Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care

Timely Analysis of Immediate Health Policy Issues

Matthew Buettgens and Caitlin Carroll

Summary

We estimate that the Patient Protection and Affordable Care Act (ACA) as enacted would reduce the number of uninsured by nearly half, from 50 million nonelderly people to 26 million. The federal legal requirement for most Americans to be covered by a health insurance plan that meets certain minimal standards or face a penalty—the so-called individual mandate—is an important part of achieving this reduction. Under health reform without a mandate, between 40 and 42 million would remain uninsured.

Tens of billions of dollars are spent each year by all levels of government and health care providers on uncompensated care for the uninsured. By reducing the number of uninsured, the ACA would reduce the amount spent on uncompensated care by about half. Without an individual mandate, the reduction in uncompensated care spending would be much lower due to the increased number of uninsured.

The ACA would increase private insurance coverage by about 7 million people. If the mandate were eliminated from the law as enacted, private coverage would fall by about 11 million, covering about 4 million fewer people than it would have without reform. The government would spend less on subsidized coverage in the exchanges due to decreased enrollment, even though the amount spent per person on subsidies would increase. With a mandate, the Medicaid expansion would increase enrollment in Medicaid and CHIP by 16 million. There would be 2 million fewer enrollees without a mandate.

The effects on nongroup insurance premiums of eliminating the individual mandate are very sensitive to the number and costs of people who would enroll in subsidized coverage in the health benefit exchanges. We analyzed the relationship between exchange enrollment and premiums, simulating the ACA with the mandate, and several alternative scenarios without it, representing different levels of exchange enrollment. Without a mandate, nongroup premiums overall would increase by roughly 10 percent with high exchange participation and by 25 percent with low participation.

With low participation, those enrolled in the exchange would be at a significantly higher risk of high health care costs than those outside the exchange. In particular, a majority of those covered in the exchange would be aged 45 or older. There would be risk adjustment between plans inside and outside the exchange, but risk adjustment methods may not be effective enough to completely eliminate risk selecting behavior by insurers. We have modeled risk adjustment as if it would do so; if actual risk adjustment were less effective, it would increase exchange premiums beyond these estimates and expose plans in the exchange to greater risk. Given the uncertainty in initial exchange enrollment, the possibility of adverse selection and potentially greater exposure to risk may make insurers reluctant to offer coverage through the exchange without an individual mandate.

Introduction

The federal legal requirement for most Americans to be covered by a health insurance plan that meets certain minimal standards or pay a penalty continues to be the most controversial aspect of the Patient Protection and Affordable Care Act (ACA). One year ago, we released an analysis comparing the effects of the ACA with and without this individual mandate.[1] In this paper, we update those findings to incorporate more recent survey data and a revised model reflecting the latest available federal draft regulations and current trends in state implementation decisions. In addition, we present new sensitivity analyses related to different levels of exchange enrollment.

The effects of eliminating the mandate, particularly for nongroup premiums, are very sensitive to the number and costs of people enrolling in subsidized coverage in the exchanges. Insurers fear substantial adverse selection in the nongroup market in the absence of an individual mandate when reforms such as guaranteed issue, prohibitions on pre-existing condition exclusions, and modified community rating are in place, as the ACA requires. The current nongroup market in New York, which is guaranteed issue and pure community rated, but does not have an individual mandate is cited as a doomsday example of what could happen. This market has an enrollment of less than 40,000 and premiums around $1,200 a month. However, New York does not have the provision under the ACA that provides subsidized coverage in the exchanges.[2]

Robert Wood Johnson Foundation

Urban Institute

We showed in the previous paper that robust enrollment in subsidized coverage could significantly mitigate adverse selection and stabilize the market at reasonable premium levels. However, the enrollment in the exchange will be heavily dependent on the effectiveness of implementation and outreach, particularly in the early years. Many new systems must be in place and operational by 2014 to smoothly determine eligibility and enroll the eligible. Outreach is crucial to early enrollment levels.[3] Investments in outreach are expected to vary across the states. There is a legitimate concern that initial exchange enrollment may not be large enough to counter adverse selection absent a requirement to obtain coverage.

