

Delaying the Individual Mandate Would Disrupt Overall Implementation of the Affordable Care Act

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Introduction

A recent bill, H.R. 2668, passed by the House of Representatives in July, would, among other changes, delay the implementation of the individual requirement to have health insurance or pay a penalty (the *individual mandate*) under the Patient Protection and Affordable Care Act (ACA) for one year. Congressional Budget Office (CBO) analysis of this bill¹ estimates that the delay would decrease insurance coverage by 11 million people in 2014 by decreasing coverage in Medicaid and the Children's Health Insurance Program (CHIP), employer-sponsored insurance, and nongroup insurance relative to ACA implementation with the individual mandate. CBO projects the lost coverage would take several years to completely recoup. Consistent with the lower projected coverage levels, CBO also finds that such a delay would create federal budget savings of \$35.4 billion over the period of 2014 to 2023. Urban Institute analysts have previously estimated similarly significant coverage and spending implications of removing the individual mandate from the ACA.² This paper places these findings and other implications of such a delay into context. It demonstrates the central role that the individual mandate plays in the overall health care reform law and the disruptions for insurers and government systems that would occur if it were delayed.

Rationale for the Individual Mandate

The objective of the individual mandate is twofold:

1. To maximize insurance coverage, short of instituting a fully financed government system into which the entire population would be automatically enrolled; and
2. To retain the currently insured and attract the healthiest currently uninsured individuals into coverage, such that health care risks of a diverse population can be shared broadly.

The reason an individual mandate is important for reaching the first objective is clear: more people will enroll in insurance if they are required to do so or are subject to a fine than would without these stipulations. The mandate's consequences for the second objective require more clarification. Absent an individual mandate, insurers fear adverse selection—the enrollment of disproportionately unhealthy individuals—particularly in the nongroup and small group insurance markets. These fears lead insurance companies to set higher premiums, pursue strategies that allow them to charge individuals (or groups) differentially based upon past and expected costs, deny coverage to some outright, and limit benefits and coverage for others. These strategies allow insurers to protect themselves financially. The result, however, is reduced affordability and access to care for individuals during the times that they are most vulnerable—when they or their family members are ill, injured, or recovering from an illness or injury, or, in the case of those covered through small employers, when their co-workers are in such situations.³

Requiring participation in insurance, regardless of health profile, the individual mandate allows for an end to coverage denials, premium discrimination based on health status or claims experience, large year-to-year premium swings based on recent health, and discrimination in benefits offered and cost-sharing requirements based on health risk. All this can be accomplished under the ACA without compromising the financial viability of private insurers since an individual mandate keeps the insurance risk pools diverse and stable while regulations require all small group and nongroup insurers to operate according to the same rules both inside and outside the exchanges.

Government Cost Implications

As CBO and the Urban Institute have found, eliminating or delaying the individual mandate significantly increases the number of uninsured, as some individuals, especially disproportionately healthy individuals, will choose not to enroll in coverage. While decreased coverage leads to government savings through increased tax revenues⁴ and lower spending on the Medicaid program and subsidized private insurance coverage, it also increases the cost per newly insured and increases uncompensated care provided through hospitals, much of which is state and federal government financed.⁵ According to the January 2012 Urban Institute analysis that estimated the effects of the ACA with and without the individual mandate, the average subsidy amount for individuals receiving a subsidy is \$700 to \$1100 higher (up to 24 percent higher) without the mandate, depending on enrollment behavior.⁶ This occurs because the average nongroup insurance enrollee is significantly more costly without the mandate than with it.

If the individual mandate is delayed and insurance coverage falls as projected by CBO and the Urban Institute, hospitals will be faced with more uncompensated care than if the mandate were in place, and most of this care is financed by state and federal governments. As the Urban Institute's analysis indicated, the increase in total uncompensated care costs is about as large as CBO's estimate of federal savings from delaying the individual mandate, which suggests that the net savings to the federal government associated with delaying the individual mandate are smaller when accounting for offsets, and the offsets are particularly large when state and private spending on uncompensated care is also taken into account.

Stability of Insurance Pools

As noted above, a central function of the individual mandate is to create insurance risk pools that reflect the distribution of health care risks in the general population, thereby creating stability in premiums and enrollment. Given the ACA's health insurance market reforms and consumer protections, the nongroup market, without a mandate, can only avoid significant adverse selection if large numbers of healthy individuals enroll in subsidized coverage. There is significant risk that low exchange enrollment in the first year due to the lack of a mandate could begin an adverse selection cycle which would make it difficult to establish viable risk pools in the exchange in future years. While the Urban Institute estimated that premiums without the mandate could be up to 24 percent higher than with the mandate, that analysis assumed fully effective risk adjustment across the exchange and nonexchange markets. Less effective risk adjustment could lead to even higher premiums in the exchange without the mandate and could dissuade insurers from participating in the new markets; this could then further dissuade healthier individuals with current nongroup coverage from entering the exchanges, exacerbating the effect in the following years.

