

How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs?

Linda J. Blumberg

Institute Fellow, Health Policy Center
Urban Institute

Matthew Buettgens

Senior Fellow, Health Policy Center
Urban Institute

John Holahan

Institute Fellow, Health Policy Center
Urban Institute

ABSTRACT

ISSUE: The Tax Cuts and Jobs Act of 2017 eliminated the financial penalty of the Affordable Care Act's individual mandate. States could reinstate a similar penalty to encourage health insurance enrollment, ensuring broad sharing of health care costs across healthy and sick populations to stabilize the marketplaces.

GOAL: To provide state-by-state estimates of the impact on insurance coverage, premiums, and mandate penalty revenues if the state were to adopt an individual mandate.

METHODS: Urban Institute's Health Insurance Policy Simulation Model (HIPSM) is used to estimate the coverage and cost impacts of state-specific individual mandates. We assume each state adopts an individual mandate similar to the ACA's.

FINDINGS AND CONCLUSION: If all states implemented individual mandates, the number of uninsured would be lower by 3.9 million in 2019 and 7.5 million in 2022. On average, marketplace premiums would be 11.8 percent lower in 2019. State mandate penalty revenues would amount to \$7.4 billion and demand for uncompensated care would be \$11.4 billion lower. The impact on coverage and on premiums varies in significant ways across states. For example, in 2019, the number of people uninsured would be 19 percent lower in Colorado and 10 percent lower in California if they implemented their own mandates. With mandates in place, average premiums would be 4 percent lower in Alaska and 15 percent lower in Washington.

KEY TAKEAWAYS

- ▶ States can implement their own individual insurance mandates to replace the federal mandate, as Massachusetts and New Jersey have done already. If all remaining states implemented individual mandates, the number of uninsured would fall by 3.9 million in 2019 and 7.5 million in 2022.
- ▶ With individual mandates in place in every state, marketplace premiums would fall by 11.8 percent on average in 2019.
- ▶ Changes in health insurance coverage and premium rates would vary by state. Premiums would decrease by 21 percent in New Mexico but by less than 5 percent in Alaska. The number of uninsured people would decrease by 19 percent in Colorado and by 10 percent in California.



The
Commonwealth
Fund

A Century of Advancing Health Care for All



BACKGROUND

One of the Affordable Care Act's central aims was to reform insurance markets by sharing health care risks and costs more broadly across the healthy and sicker populations. Strategies to accomplish this goal include modified community rating, guaranteed issue, and benefit standards, with the greatest changes made to nongroup insurance markets. Spreading risks tends to decrease costs for people with medical needs and increase them for healthy people. As a consequence, financial incentives to become and remain insured regardless of health status are necessary to ensure the risk pool is large and stable. The ACA established the individual responsibility requirement — also referred to as the individual mandate — to require most people to enroll in minimum essential health care coverage or pay a tax penalty. The Tax Cut and Jobs Act of 2017 sets the ACA's penalties for individuals who remain uninsured to \$0, beginning in 2019.

The Congressional Budget Office (CBO) estimated that eliminating the individual mandate penalties would lead to an additional 3 million uninsured people in 2019.¹ It also estimated that premiums in the nongroup insurance market will increase by 15 percent between 2018 and 2019. Because of the elimination of mandate penalties, fewer healthy people are estimated to enroll in nongroup insurance; thus, the average nongroup insurance enrollee will be more likely to have higher health care expenses. As a result, premiums will be higher. Other pending changes, such as expansion of short-term, limited-duration plans, are expected to worsen the nongroup risk pool and increase premiums as well. The changes, taken together, may lead to some insurers ending or limiting their participation in ACA-compliant nongroup insurance markets.² Acting on these concerns, some states have considered or passed legislation to implement state-specific individual mandates.³ New Jersey enacted its individual mandate on May 30, 2018;⁴ Massachusetts did so in 2006, well before the passage of the ACA.

This analysis provides estimates of the effects of state-specific individual mandates on insurance coverage, nongroup insurance premiums, federal and state government spending (including penalty revenue to states), and demand for uncompensated care. Findings

are provided nationally as if every state adopted its own individual mandate and for 48 states and the District of Columbia (but excluding Massachusetts and New Jersey because they have their own mandates under current law), assuming each state adopts a penalty structure similar to that of the ACA. We do not anticipate every state taking this approach, but present findings this way for ease of exposition and as a reference point for understanding the effects of the mandate. (A full description of our methods is available [below](#).)

KEY FINDINGS

Our central estimates assume that state mandates are implemented in each state as soon as the federal penalties are eliminated in 2019. The effect of a mandate grows over time as health care costs grow relative to incomes; we show some of our results in 2022 to illustrate this. State mandates would have two central effects. First, more people would retain insurance coverage to avoid the penalty. Second, premiums in the nongroup market would be lower because the insurance pool will not lose healthy people that would otherwise drop their coverage without a mandate. As a result, even more people will enroll because of the lower premiums.

National Distribution of Health Insurance Coverage, 2019

If all states adopted a mandate, the number of uninsured would fall by 3.9 million people, a decrease of 11.4 percent (Exhibit 1). The uninsured rate would decline from 12.4 percent of the nonelderly (i.e., under age 65) to 11.0 percent. About 452,000 additional people would enroll in employer-sponsored insurance (through their own employer or a family member's) with the mandates in place. Another 1.2 million people would enroll in nongroup coverage with subsidies. Another 1.7 million people would enroll in marketplace or nonmarketplace nongroup coverage without federal subsidies. Finally, 623,000 additional people would enroll in Medicaid or the Children's Health Insurance Program (CHIP). In most cases, these will be children; when parents apply for marketplace coverage, they find out their children are eligible for Medicaid or CHIP. (See [box](#) below for comparison with CBO estimates.)

Exhibit 1. Health Insurance Coverage Distribution of the Nonelderly (thousands of people), 2019 Current Law Compared to Scenario with Individual Mandate Adopted in Each State

	Current law		With state individual mandates		Change	Percentage-point change
Insured	240,186	87.6%	244,093	89.0%	3,907	1.4%
Employer	148,665	54.2%	149,117	54.4%	452	0.2%
Nongroup (with tax credits)	7,999	2.9%	9,152	3.3%	1,153	0.4%
Nongroup (without tax credits)	6,005	2.2%	7,684	2.8%	1,679	0.6%
Medicaid/CHIP	68,944	25.1%	69,567	25.4%	623	0.2%
Other (including Medicare)	8,574	3.1%	8,574	3.1%	0	0.0%
Uninsured	34,130	12.4%	30,223	11.0%	-3,907	-1.4%
Total	274,316	100.0%	274,316	100.0%	0	0.0%

Data: Urban Institute analysis of its Health Insurance Policy Simulation Model (HIPSM) 2018. Reform simulated in 2019.

Health Insurance Coverage by Income, 2019

For people with incomes below 138 percent of the federal poverty level,⁵ the number of uninsured would fall by 582,000 people, or 3.8 percent, with the state mandates in place (Exhibit 2). The relatively small effect in this group, a 0.7 percentage-point drop in the share of nonelderly people uninsured, occurs because most people in this cohort are eligible for Medicaid or large marketplace subsidies, depending on where they live. Since they are eligible for free or very-low-cost insurance with minor or no out-of-pocket requirements and most are exempt from the individual mandate because of income level, they are the least likely to drop coverage when the federal penalties end and the least likely to take it up when a state penalty is put in place.

Among people with incomes between 138 percent and 400 percent of poverty, 1.8 million fewer people would be uninsured with the state mandates in place, a reduction of 12.7 percent. People in this income group are eligible for marketplace subsidies in every state if no one in the

family has access to affordable employer coverage, they are not eligible for other public health insurance, and they are legal residents. About two-thirds of the 1.8 million additional insured would take up nongroup insurance coverage. The remainder would be roughly split between people enrolling in Medicaid or CHIP (mostly children who would enroll in CHIP) and employer-sponsored insurance. People who are only eligible for smaller marketplace subsidies — that is, those at the higher end of the income scale — or ineligible for subsidies are the most likely to be affected by a mandate, meaning they are most likely to become uninsured or face significantly larger premiums to retain coverage.

