What is the Evidence of the Effects of the ACA's Individual Mandate and of Its Repeal?

Leighton Ku, PhD, MPH

Revised Feb. 12, 2018

The Tax Cut and Jobs Act of 2017, enacted in late 2017, terminated the Affordable Care Act's Individual responsibility requirement (hereafter, individual mandate) by reducing the tax penalty to $0, effective January 1, 2019. As the District of Columbia (and other states) considers the possibility of creating a state-level mandate, an important question is what is known about the effect of the mandate, its repeal and its replacement?

- The Congressional Budget Office (CBO) estimated repealing the individual mandate would lead 4 million Americans to lose coverage in 2019, rising quickly to 12 million by 2021 and to 13 million by 2025. This includes losses in nongroup coverage, including exchanges, Medicaid and employer-sponsored coverage.[1]

Effects of Repealing the Individual Mandate on Health Insurance Coverage

Millions of People Under Age 65, by Calendar Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Change in Coverage Under the Policy										
Medicaid	0	-1	-2	-4	-4	-4	-4	-5	-5	-5
Nongroup coverage, including exchanges	0	-3	-4	-5	-5	-5	-5	-5	-5	-5
Employment-based coverage	0	*	-1	-2	-2	-3	-3	-3	-2	-2
Uninsured	0	4	7	12	12	12	12	13	13	13

Source: CBO, November 2017

- CBO also concluded that the cost of nongroup insurance premiums would rise by 10% because those retaining coverage would tend to be less healthy and older, while those dropping coverage would be younger and healthier. Thus, average insurance premiums for those remaining insured would rise because the risk pool becomes less healthy overall.
- The American Academy of Actuaries[2] agreed that insurance premiums would rise, but went on to note that this would weaken insurer solvency, could cause more insurers to withdraw from the market and that strong actions would be needed to counteract these adverse effects.
- Prior, independent research by the RAND Corporation reached similar conclusions.[3]
- Research by economists from Harvard and MIT, based on early data from 2014, found that, while the primary effects of the ACA on insurance coverage were caused by changes in Medicaid eligibility and the creation and subsidies for health insurance exchanges, about 30% of insurance expansions were likely attributable to other causes, including social perceptions of the insurance mandate.[4] Although there were exemptions from the tax penalties for those with low incomes or hardships, it is not clear how well the public understood these policy details. They

also note that effects were likely to rise in later years, as tax penalties rose substantially after the first year.

- A national poll done in September 2017 found that the public was roughly evenly divided in opinions about keeping or ending the individual mandate: 30% favored keeping it, 40% favored ending it and 30% was not sure. Support for retaining the mandate was higher among African Americans, those with higher income, those with more education and Democrats.[5] Given the profile of DC residents, this suggests greater support for the mandate in the District.

Findings from Massachusetts

Much of the evidence about the effects of an individual mandate relies on findings from Massachusetts, which instituted its mandate in 2006, as part of its state health reform. Research indicates that:

- The mandate resulted in overall increases in insurance coverage and in lower insurance premiums.[6]
- The mandate was associated with increases in employer coverage. In addition, there were health care savings as preventable hospital admissions declined and length of stay fell, although there were no overall increases in hospital costs.[7]
- Although there were no major changes in Medicaid eligibility in Massachusetts, there was nonetheless a substantial increase in Medicaid enrollment.[8]
- Overall, Massachusetts' health reform helped reduce economic problems, including reduced past due debt, improved credit scores and reduced personal bankruptcies.[9]

In discussions with the ACA Working Group by officials from the Massachusetts Connector indicated that there is no evidence that the state's individual mandate has any significant adverse effects on the state's economy or employment.[10]

The experience of Massachusetts is particularly relevant to the District, since both pre-reform Massachusetts, as well as the pre-reform District, had relatively strong insurance coverage levels (compared to other states) before reform and already had relatively generous Medicaid coverage and strong employer sponsored coverage.