To examine this concern, we conducted a sensitivity analysis, simulating four alternative scenarios: First, we simulated the ACA as enacted, including the individual mandate. Second, we simulated the ACA without the mandate and with enrollment consistent with a successful exchange and effective outreach to those who would be eligible for subsidized coverage. We will call this robust exchange participation. Third, we simulated the ACA without the mandate, using a lower preference for the nongroup and small group exchanges. This sensitivity demonstrates potentially lower exchange enrollment due to factors that are difficult to model directly, such as low carrier participation, insurance agent steering of consumers to non-exchange coverage, inadequate publicity, or Web interface difficulties. Such barriers to enrollment would affect all seeking coverage in either the nongroup or small group markets, regardless of eligibility for subsidies. Those discouraged from enrolling in the exchange would either enroll in coverage outside the exchange or choose to go without insurance. Fourth, we simulated the ACA without the mandate, using a lower preference for the exchange combined with lower take-up of subsidized coverage. Lower take-up of subsidized coverage could result from inadequate outreach to those eligible, difficulties with the

eligibility and enrollment interface, or a discouraging effect of the end-of-year tax reconciliation process. We separate the last two scenarios because their potential causes are distinct, their effects on premiums differ, and either could occur during exchange implementation in a particular state.

Methods

To estimate the effects of health reform and the individual mandate, we use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).[4] 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.[5]

We simulate the main coverage provisions of the ACA is if they were fully implemented in 2011, and compare results to the HIPSM baseline results for 2011 without 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 individual mandate 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.[6]

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.[7] The resulting model behavior is applicable for a voluntary health insurance regime, so 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.[8] Our simulation of how behavior

would change under the mandate has three components. First, we compute the financial penalty the family (tax unit) would face, as defined in the law. Second, the mandate is more than a dollar amount; it is a legal requirement. Desire to comply with the law, aversion to an income tax penalty, and the new social norm to have health coverage can lead to behavioral responses much stronger than the nominal amount of the penalty would suggest. We operationalize this by making being uninsured less attractive to families affected by the mandate.

Results were benchmarked by comparing the results of a simulation based on Massachusetts law with the results of health reform in Massachusetts.[9] Third, the introduction of the mandate in Massachusetts affected the behavior of many not subject to penalties. Some may have been uncertain whether or not they would face penalties at the end of the year due to changes in income or other circumstances. Others may have responded to outreach that represented having coverage as a new social norm. Since these will also be factors under the ACA, we make being uninsured slightly less attractive to families who would not face mandate penalties when the mandate is in effect. Again, we used Massachusetts data to calibrate this effect.

When we reduced the preferences for the nongroup exchange and the take-up of subsidized coverage, we did so by adjusting the expected utility of the affected options by a flat amount for all families in the relevant group. The effects we intended to capture—enrollment interface problems, ineffective outreach, etc.—would affect all families roughly equally as barriers to enrollment. Those discouraged from enrolling would either take up private coverage outside the exchange or choose to remain uninsured. In particular, most of those eligible for subsidies would find unsubsidized private coverage unaffordable.

This adjustment to take-up behavior preserves the relative preferences of families for the exchange and subsidized coverage; those who have the strongest

preferences, (i.e., have the most to gain from subsidies and exchange coverage,) are still the most likely to enroll. In particular, those eligible for subsidies and currently uninsured who have higher health care needs would be more likely to enroll than those who believe they will incur low health care costs. This is the basic driver of adverse selection without the mandate. For the scenario with low exchange preference, we shifted the preference until the overall nongroup exchange was about half as large as under the ACA with the mandate. For the scenario with low subsidy take-up and low exchange preference, we reduced the number enrolled in subsidized coverage to half the enrollment under the ACA with the mandate.

The results here differ from HIPSM estimates published in early 2011 for several reasons. First, since that time, we have developed detailed state-specific versions of the model for Massachusetts, Missouri, New York, and Virginia. The experience of adapting the model to a diverse set of states and new collaborations with experts in several fields has led to improvements in the model, notably in the modeling of the affordability exemption to the mandate, the affordable ESI offer test for subsidy eligibility, the choice of exchange versus non-exchange plans for families and

small businesses, and Medicaid/CHIP eligibility testing and enrollment for those seeking coverage in the exchange.

Second, we assumed that the nongroup and small group markets would not be pooled together when computing premiums. Previous papers using HIPSM modeled the two markets being pooled together. A few states, such as Massachusetts, have already pooled these markets and a few more are considering doing so, but the large majority of states are expected to leave them separate, at least in the near term.[10]

Third, for this analysis, we simulated the affordability exemption to the individual mandate that observers expect to be in the forthcoming regulations; this is different from the interpretation of the Joint Committee on Taxation and Congressional Budget Office that we used in earlier modeling. We assume that dependents will not incur mandate penalties if they do not obtain coverage and the lowest available family premium is above 8 percent of family income. A family would still be barred from subsidized exchange coverage if the lowest single premium offered to one member was less than 9.5 percent of family income.