Comparison to Delay of the Employer Mandate

In July 2013, the Administration announced a one year delay in the implementation of the ACA's penalties that would be assessed on large employers (50 or more workers) who do not offer affordable coverage to their full-time workers (30 or more hours per week).⁷ Under the law, a penalty will be imposed on larger employers if at least one of their full-time employees purchases coverage through one of the new nongroup health insurance exchanges and uses a federal subsidy to do so. Soon after the delay announcement, an Urban Institute analysis⁸ demonstrated that the individual mandate plays a substantial role in expanding insurance coverage under the law, but the employer mandate does not. Our analysis found that the effect of the delay of the employer mandate was a modest reduction in government revenue and modest employer savings (from not having to pay penalties), with very little effect on coverage. CBO estimated a somewhat larger, but still small coverage effect associated with delaying the employer mandate.

Impact of Individual Mandate Delay on State Governments, Insurers, and Exchanges

Delay in the individual mandate would have a significant impact on the state systems that have already been established. Eighteen states (including the District of Columbia) have developed state based exchanges, another seven have participated in exchange development in formal partnerships with the federal government, and seven others are taking responsibility for insurance plan management in the federal exchanges being developed in their states outside of formal partnerships.⁹ As such, 32 states, and their departments of insurance, and for more than half of those, a much larger staff developing exchanges, have worked for the past three years to prepare the necessary structures for the open enrollment period set to begin on October 1, 2013 and the implementation of market reforms to begin on January 1, 2014. This effort included development of requests for insurer participation as qualified health plans in the exchanges; development of new administrative processes for reviewing rates and policies for all nongroup and small group insurance plans in each state insurance market; evaluation of all plan filings; negotiations, in some cases, with insurers over rates and participation; and publication and explanation of rates and changes in plans. As of April 2012, the federal government had awarded more than \$2.6 billion in grants to states to plan for and establish health insurance exchanges and make modifications to or establish private insurance programs, oversight systems, and provide consumer assistance.¹⁰ Participation in these new state and federal processes and creation of new internal administrative systems also required significant spending by private insurers.

In states that have made premium bids public to date, these substantial reform efforts have resulted in premium bids that, while encompassing some significant variation, have generally been lower than those that had been predicted by CBO.¹¹ These premium bids are contingent upon the presence of the ACA's individual mandate. Delaying the mandate for even one year invalidates the established premiums and nearly negates the efforts to complete the administrative processes. A delay of the individual mandate would significantly change the number and health-related characteristics of nongroup insurance enrollees, and it may have significant effects on enrollment in plans in the small group market. As a result, projected premiums for 2014 will likely not reflect their actual costs and potentially would threaten their solvency if they were to remain in place.

To guard against potential insolvencies, insurers will likely need an opportunity to re-evaluate the expected number and risk profile of enrollees to account for the lack of an individual mandate and propose new rates for 2014. These rates would then need to undergo another review and approval process, making it impossible to be ready for the October 1 open enrollment period and making it extremely difficult to be

ready for the beginning of the new plan year on January 1. This would cause disruptions in coverage not only for those wishing to newly enroll in coverage, but also for many of those already enrolled in coverage today who want to maintain their status.¹² Insurers would have no relevant approved rates to use for these populations until an entire new approval process could be completed. In addition to higher premiums, a delay would lead to consumer confusion, potential disruptions in coverage, and enormous wasted time and effort by state and federal government personnel and the private sector.

Some insurers, fearing an adverse selection consequence, may decline to participate in some markets that include the ACA's consumer protections but do not have a requirement for individuals to participate. As a result, consumers could experience a reduction in their plan choices in addition to higher premiums. This could, in turn, lead to strong political pressure to eliminate the consumer protections (e.g., prohibitions on denials of coverage, price discrimination for those with health problems, benefit and cost-sharing discrimination by health status, gender rating, plans not providing essential health benefits), thereby sacrificing one of the central and most popular objectives of the law. Such last minute changes are likely to weaken consumer, insurer, and state government confidence in the value of planning and participating in markets and reforms over the longer term.

In contrast, the employer mandate delay does not affect insurer premium bids or state administrative systems. The employer mandate affects only employers with 50 or more workers, known as the large group insurance market. This market is not subject to the broad insurance market reforms that the ACA introduced in the small group and nongroup markets that required substantial administrative system changes for state and federal governments and insurers. As previously cited analysis shows, the employer mandate has very little effect on overall insurance coverage. Thus, delaying it would not noticeably change insurance risk pools or appropriate premiums in the small group or nongroup markets.

Conclusion

At this late date, a change as significant as delaying the individual mandate would also delay or seriously disrupt the implementation of all reforms related to private insurance markets scheduled to begin January 1, 2014. Completed processes related to insurer rate and policy filings, review of these filings by state departments of insurance, and approval for qualified health plans to be sold in exchanges would be invalidated and would have to begin again. Plan participation decisions could change as well, as a consequence. Analyses by The Urban Institute and CBO find that, without the individual mandate in place, insurance coverage would be significantly lower, average premiums would be higher, and the government cost per newly insured person would be higher as well.