For those with incomes above 400 percent of poverty, 1.5 million fewer people would be uninsured with the state mandates in place, a decrease of 33.4 percent. In this income group, about 78 percent of the otherwise uninsured would take up nongroup insurance coverage with the state mandates. Almost all of the remainder would enroll in employer-sponsored insurance coverage.

Exhibit 2. Distribution of Health Insurance Coverage (thousands of people) by Income Group, 2019
Current Law Compared to Scenario with Individual Mandate Adopted in Each State

Panel A. Nonelderly with Income Under 138% FPL

	Current law		With state individual mandates		Change	Percentage-point change
Insured	72,529	82.5%	73,112	83.1%	582	0.7%
Employer	13,768	15.7%	13,608	15.5%	-161	-0.2%
Nongroup (with tax credits)	1,806	2.1%	2,085	2.4%	279	0.3%
Nongroup (without tax credits)	683	0.8%	868	1.0%	185	0.2%
Medicaid/CHIP	53,522	60.9%	53,802	61.2%	279	0.3%
Other (including Medicare)	2,750	3.1%	2,750	3.1%	0	0.0%
Uninsured	15,421	17.5%	14,838	16.9%	-582	-0.7%
Total	87,950	100.0%	87,950	100.0%	0	0.0%

Panel B. Nonelderly with Income of 138%–400% FPL

	Current law		With state individual mandates		Change	Percentage-point change
Insured	90,572	86.5%	92,373	88.2%	1,801	1.7%
Employer	64,927	62.0%	65,219	62.3%	292	0.3%
Nongroup (with tax credits)	6,193	5.9%	7,067	6.7%	874	0.8%
Nongroup (without tax credits)	1,676	1.6%	1,976	1.9%	300	0.3%
Medicaid/CHIP	13,904	13.3%	14,239	13.6%	335	0.3%
Other (including Medicare)	3,872	3.7%	3,872	3.7%	0	0.0%
Uninsured	14,147	13.5%	12,346	11.8%	-1,801	-1.7%
Total	104,719	100.0%	104,719	100.0%	0	0.0%

Panel C. Nonelderly with Income Above 400% FPL

	Current law		With state individual mandates		Change	Percentage-point change
Insured	77,084	94.4%	78,608	96.3%	1,524	1.9%
Employer	69,969	85.7%	70,290	86.1%	321	0.4%
Nongroup (with tax credits)	0	0.0%	0	0.0%	0	0.0%
Nongroup (without tax credits)	3,646	4.5%	4,841	5.9%	1,195	1.5%
Medicaid/CHIP	1,517	1.9%	1,526	1.9%	9	0.0%
Other (including Medicare)	1,952	2.4%	1,952	2.4%	0	0.0%
Uninsured	4,563	5.6%	3,039	3.7%	-1,524	-1.9%
Total	81,647	100.0%	81,647	100.0%	0	0.0%

Data: Urban Institute analysis of its Health Insurance Policy Simulation Model (HIPSM) 2018. Reform simulated in 2019.

Note: FPL = federal poverty level.

Health Insurance Coverage by State, 2019

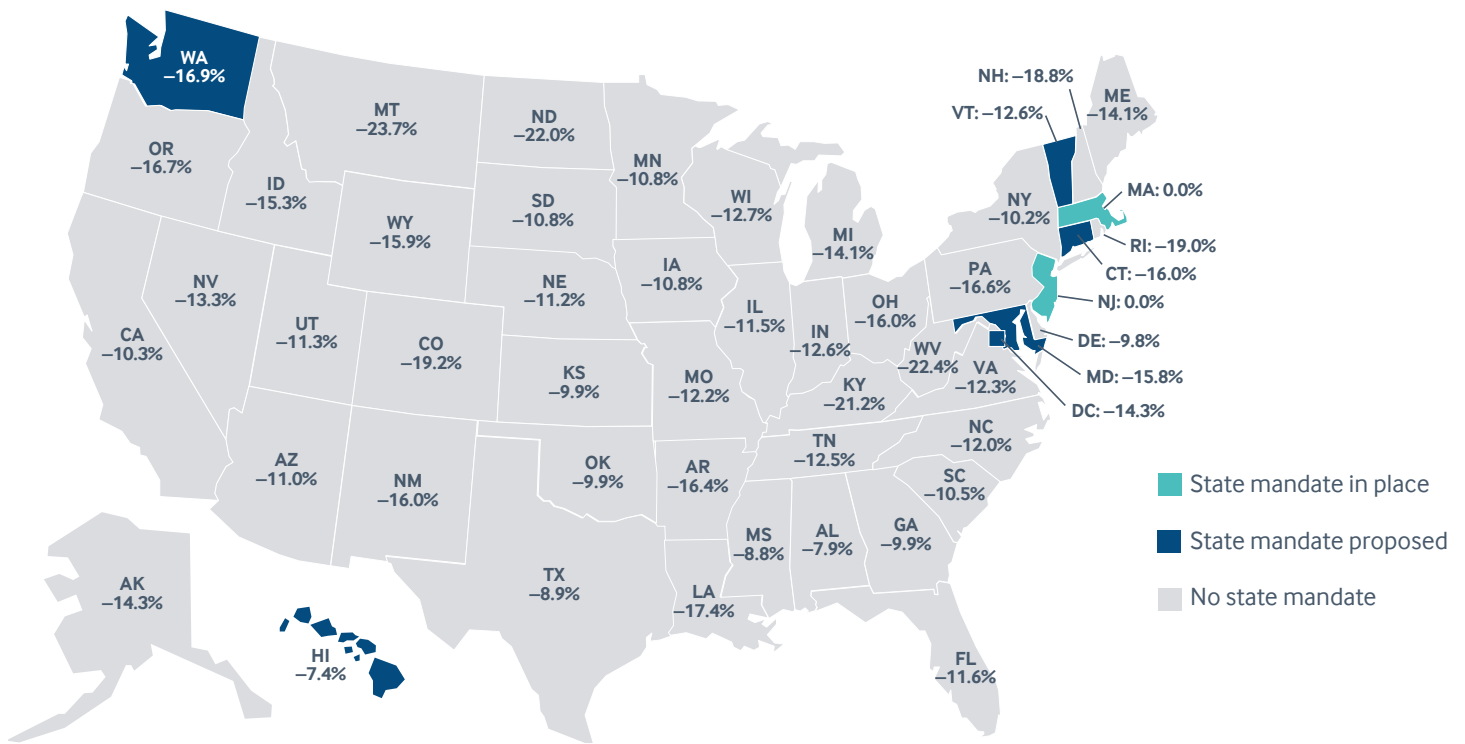
With its own mandate in place, California would see a reduction of 389,000 uninsured (10.3%) in 2019 (Exhibits 3 and 4). About 60 percent of this decrease is attributable to otherwise uninsured people enrolling in nongroup coverage. There also would be an increase in Medicaid and CHIP coverage of 167,000 people.

In New York, the number of uninsured would fall by 142,000, with the bulk coming from people taking up nongroup coverage. The effect in New York is smaller in percentage terms than in many other states because the state offers the Essential Plan (a Basic Health Program), with lower premiums and cost-sharing for people between 138 percent and 200 percent of poverty. This plan already encourages greater retention of coverage, regardless of mandates.

In Texas, the number of uninsured people would fall by 483,000. We estimate that 410,000 more people would enroll in nongroup coverage, and 48,000 more would enroll in employer coverage. Texas has not expanded Medicaid eligibility under the ACA and has not aggressively undertaken marketplace outreach and enrollment assistance. As a result, coverage gains have been smaller than average. The effects of reinstating the mandate would be relatively small as well.

Beyond Massachusetts and New Jersey, two states — Hawaii and Vermont — and the District of Columbia have explored implementing their own individual mandates. They would see reductions in the number of uninsured residents of 8,000, 4,000, and 5,000, respectively.

Exhibit 3. Percent Change in Number of Uninsured Following Implementation of a State Individual Mandate, 2019



Data: Urban Institute analysis of its Health Insurance Policy Simulation Model (HIPSM) 2018. Reform simulated in 2019.

Note: New Jersey and Vermont have both recently passed legislation; Vermont’s legislation requires specification of the penalties during the course of 2019 with implementation in 2020. Connecticut, the District of Columbia, Hawaii, Maryland, and Washington have all considered or are continuing to consider their own legislation. See Dania Palanker, Rachel Schwab, and Justin Giovannelli, “State Efforts to Pass Individual Mandate Requirements Aim to Stabilize Markets and Protect Consumers,” *To the Point* (blog), Commonwealth Fund, June 14, 2018.