As a result of these changes, the number of remaining uninsured is about 4

million higher than in previous estimates. About half of this difference is due the first update described above, and the remainder is due to the second and third. Care must be taken when comparing these numbers with CBO estimates of numbers of the uninsured, since ours are for full implementation in 2011, whereas CBO phases in implementation over the period 2014 to 2017.[11]

Results

Coverage

We first consider how the distribution of health insurance coverage would change under health reform (Table 1). Relative to current levels, full implementation of the ACA with a mandate would increase private insurance by 7.4 million nonelderly enrollees, from 164.9 million without reform to 172.3 million. The nongroup exchange would cover 15.3 million nonelderly residents, or 5.7 percent of the nonelderly population. Within the nongroup exchange, approximately 55 percent, or 8.5 million enrollees, would receive subsidies. In addition to increased coverage through private insurance, nonelderly Medicaid enrollment would increase by 16.4 million. In total, full implementation of the ACA would decrease the nonelderly uninsured population by 23.9 million, from 50.3 million to 26.4 million.

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

	Without Reform		ACA With Mandate		ACA Without Mandate, Robust Exchange Enrollment		ACA Without Mandate, Low Exchange Preference		ACA Without Mandate, Low Exchange Preference, Low Subsidy Take-Up	
	N	%	N	%	N	%	N	%	N	%
Coverage (in millions)										
Private	164.9	61.4%	172.3	64.1%	161.3	60.0%	161.6	60.1%	160.0	59.5%
Employer (non-exchange)	150.4	56.0%	144.6	53.8%	139.5	51.9%	144.4	53.7%	145.2	54.0%
Nongroup (non-exchange)	14.5	5.4%	2.5	0.9%	1.9	0.7%	5.6	2.1%	5.2	1.9%
Exchange employer	---	---	9.9	3.7%	8.8	3.3%	4.2	1.6%	4.4	1.6%
Exchange nongroup	---	---	15.3	5.7%	11.1	4.1%	7.4	2.8%	5.2	1.9%
Subsidized Consumer	---	---	8.5	3.1%	6.2	2.3%	5.5	2.1%	3.6	1.3%
Unsubsidized Consumer	---	---	6.8	2.5%	4.9	1.8%	1.9	0.7%	1.6	0.6%
Medicaid/CHIP	45.1	16.8%	61.5	22.9%	59.0	22.0%	58.6	21.8%	58.0	21.6%
Other (including Medicare)	8.5	3.2%	8.5	3.2%	8.5	3.2%	8.5	3.2%	8.5	3.2%
Uninsured	**50.3**	**18.7%**	**26.4**	**9.8%**	**39.8**	**14.8%**	**40.0**	**14.9%**	**42.2**	**15.7%**

Source: Urban Institute analysis, HIPSM 2011.

We then estimated the effects of removing the mandate from an otherwise complete implementation of the ACA, but assuming robust exchange enrollment. The nongroup exchange would be noticeably smaller without the mandate, decreasing by 4.2 million enrollees to 11.1 million. Despite this decrease, the proportion of subsidized enrollees in the nongroup exchange remains relatively constant at 56 percent for a total of 6.2 million subsidized consumers. Relative to current levels, enacting the ACA without a mandate would decrease overall private insurance coverage from 164.9 million to 161.3 million, a difference of 3.6 million. This difference is due largely to the expansion of Medicaid eligibility without the simultaneous increase in private coverage take-up that the mandate will bring. The ACA with a mandate would increase private coverage by 7.4 million since the mandate will significantly increase demand for private insurance.

Removing the mandate would also have a modest effect on the Medicaid expansion; 59.0 million nonelderly residents would enroll in Medicaid/CHIP programs without the mandate, 2.5 million fewer than with the mandate. Some of those eligible for Medicaid and CHIP would be subject to the mandate. For example, CHIP eligibility includes children in families with incomes up to 400 percent of the poverty level in some states. Without the mandate, parents would be much less likely to seek coverage for their children and themselves. Also, as noted in the methods section above, the presence of a mandate has a small effect even on those who do

not end up subject to penalties. There would be somewhat lower enrollment among this group as well. Overall, 10.5 million fewer nonelderly people would be uninsured than without health reform; however, this is less than half the decrease with the mandate. Nearly 40 million would remain uninsured.

