reform baseline and of various reform scenarios with each other. The key coverage provisions of the ACA and their implications for coverage and costs were summarized in an earlier policy brief.<sup>7</sup> To demonstrate the effect of the individual mandate, we also simulate a health reform with the individual mandate omitted but including the other coverage provisions of the ACA. This allows us to estimate what could result if, for example, legal challenges to the mandate were to succeed.

To model the individual mandate, we begin with the baseline HIPSM model, in which behavior is calibrated to agree with results from the empirical health economics literature. The resulting model behavior is applicable for a voluntary health insurance regime, whereas we must also simulate how behavior would change in the presence of a mandate. Since a similar law only exists in Massachusetts after its health reforms, the only available empirical data are from that state.<sup>8</sup> Our simulation of how behavior would change under the mandate has three components:

1. ***The applicable financial penalty.***  
A computation of whether the penalty is applicable and the amount of the penalty as defined by the law, i.e., the fully phased in amount discounted to present dollars.
2. ***An additional "disutility" of not complying with the mandate.***  
The mandate is more than a dollar amount, it is a legal requirement. Desire to comply with the law, or at least to avoid enforcement and the stigma of noncompliance, can lead to behavioral responses much stronger than the amount of the nominal penalty would suggest as appears to be the case in Massachusetts. The mandate has the effect of making being uninsured less desirable. We operationalize this in the model by applying an additional "psychic penalty" to being uninsured.<sup>9</sup>
3. ***A relatively small "spillover" disutility of being uninsured on populations not bound by***

**the mandate.** The mandate in Massachusetts was associated with an increase in coverage among those not actually bound by the mandate. We assume that this association was driven, in part, by a spillover effect of the mandate on those who were not bound by it who either mistakenly assumed they were or who reacted to a new social norm to have coverage. In addition to uncertainty about the current applicability of the mandate, people may also be making a judgment about whether they will lose their mandate exemption in the future due to rising income. For those exempt from the mandate, the amount of additional disutility of being uninsured is far smaller than for those bound by the mandate.

## Results

### Changes in Health Insurance Coverage

We begin by examining how the distribution of health insurance coverage differs in the three scenarios simulated. Table 1 gives detailed results, while Figure 1 shows the percentages of nonelderly persons with various types of coverage. Without health reform, 18.6 percent of nonelderly persons (49.9 million) would be without health insurance.<sup>10</sup> Under the ACA, there would be a dramatic increase in coverage: only 8.3 percent (22.1 million) would be without insurance. As we have shown in an earlier policy brief, nearly two-fifths of these are eligible for Medicaid or CHIP but have not enrolled, and just over a quarter are undocumented immigrants barred from the benefits of health reform.<sup>11</sup> If the individual mandate were dropped, insurance coverage would be significantly lower; 14.9 percent (39.8 million) would be without insurance.

Without a mandate, the net increase in insurance coverage is due entirely to the expansion of Medicaid. In fact, the share of nonelderly persons covered by private health insurance would actually decline from 62.1 percent without reform to 61 percent under reform with no

mandate, largely because some would leave private coverage to enroll in the expanded Medicaid program or to take advantage of subsidies in the exchanges.<sup>12</sup> With a mandate, enrollment in the new health insurance exchanges as well as in employer-sponsored insurance would be noticeably higher, with 66.3 percent of the nonelderly covered by private insurance.

Without health reform, 42.9 million nonelderly Americans would be enrolled

in Medicaid or CHIP. Under health reform, eligibility for Medicaid will be expanded to 133 percent of the federal poverty level with a 5 percent income disregard.<sup>13</sup> This is the same with or without a mandate, so we would see a significant increase in enrollment under either reform scenario (55.6 million without a mandate and 59.7 million with a mandate). The mandate would increase Medicaid enrollment by several million people, due to the behavioral effects we describe above.