Without the individual mandate, uncompensated care costs would be higher as well, which would significantly affect hospitals. Cuts to Disproportionate Share Hospital (DSH) funds—federal dollars provided by the Medicare program to help support hospitals serving high percentages of uninsured and low-income populations—are in place under the ACA; the proposal to delay the individual mandate would not delay these hospital funding reductions nor would it delay other enacted reductions to Medicare payment rates.¹³ Hospitals agreed to these cuts due to expected offsetting revenues they would receive from significant numbers of newly insured individuals receiving care under the ACA. Significantly reducing the number of newly insured while also cutting federal payments to hospitals would upset the balance and be financially detrimental to hospitals.

Eliminating the individual mandate may also compromise the stability of insurance pools inside and outside exchanges due to the likelihood of increasing the share of insured persons with high cost medical needs, as compared to full implementation of the ACA. This reduced stability could lead to political pressure for changes in consumer protections. With uncertainty about the actual length of the delay in the individual mandate and potential changes in related reforms likely to persist in 2014, participation and coverage decisions by insurers, employers, and households would become increasingly complex. Thus, delay of the individual mandate is not a modest change to the ACA. It would instead have substantial implications for the feasibility of effectively implementing the law in the coming years.

Endnotes

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3. See for example: Doty M, et. al. 2009. "Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families." Issue Brief, The Commonwealth Fund. <http://www.commonwealthfund.org/Publications/Issue-Briefs/2009/Jul/Failure-to-Protect.aspx>; Pollitz K, et.al. 2001. "How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" Issue Brief, The Henry J. Kaiser Family Foundation. <http://kff.org/health-costs/report/how-accessible-is-individual-health-insurance-for/>; Corlette S, J Volk, and K Lucia. 2013. "Real Stories, Real Reforms." Georgetown University, Center for Health Insurance Reforms Report; Blumberg LJ and LM Nichols. 2004. "Why are So Many Americans Uninsured?" *Health Policy and the Uninsured*, Catherine G. McLaughlin, ed. Washington, DC: Urban Institute Press.
4. CBO estimates that lower rates of employer contributions to health insurance due to decreased worker preferences for and take-up of coverage, leads to higher wages and salaries. Wages and salaries are taxed income, whereas employer-based health insurance benefits are not. As a consequence, eliminating the individual mandate means that some workers will pay higher taxes than they would otherwise.
5. Hadley J, J Holahan, T Coughlin and D Miller. 2008. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs." *Health Affairs* web exclusive 27 (5): w399–415.
6. Options were simulated as if the reforms were fully phased in and implemented in 2011 and, as such, the dollar levels are lower than would be the case if they had been estimated in 2014 dollars due to inflation in medical costs.
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8. Blumberg LJ, J Holahan, M Buettgens. 2013. "It's No Contest: The ACA's Employer Mandate Has Far Less Effect on Coverage and Costs Than the Individual Mandate." Washington, DC: Urban Institute. http://www.urban.org/health_policy/url.cfm?ID=412865
9. Health Affairs. "Health Policy Brief: Health Insurance Exchanges and State Decisions," http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=96 (accessed September 18, 2013).
10. Kaiser Family Foundation. 2012. "Federal Funding Under the Affordable Care Act." Focus on Health Reform Policy Brief. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8301.pdf>.
11. See Cox C, G Claxton, L Levitt, and H Khosla. 2013. "An Early Look at Premiums and Insurer Participation in Health Insurance Marketplaces, 2014." Kaiser Family Foundation, <http://kff.org/health-reform/issue-brief/an-early-look-at-premiums-and-insurer-participation-in-health-insurance-marketplaces-2014/> (accessed September 19, 2013); and Holahan, J, K Lucia, R Peters, C Monahan. 2013. "Cross-Cutting Issues: Insurer Participation and Competition in Health

Insurance Exchanges: Early Indications from Selected States.” ACA Implementation—Monitoring and Tracking Report. http://www.urban.org/health_policy/url.cfm?ID=412858

12. Those insurance plans held continuously by insured persons as of the date of enactment of the ACA, or *grandfathered plans*, are exempt from many of the law’s consumer protections and are unlikely to have their premiums affected by the presence or absence of the mandate. All those enrolled in non-grandfathered plans,

however, in the nongroup and small group markets will be affected. These include individuals who are currently in nongroup or small group coverage purchased since March of 2010 or policies that changed significantly since that date, since even these nonexchange policies must comply with the insurance market reforms that begin on January 1, 2014.

13. Additional DSH funds are financed by the Medicaid program; however, the cuts to these funds under the ACA have already been delayed.

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Linda Blumberg is a Senior Fellow and John Holahan is an Institute Fellow in the Urban Institute’s Health Policy Center. The authors are grateful for comments and suggestions made by Sabrina Corlette, Genevieve Kenney, Kevin Lucia, and Steve Zuckerman.

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