Next, we estimated two scenarios in which implementation difficulties reduce the impact of the ACA without a mandate. In the first scenario, factors such as inadequate publicity and low carrier participation cause a lowered preference for the exchange. Enrollment in the nongroup exchange would decrease to 7.4 million people. This reduction would be offset by a 3.7 million enrollee increase in the nongroup market outside of the exchange. Almost 75 percent of those covered in the nongroup exchange would receive subsidized coverage. This increased proportion is not surprising given that those eligible for subsidies have the most to gain in the exchange, and thus are least likely to be deterred by implementation difficulties. The low exchange preference would also affect the employer exchange, reducing the number of enrollees from 8.8 million without a mandate but robust exchange participation to 4.2 million without a mandate and lower exchange participation. Again, this would be offset by an increase in the employer market outside the exchange.

A low preference for the exchange would also have a modest effect on Medicaid, with nonelderly enrollment decreasing by 400,000. Overall, a low exchange

preference has only a small effect on overall insurance coverage; only 200,000 more would be uninsured compared with robust exchange enrollment under the ACA without the mandate.

The second scenario with lower exchange participation combines low subsidy take-up with the lower preference for exchange coverage. Nongroup enrollment outside the exchange would fall to 5.2 million nonelderly enrollees. Overall, the nongroup exchange would account for 1.9 percent of the nonelderly population, less than half the size of the exchange with implementation of the ACA without a mandate but with robust exchange participation. The number of subsidized enrollees in the nongroup exchange would decrease to 3.6 million, or 69 percent of the total nongroup exchange. Again, the decreased use of the exchange and reduced spillover effect would cause a further reduction in nonelderly Medicaid enrollment of 0.6 million people. The lower exchange preference combined with lower take-up would result in a 15.7 percent uninsured rate, or 42.2 million nonelderly residents. This figure represents an increase of 2.4 million uninsured nonelderly people compared to a robust exchange participation level of the ACA without a mandate and almost 16 million more uninsured than with a mandate.

Spending – All Sources

In Table 2, we estimate the total amount of health care spending on acute care for the nonelderly. Full implementation of the ACA with a mandate would increase government spending from

Table 2. New Health Care Spending of the Government, Employers, Individuals, and Uncompensated Care - Acute Care, Nonelderly (in billions)

	Without Reform	ACA With Mandate	ACA Without Mandate, Robust Exchange Enrollment		ACA Without Mandate, Low Exchange Preference		ACA Without Mandate, Low Exchange Preference, Low Subsidy Take-Up	
	$	$	$	Δ Mandate	$	Δ Mandate	$	Δ Mandate
Government	$253	$340	$330	-$10	$327	-$14	$315	-$26
Employer	$529	$540	$507	-$34	$511	-$30	$515	-$26
Individual	$360	$371	$342	-$29	$346	-$25	$342	-$30
Uncompensated Care	$78	$39	$59	$20	$59	$21	$61	$23

Source: Urban Institute analysis, HIPSM 2011.

$253 billion without reform to $340 billion. Aggregate employer and individual spending would each increase by $11 billion to $540 billion and $371 billion, respectively. Uncompensated care, paid for by federal, state, and local governments as well as health care providers, would decrease by 50 percent from $78 billion to $39 billion.[12]

Without the mandate, we would see aggregate decreases in government, employer, and individual spending due to lower health insurance coverage. However, costs do not decrease proportionally with declines in coverage. With the mandate, we would see a decrease in uninsurance of 48 percent (Table 1) relative to current levels, with an increase in government costs of 34 percent. Without the mandate, uninsurance would decrease by 21 percent relative to no reform with an increase in government spending of 30 percent. The government would spend about 3 percent less for less than half the increase in coverage. Additionally, removing the mandate would mean $20 billion more in uncompensated care provided to the uninsured.

We would continue to see decreases in aggregate government, employer, and individual spending as exchange participation falls. Government spending would decrease to $327 billion with a lower exchange preference and $315

billion, or 8 percent, when also lowering subsidy take-up. Uncompensated care would remain relatively constant across the exchange participation levels, changing by roughly the same percentages as the uninsured (Table 1).