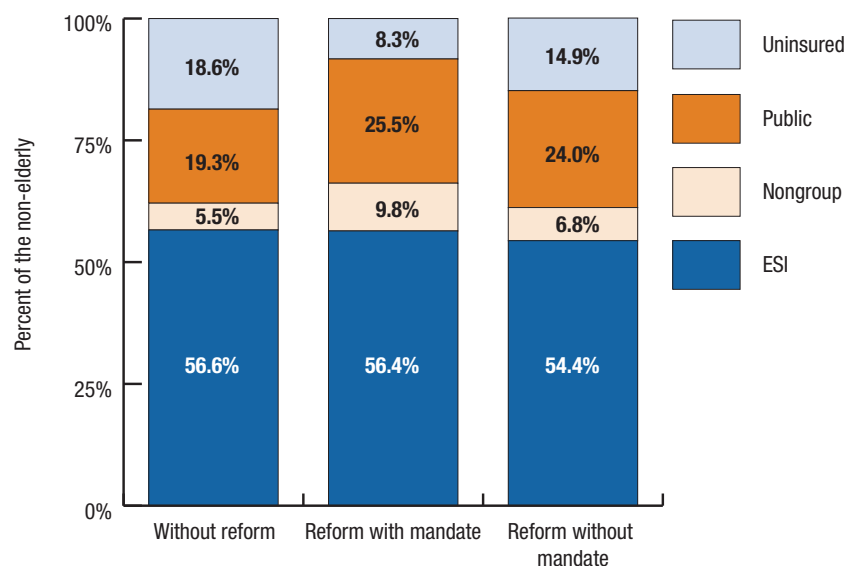
**Table 1. Health Insurance Coverage Distribution of the Nonelderly in Baseline and Reform**

	Without reform		Reform with mandate		Reform without mandate	
<b>Coverage (in millions)</b>						
<b>Private</b>	166.4	62.1%	177.5	66.3%	164.0	61.2%
Employer (non-exchange)	151.6	56.6%	130.4	48.7%	127.4	47.6%
Nongroup (non-exchange)	14.8	5.5%	3.3	1.2%	2.6	1.0%
Exchange employer	n.a.	n.a.	20.7	7.7%	18.2	6.8%
Exchange nongroup	n.a.	n.a.	23.1	8.7%	15.7	5.8%
<b>Medicaid/CHIP</b>	42.9	16.0%	59.7	22.3%	55.5	20.7%
<b>Other (including Medicare)</b>	8.7	3.2%	8.7	3.2%	8.7	3.2%
<b>Uninsured</b>	49.9	18.6%	22.1	8.3%	39.8	14.9%

Source: Urban Institute analysis, HIPSMS 2010.

Note: We simulate the provisions of the Affordable Care Act as if fully implemented in 2010.

**Figure 1. Health Insurance Coverage Distribution of the Non-Elderly**



## The Uninsured

Most of the impact of eliminating the mandate would fall on those below 200 percent of the FPL. Without health reform, the uninsured are heavily concentrated among those with incomes below 200 percent of the federal poverty level (FPL). Under the ACA, there would be only 13.7 million uninsured in this income group, as opposed to 33.1 million uninsured without reform (Figure 2). Under health reform with no mandate, the number of uninsured

nonelderly persons below 200 percent of the FPL would be 21 million, 7.3 million more than with the mandate.

## Changes in Health Care Spending

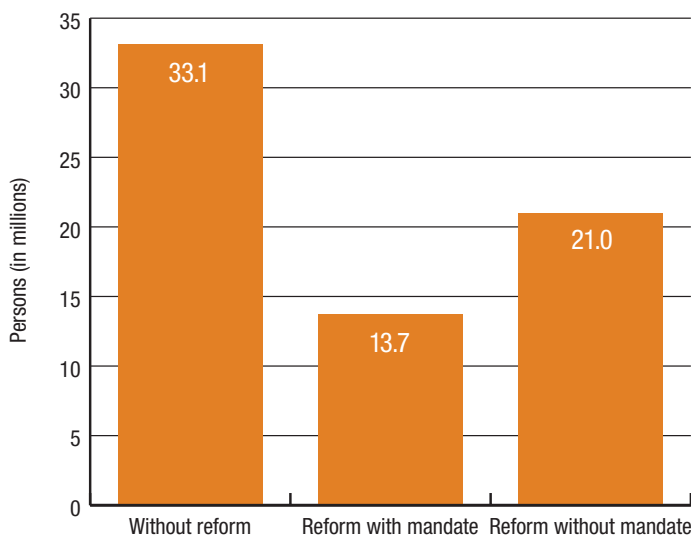
Figure 3 shows how spending on acute care for the nonelderly would differ without reform, with reform excluding the mandate, and with reform including the individual mandate. As noted earlier, we do not simulate offsetting multiyear cost control provisions or provisions such as eliminating enhanced payments to Medicare HMOs. Single-year estimates

