



Statement before the House Committee on Ways and Means
Subcommittee on Oversight

Examining the Effectiveness of the Individual Mandate under the Affordable Care Act

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Thank you Chairman Buchanan, Subcommittee Ranking Member Lewis, and Members of the Subcommittee for the opportunity to testify today to examine the effectiveness of the individual mandate under the Affordable Care Act (ACA).

I am testifying today as a health policy researcher and a resident fellow at the American Enterprise Institute (AEI). I also will draw upon previous experience as a senior health economist at the Joint Economic Committee and health policy researcher at several other Washington-based research organizations.

My testimony will outline the rationales and motivations behind use of the individual mandate within the ACA and then examine its disappointing record in trying to achieve its goals. I will summarize the inherent political, economic, and legal limits in attempting to implement and enforce a strong mandate, as well as the potential dangers and drawbacks in doing so. Finally, I will suggest that we need to distinguish the actual effects of the mandate from those due to other health policy changes, either in increasing insurance coverage or limiting its costs. I will conclude by outlining a variety of alternative policy remedies that could be pursued if the individual mandate is either weakened further or repealed.

The shaky case for the individual mandate is based on mistaken premises, faulty economic analysis, short-sighted politics, and flawed health policy. Opponents have found the mandate to be administratively challenging, politically unsustainable, economically unnecessary, beyond the proper role of government, and constitutionally questionable.

Arguments in favor of the individual mandate usually present it as a necessary, though far less popular, means to more laudable ends such as universal coverage, better access to health care for persons with preexisting health conditions, and lower health care costs for those already insured. However, the relationship between the mandate and the problems it purportedly could

solve always has been tenuous and contradictory at best. It turns out that the type of mandate that the U.S. political economy and health care system is likely to deliver in practice is very different and more complicated than what might be assumed under best-case theories.

Rearranging Increased Coverage Costs

One of the strongest driving forces behind officeholders resorting to the individual mandate is the desire to substitute “off-budget” mandated private funds in place of more visible taxes that they would otherwise find hard to impose to meet their insurance coverage goals and finance additional health care spending. Making the full costs of mandatory coverage more transparent reduces popular support for the latter. The hope instead is that an individual mandate can obscure the full sticker-price shock to taxpayers because mandated private spending is not officially treated as part of the federal budget. Instead, employers and insurers are enlisted as surrogate “tax collectors” through less transparent and politically accountable means.

Not surprisingly an individual mandate has the least support from those it is purported to help: people who currently do not enroll in public coverage or employer-sponsored insurance or who do not already purchase individual-market coverage. After all, coercing some people to do what they otherwise would not is the very point of a legal mandate. However, trying to force them to buy insurance they cannot afford or pay more for such coverage than it actually appears to be worth to them remains politically difficult.

Hence, an individual mandate often promises, but never manages, to pay for itself. In order to get lower-income individuals to comply with a mandate to purchase more insurance than they can afford, or want, to purchase, substantial taxpayer subsidies are used to fill some of the affordability gap. Insurance mandates create a perpetual conflict between their escalating costs, limited public and private resources to pay for them, and the false guarantees of richer coverage

ahead. The imbalances may be financed through various combinations of higher taxes, reduced benefits, higher premiums, lower take-home pay, fewer economic opportunities, and less insurance coverage for everyone else. Doing so also reduces portions of any projected increases in new premium “revenue” expected by insurers and health care providers from expanded coverage. Eventually, some of those less-visible costs are reimposed on the initially more “fortunate” newly insured.

Weak Enforcement

In their comprehensive review of the likely efficacy of mandates for health insurance, Glied, Hartz, and Giorgi (2007) concluded that predicting a target population’s response to a mandate is, at best, an inexact science. Performance of mandates varies greatly with such important factors as the affordability of costs of compliance, the size of penalties, and the probability that penalties will be imposed in a timely manner. Glied, Hartz, and Giorgi also noted that even the best mandate is unlikely to affect the behavior of those who are transient (in terms of place of residence or employment status) and have few assets.

Some modelers of the coverage take-up effects of an individual mandate appear to assume reflexively that its commands will be obeyed faithfully, enforced consistently, and executed with nearly flawless precision. Actual enforcement practice under the ACA provides more of a muffled bark and toothless bite.