The mandate, or lack thereof, may affect the federal government's ability to achieve uncompensated care savings. Fewer uninsured means less spending on uncompensated care, but this does not automatically translate into government savings. About 35 percent of uncompensated care is paid for by the federal government.[13] The two largest sources of federal funding for uncompensated care are Medicaid and Medicare Disproportionate Share Hospital (DSH) payments. Under the ACA, federal Medicaid DSH payments will not decrease until a state's uninsurance rate decreases by 45 percent, which is unlikely to happen without an individual mandate (Table 1), compromising this potential cost offset for the federal government.

Spending – Government

In Table 3, we take a more detailed look at government spending on acute care for the nonelderly. Full implementation of the ACA with a mandate would result in $306 billion in Medicaid/CHIP spending on acute care for the nonelderly, an increase of approximately $50 billion relative to expenditures absent reform. The government would spend a little under $37.5 billion on premium and

cost sharing subsidies in the exchange. Employer subsidies would total $3.8 billion, although those costs would be largely offset by government revenue from employer penalties. There would be modest government revenue of $3.4 billion from individual mandate penalties.

Removing the mandate from the ACA would result in lower costs across the board, because fewer people would have health insurance. Lower take-up of Medicaid and CHIP without a mandate would reduce spending by approximately $6 billion. Without a mandate but with robust exchange participation, government spending on premium and cost-sharing subsidies in the exchange would be about $6 billion less than under the ACA with a mandate. There would be about 2 million fewer people enrolled in subsidized coverage (Table 1). However, the amount of subsidies paid per enrollee would be more than $700 higher (Table 3) as a result of higher premiums in the exchange. We will examine changes in premiums below. There would also be an increase in employer penalties, while employer subsidies would decrease slightly.

Government spending would decrease slightly with lower exchange enrollment. Compared to the ACA without a mandate with robust exchange enrollment, both Medicaid and premium subsidy expenditures would remain relatively constant with a lower exchange

Table 3. Health Care Spending of the Government

	Without Reform	ACA With Mandate	ACA Without Mandate, Robust Exchange Enrollment		ACA Without Mandate, Low Exchange Preference		ACA Without Mandate, Low Exchange Preference, Low Subsidy Take-Up	
	$	$	$	Δ Mandate	$	Δ Mandate	$	Δ Mandate
Government Spending (in millions)								
Medicaid/CHIP[a]	$252,560	$306,000	$300,510	-$5,490	$299,340	-$6,660	$298,060	-$7,940
Premium subsidies	$0	$32,767	$27,886	-$4,880	$27,370	-$5,397	$17,170	-$15,596
Cost-sharing subsidies	$0	$4,703	$3,836	-$867	$3,192	-$1,511	$2,430	-$2,273
Employer subsidies	$0	$3,794	$3,515	-$278	$2,629	-$1,164	$2,734	-$1,060
Individual Mandates	$0	-$3,414	$0	$3,414	$0	$3,414	$0	$3,414
Employer Penalties	$0	-$3,457	-$5,675	-$2,218	-$5,675	-$2,218	-$5,677	-$2,220
Net government spending	$252,560	$340,391	$330,073	-$10,319	$326,856	-$13,536	$314,717	-$25,675
Avg. Subsidy Amount	$0	$4,426	$5,145	$719	$5,510	$1,084	$5,414	$988

Source: Urban Institute analysis, HIPSM 2011.   [a] Spending on acute care for the non-elderly.

Table 4. Average Premium Per Covered Life, Average Age, and Tobacco Use Rate Among Adults in the Nongroup Market[a]

	ACA With Mandate	ACA Without Mandate, Robust Exchange Enrollment		ACA Without Mandate, Low Exchange Preference		ACA Without Mandate, Low Exchange Preference, Low Subsidy Take-Up	
	$	$	Δ Mandate	$	Δ Mandate	$	Δ Mandate
Avg. Premium Per Covered Life							
Total Nongroup	$5,100	$5,600	10%	$5,700	12%	$6,100	20%
Non-Exchange	$4,900	$5,100	4%	$5,400	10%	$5,600	14%
Exchange	$5,200	$5,700	10%	$5,900	13%	$6,500	25%
Percent Aged 45 and Older							
Total Nongroup	37.1%	42.5%	---	42.0%	---	42.8%	---
Non-Exchange	25.5%	28.2%	---	32.3%	---	30.3%	---
Exchange	39.0%	44.9%	---	49.4%	---	55.4%	---
Tobacco Use Rate Among Adults							
Total Nongroup	13.4%	12.4%	---	12.2%	---	11.7%	---
Non-Exchange	9.8%	8.2%	---	9.6%	---	9.4%	---
Exchange	14.0%	13.0%	---	14.0%	---	13.7%	---

Source: Urban Institute analysis, HIPSM 2011.   [a] Averaged over all benefit levels in the exchanges.

preference, decreasing by $1.2 billion and $0.5 billion respectively. Enrollment in Medicaid and subsidized coverage is only modestly lower (Table 1), so the differences in cost are small.