Exhibit 4. Difference and Percent Difference in Insurance Coverage (by type of coverage) by State, (thousands of people), 2019

Current Law Compared to Scenario with Individual Mandate Adopted in Each State

	Employer		Nongroup		Medicaid and CHIP		Uninsured	
	Difference from current law	Percent difference from current law	Difference from current law	Percent difference from current law	Difference from current law	Percent difference from current law	Difference from current law	Percent difference from current law
Alabama	2	0.1%	42	24.4%	5	0.5%	-48	-7.9%
Alaska	3	0.7%	10	70.9%	2	1.0%	-14	-14.3%
Arizona	22	0.7%	67	36.7%	8	0.5%	-97	-11.0%
Arkansas	4	0.3%	23	31.1%	11	1.2%	-38	-16.4%
California	-10	-0.1%	232	12.8%	167	1.4%	-389	-10.3%
Colorado	15	0.6%	54	27.9%	32	2.5%	-101	-19.2%
Connecticut	8	0.4%	17	12.0%	8	1.1%	-33	-16.0%
Delaware	0	0.1%	6	21.8%	1	0.5%	-7	-9.8%
District of Columbia	2	0.7%	1	6.7%	2	1.1%	-5	-14.3%
Florida	24	0.3%	221	12.7%	63	1.7%	-307	-11.6%
Georgia	11	0.2%	158	34.2%	13	0.7%	-182	-9.9%
Hawaii	1	0.2%	7	18.1%	0	0.0%	-8	-7.4%
Idaho	4	0.5%	24	21.5%	7	2.3%	-35	-15.3%
Illinois	26	0.4%	102	20.4%	15	0.6%	-143	-11.5%
Indiana	9	0.3%	63	32.2%	6	0.5%	-78	-12.6%
Iowa	4	0.2%	15	18.7%	2	0.4%	-21	-10.8%
Kansas	4	0.3%	31	24.6%	2	0.4%	-38	-9.9%
Kentucky	10	0.5%	28	26.5%	15	1.1%	-53	-21.2%
Louisiana	8	0.4%	42	30.2%	15	1.1%	-65	-17.4%
Maine	1	0.1%	13	19.8%	1	0.3%	-15	-14.1%
Maryland	10	0.3%	43	19.3%	16	1.3%	-69	-15.8%
Michigan	11	0.2%	83	21.7%	-4	-0.2%	-90	-14.1%
Minnesota	17	0.5%	34	19.7%	-4	-0.5%	-46	-10.8%
Mississippi	2	0.2%	35	47.2%	2	0.3%	-40	-8.8%
Missouri	9	0.3%	63	25.1%	13	1.3%	-86	-12.2%
Montana	1	0.2%	9	17.9%	9	3.5%	-19	-23.7%
Nebraska	5	0.5%	18	17.1%	1	0.3%	-23	-11.2%
Nevada	5	0.3%	35	35.2%	14	2.2%	-54	-13.3%
New Hampshire	2	0.3%	13	26.5%	1	0.5%	-16	-18.8%
New Mexico	5	0.7%	18	35.8%	11	1.5%	-34	-16.0%
New York	49	0.5%	93	8.0%	0	0.0%	-142	-10.2%
North Carolina	12	0.3%	122	24.6%	41	2.0%	-174	-12.0%
North Dakota	3	0.9%	7	16.4%	1	1.3%	-11	-22.0%
Ohio	21	0.4%	93	30.4%	7	0.3%	-121	-16.0%
Oklahoma	10	0.6%	53	40.2%	3	0.5%	-66	-9.9%
Oregon	11	0.6%	34	21.6%	8	0.8%	-53	-16.7%
Pennsylvania	23	0.4%	98	20.4%	1	0.1%	-123	-16.6%
Rhode Island	1	0.2%	7	16.6%	3	1.0%	-11	-19.0%
South Carolina	0	0.0%	56	28.1%	13	1.5%	-70	-10.5%
South Dakota	3	0.7%	9	21.4%	0	0.3%	-12	-10.8%
Tennessee	4	0.1%	60	24.6%	38	2.7%	-103	-12.5%
Texas	48	0.4%	410	37.2%	25	0.5%	-483	-8.9%
Utah	11	0.6%	29	13.2%	2	0.5%	-42	-11.3%
Vermont	1	0.3%	3	9.6%	0	0.0%	-4	-12.6%
Virginia	19	0.4%	112	26.8%	6	0.6%	-137	-12.3%
Washington	13	0.4%	63	27.8%	28	1.7%	-104	-16.9%
West Virginia	1	0.2%	14	53.8%	9	1.8%	-24	-22.4%
Wisconsin	7	0.2%	48	18.5%	3	0.3%	-58	-12.7%
Wyoming	1	0.5%	11	47.6%	0	0.7%	-13	-15.9%
Total	452	0.3%	2,832	21.3%	623	0.9%	-3,907	-11.7%

Data: Urban Institute analysis of its Health Insurance Policy Simulation Model (HIPSIM) 2018. Reform simulated in 2019.

Note: Table excludes Massachusetts and New Jersey. Massachusetts has its own individual mandate under current law, and New Jersey's individual mandate is expected to go into effect in 2019.

Marketplace Premiums, 2019

Exhibit 5 shows the changes in marketplace premiums by state that would result from each state implementing an individual mandate. We use monthly benchmark single premiums for a 40-year-old to illustrate the effect, although the percentage change in premiums would be the same for any age and any coverage level because of the ACA's fixed age-rating curves and uniform risk pool. On average, the state mandates would reduce marketplace premiums by 11.8 percent if all states adopted the ACA's federal individual mandate structure. The impact of the mandate varies somewhat across states (Exhibit 6). States with larger shares of healthy people who have enrolled in coverage under the ACA because of the mandate will experience larger premium declines if it is reinstated at the state level. For example, states with more people who either receive small tax credits or no credits (based on higher income levels) will tend to have large declines. This is because enrollees who pay the full premium themselves tend to have lower health care expenses than those getting tax credits. In turn, people in better health and those who have to pay more for coverage are most likely to go uninsured without a mandate.

States with the highest marketplace enrollment rates tended to attract healthier enrollees even among those eligible for tax credits. Therefore, the average health care risk of the subsidized populations varies by state and will lead to differential individual mandate effects. Because of their Basic Health Programs, New York and Minnesota can be expected to see less of an effect in their marketplaces if a mandate were implemented. States with small nongroup insurance markets are likely to experience large effects from changes in the number of enrollees. Premiums would decrease by 21.1 percent in New Mexico and by 15 percent or more in Colorado, the District of Columbia, Kentucky, Nevada, North Dakota, Washington, and West Virginia. Premiums would fall by less than 10 percent in Alaska, Hawaii, Minnesota, Mississippi, New York, and Wisconsin.