based on 2010 costs are presented, which do not reflect the effects of multiyear cost savings and Medicare and Medicaid cost savings. Under the ACA, the amount spent on uncompensated care would fall from \$70 billion in the baseline to \$27 billion due to the expansion of health insurance coverage. Spending by individuals would increase from \$340 billion to \$370 billion. Spending by individuals would increase from \$340 billion to \$370 billion. Many more people would purchase insurance; this cost would be partially offset by cost savings in the exchanges. Employer spending would decline slightly. Government spending on acute care for the nonelderly would rise from \$244 billion to \$313 billion due to the Medicaid expansion and various subsidies. In total, system spending on health care would rise 4.5 percent from \$1,168 billion without reform to \$1,221 billion under the ACA.

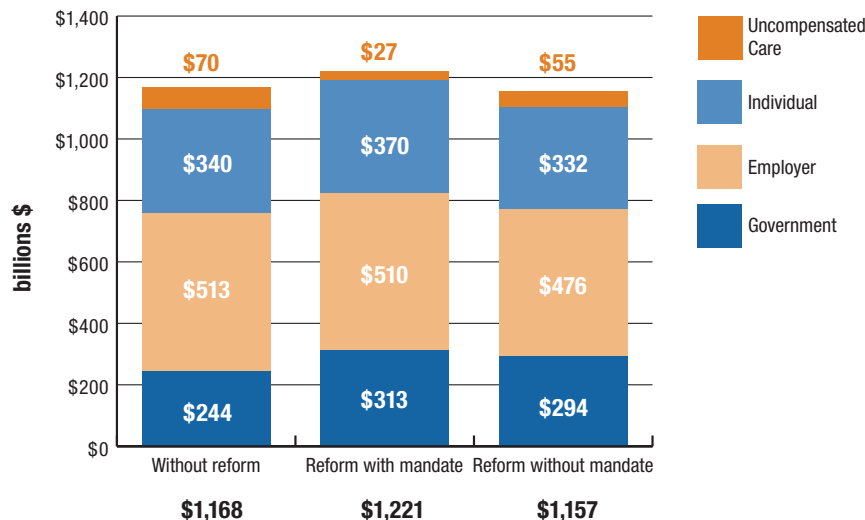
If the mandate were dropped from health reform, uncompensated care would rise to \$55 billion because there would be many more without health insurance. Individual and employer spending would fall somewhat due to cost savings in the exchanges and a decline in private health insurance coverage. Government spending would decline modestly to \$294 billion, \$19 billion less than with the mandate; government spending remains high because without a mandate, reform covers a large number of less healthy people. Overall, acute health care spending by the nonelderly would be \$1,157 billion, modestly lower than with no reform, primarily because Medicaid and the costs of exchange plans substitute for higher cost private insurance.

Table 2 shows more detail on how government spending on acute health care for the nonelderly changes under the three scenarios simulated. Government costs are significantly higher under the ACA because of the Medicaid expansion, as well as subsidies for exchange coverage and small employers. Under the ACA, spending on acute care for the nonelderly through Medicaid and CHIP would increase by \$53.6 billion; \$37.5

**Figure 2. Non-elderly Uninsured Below 200% of the FPL**



**Figure 3. Net Health Care Spending of the Government, Employers, Individuals, and Uncompensated Care—Acute Care, Nonelderly**





billion would be spent on total subsidies (premium, cost-sharing, and employer). Offsetting some of this spending, \$17.6 billion would be collected in employer assessments and \$4.3 billion in individual mandate penalties.