Government spending would fall further if subsidy take-up was also lower than in the robust participation scenario. Government spending on premium and cost-sharing subsidies would total only $19.6 billion, a little over 50 percent of the same expenditure category under full implementation of the ACA with a mandate. The subsidized population would be 60 percent lower than with a mandate (Table 1), while the average subsidy dollars per enrollee would be about $1,000 higher than with a mandate.

Premiums

In Table 4, we show estimated premiums in the nongroup market under the four scenarios. With a mandate, average premiums in the total nongroup market would be $5,100; premiums would be slightly higher in the exchange, $5,200 on average, than outside it ($4,900 on average). Without a mandate, but with robust exchange participation, overall nongroup premiums rise about 10 percent due to

adverse selection. We observe a similar increase in the nongroup exchange premiums, which would rise to $5,700. The effects of adverse selection in the exchange are mitigated by the large subsidized population (Table 1). Removing the mandate has a much smaller effect on premiums in the nongroup market outside the exchange, where premiums would only rise by about 4 percent.

A natural question is how nongroup premiums inside and outside the exchange can change at different rates when there is risk adjustment between them. Nongroup premiums are rated by age and tobacco use.[14] Different distributions of enrollees who vary on these characteristics can lead to very different average premiums. The premium charged to a 64-year-old may be up to three times that charged to the youngest adult, and premiums charged to tobacco users can be up to 1.5 times the premiums charged to a non-tobacco user of the same age.[15] Subsidies are higher for older adults, since the premium charged to a subsidy-eligible enrollee in the exchange is capped at a percent of family income. Not so with tobacco use rating; the additional premium cost for tobacco users is not subsidized by the

government, leading to a substantial out-of-pocket cost for the affected families (low-income or not).

Under all reform scenarios, nongroup exchange enrollees are older and use tobacco at a higher rate than those covered by nongroup policies outside the exchange (Table 4). Those covered outside the exchange in the nongroup market consist mostly of those who were in the nongroup market before guaranteed issue, modified community rating, and other market reforms were implemented.[16] These would be healthier than the population in general because they passed the former restrictions on access to coverage. Most of those in the exchange would be eligible for subsidies, and low income is associated with higher tobacco use.

Without the mandate, the share of covered lives aged 45 and older rises from 26 to 28 percent outside the exchange, and from 39 to 45 percent in the exchange. The greater rise in in the share of enrollees over age 45 inside the exchange is the reason why the average exchange premium rises 10 percent in the exchange, but only 5 percent outside it. In Table 5, we show how health care costs vary by age, listing average single nongroup

Table 5. Average Single Nongroup Premium by Age Category

	ACA With Mandate
18-24	$3,000
25-34	$3,900
35-44	$4,100
45-54	$6,200
55-64	$8,700

Source: Urban Institute analysis, HIPSM 2011.

premiums for non-tobacco users by age group. The difference between the 18 to 24 and 35 to 44 categories is about $1,100, while the premium for ages 55 to 64 is more than twice that for 35- to 44-year-olds. Thus, even moderate changes in the share of enrollees 45 and older can lead to substantial changes in the average premium.

The share of tobacco users with nongroup coverage would be lower without a mandate than with one, as more tobacco users are discouraged from obtaining insurance coverage once the requirement is removed because of the additional premium cost (data not shown). Since the full premium for tobacco users would be up to 50 percent higher than for a non-tobacco user of the same age, small differences in the share of tobacco users can change the average premium noticeably.

Adverse selection would increase as exchange participation falls. Premiums in the nongroup exchange would rise by 13.5 percent with a low exchange preference relative to a full implementation of the ACA with a mandate; nongroup non-exchange average premiums would rise by just over 10 percent. The growth rates inside and outside the exchange are much closer because this scenario moves a number of higher-cost people previously enrolled in the exchange to non-exchange policies.