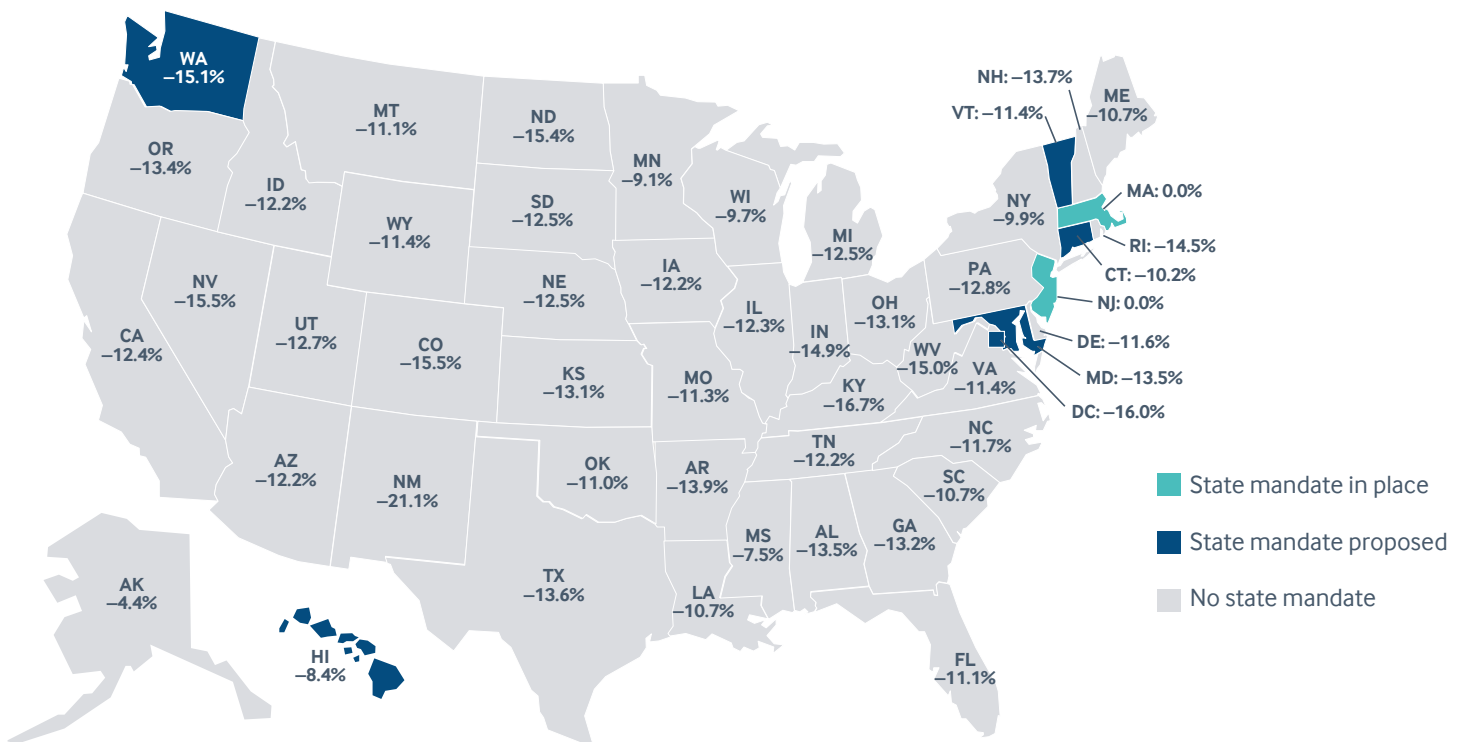
Exhibit 5. Marketplace Monthly Single Premium for a 40-Year-Old Adult, Current Law and with State Individual Mandates, 2019

	Current law	With state individual mandates	Percent change
Alabama	\$630	\$550	-13.5%
Alaska	\$760	\$730	-4.4%
Arizona	\$580	\$510	-12.2%
Arkansas	\$410	\$360	-13.9%
California	\$470	\$410	-12.4%
Colorado	\$510	\$430	-15.5%
Connecticut	\$590	\$530	-10.2%
Delaware	\$670	\$590	-11.6%
District of Columbia	\$360	\$300	-16.0%
Florida	\$530	\$470	-11.1%
Georgia	\$560	\$490	-13.2%
Hawaii	\$500	\$460	-8.4%
Idaho	\$530	\$470	-12.2%
Illinois	\$560	\$490	-12.3%
Indiana	\$390	\$330	-14.9%
Iowa	\$850	\$740	-12.2%
Kansas	\$550	\$480	-13.1%
Kentucky	\$470	\$390	-16.7%
Louisiana	\$540	\$490	-10.7%
Maine	\$630	\$560	-10.7%
Maryland	\$520	\$450	-13.5%
Michigan	\$420	\$360	-12.5%
Minnesota	\$420	\$380	-9.1%
Mississippi	\$540	\$500	-7.5%
Missouri	\$580	\$510	-11.3%
Montana	\$580	\$520	-11.1%
Nebraska	\$860	\$750	-12.5%
Nevada	\$540	\$460	-15.5%
New Hampshire	\$540	\$460	-13.7%
New Mexico	\$490	\$380	-21.1%
New York	\$550	\$490	-9.9%
North Carolina	\$690	\$610	-11.7%
North Dakota	\$360	\$300	-15.4%
Ohio	\$410	\$360	-13.1%
Oklahoma	\$730	\$650	-11.0%
Oregon	\$450	\$390	-13.4%
Pennsylvania	\$590	\$520	-12.8%
Rhode Island	\$360	\$310	-14.5%
South Carolina	\$580	\$520	-10.7%
South Dakota	\$560	\$490	-12.5%
Tennessee	\$830	\$730	-12.2%
Texas	\$460	\$400	-13.6%
Utah	\$620	\$540	-12.7%
Vermont	\$570	\$500	-11.4%
Virginia	\$590	\$530	-11.4%
Washington	\$390	\$330	-15.1%
West Virginia	\$600	\$510	-15.0%
Wisconsin	\$590	\$540	-9.7%
Wyoming	\$970	\$860	-11.4%
Total	\$530	\$470	-11.8%

Data: Urban Institute analysis of its Health Insurance Policy Simulation Model (HIPSM) 2018. Reform simulated in 2019.

Notes: Monthly premium amounts are rounded to the nearest \$10. Table excludes Massachusetts and New Jersey. Massachusetts has its own individual mandate under current law, and New Jersey's individual mandate is expected to go into effect in 2019.

Exhibit 6. Percent Change in Average Nongroup Premium Following Implementation of a State Individual Mandate, 2019



Data: Urban Institute analysis of its Health Insurance Policy Simulation Model (HIPSM) 2018. Reform simulated in 2019.

Note: New Jersey and Vermont have both recently passed legislation; Vermont's legislation requires specification of the penalties during the course of 2019 with implementation in 2020. Connecticut, the District of Columbia, Hawaii, Maryland, and Washington have all considered or are continuing to consider their own legislation. See Dania Palanker, Rachel Schwab, and Justin Giovannelli, "State Efforts to Pass Individual Mandate Requirements Aim to Stabilize Markets and Protect Consumers," *To the Point* (blog), Commonwealth Fund, June 14, 2018.

Federal and State Health Care Spending, 2019

The flow of federal dollars would increase to most states as more people enrolled in Medicaid or took advantage of marketplace premium tax credits (Exhibit 7). In general, with more coverage, there is more federal spending. However, in 21 states, federal spending actually declines if there is a mandate in place because of a decrease in premiums due to healthier people enrolling in nongroup coverage. With a mandate, average premiums would decrease with the entrance of healthier people into the market, and since the premium subsidies are computed based on a standard premium, the average subsidy would fall at the same time. In these 21 states, the lower average premium subsidies offset the fact that larger numbers

of subsidized people enroll and federal spending drops somewhat. As a result, relative to current law, federal health care spending in California would decrease by \$356 million, or 0.7 percent, in Florida by \$690 million or 3 percent, and in Michigan by \$137 million, or 1 percent. On the other hand, Louisiana would see an increase in federal health care spending of \$92 million or 1.3 percent, and Texas would see an increase of \$396 million or 1.4 percent.

Spending for the state-financed portion of Medicaid and CHIP would increase by \$1.1 billion nationally in 2019 (Exhibit 8). The changes in state spending are small in percentage terms across all the states, with 41 states and the District of Columbia experiencing an increase of 1 percent or less.

Exhibit 7. Federal Spending (\$ millions)