Changes in Insurance Coverage in the District

At the request of the DC Health Benefit Exchange Authority, actuaries from the Oliver Wyman consulting firm provided estimates of the effects of the repeal of the mandate for the District of Columbia, drawing on its microsimulation model and data about the composition of DC Health Link beneficiaries.[11] The firm found *the repeal of the mandate would result in a decrease in the District's 2019 individual ACA enrollment of about 15.1%, or about 2,500 covered lives.* It also estimated that *repeal would lead to an increase in average claim costs in the individual ACA market equal to 7.2% per member per month*. Insurance carriers would have to increase premium rates to cover those costs, although insurance representatives in the working group orally mentioned that their internal estimates of the impact could be higher. Oliver Wyman did not include estimates about the employer

market or Medicaid because they lacked comparable data about the composition of those beneficiaries, but orally agreed that the repeal would have negative effects in those markets too.

Other data show how conditions in the District have improved since ACA implementation in 2014, suggesting the harm that could occur if the mandate is terminated:

- Analyses of Census data show that the overall percent of uninsured residents fell from 6.7% in 2013 before ACA implementation and creation of DC Health Link to 4.0% in 2016; Medicaid participation rose, while private insurance coverage did not change.[12]

- Data from the State Health Planning and Development Agency of the District of Columbia Department of Health indicate that the level of hospital uncompensated care expenses (including charity care and bad debt) fell by 60% between 2010 and 2015, falling from $250.7 million in 2010 to $101.2 million in 2015.[13] Reductions in uncompensated care expenses strengthen health care providers' finances and strengthen their ability to provide quality care to all patients.

- There was lower growth in health insurance premiums for employer-sponsored insurance in the District than for the overall U.S. Data from the Medical Expenditure Panel Survey (Agency for Healthcare Research and Quality) indicate that the average premium for a single person rose 9.5% between 2013 and 2016 for the nation, but only 8.1% in DC, while the average premium for family coverage rose 11.0% for the nation, but 9.2% in DC. Changes in the District market may have helped stabilize private insurance premiums, compared to overall national changes.

An economic analysis conducted in July 2017 of the Senate's "skinny" repeal bill, which mostly proposed to repeal the ACA's individual and employer mandates, estimated that the losses in federal funding caused by that bill would reduce overall employment in the District by 714 jobs in 2020 and 1,191 in 2026 (and overall losses of 67,000 jobs nationwide in 2020 and 131,000 by 2026).[14] These losses were driven by reductions in Medicaid and premium tax credit revenue in the District. While that bill differs somewhat from the change enacted in the tax law, it demonstrates the harmful negative economic impact of repealing the mandate on the District.

Taken together, these data suggest that loss of the individual mandate poses significant risks to the District, its residents, the insurance market and health care providers. Creating a District replacement for the discontinued federal mandate could help prevent those losses. If a District replacement is comparable to the federal mandate, this could be accomplished without creating serious new burdens for District residents.

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[5] J. Holahan, M. Karpman, S. Zuckerman. What Explains Attitudes toward the Individual Mandate? Urban Institute. Nov. 21, 2017.
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[9] M. Bazumder and S. Miller. The Effects of the Massachusetts Health Reform on Household Financial Distress. Am Econ J: Economic Policy 2016, 8(3): 284–313
[10] Audrey Morse Gasteier. Chief of Policy and Strategy, Massachusetts Connector, Jan. 23, 2018.
[11] R. Schultz, Oliver Wyman. Letter to Mila Kofman on Impact of the Repeal of the Individual Mandate. Feb. 6, 2018.
[12] Data from the Census Bureau's American Community Survey, including tabulations from the DC Fiscal Policy Institute provided by Jodi Kwarciany.
[13] State Health Planning and Development Agency, District of Columbia Department of Health. 20010-11, 2015 Uncompensated Care Summary. Data provided to ACA Working Group, Feb. 2018.
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