When we simulate low subsidy take-up, average nongroup premiums would rise 20 percent. Nongroup exchange premiums would rise by 25 percent. Not only does this mean higher premiums for those not eligible for subsidies, but

the federal government would have to pay more premium subsidies for each subsidized enrollee. This increase would be high enough that some plans might be discouraged from participating in the exchange, particularly when, in addition, 55 percent of those covered in the exchange would be aged 45 or older. The differential between growth rates inside versus outside the exchange increase without a large subsidized population to mitigate adverse selection in the exchange. Nongroup premiums outside the exchange would also rise, but at the lower rate of 14 percent.

Discussion

With an individual mandate, our model predicts that the number of uninsured would fall from 50 million to 26 million under health reform. Without the mandate, 40 to 42 million would be left uninsured under reform. Even though the gain in coverage under reform is cut by more than half, the government would only spend 3 to 8 percent less on acute care for the nonelderly. Reductions in uncompensated care, paid on behalf of the uninsured by taxpayers and health care providers, would also be much smaller without a mandate. Also, the reduction in Medicaid Disproportionate Share Hospital (DSH) payments in the ACA is conditional on a 45 percent reduction in the uninsured. Without a mandate, this condition may not be met, in which case there would be no Medicaid DSH savings to the federal government.

The Medicaid expansion clearly does not need the individual mandate to increase coverage; experience with previous expansions and the CHIP program has demonstrated that. Also, the lack of an individual mandate is unlikely to undermine coverage in the small group market. An exchange for small businesses currently operates in Utah without a mandate, and there is a history of such entities operating over time.[17] The small group market is already guaranteed issue by federal law, and is subject to rate bands in many states. In New York, for example, the small group market is community-rated like the nongroup

market, but the small group market has not seen the substantial decline in enrollment that the nongroup market has. In fact, 50.6 percent of New York small businesses offer coverage, much higher than the national average of 39.2 percent.[18] The effects of not having an individual mandate or an effective equivalent will be most pronounced in the nongroup market.

Given the debate over the legality of the individual mandate, several alternatives have been discussed. The Government Accountability Office (GAO) released a thorough report on various mandate alternatives including, but not limited to, the following[19]: Insurers commonly limit enrollment to certain specified periods in order to help reduce adverse selection. Increasing the time interval between open enrollment periods, currently one year[20], has been proposed as a potential substitute for the individual mandate. In the same vein, take-up could be incentivized by providing only limited or penalized coverage options between open enrollment periods. Alternatively, the individual mandate could be removed in favor of a tax on all taxpayers that is waived with proof of health insurance. In another proposal, the mandate could be removed, and instead, the government could make certain services conditional on having health insurance, such as a college loan, or receiving certain tax breaks.[21] These options each have their advantages and disadvantages, but there is little evidence on which to model their effectiveness.

Making subsidies more generous would increase take-up, but the barriers to exchange enrollment and limitations of outreach simulated in our last two scenarios would still be problematic regardless of subsidy amounts. Also, increasing subsidy amounts would not necessarily reduce adverse selection. It could attract those with higher health costs, depending on how the subsidies were restructured.[22]

Barring any effective equivalent for the mandate, the nongroup market would avoid substantial adverse selection under

the ACA market reforms only with a large number of modest-income persons enrolled in subsidized coverage. There is a genuine risk that low initial exchange enrollment could start an adverse selection cycle. Under our low subsidy take-up scenario, exchange premiums would rise 25 percent compared to the scenario with a mandate in place. The population enrolled in the exchange would have higher health risk than the population in the nongroup market outside the exchange in this scenario. In particular, a majority of those enrolled in the nongroup exchange would be age 45 or older.

There would be risk adjustment between plans inside and outside the exchange, but risk adjustment methods may not be effective enough to completely eliminate risk selecting behavior by insurers. We have modeled risk adjustment as if it would do so; if actual risk adjustment were less effective, it would increase exchange premiums beyond these estimates and expose plans in the exchange to greater risk. Such differential risk would be likely to discourage some plans from participating in the exchange. Those individuals currently in the nongroup market would be particularly

likely to stay outside the exchange. Also, if low exchange enrollment continues after 2019, there will be an additional problem in that subsidy amounts would be indexed based on the rate of income growth. Historically, premiums have grown faster than income. Thus, those in subsidized coverage would pay an increasing share of their incomes in premiums, further discouraging enrollment. As such, the nongroup exchange may not be viable in some states without an individual mandate.