Current Law Compared to Scenario with Individual Mandate Adopted in Each State

	Current law			With state individual mandates			Difference	
	Medicaid and CHIP	Tax credits and subsidies	Total federal spending	Medicaid and CHIP	Tax credits	Total federal spending	Total federal spending	Percent change
Alabama	3,695	1,287	4,982	3,718	1,261	4,979	-3	-0.1%
Alaska	1,067	113	1,180	1,076	152	1,227	47	4.0%
Arizona	9,623	830	10,453	9,693	884	10,577	124	1.2%
Arkansas	4,937	258	5,195	4,994	252	5,246	51	1.0%
California	42,738	6,856	49,594	43,239	5,999	49,238	-356	-0.7%
Colorado	5,328	468	5,796	5,413	492	5,905	109	1.9%
Connecticut	4,225	630	4,854	4,256	566	4,822	-32	-0.7%
Delaware	1,222	160	1,382	1,228	153	1,382	-1	0.0%
District of Columbia	1,404	5	1,409	1,417	5	1,422	13	0.9%
Florida	13,777	9,419	23,196	14,020	8,486	22,507	-690	-3.0%
Georgia	7,788	2,884	10,672	7,851	2,924	10,775	103	1.0%
Hawaii	973	124	1,097	974	136	1,110	13	1.2%
Idaho	1,451	519	1,970	1,481	511	1,993	22	1.1%
Illinois	7,735	2,107	9,842	7,791	1,994	9,785	-58	-0.6%
Indiana	8,061	476	8,537	8,110	461	8,571	34	0.4%
Iowa	3,069	536	3,605	3,080	546	3,626	21	0.6%
Kansas	1,455	532	1,987	1,461	559	2,020	32	1.6%
Kentucky	8,356	442	8,798	8,426	453	8,879	81	0.9%
Louisiana	6,736	620	7,357	6,817	632	7,449	92	1.3%
Maine	1,405	535	1,940	1,407	490	1,897	-43	-2.2%
Maryland	6,067	794	6,861	6,120	749	6,869	9	0.1%
Michigan	13,075	1,142	14,216	13,053	1,026	14,080	-137	-1.0%
Minnesota	6,411	432	6,843	6,381	421	6,802	-41	-0.6%
Mississippi	3,964	434	4,398	3,985	554	4,539	141	3.2%
Missouri	6,641	1,484	8,125	6,714	1,574	8,288	163	2.0%
Montana	1,966	362	2,329	2,002	318	2,320	-8	-0.4%
Nebraska	930	936	1,866	932	888	1,821	-45	-2.4%
Nevada	2,815	433	3,248	2,860	413	3,272	25	0.8%
New Hampshire	841	221	1,062	843	207	1,051	-11	-1.0%
New Mexico	4,954	194	5,148	5,014	196	5,211	63	1.2%
New York	23,700	4,418	28,118	23,695	3,919	27,615	-503	-1.8%
North Carolina	11,011	4,006	15,018	11,227	3,948	15,175	157	1.0%
North Dakota	503	56	559	505	50	554	-5	-0.9%
Ohio	13,934	774	14,708	13,977	848	14,826	118	0.8%
Oklahoma	3,419	1,293	4,713	3,432	1,347	4,779	66	1.4%
Oregon	5,605	611	6,216	5,642	590	6,232	16	0.3%
Pennsylvania	14,183	2,337	16,520	14,199	2,137	16,336	-184	-1.1%
Rhode Island	1,148	82	1,230	1,158	71	1,229	-1	-0.1%
South Carolina	3,883	1,273	5,156	3,942	1,335	5,276	120	2.3%
South Dakota	568	217	785	569	211	780	-5	-0.6%
Tennessee	7,180	2,221	9,401	7,346	2,324	9,670	268	2.9%
Texas	24,360	4,856	29,216	24,476	5,136	29,612	396	1.4%
Utah	2,368	1,252	3,619	2,377	1,146	3,524	-96	-2.6%
Vermont	1,148	105	1,254	1,150	89	1,239	-15	-1.2%
Virginia	4,291	2,558	6,848	4,314	2,485	6,798	-50	-0.7%
Washington	7,594	572	8,166	7,710	554	8,264	98	1.2%
West Virginia	2,738	198	2,936	2,775	166	2,941	5	0.2%
Wisconsin	3,931	1,423	5,355	3,937	1,324	5,262	-93	-1.7%
Wyoming	310	257	567	312	272	583	16	2.9%
Total	314,586	63,740	378,327	317,100	61,255	378,354	28	0.0%

Data: Urban Institute analysis of its Health Insurance Policy Simulation Model (HIPSM) 2018. Reform simulated in 2019.

Note: Table excludes Massachusetts and New Jersey. Massachusetts has its own individual mandate under current law, and New Jersey's individual mandate is expected to go into effect in 2019.

Exhibit 8. State Medicaid & CHIP Spending (\$ millions) Current Law Compared to Scenario with Individual Mandate Adopted in Each State

	Current law	With state individual mandates	Difference in 2019	
			Amount	Percent of total
Alabama	1,676	1,686	10	0.6%
Alaska	715	720	4	0.6%
Arizona	4,006	4,021	15	0.4%
Arkansas	1,538	1,549	11	0.7%
California	27,818	28,063	245	0.9%
Colorado	3,132	3,170	37	1.2%
Connecticut	2,973	2,989	16	0.5%
Delaware	737	738	2	0.2%
District of Columbia	507	509	2	0.5%
Florida	9,452	9,610	159	1.7%
Georgia	3,915	3,945	30	0.8%
Hawaii	660	661	1	0.1%
Idaho	564	576	11	2.0%
Illinois	5,863	5,873	10	0.2%
Indiana	2,758	2,767	9	0.3%
Iowa	1,601	1,603	2	0.1%
Kansas	1,050	1,054	4	0.4%
Kentucky	2,252	2,267	16	0.7%
Louisiana	2,843	2,858	14	0.5%
Maine	861	862	1	0.1%
Maryland	4,132	4,154	22	0.5%
Michigan	4,668	4,672	3	0.1%
Minnesota	4,655	4,662	7	0.1%
Mississippi	1,438	1,446	8	0.5%
Missouri	3,974	4,014	39	1.0%
Montana	636	645	9	1.4%
Nebraska	769	771	2	0.3%
Nevada	1,172	1,182	10	0.9%
New Hampshire	598	599	0	0.0%
New Mexico	1,461	1,474	13	0.9%
New York	16,704	16,708	4	0.0%
North Carolina	5,611	5,715	104	1.9%
North Dakota	297	298	1	0.3%
Ohio	6,048	6,059	11	0.2%
Oklahoma	1,922	1,929	7	0.4%
Oregon	2,049	2,057	9	0.4%
Pennsylvania	8,867	8,882	15	0.2%
Rhode Island	845	853	8	0.9%
South Carolina	1,620	1,644	24	1.5%
South Dakota	490	491	1	0.2%
Tennessee	3,711	3,788	77	2.1%
Texas	16,703	16,780	77	0.5%
Utah	975	979	4	0.4%
Vermont	679	679	0	0.1%
Virginia	4,205	4,226	21	0.5%
Washington	3,961	3,998	37	0.9%
West Virginia	794	802	8	1.0%
Wisconsin	2,666	2,670	4	0.2%
Wyoming	304	306	1	0.5%
Total	176,878	178,003	1,125	0.6%

Data: Urban Institute analysis of its Health Insurance Policy Simulation Model (HIPSM) 2018. Reform simulated in 2019.

Note: Table excludes Massachusetts and New Jersey. Massachusetts has its own individual mandate under current law, and New Jersey's individual mandate is expected to go into effect in 2019.

Individual Mandate Penalties, 2019

Exhibit 9 shows the number of tax units (i.e., families) that would pay individual mandate penalties in each state and the revenue states would collect. While the penalty structure is assumed to be the same in each state, low-income states have fewer residents as a percentage of their total populations who would be subject to the mandate. In addition, low-income families who are subject to the mandate are assessed smaller penalties, so poorer states will collect less. Also, residents in some states have shown they are less likely to enroll in coverage when the mandate is in place. Nationally, in 2019, 8.8 million families would pay individual mandate penalties; the aggregate penalties would amount to \$7.4 billion if every state instituted its own mandate. This reflects an average mandate penalty across all states of \$830 per family. Average penalties per family range from a high of \$1,270 in Delaware to a low of \$630 in West Virginia. The largest states will collect the most revenue from the penalties.

Demand for Uncompensated Care, 2019

Demand for uncompensated care would fall by \$11.4 billion nationally with the implementation of state mandates (Exhibit 10). Uncompensated care is paid for by federal and state governments as well as through in-kind donations of care by providers. The effect of the mandate on uncompensated care is directly related to the decrease in the number of uninsured people and the health status of the people getting coverage.

National Distribution of Health Insurance Coverage, 2022

We also estimate the changes in health insurance coverage that would occur in 2022 if all states adopted individual mandates (Exhibit 11). Restoration of the mandate at the state level would increase insurance coverage nationally by an estimated 7.5 million people in 2022. We estimate that the number of people with employer-sponsored insurance would increase by 2.3 million people compared to there being no mandates in place (other than Massachusetts and New Jersey). An additional 1.5 million people would enroll in marketplace nongroup coverage with tax credits, 2.7 million more would enroll in nongroup coverage without tax credits, and 1 million more would enroll in Medicaid.