If the mandate were dropped from health reform, Medicaid and CHIP spending would fall by \$12.6 billion. Eliminating the mandate does not affect eligibility for these programs, but does reduce the enrollment of those eligible. Total spending on subsidies (premium, cost-sharing, and employer) would be \$26.8 billion, and the government would collect \$17.8 billion in employer

assessments. The lower exchange enrollment without a mandate leads to lower, but still substantial, premium and cost-sharing subsidies. Without a mandate, there is less worker demand for ESI coverage and thus lower rates of employers offering coverage and lower rates of workers taking up offers. As a result, employer subsidies are lower and assessments are higher.

Under the ACA, total employer health care spending would decrease slightly (Table 3). Employers would have lower premium contributions because of cost savings in the exchange and small employers would benefit from subsidies,

but at the same time face significant employer assessments.

Without a mandate, total employer health care spending would decline compared with the ACA by \$34 billion or 6.7 percent (from \$510.2 billion to \$476.3 billion). Employer spending with no mandate is significantly lower than spending under the ACA due primarily to the total spent in ESI premium contributions. Nearly 7 million more people are covered by employer-sponsored insurance when the individual mandate is in effect than under reform without a mandate.

Individual spending on acute care for the nonelderly would be \$29.5 billion higher under the ACA than without reform, \$370.0 billion versus \$340.5 billion. This is due to the substantial expansion of private insurance coverage. This is partially offset by savings in the exchanges. Note that out-of-pocket cost sharing declines significantly even with increased coverage. This means that insurance coverage under the ACA is in general more comprehensive than without reform due to the Medicaid expansion and insurance market reforms, particularly in the nongroup market. Those below 200 percent of the FPL would see a substantial reduction in their spending, \$10.7 billion, due the exchange subsidies and the Medicaid expansion. Those with higher incomes would pay more in total due to spending by those newly purchasing private insurance.

Without a mandate, individual spending would be \$332.2 billion, much lower than under the ACA. Individual spending falls without a mandate because of the decline in private coverage. Health reform with the individual mandate would cover 18 million more people than without the mandate. Of these, 14.5 million would be covered by private health insurance and would have to pay some share of the premiums for this coverage.

Uncompensated care provided to the uninsured is currently a substantial cost

**Table 2. Health Care Spending of the Government**

	Without reform (in millions)	Reform with mandate (in millions)	Change (in millions)	Reform without mandate (in millions)	Change (in millions)
<b>Government Spending<sup>a</sup></b>					
Medicaid/SCHIP	\$244,180	\$297,740	\$53,560	\$285,070	\$40,890
Premium subsidies	n.a.	\$26,860	\$26,860	\$18,578	\$18,578
Cost-sharing subsidies	n.a.	\$6,090	\$6,090	\$4,543	\$4,543
Employer subsidies	n.a.	\$4,479	\$4,479	\$3,738	\$3,738
Individual mandates	n.a.	-\$4,290	-\$4,290	n.a.	n.a.
Employer assessments	n.a.	-\$17,601	-\$17,601	-\$17,761	-\$17,761
<b>Net government spending</b>	<b>\$244,180</b>	<b>\$313,277</b>	<b>\$69,097</b>	<b>\$294,168</b>	<b>\$49,988</b>

Source: Urban Institute analysis, HIPSIM 2010.

Note: We simulate the provisions of the Affordable Care Act as if fully implemented in 2010.

<sup>a</sup>Spending on acute care for the non-elderly.

**Table 3. Health Care Spending of Employers**

	Without reform (in millions)	Reform with mandate (in millions)	Change (in millions)	Reform without mandate (in millions)	Change (in millions)
<b>Employer Spending</b>					
ESI premiums	\$513,293	\$494,068	-\$19,225	\$459,579	-\$53,714
Employer assessments	n.a.	\$17,601	\$17,601	\$17,761	\$17,761
Voucher amount	n.a.	\$2,995	\$2,995	\$2,688	\$2,688
Employer subsidies	n.a.	-\$4,479	-\$4,479	-\$3,738	-\$3,738
<b>Net employer spending</b>	<b>\$513,293</b>	<b>\$510,185</b>	<b>-\$3,108</b>	<b>\$476,290</b>	<b>-\$37,003</b>

Source: Urban Institute analysis, HIPSIM 2010.