Endnotes

1 Buettgens M, Garrett B, and Holahan J. "Why the Individual Mandate Matters." Washington, DC: The Urban Institute, 2010, http://www.urban.org/health_policy/url.cfm?ID=412280.

2 In New York about 160,000 people below 250 percent of poverty obtain coverage through the Healthy NY program. Coverage is indirectly subsidized by substantial reinsurance funded by the state and benefit standards are lower, so premiums are far lower. Most purchase nongroup policies, so this is essentially an additional nongroup market.

3 Dorn S, Hill I, and Hogan S. "The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage." Washington, DC: The Urban Institute, 2009, http://www.urban.org/health_policy/url.cfm?ID=411987.

4 For more about HIPSM and a list of recent research using it, see http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf. In addition, detailed technical documentation is available: HIPSM Methodology, 2011 National Version, Washington, DC: The Urban Institute, 2011, http://www.urban.org/health_policy/url.cfm?ID=412471.

5 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.

6 Buettgens M, Garrett B, and Holahan J. "America under the Affordable Care Act." Washington, DC: The Urban Institute, 2010, http://www.urban.org/url.cfm?ID=412267.

7 HIPSM Methodology Documentation, 2011, pp. 15-18.

8 Long SK, Cook A, and Stockley K. "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 The predecessor model to HIPSM was used in the development of the Massachusetts health reform law. Predictions of the change in the uninsured due to the law proved to be accurate, though there were differences between the law as finally enacted and the provisions we simulated. Blumberg LJ, Holahan J, Weil A, et al. "Toward Universal Coverage in Massachusetts," *Inquiry* 43(2): 102–121, Summer 2006, http://www.inquiryjournalonline.org/inqronline/?request=get-abstract&issn=0046-9580&volume=043&issue=02&page=0102.

10 Also, small firms were defined as those of up to 100 workers (FTEs). All states must use this definition beginning in 2016, though most currently use a threshold of 50 workers. This is *not* a change from earlier HIPSM modeling.

11 For a discussion comparing earlier HIPSM and CBO estimates, see Buettgens et al. "America Under the Affordable Care Act.

12 We list uncompensated care separately because it is difficult to allocate precisely between providers and the various levels of government. Also, payments to providers from government programs used to fund uncompensated care do not necessarily correspond to the amount of uncompensated care consumed. We model the latter, without attempting to reproduce the details of diverse payment programs. For details on how uncompensated cares is funded, see Hadley J, Holahan J, Coughlin T, and Miller D. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs." *Health Affairs* Web Exclusive, August 25, 2008.

13 Hadley at el.

14 We take our indicator of tobacco use from the Medical Expenditure Panel Survey, which is also our primary source for health care costs.

15 The 3:1 age and 1.5:1 tobacco use ratios in the law are maxima; a state could choose to implement lower ratios.

16 This does not apply to certain states such as New York which have already introduced modified community rating and/or guaranteed issue into their markets.

17 *Cooperatives Offer Small Employers Plan Choice and Market Prices.* GAO/HEHS-00-49. Washington, DC: General Accounting Office, Report to the Chairman, Committee on Commerce, House of Representatives, 2000, http://www.gao.gov/archive/2000/he00049.pdf.

18 MEPS-IC Summary Table II.A.2 (2010). http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables.jsp.

19 *Private Health Insurance Coverage: Expert Views on Approaches to Encourage Voluntary Enrollment.* GAO-11-392R. Washington, DC: Government Accountability Office, 2011, http://www.gao.gov/new.items/d11392r.pdf.

20 *Compilation of Patient Protection and Affordable Care Act.* Washington, DC: Office of the Legislative Council, House of Representatives, 2011, http://docs.house.gov/energycommerce/ppacacon.pdf.

21 Steuerle, EC. "Health Care Brawl: All or Nothing Doesn't Work." The *Fiscal Times*, January 17, 2011, http://www.urban.org/publications/901401.html.

22 For example, increased cost sharing subsidies would be most valuable to those who expect to consume more health care. Since out-of-pocket premiums for subsidized coverage would vary only by income and tobacco use, the benefits of higher premium subsidies would not be as clearly targeted.

About the Authors and Acknowledgments

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.

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 nearly 40 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 healthy lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org.