Exhibit 9. Number of Tax Units Paying Individual Mandate Penalties, Total State Penalty Revenue, and Average Penalty Paid per Unit Paying

By State Assuming Mandates Adopted in Every State, 2019

	Number of tax units paying penalties (1,000s)	Aggregate penalty payments collected by states (\$ millions)	Average paid per tax unit paying a penalty
Alabama	151	\$120	\$790
Alaska	48	\$48	\$1,000
Arizona	245	\$206	\$840
Arkansas	78	\$79	\$1,010
California	908	\$920	\$1,010
Colorado	200	\$163	\$820
Connecticut	57	\$61	\$1,070
Delaware	21	\$27	\$1,270
District of Columbia	17	\$18	\$1,060
Florida	501	\$402	\$800
Georgia	398	\$315	\$790
Hawaii	55	\$48	\$870
Idaho	57	\$47	\$820
Illinois	307	\$244	\$790
Indiana	176	\$125	\$710
Iowa	79	\$63	\$800
Kansas	99	\$76	\$770
Kentucky	100	\$66	\$650
Louisiana	144	\$116	\$810
Maine	33	\$30	\$900
Maryland	132	\$116	\$880
Michigan	189	\$140	\$740
Minnesota	122	\$132	\$1,090
Mississippi	112	\$100	\$890
Missouri	198	\$144	\$730
Montana	32	\$25	\$790
Nebraska	51	\$53	\$1,030
Nevada	97	\$70	\$720
New Hampshire	40	\$33	\$840
New Mexico	72	\$50	\$700
New York	284	\$271	\$960
North Carolina	357	\$288	\$810
North Dakota	23	\$19	\$840
Ohio	281	\$202	\$720
Oklahoma	179	\$129	\$720
Oregon	94	\$78	\$830
Pennsylvania	240	\$194	\$810
Rhode Island	19	\$14	\$760
South Carolina	172	\$117	\$680
South Dakota	36	\$31	\$840
Tennessee	232	\$188	\$810
Texas	1,187	\$947	\$800
Utah	63	\$70	\$1,110
Vermont	12	\$11	\$870
Virginia	312	\$274	\$880
Washington	221	\$165	\$750
West Virginia	45	\$28	\$630
Wisconsin	108	\$79	\$730
Wyoming	26	\$21	\$820
Total	8,849	\$7,384	\$830

Data: Urban Institute analysis of its Health Insurance Policy Simulation Model (HIPSM) 2018. Reform simulated in 2019.

Notes: Average penalty amounts are rounded to the nearest \$10. Table excludes Massachusetts and New Jersey. Massachusetts has its own individual mandate under current law, and New Jersey's individual mandate is expected to go into effect in 2019. commonwealthfund.org

Exhibit 10. Uncompensated Care by State (\$ millions) Current Law Compared to Scenario with Individual Mandate Adopted in Each State

	Current law	With state individual mandates	Difference
	Total	Total	Total
Alabama	1,399	1,253	-146
Alaska	268	241	-28
Arizona	1,983	1,708	-276
Arkansas	836	694	-142
California	8,141	7,249	-892
Colorado	1,575	1,283	-292
Connecticut	717	546	-170
Delaware	134	115	-19
District of Columbia	108	100	-8
Florida	5,207	4,460	-747
Georgia	3,225	2,677	-548
Hawaii	163	141	-22
Idaho	604	480	-124
Illinois	3,017	2,550	-467
Indiana	1,445	1,241	-205
Iowa	652	580	-72
Kansas	928	798	-130
Kentucky	720	549	-171
Louisiana	1,260	1,092	-168
Maine	339	310	-29
Maryland	920	702	-217
Michigan	2,244	1,826	-418
Minnesota	1,760	1,544	-216
Mississippi	1,088	950	-139
Missouri	2,044	1,749	-295
Montana	388	312	-76
Nebraska	483	417	-66
Nevada	683	560	-123
New Hampshire	237	188	-50
New Mexico	431	333	-97
New York	2,695	2,284	-411
North Carolina	2,612	2,184	-428
North Dakota	140	95	-44
Ohio	1,877	1,518	-360
Oklahoma	1,822	1,596	-227
Oregon	787	621	-166
Pennsylvania	1,807	1,388	-419
Rhode Island	100	74	-25
South Carolina	1,214	1,035	-179
South Dakota	277	231	-45
Tennessee	1,669	1,429	-241
Texas	7,974	6,773	-1,201
Utah	765	664	-101
Vermont	121	108	-13
Virginia	2,687	2,233	-454
Washington	1,674	1,257	-417
West Virginia	350	266	-84
Wisconsin	1,196	1,018	-178
Wyoming	211	176	-35
Total	72,978	61,598	-11,381

Data: Urban Institute analysis of its Health Insurance Policy Simulation Model (HIPSM) 2018. Reform simulated in 2019.

Note: Table excludes Massachusetts and New Jersey. Massachusetts has its own individual mandate under current law, and New Jersey's individual mandate is expected to go into effect in 2019.

Exhibit 11. Health Insurance Coverage Distribution of the Nonelderly (thousands of people), 2022
Current Law Compared to Scenario with Individual Mandate Adopted in Each State

	Current law		With state individual mandates		Change	Percentage-point change
Insured	238,239	86.1%	245,736	88.8%	7,497	2.7%
Employer	147,268	53.2%	149,534	54.1%	2,266	0.8%
Nongroup (with tax credits)	7,798	2.8%	9,269	3.4%	1,471	0.5%
Nongroup (without tax credits)	5,165	1.9%	7,891	2.9%	2,726	1.0%
Medicaid/CHIP	69,389	25.1%	70,423	25.5%	1,034	0.4%
Other (including Medicare)	8,619	3.1%	8,619	3.1%	0	0.0%
Uninsured	38,416	13.9%	30,919	11.2%	-7,497	-2.7%
Total	276,654	100.0%	276,654	100.0%	0	0.0%

Data: Urban Institute analysis of its Health Insurance Policy Simulation Model (HIPSM) 2018. Reform simulated in 2022.

In 2022, the largest absolute decreases in rates of uninsured are in large states like California, Florida, and Texas (Exhibit 12). As health care costs get more expensive relative to incomes over time, fewer people tend to purchase insurance and the number of uninsured rises. However, with an individual mandate in place, the effect of health care cost growth is lessened because more people hold on to their insurance to comply with the mandate. As a result, the effect of the individual mandate on reducing the number of people without insurance increases over time in percentage terms.

DISCUSSION

If they implement their own individual mandates, states could mitigate the negative impact the elimination of the ACA penalties will have on coverage and premiums. Massachusetts legislated its own individual mandate as part of its 2006 broad-based health reforms; New Jersey did so this year. This approach does pose significant challenges. For example, Alaska, Florida, Nevada, New Hampshire, South Dakota, Texas, Washington, and Wyoming do not have state income taxes, and thus

new structures would have to be developed to collect individual mandate penalties, making the arrangement far less feasible.

In addition, the political environment in some states has been actively hostile to the ACA, making the adoption of state mandates extremely unlikely. Even states that have governors and state legislators who are generally supportive of the ACA are likely to find it politically challenging to impose mandate penalties. Still, some states are considering such a move. In addition to the individual mandate law passed by New Jersey this year,⁶ Vermont has passed a bill into law but must work out penalty amounts and enforcement mechanisms through a working group, with implementation requiring further legislation. D.C.'s bill is still pending, but may be resolved soon. Connecticut, Hawaii, Maryland, and Washington considered bills. These are currently inactive, although there is a chance that other bills may be considered in the future. Other states may consider such a step after the consequences of elimination of the federal penalties become evident in 2019.