Note: We simulate the provisions of the Affordable Care Act as if fully implemented in 2010.

for federal, state, and local governments, health care providers, and others. Hadley et al. (2008) find that about three-quarters of uncompensated care is financed by federal, state, and local governments, through DSH payments, and other programs.<sup>14</sup> Under the ACA, uncompensated care declines by \$42.3 billion to \$27 billion (Figure 3). Without a mandate, uncompensated care would remain high (\$55 billion) due to the additional 18 million people without health insurance. Programs that support uncompensated care would have to be largely maintained.

### Government Costs per Newly Insured

Because the uninsured are heavily concentrated in the income groups eligible for Medicaid and exchange subsidies, it makes sense to consider the government costs per newly-insured person (here the government costs of acute care for the nonelderly) as a measure of the efficiency of a health reform scenario. The difference between reform with and without an individual mandate is dramatic. Without a mandate, the average cost per newly-insured would be \$4,795; under the ACA it would be far lower, \$2,451 (Figure 4). The increase in coverage without a mandate was due entirely to the Medicaid expansion, so that nearly all

newly insured have their costs borne by the government. With the ACA's individual mandate, half of the newly insured would have private coverage and half public coverage.

### Premiums in the Exchanges

An important argument used by advocates of an individual mandate is that there would be substantial adverse selection in the exchange without it, leading to higher premiums. Our simulation confirms that adverse selection would result, but the amount is not large (Table 5). The reason for this is the presence of premium and cost-sharing subsidies. Under the ACA, we estimate that about two thirds of those covered in the nongroup exchanges would be in the subsidy eligibility range.<sup>15</sup> As we have seen, exchange enrollment would be significantly lower without a mandate, but most of the difference would come from those above the subsidy eligibility threshold. Those eligible for subsidies are on average younger than the population at large and have lower average costs. Thus, there would be a large pool of lower-than-average-cost enrollees in the exchanges with or without a mandate, moderating the effects of adverse selection.<sup>16</sup> If subsidies are reduced or eroded over time, our model would show greater adverse selection.

CBO estimates that the average premium per person covered in new nongroup policies would be 10-13 percent higher under reform with a mandate in 2016 than under current law.<sup>17</sup> They also estimate, that without a mandate, such premiums would rise 15-20 percent. The difference in these ranges is their estimate of the magnitude of adverse selection.<sup>18</sup> Our premium changes are at the low end of their range. We simulate the nongroup and ESI exchanges pooled together; if they were separate, the adverse selection effects of eliminating the mandate would be somewhat higher.

### Conclusion

***Without a mandate, many more would be uninsured.*** We find that health reform as passed with an individual mandate would reduce the uninsured by 27.8 million people. Reform without the mandate would reduce the number of nonelderly Americans without health insurance by 10.1 million relative to the number who are uninsured today. Without the mandate, the coverage decline would be entirely due to the Medicaid expansion, as the number of people covered by private insurance would be slightly lower than without health reform. Without a mandate, insurance coverage (public and private) increases only among those with the lowest incomes. In contrast, with the mandate, the ACA reduces the number of uninsured at all income levels and increases the number of people with private health insurance.

***Without a mandate, fewer people would have employer-sponsored insurance.*** Under the ACA, 151.1 million people would have employer coverage, which is similar to the number who have such coverage now. Without a mandate, only 145.6 million would be covered by ESI. The presence of the individual mandate would not have a large effect on the number offered ESI through the health insurance exchanges, but the nongroup exchanges would cover far fewer people without the mandate (15.7 million versus 23.1 million).

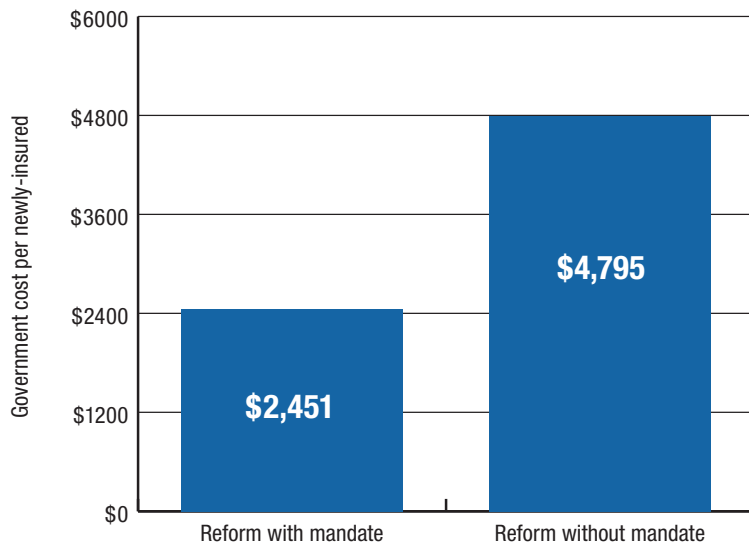
**Table 4. Health Care Spending of Individuals**