One early indication was that the mandate did not even begin to apply until January 1, 2014, even though the law was enacted in March 2010. Although the mandate penalties were supposed to be enforced by the Internal Revenue Service and collected through taxpayers’ annual income tax returns, the agency is not allowed to use many of its standard enforcement tools to ensure payment of those taxes. The law provides that anyone who fails to pay in a timely

manner any penalty imposed by the mandate “shall not be subject to any criminal prosecution or penalty” and that the secretary of the Treasury shall not “file notice of lien” or “levy” on any property of a taxpayer by reason of such failure.ⁱ

The penalties for failing to comply with the mandate also are rather modest in proportion to the likely average premium cost of required coverage.ⁱⁱ The predictable result was that millions of individuals calculated that it is much less expensive to pay the penalty than to purchase mandatory insurance. The law’s guaranteed-issue incentives for potential purchasers, coupled with loose enforcement of eligibility for special enrollment periods between annual open season windows, encouraged individuals to enroll “just in time” when sick and “go bare” when healthy (and pay less in penalties than in total premiums), further ensuring limited and erratic mandate compliance.

Moreover, the ACA provisions for exemptions from the individual mandate -- involving illegal immigrants, foreign nationals, religious prohibitions, and most importantly “unaffordability”ⁱⁱⁱ all reveal how various political and economic factors limit the enforceable scope of any theoretically universal mandate. Once the individual mandate was first put into effect for the 2014 plan year, other permissive exemptions were added, for such excuses as recent death of a close family member, facing evictions, and having medical expenses that could not be paid in the last 24 months that resulted in substantial debt. In addition, reliance on the federal income tax system and the IRS as primary enforcers of the mandate fails to reach millions of Americans who are not required to (or do not) file a federal income tax return. The penalty is pro-rated for people who are uninsured for a portion of the year and waived for people who have a period without insurance of less than three months.

Ironically, even the strongest version of an individual mandate to purchase health

insurance would be too weak to guarantee what should be its ultimate objective – improvements in people’s health. Requiring that someone have health insurance is not the same as ensuring they actually receive all of the effective health care services they may need in a timely manner and comply with their physicians’ advice, let alone that we all take many other steps beyond even the delivery of covered medical services that might do more to improve their current and future health. To do that, one might need to mandate not just the purchase of health insurance but also delivery of the actual “treatment”! Yet somehow the image of a mandate that all preventive and therapeutic “treatment” be received at the right time and right place (or even the right physical point of entry?) with no questions asked or informed consent required suggests more vividly the limits of government coercion in achieving health goals.

Weak Compliance

Projections for compliance versus penalty payment under the individual mandate by the Congressional Budget Office (CBO) have tended to overestimate the degree of compliance, but in a choppy manner. For example, using 2016 as a baseline year, CBO first projected in April 2010 that the ACA’s individual mandate would help produce more coverage of the uninsured and collect only \$4.2 billion in mandate penalties from 3.9 million individuals, even while leaving 13-14 million Americans exempt from its reach. In 2012, CBO revised those numbers to project a higher amount of \$6.9 billion in mandate penalties from about 5.9 million individuals. In 2014, CBO lowered those estimates to \$4.2 billion, to be collected from about 3.9 million individuals. In 2016, the CBO estimates dipped slightly again, to \$3 billion collected from a monthly average of 3 million individuals. CBO’s reported estimates regarding the number of exempted individuals for the years 2014-2016 are not reported in a consistent manner, particularly in distinguishing between individuals who did not have to report on compliance

because they were exempt from filing federal income taxes and others who were exempt from the individual mandate for other reasons.

These varying estimates somewhat reflect changes in underlying assumptions, reporting methods, and ACA implementation policy, but they also suggest their inexact nature and limited degrees of predictive accuracy. In practice, the IRS has reported noticeably higher numbers of individual mandate penalty payers (7.5 million in 2014, 6.5 million in 2015), despite lower amounts of actual revenue collected (\$1.5 billion in 2014, \$1.7 billion in 2015). The IRS also reports that about 12 million individuals in 2014 and 12.7 million individuals in 2015 were exempted from the mandate. (The 2015 estimates are preliminary and likely to grow somewhat higher, based on past trends).

Still the Most Unpopular Part of the ACA

The individual mandate issues touches expose nerves and offends core principles in ways that other elements of the modern regulatory state do not. Many Americans remain troubled by the idea of Congress imposing a legal mandate on citizens to purchase a private (but highly regulated) product, regardless of their wishes. They worry that implementing an individual mandate inevitably generates more and more rules regarding exactly what it requires, how it is carried out, and who pays for it. Hence, the individual mandate has consistently remained the most intensely unpopular provision of the new health law since it first took shape. For example, the November Kaiser Health Tracking Poll conducted shortly after the November elections found that only 35 percent of all Americans held favorable views about the individual mandate.^{iv}

Concerns that an individual mandate violates basic principles of economic freedom, personal choice, and limited government under the U.S. Constitution have persisted years after the Supreme Court's narrowly divided decision in *NFIB v. Sebelius* to uphold the ACA mandate

as a constitutionally valid exercise of the congressional power to tax, rather than as a regulatory penalty under the power of Congress to regulate interstate commerce.^v It appears that the individual mandate remains politically unpopular whether it is viewed as a limited regulatory penalty to spur more purchasing of required health insurance or a modest tax to help finance subsidies to do so.