Exhibit 12. Difference and Percent Difference in Insurance Coverage (by type of coverage) by State (thousands of people), 2022

Current Law Compared to Scenario with Individual Mandate Adopted in Each State

	Employer		Nongroup		Medicaid and CHIP		Uninsured	
	Difference from current law	Percent difference from current law	Difference from current law	Percent difference from current law	Difference from current law	Percent difference from current law	Difference from current law	Percent difference from current law
Alabama	27	1.3%	55	34.3%	-1	-0.1%	-81	-12.3%
Alaska	12	3.1%	12	101.6%	0	0.3%	-24	-21.8%
Arizona	72	2.4%	104	67.6%	18	1.0%	-195	-19.4%
Arkansas	15	1.2%	35	54.4%	19	2.1%	-70	-25.3%
California	110	0.7%	353	20.8%	360	3.2%	-823	-19.6%
Colorado	50	2.0%	93	57.1%	66	5.2%	-209	-32.8%
Connecticut	23	1.3%	32	24.7%	33	4.4%	-88	-33.6%
Delaware	7	1.6%	10	42.5%	0	0.2%	-18	-20.8%
District of Columbia	9	2.6%	5	38.0%	5	2.8%	-19	-36.0%
Florida	123	1.6%	342	20.6%	91	2.5%	-556	-18.8%
Georgia	87	1.8%	215	49.0%	-4	-0.2%	-298	-14.4%
Hawaii	9	1.2%	12	38.1%	1	0.3%	-22	-18.8%
Idaho	17	2.2%	39	38.1%	9	3.0%	-65	-24.3%
Illinois	107	1.7%	167	37.7%	18	0.7%	-292	-20.9%
Indiana	35	1.1%	88	50.3%	5	0.4%	-128	-18.7%
Iowa	21	1.3%	28	40.1%	-2	-0.3%	-47	-21.1%
Kansas	32	2.1%	48	42.6%	2	0.6%	-82	-19.2%
Kentucky	29	1.7%	42	45.4%	36	2.7%	-107	-34.8%
Louisiana	29	1.6%	63	53.2%	-25	-1.8%	-68	-15.6%
Maine	3	0.6%	17	27.3%	1	0.4%	-22	-19.6%
Maryland	51	1.6%	72	35.1%	42	3.3%	-164	-29.7%
Michigan	61	1.4%	115	32.9%	-6	-0.3%	-170	-24.1%
Minnesota	58	1.9%	62	41.3%	-9	-0.9%	-111	-22.4%
Mississippi	17	1.5%	43	64.1%	-1	-0.1%	-60	-12.7%
Missouri	64	2.2%	85	36.3%	12	1.2%	-160	-20.6%
Montana	7	1.7%	18	40.2%	-2	-0.6%	-23	-24.0%
Nebraska	27	2.8%	30	30.5%	1	0.2%	-57	-23.3%
Nevada	24	1.6%	54	60.3%	33	5.0%	-110	-23.0%
New Hampshire	9	1.3%	19	44.5%	0	-0.1%	-28	-29.2%
New Mexico	18	2.5%	26	60.5%	25	3.3%	-68	-27.5%
New York	186	2.1%	139	12.5%	25	0.5%	-350	-21.9%
North Carolina	63	1.5%	174	37.6%	75	3.6%	-313	-18.8%
North Dakota	12	3.2%	13	36.8%	2	1.7%	-26	-39.3%
Ohio	88	1.6%	135	51.2%	1	0.0%	-224	-26.3%
Oklahoma	37	2.1%	67	53.4%	4	0.5%	-107	-14.7%
Oregon	43	2.4%	58	41.5%	11	1.1%	-111	-29.3%
Pennsylvania	98	1.6%	148	33.7%	-25	-1.0%	-220	-26.3%
Rhode Island	10	2.2%	11	28.6%	9	3.3%	-30	-38.9%
South Carolina	27	1.3%	73	38.8%	21	2.3%	-120	-16.4%
South Dakota	9	2.2%	16	42.1%	0	0.2%	-25	-19.6%
Tennessee	33	1.2%	96	43.6%	67	4.8%	-195	-20.7%
Texas	245	2.0%	576	57.8%	30	0.6%	-850	-14.3%
Utah	56	3.1%	43	19.4%	2	0.6%	-101	-22.5%
Vermont	4	1.4%	4	11.4%	1	0.4%	-8	-22.9%
Virginia	104	2.2%	166	42.2%	8	0.8%	-278	-21.3%
Washington	49	1.4%	95	47.1%	58	3.5%	-201	-27.9%
West Virginia	5	0.6%	16	68.5%	15	3.0%	-35	-29.7%
Wisconsin	40	1.4%	71	30.1%	3	0.3%	-115	-22.3%
Wyoming	5	1.5%	15	66.3%	1	0.8%	-20	-21.7%
Total	2,266	1.6%	4,197	34.3%	1,034	1.6%	-7,497	-19.9%

Data: Urban Institute analysis of its Health Insurance Policy Simulation Model (HIPSM) 2018. Reform simulated in 2022.

Note: Table excludes Massachusetts and New Jersey. Massachusetts has its own individual mandate under current law, and New Jersey's individual mandate is expected to go into effect in 2019.

METHODS

This analysis estimates the coverage and health care spending effects that would occur if each state implemented an individual mandate to replace the federal penalties that will be eliminated in 2019 under the 2017 Tax Cuts and Jobs Act. We assume that each state would implement a mandate with the same structure as the ACA's federal mandate. Massachusetts and New Jersey are the only states that currently have their own individual mandates. Massachusetts's requirements and penalties associated with its mandate are different than the federal requirements in the ACA. The New Jersey mandate structure and penalties are very similar to the ACA. Consequently, we exclude Massachusetts and New Jersey from the state-specific tables. Our analysis relies upon the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).

HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. HIPSM is based on two years of the American Community Survey (ACS), which provides a representative sample of families that is large enough to produce estimates for individual states. The population is aged to future years using projections from the Urban Institute's Mapping America's Futures program. HIPSM is designed to incorporate timely, real-world data when they are available. As described below, we regularly update the model to reflect published Medicaid and marketplace enrollment and costs in each state. The enrollment experience in each state under current law affects how the model simulates policy alternatives.

HIPSM is unique among microsimulation models of health coverage and costs because individual and family decisions combine the two most common types of microsimulation decision-making: elasticity and expected utility. Decision-making follows an expected-utility framework that captures factors such as individual health risk, but we add a term for each observation that represents factors involved in their observed choices that the expected-utility approach alone could not capture. These terms are set so the model leads to each person in

COMPARISON OF URBAN INSTITUTE AND CONGRESSIONAL BUDGET OFFICE ESTIMATES

Our estimates are consistent with CBO's 2019 estimates of the effect of eliminating the federal individual mandate.* The CBO estimated that in 2019 eliminating the individual mandate would decrease Medicaid coverage by approximately 1 million people and nongroup insurance coverage (marketplace and nonmarketplace) by 3 million people, and would increase the number of uninsured by 4 million. Our estimates represent an inverse effect of the same size.

The estimates presented in our analysis are essentially the mirror image of the types of estimates made by CBO. Our estimates differ somewhat from CBO's in terms of the effect of eliminating the individual mandate in 2022. They diverge most with regard to the effect on Medicaid enrollment; CBO rounds coverage effects to the nearest 1 million people, which makes precise comparisons difficult. CBO estimates that elimination of the individual mandate would decrease Medicaid coverage by 4 million people in 2022, whereas we estimate a smaller inverse effect of 1 million additional people enrolling in Medicaid with state mandates in place. Our smaller estimate may reflect the fact that CBO's baseline assumes that some states that had not yet expanded Medicaid under the ACA by 2017 would do so in future years; we make no such assumptions. CBO estimates a 2022 nongroup coverage effect from eliminating the individual mandate of 5 million people, compared to our estimate of 4.2 million people gaining coverage nationally under state mandates. CBO estimates that 2 million fewer people would have employer coverage without a mandate, compared to our estimate of 2.3 million people gaining employer coverage with state mandates. Taken together, CBO estimates that the number of uninsured would be 12 million people higher in 2022 absent mandate penalties, compared to our estimate that 7.5 million fewer people would be uninsured with state mandates introduced across the country.

* Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (CBO, May 2018), <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf>.

the data making the choice they reported in the survey, and the distribution of the terms is set so the model replicates premium elasticity targets from the literature. In this way, the model has the overall population change insurance enrollment decisions at a rate consistent with the research literature. Still, individuals within the model respond to changes in prices in a way that is consistent with their characteristics and their decisions observed in the data. This approach makes it easier to simulate novel policies consistently while calibrating the model to a wide range of real-world data, such as Medicaid and marketplace enrollment.