	Without reform (in millions)	Reform with mandate (in millions)	Change (in millions)	Reform without mandate (in millions)	Change (in millions)
<b>Individual Spending</b>					
Net out-of-pocket premiums	\$180,786	\$211,538	\$30,752	\$178,728	-\$2,057
Net out-of-pocket cost-sharing	\$159,694	\$158,428	-\$1,266	\$153,503	-\$6,191
<b>Total individual spending</b>	<b>\$340,479</b>	<b>\$369,966</b>	<b>\$29,487</b>	<b>\$332,231</b>	<b>-\$8,248</b>
<b>Distribution by income</b>					
<200% FPL	\$70,513	\$59,824	-\$10,689	\$55,033	-\$15,480
200-399% FPL	\$100,316	\$112,871	\$12,555	\$96,238	-\$4,079
>400% FPL	\$169,650	\$197,271	\$27,621	\$180,961	\$11,311

Source: Urban Institute analysis, HIPSM 2010.

Note: We simulate the provisions of the Affordable Care Act as if fully implemented in 2010.

**Figure 4. Government Costs per Newly-Insured Person**



**Table 5. Average Premiums Paid by Policyholders in the Nongroup Exchanges<sup>1</sup>**

	Reform with Mandate <sup>2</sup>	Reform without Mandate
Single	\$4,105	\$4,246
Family	\$11,202	\$11,605

Source: Urban Institute analysis, HIPSM 2010.

<sup>1</sup> Averaged over all benefit levels in the exchanges.

<sup>2</sup> We simulate the provisions of the Affordable Care Act as if fully implemented in 2010.

**Government spending would still increase significantly without a mandate.** Government spending on acute care for the nonelderly would increase significantly under either health reform scenario: by \$50 billion without a mandate and by \$69.1 billion with the mandate. This includes spending on Medicaid, subsidies for coverage in the exchanges and subsidies to small employers. This spending is reduced by the amount collected in employer assessments and individual mandate penalties. There is a dramatic difference in the efficiency of this additional government spending. The spending per newly insured person

would be \$4,795 under reform without a mandate, but only \$2,451 under the ACA with the mandate. Note that spending here is based on projected health care costs for 2010 and do not reflect the effects of multiyear cost-containment provisions and Medicare and Medicaid cost savings.

**Employer spending would be lower without a mandate.** Employers would spend less on health care overall under voluntary health reform than they would with no health reform because of less coverage and the cost savings in the new ESI (SHOP) exchanges available to firms of up to 100 workers and to a slight decline in overall ESI enrollment. Under the ACA with the mandate, they would spend more than without reform due to increased enrollment. However, the differences in both cases are relatively small (about 4 percent).

**Individual spending would be lower without the mandate.** Individuals would spend very slightly less on health care under voluntary reform than they would with no reform, and would spend 8.7 percent more under the ACA than with no reform. This increase in spending is due almost entirely to premiums and individual

mandate penalties paid by those uninsured without reform with incomes too high to qualify for Medicaid. The increase in health insurance coverage under reform with no mandate is due entirely to the Medicaid expansion, and the government bears the costs for these persons. Health reform with the mandate would cover 18 million more people than without it, 14.5 million of whom would be covered by private insurance and would pay premiums that they did not pay before.