Reciprocal Floors and Ceilings Limit the Individual Mandate

The ACA's individual mandate was primarily designed to help fill in the gaps between what the law's advocates could deliver politically in larger taxpayer subsidies for expanded health insurance coverage and the higher costs of coverage produced by more aggressive regulation of health insurance. It essentially aimed to require less-cost, low-risk individuals not only to obtain or retain federally-mandated minimum essential coverage, but also to pay more for it, in order to cross-subsidize lower premiums for other high-risk and/or low-income individuals. However, the individual mandate continues to face significant political limits on how large the mandate's penalties can be, how aggressively they can be enforced, and how much compliance the mandate will produce. Hence, the mandate's best future for continued survival involves operating much more as a gentle "suggestion" or nudge (with modest penalties and weak enforcement) rather than a more polarizing "command."

In short, the space separating the floor and ceiling for the individual mandate is narrow. If the individual mandate ever begins to reach the point in practice at which it threatens to become more binding and effective, political feedback and pressure to pull back will intensify.

Impact on Insurance Coverage Expansion?

It's a fact that health insurance coverage has increased significantly since the ACA was enacted into law and implemented. The causal factors are more complex and contestable.

CBO has tended to be on the high side of claims that the ACA would rapidly and substantially increase coverage in the new law's exchanges (later renamed "Marketplaces") for individual coverage. It also has repeatedly overestimated the role of the individual mandate in delivering such gains. CBO's original projections assumed far more stability in the exchanges by now, and much larger enrollment in them (about 21-22 million people, rather than a little more than half that number). Rather than reexamine the flawed foundations of its previous assumptions, CBO appears to have recently doubled down on them in projecting that a partial repeal of the ACA (similar to one passed by Congress but vetoed in January 2016), without additional provisions to replace it, would increase the number of uninsured by 18 million in 2018, 27 million in 2020, and 32 million in 2026.

The CBO estimates are flawed in overstating its baseline assumptions for future growth in the ACA's version of individual market coverage, exaggerating the response rate of those subject to the individual mandate before and after its possible repeal, misestimating Medicaid coverage effects, and setting unrealistic parameters for future health policy changes.^{vi}

To be fair, the ACA in practice has evolved through numerous iterations of interrelated moving parts, unforeseen modifications in policies and practices, and changes in economic assumptions. However, it's still accurate to conclude that the most significant force behind the size and shape of insurance coverage gains has been large taxpayer subsidies, particularly through the expanded Medicaid program. Indeed, even the most recent estimate by one of the ACA's past architects, Jonathan Gruber, concluded that overall coverage rates in 2014 did not respond to either the mandate's penalties or exemptions for lacking coverage. Gruber and his co-authors did find that Medicaid accounted for 63 percent of the coverage gains in 2014 that their methods could identify, and that the fairly modest effects of the law's premium subsidies for

ACA exchange coverage accounted for the rest.^{vii}

This type of analysis is consistent with other findings that enrollment rates for ACA exchanges are sensitive to one's income and premium tax credit subsidy level,^{viii} and that enrollment by younger and healthier risks – the primary targets of the individual mandate -- has failed to reach expected levels.^{ix}

Future Unknowns

Given that the practical consequences of the individual mandate in increasing insurance market coverage appear to be minimal, at best, what accounts for other sources of support or opposition to it? One well-worn hope is that the individual mandate can help to strengthen and lock in the effects of other ACA health insurance regulations for minimum essential health benefits, qualified health plans, adjusted community rating, and guaranteed issue, in part by reducing their most visible on-budget costs. The ultimate aim on the regulatory side would be to make the purchase of any other alternative health care arrangements all but impossible.

Opponents of the individual mandate want to short-circuit any future evolution of a stronger mandate that requires compliance with potentially more sweeping regulations not yet implemented, or even proposed. Hence, a large portion of the ongoing debate over the individual mandate is as much about what it might become later than what it is currently.

Alternatives

Focus on the individual mandate in the ACA's drafting, implementation, and post-enactment debate has tended to obscure and preempt consideration of other policy alternatives.