In this analysis, we provide all results in 2019 and a subset of results for 2022. Our current law — or baseline — scenario implicitly takes into account policy changes made since early 2017 that affected health insurance coverage for the 2018 open-enrollment period; our model is calibrated to 2018 state marketplace enrollment figures⁷ and the most recent state-specific estimates of Medicaid enrollment.⁸ We also use state average marketplace premiums for the 2018 plan year. While estimates of nonmarketplace nongroup insurance enrollment are not currently available, HIPSM uses premium growth in marketplace bronze plans between 2017 and 2018 to estimate enrollment in unsubsidized nonmarketplace plans. The current-law scenario assumes the elimination of the federal mandate penalties but does not assume the expansion of the short-term, limited-duration plans in proposed regulations as they have yet to be made final.

The 2018 ACA penalty for being uninsured for a full year is equal to the maximum of 1) \$695 per adult; half that amount for children and 2) 2.5 percent of household income. The penalty is capped at the national average premium of a marketplace bronze plan, and it is prorated for people uninsured for fewer than 12 months. There are a number of penalty exemptions.⁹ We assume that each state's own penalty would use the state average premium

of a marketplace bronze plan as the penalty cap, instead of the national average. We also assume that the state mandates would be as effective as the federal mandate.

The IRS has released state specific data on individual mandate penalty payments through 2015.¹⁰ HIPSM estimates of the number of households paying penalties by household adjusted gross income (AGI) level in each state correspond well with IRS data. However, HIPSM does not simulate monthly coverage decisions, so the model computes the amounts households would pay if members were uninsured for a full year. The IRS reports actual penalty collections and, as such, it reflects that some people are uninsured for only part of a year (and thus pay proportional penalties), the fact that some people receive hardship exemptions unrelated to individual data collected by household surveys like the ACS, as well as idiosyncrasies in the way that the law is being implemented. Consequently, we make adjustments to the level of our revenue estimates that reflect the differences between IRS and HIPSM full-year penalties per household for 2015 at each AGI level and state. These adjustments are applied to penalties computed using the tax brackets enacted by the Tax Cuts and Jobs Act of 2017.

Demand for uncompensated care for the uninsured is estimated in our model based on data from the Medical Expenditure Panel Survey–Household Component adjusted to the results of a detailed analysis of uncompensated care in 2013.¹¹ The authors of that analysis found that the uninsured pay for about 30 percent of their health care out-of-pocket, with the remainder becoming uncompensated care. About 45 percent of uncompensated care is funded by the federal government through programs such as Medicaid Disproportionate Share Hospital (DSH) funding, Medicare DSH, and the Veterans Administration. About 24 percent is funded through state and local governments. The remainder is funded by health care providers themselves.

NOTES

1. Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (CBO, May 2018), <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf>.
2. Sabrina Corlette et al., *Insurers Remaining in Affordable Care Act Markets Prepare for Continued Uncertainty in 2018, 2019* (Urban Institute, March 2018), https://www.urban.org/sites/default/files/publication/97326/mon_i_insurercanvas2018_2001756.pdf.
3. New Jersey and Vermont have both recently passed legislation; Vermont's legislation requires specification of the penalties during the course of 2019 with implementation in 2020. Connecticut, Hawaii, Maryland, Washington, and the District of Columbia have all considered or are continuing to consider their own legislation. See Dania Palanker, Rachel Schwab, and Justin Giovannelli, "State Efforts to Pass Individual Mandate Requirements Aim to Stabilize Markets and Protect Consumers," *To the Point* (blog), Commonwealth Fund, June 14, 2018, <https://www.commonwealthfund.org/blog/2018/state-efforts-pass-individual-mandate-requirements-aim-stabilize-markets-and-protect>. As this report was going to press, an individual mandate was passed by the Council of the District of Columbia as part of a larger budget bill. It has not yet been signed by the mayor, although she is expected to do so. In addition, there are riders to the D.C. budget in the U.S. House of Representatives intended to inhibit implementation, although it is not clear they would be successful.
4. Katie Jennings, "New Jersey Will Become Second State to Enact Individual Health Insurance Mandate," *Politico*, May 30, 2018, <https://www.politico.com/states/new-jersey/story/2018/05/30/new-jersey-becomes-second-state-to-adopt-individual-health-insurance-mandate-442183>.
5. In 2019, 138 percent of the federal poverty level in the 48 contiguous states will be \$16,753 for an individual and \$34,638 for a four-person household; 400 percent of poverty will be \$48,560 for an individual and \$100,400 for four-person household.
6. Palanker, Schwab, and Giovannelli, "State Efforts," 2018; and New Jersey State Legislature, "A3380 Aca (1R) — New Jersey Health Insurance Market Preservation Act" (State of New Jersey, May 30, 2018), <http://www.njleg.state.nj.us/bills/BillView.asp?BillNumber=A3380>.
7. Centers for Medicare and Medicaid Services, *2018 Marketplace Open Enrollment Period Public Use Files* (CMS, updated Apr. 4, 2018), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html.
8. We used Centers for Medicare and Medicaid Services Monthly Enrollment Snapshots to determine the change in Medicaid enrollment in each state since 2013. See Centers for Medicare and Medicaid Services, *MMCO Statistical & Analytic Reports* (CMS, updated Mar. 16, 2018), <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html>.
9. Exemptions from the individual mandate penalties include: income below the tax filing threshold, religious conscience, members of health care sharing ministries, people not lawfully present in the United States, incarcerated individuals, people uninsured for less than three months in the year, people for whom the cost of coverage exceeds 8 percent of household income (with the 8 percent indexed over time), members of Indian tribes, a person who would be eligible for Medicaid but who lives in a state that had not expanded Medicaid eligibility under the ACA, people receiving a hardship exemption from the Secretary of Health and Human Services.
10. Internal Revenue Service, *SOI Tax Stats — Historic Table 2* (IRS, updated Oct. 11, 2017), <https://www.irs.gov/statistics/soi-tax-stats-historic-table-2>.
11. Teresa A. Coughlin et al., *Uncompensated Care for the Uninsured in 2013: A Detailed Examination* (Urban Institute, May 2014), <http://www.urban.org/research/publication/uncompensated-care-uninsured-2013>.

ABOUT THE AUTHORS

Linda J. Blumberg, Ph.D., is an economist and Institute Fellow in the Urban Institute's Health Policy Center. She is an expert on private health insurance, health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decision-making and implementation at the state and federal levels, and interpreting and analyzing the implications of particular policies. Examples of her work include analyses of the implications of congressional proposals to repeal and replace the ACA, delineation of strategies to fix problems associated with the ACA, estimation of the cost and coverage potential of high-risk pools, analysis of the implications of the *King v. Burwell* case, and several studies of competition in ACA marketplaces. In addition, Dr. Blumberg led the quantitative analysis supporting the development of a "Road Map to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed that state's comprehensive health reforms in 2006. She received a Ph.D. in economics from the University of Michigan.

Matthew Buettgens, Ph.D., is a mathematician and Senior Fellow in the Urban Institute's Health Policy Center. He leads the development of the Urban Institute's Health Insurance Policy Simulation Model. The model has been used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes papers analyzing proposals to repeal and replace the Affordable Care Act, both nationally and state-by-state. Topics have included the costs and savings of health reform for both federal and state governments, state-by-state analysis of changes in health insurance coverage and the remaining uninsured, the effect of reform on employers, the role of the individual mandate, the affordability of coverage under health insurance exchanges, and the implications of age rating for the affordability of coverage. Dr. Buettgens received a Ph.D. in mathematics from the State University of New York at Buffalo.

John Holahan, Ph.D., is an Institute Fellow in the Health Policy Center at the Urban Institute, where he previously served as director for more than 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth. He has examined the coverage, costs, and economic impact of the Affordable Care Act, including the costs of Medicaid expansion and the macroeconomic effects of the law. He also has analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Dr. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA. He received a Ph.D. in economics from Georgetown University.

.....
Editorial support was provided by Deborah Lorber.

ACKNOWLEDGMENTS

In addition to Commonwealth Fund support for this research, the Robert Wood Johnson Foundation provided substantial funding for the development of the Health Insurance Policy Simulation Model, which was used in this analysis. The authors are grateful for comments and suggestions from Kevin Lucia, Justin Giovanelli, and Sara Collins, and for research assistance from Robin Wang and Erik Wengle.

For more information about this report, please contact:

Linda J. Blumberg, Ph.D.
 Institute Fellow, Health Policy Center
 Urban Institute
lblumberg@urban.org

About the Commonwealth Fund

The mission of the Commonwealth Fund is to promote a high-performing health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