**Uncompensated care would remain high without a mandate.** The amount spent on uncompensated care for the uninsured decreases by \$42.3 billion under the ACA, but by only \$14.7 billion without a mandate, relative to no reform. The larger reduction under the ACA with the mandate would allow the federal and state governments to reduce spending on programs that now support the uninsured and could also result in lower private premiums and higher provider revenue.<sup>19</sup> This suggests that the lower level of individual spending and higher uninsured rates without a mandate reflects, in part, the shifting the costs of health care that the uninsured will inevitably need and use onto the rest of society.

Our simulation results show that the market-based provisions of the ACA would not expand private insurance coverage without an individual mandate. The additional demand for private insurance due to exchange subsidies would be counter-balanced by other factors such as the Medicaid expansion. Without a mandate, the net expansion of coverage is limited to those eligible for Medicaid or CHIP. Thus, health reform without a mandate would incur a substantial government cost not very different from the cost of the ACA while covering far fewer people.

The Medicaid expansion and exchange subsidies, coupled with the mandate, would make a substantial dent in the number of uninsured, a result that does not occur if the mandate were eliminated. The individual mandate, with income related subsidies, is essential to market based reform



because it reduces adverse selection and broadens the sharing of risk. Requiring individuals to have coverage once financial assistance is made available dramatically reduces the costs that are shifted on to others in the form of

uncompensated care. The mandate also lowers premiums by reducing adverse selection. We show that the extent of adverse selection in the ACA is mitigated by the subsidies. But if subsidies were less generous (as they will be

eventually<sup>20</sup>) the impact of adverse selection will be more apparent.<sup>21</sup> Those who remain uninsured without the mandate are essentially free riders who ultimately benefit from taxes or higher premiums paid by others.

## Notes

- 1 For example, Linda J. Blumberg and John Holahan, "The Individual Mandate—An Affordable and Fair Approach to Achieving Universal Coverage," *New England Journal of Medicine* 361, no. 1 (2009), <http://www.nejm.org/doi/full/10.1056/NEJMp0904729#t=article>; and America's Health Insurance Plans, "Health Plans Propose Guaranteed Coverage for Pre-Existing Conditions and Individual Coverage Mandate," Press Release, November 19, 2008, <http://www.ahip.org/content/pressrelease.aspx?docid=25068>.
- 2 For more on the legal issues surrounding the mandate, see, for example, Randall R. Bovbjerg, "Are State Challenges to the Legality of the Patient Protection and Affordable Care Act Likely to Succeed?" (Washington, DC: The Urban Institute, 2010), <http://www.urban.org/url.cfm?ID=412116>.
- 3 There is a peculiarity in the affordability exemption worth pointing out. An individual is exempt if the individual premium he or she faces is more than 8 percent of family income. According to the Joint Committee on Taxation's Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010, as Amended, in Combination with the Patient Protection and Affordable Care Act (JCX-18-10, March 21, 2010), if self-only coverage is affordable for the worker but family coverage is not, the employee will be subject to the penalty for nonenrollment, while the family members eligible for employer coverage through that employee would not be penalized. It is unclear at the present time whether those family members would then be eligible for subsidies for coverage purchased through the exchange. JCT's explanation of this provision highlighted the lack of clarity in the language of the statute. Their interpretation is not binding; the actual implementation will be specified in regulations to be issued by the executive branch. It is, however, the most authoritative interpretation currently available, so we use it in our modeling. The ACA also allows other financial hardship exemptions to be granted. The requirements for these are left to the discretion of the Secretary of the Department of Health and Human Services.  
  