They include:

- Extension of HIPAA-like protection against health status risk-rating to individuals who maintain “continuous” qualified insurance coverage while switching between individual market health plans or between group-market and individual-market plans,
- Imposing penalties in the form of higher insurance premium surcharges for each time that an individual fails to obtain or maintain minimum qualified coverage during annual open enrollment periods. This would operate somewhat like the delayed enrollment penalty for coverage in Medicare Part B or Medicare Part D.^x
- Tightening eligibility and enforcement further for “special enrollment” periods between annual open seasons in ACA exchanges
- Default enrollment in minimum qualified coverage costing no more than the value of applicable federal taxpayer subsidies for insurance, provided that sufficient notice and simple mechanisms to “opt out” are ensured,
- Providing even more generous, but also more transparent, taxpayer subsidies for obtaining and maintaining qualified insurance coverage in the individual market. This would emulate part of the success of employer-sponsored insurance and federal employee health benefits program coverage, albeit at an even-higher per-enrollee budgetary cost.
- Enabling and incentivizing insurers to offer coverage that is less expensive and more attractive to potential uninsured customers.

Of course, the last option --- though closest to market-based, competitive, patient-centered health insurance -- is likely to be considered only as a last resort if and when the other policy options fail!

¹ Patient Protection and Affordable Care Act, 2010, section 1501(g)(2)[(A) and (B)(i-ii)].

ⁱⁱ The penalty is the greater of a flat-dollar amount or a percentage of the violator's income. After the penalty amounts were phased in over three years (ending in 2016), the flat-dollar version equaled \$695 per individual, and the percentage-of-income version equaled 2.5 percent of income. The total family penalty for the flat-dollar version is capped at 300% of the amount per individual. The total monthly penalty for a taxpayer and his or her dependents for the percentage-of-income version cannot be more than the cost of the national average premium for bronze-level health plans (60 percent actuarial value) offered through health insurance exchanges (for the relevant family size). The latter penalty amount can be multiplied by the number of individuals in a family subject to a penalty, up to a maximum of five individuals. The flat dollar penalty amount is indexed to increase at the rate of inflation in years after 2016.

ⁱⁱⁱ Unaffordability in the ACA statute is defined as when one's required health premium costs would be greater than, 8 percent of household income, beginning in 2014. This unaffordability measure has been subsequently indexed upward to 8.13 percent for 2016.

^{iv} Ashley Kirzinger, Elise Sugarman, and Mollyann Brodie, Kaiser Health Tracking Poll: November 2016, Kaiser Family Foundation, December 1, 2016, Figure 11, <http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-november-2016/>. See also Dennis Thompson, "6 Years Later, Obamacare Still Divides America: Poll," *HealthDay*, May 5, 2016, (Table 3 notes a Harris Poll finding that 64 percent of U.S. adults would like to repeal the ACA's individual mandate), <http://www.theharrispoll.com/politics/Obamacare-Still-Divides-America.html>.

^v See Thomas A. Lambert, "How the Supreme Court Doomed the ACA to Failure," *Regulation*, Winter 2012-2013, <https://object.cato.org/sites/cato.org/files/serials/files/regulation/2013/1/v35n4-5.pdf>, asserting that Chief Justice Roberts' majority opinion also means that the penalty for failure to carry health insurance can count as a tax for constitutional purposes, and remain a valid exercise of congressional power, but only if it is kept so small as to be largely ineffective.

^{vi} See, e.g., Brian Blasé, "Learning from CBO's History of Incorrect ObamaCare Projections," *The Apothecary*, January 2, 2017, <http://www.forbes.com/sites/theapothecary/2017-01-02/learning-from-cbos-history-of-incorrect-obamacare-projections/print/>; Avik Roy, "Four Critical Problems with the CBO's Latest Obamacare Repeal Estimates," *The Apothecary*, January 17, 2017, <http://www.forbes.com/sites/theapothecary/2017/01/17/four-critical-problems-with-the-cbos-latest-obamacare-repeal-estimates/#1292a6b77862>.

^{vii} Molly Frean, Jonathan Gruber, and Benjamin D. Sommers, "Disentangling the ACA's Coverage Effects – Lessons for Policymakers," *New England Journal of Medicine*, 375, no. 17 (2016): 1605-1607. See also Molly Frean, Jonathan Gruber, and Benjamin D. Sommers, "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act," National Bureau of Economic Research Working Paper no. 22213, April 2016 (finding that "the mandate penalty had a negligible impact on coverage").

^{viii} Caroline F. Pearson, "Exchanges Struggle to Enroll Consumers as Income Increases," *Avalere*, March 25, 2015, <http://avalere.com/expertise/managed-care/insights/exchanges-struggle-to-enroll-consumers-as-income-increases>.

^{ix} Brian Blasé, "ObamaCare's Failure and Moving Health Care Policy in a New Direction," *The Apothecary*, December 15, 2016, <http://www.forbes.com/sites/theapothecary/2016/12/15/obamcares-failure-and-moving-health-care-policy-in-a-new-direction/print/>

^x The penalty would not necessarily be cumulative over one's remaining lifetime if one "requalifies" again by obtaining and maintaining such coverage in several subsequent, consecutive years.