Also, there are a few other reasons for exemption from the mandate. For example, some Americans who reside outside the United States are exempt. For more details on the mandate, see the two-volume publication *Law, Explanation, and Analysis of the Patient Protection and Affordable Care Act Including Reconciliation Act Impact*, CCH Editorial Staff Publication (New York: Wolters Kluwer, 2010).
- 4 There are many details and complexities in computing the penalty that we omit here. Bronze-level coverage will have an actuarial value of 60 percent. In other words, it will be designed to cover, on average, 60 percent of covered health expenses for the enrolled population.
- 5 For more about HIPSM and a list of recent research using it, see <http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf>. A more technical description of the construction of the model can be found in Bowen Garrett, John Holahan, Irene Headen, and Aaron Lucas, "The Coverage and Cost Impacts of Expanding Medicaid" (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2009), <http://www.urban.org/url.cfm?ID=411905>.
- 6 HIPSM uses data from several national data sets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File, and the Statistics of U.S. Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount.
- 7 Matthew Buettgens, Bowen Garrett, and John Holahan, "America under the Affordable Care Act," (Washington, DC: The Urban Institute, 2010), <http://www.urban.org/url.cfm?ID=412267>.
- 8 Sharon K. Long, Allison Cook, and Karen Stockley, "Access to Health Care in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey" (Washington, DC: The Urban Institute, 2010), <http://www.urban.org/url.cfm?ID=1001403>. See also earlier work using the Massachusetts Health Insurance Survey by Sharon Long and other coauthors.
- 9 Behavior in HIPSM is modeled using an expected utility framework. This "penalty" is thus the disutility of not complying with the law.
- 10 The number of uninsured without health insurance is based on results from the 2009 Current Population Survey aged to 2010. This was the latest CPS available at the time of writing. The aging takes into account demographic changes projected by the Census Bureau as well as economic changes, such as changes in the unemployment rate. The latest 2010 CPS released mid-September showed an estimated 50.7 million uninsured. Our 2010 estimate is somewhat lower primarily because the Medicaid undercount adjustment results in fewer uninsured than the unadjusted CPS.
- 11 Buettgens, Garrett, and Holahan, "America under the Affordable Care Act," 2010.
- 12 This small decline in private coverage without the mandate is actually the net result of many factors. The introduction of subsidies makes nongroup coverage more attractive for those eligible. The Medicaid expansion extends eligibility to some currently covered by private insurance. Nongroup market reforms would lead some currently with nongroup coverage to face higher premiums (due to age-rating and coverage being more comprehensive in some cases). Finally, provisions of the ACA could lead some employers to stop offering ESI coverage that they would otherwise offer without reform or when reform includes the individual mandate.
- 13 In the 48 contiguous states and the District of Columbia, the 2009 federal poverty level is \$14,570 for a family of two and \$22,050 for a family of four. The 2009 levels were still in effect for 2010 at the time of writing. For more information, see <http://aspe.hhs.gov/poverty/09poverty.shtml>.
- 14 Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs* web exclusive, August 25, 2008.
- 15 See Table 4 of Buettgens and Garrett, 2010.
- 16 In reform scenarios we have modeled using HIPSM without the subsidies we do find substantial adverse selection. For example, making nongroup insurance guaranteed-issue without making any other changes does lead to dramatically higher premiums and reduced enrollment.
- 17 Congressional Budget Office, "An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act," November 30, 2009.
- 18 Congressional Budget Office, "Effects of Eliminating the Individual Mandate to Obtain Health Insurance," June 16, 2010.
- 19 The amount spent by government at various levels on programs that support the uninsured is not included in our government costs table above. Less uncompensated care could also result in lower private premiums and higher provider revenue.
- 20 Beginning in 2019, the requirements for indexing subsidy amounts change and may not reflect the full increase of premium growth over the rate of income growth.
- 21 State regulatory decisions could also have an impact on adverse selection. For example, if risk adjustment inside and outside the exchanges is less effective than we have modeled or if plans outside the exchange are able to differentiate themselves in a way that attracts healthier people—such as offering only Bronze level coverage—the resulting adverse selection would be somewhat greater than shown here. The number of subsidized enrollees would still be large enough, though, to moderate adverse selection significantly.



---

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

## **About the Authors and Acknowledgements**

Matthew Buettgens, Ph.D., is a research associate and John Holahan, Ph.D., is director of the Urban Institute's Health Policy Center. Until recently a senior research associate in the Health Policy Center, Bowen Garrett, Ph.D., is an affiliated scholar at the Urban Institute and chief economist at McKinsey and Company's Center for U.S. Health System Reform. The authors are grateful to Linda Blumberg and Len Nichols for helpful comments and Caitlin Carroll for excellent research assistance. This research was funded by the Robert Wood Johnson Foundation.

## **About the Urban Institute**

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation. For more information, visit [www.urban.org](http://www.urban.org).

## **About the Robert Wood Johnson Foundation**

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful, and timely change. For more than 35 years, the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit [www.rwjf.org](http://www.rwjf.org).