Testimony

Assessing Alternatives to the ACA's Individual Mandate

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Chairman Brady, Ranking Member McDermott, and members of the Subcommittee, thank you for the opportunity to testify today regarding potential alternatives to the individual and employer mandates imposed by the Patient Protection and Affordable Care Act (ACA). I hope to convey three main points today:

1. The individual mandate is not working as envisioned. Even for those who complied, the end result is coercive purchase of coverage they do not value.

2. The American Action Forum (AAF) found that repealing the individual mandate and other restrictions imposed on health insurance products under the ACA can lower premium costs, cover a comparable number of individuals, and allow the market to more accurately reflect consumers' desires.

3. The employer mandate will contribute to slower job growth and lead to a greater reliance on a part-time workforce.

Introduction

This tax season, millions of Americans are feeling the impact of the ACA on their tax return for the first time. Those who failed to obtain minimum essential health insurance coverage last year will have had to send the Internal Revenue Service (IRS) a check for $1,130, on average.[1] Setting aside the impact on these millions of people's wallets, this figure is also worth noting because it highlights the ineffectiveness of the individual mandate. Yes, the estimated 6.3 million people paying the penalty didn't buy health insurance, but neither did the more than 30 million who qualified for an exemption from the mandate.[2] If the mandate were 100 percent effective, everyone would have health insurance. However, there were still tens of millions of people uninsured in the U.S in 2014.

The Individual Mandate: Theory vs. Reality

The individual mandate, in concert with the guaranteed issue and community rating provisions, is the theoretical keystone of coverage in the ACA. In reality, however, it is not being enforced in a manner that fully realizes its potential. This undermines the law's ability to achieve its goals of affordable access to health care for all. The importance of the individual mandate is best understood as a support for the guaranteed issue and community rating provisions. These provisions are intended to ensure that everyone is able to purchase insurance at a reasonable price, regardless of any preexisting conditions. In a market with guaranteed issue and community rating, a healthy person may wait until the onset of poor health to purchase coverage, defeating the very purpose of insurance. The individual mandate must be included, requiring everyone to purchase and maintain coverage, in order to bring healthy people into the insurance pool, spread the risk, and lower the average premium cost relative to what it would be if all people in the pool were unhealthy. The combination of these three things—guaranteed issue, community rating, and the individual mandate—underlie the ACA's theory for creating an affordable health insurance pool for everyone.

In reality, the individual mandate has been less of a mandate and more of a suggestion. We estimate that 6.3 million people will be required to pay the mandate penalty as a result of not purchasing qualified coverage in 2014. Many of these individuals will escape the mandate by applying for hardship exemptions, and there remain more than 30 million uninsured individuals who are exempted from the mandate because of Medicaid expansion decisions or low household income. The individuals that have responded to the mandate tend to be older (65 percent of Marketplace enrollees in 2015 were aged 35 and older) and presumably less healthy, thus not holding premium prices down as much as anticipated.[3] Given the inability to implement and enforce these policies as necessary to achieve the results imagined from their theoretical application, we should instead seek other avenues for achieving the availability of affordable coverage for all. Some such options include:

1. Require guaranteed renewability of coverage conditioned on maintaining continuous coverage.

2. Support the creation/continuation of high-risk pools for those with excessive health care costs.

3. Repeal the community rating restrictions under the ACA.

4. Allow non-qualified health plans to be sold outside of the Marketplace.

5. Repeal the community rating restrictions and allow non-qualified health plans outside of the Marketplace.

Alternatives to the Individual Mandate

Using a microsimulation model for the U.S. health insurance market, AAF has examined the effects of possible alternatives to the individual mandate on the number of people insured and the cost to the government.[4] In looking at the impact of these various options, we first estimated the impact of just repealing the individual mandate. We estimate that repealing the mandate by itself and doing nothing else would result in 7 million fewer people insured in 2025 and reduced spending by the federal government on premium and cost-sharing assistance of $191 billion over 10 years compared with expectations under current law. Without any replacement provisions, repealing the mandate would also lead to significant premium increases, especially among generous insurance products.

1. Require guaranteed renewability of coverage conditioned on maintaining continuous coverage

An alternative policy for protecting against expensive medically underwritten insurance premiums is to require individuals to maintain continuous coverage in exchange for guaranteed renewability of insurance. Guaranteed

renewability provides similar protections to guaranteed issue for those with poor health status and relief from the fear of coverage cancellation while the conditional continuous coverage provision diminishes the incentive to not purchase insurance until one's health status becomes poor, thus reducing the likelihood of sending the market into a death spiral, as predicated in the theory discussed previously. Guaranteed renewability, rather than guaranteed issuance, and the removal of the mandate to purchase insurance limits the heavy-handed intrusion of the federal government into the marketplace and instead allows individuals to make a decision as to what is best for them while still encouraging the purchase of coverage at a young age, before one is unhealthy and forced to accept higher premiums and risk denial of coverage when it is desperately needed.

2. Create of high-risk pools for those with pre-existing conditions

While continuous coverage and guaranteed renewability will work well to keep the uninsured rate low for a majority of the population and eliminate the issue of "pre-existing conditions" for those who are currently healthy, it is not a well-suited solution for those who currently have a pre-existing condition and does not provide a safety net for individuals who forgo insurance and develop sudden illness.[5] For this population, high-risk pools can be established and/or continued where individuals can gain insurance made affordable through the provision of subsidies.

3. Repeal community rating restrictions under the ACA

In addition to repealing the individual mandate and instituting alternative protections against medical underwriting, we next estimated the effects of simultaneously repealing the community rating restrictions imposed by the ACA, which prevents an insurer from accounting for health status and limits the amount an insurer may vary premium rates based on age to a 3:1 ratio, meaning an elderly person cannot be charged more than three times what a younger person is charged. Prior to the ACA, the average ratio of age variations was 5:1.[6] The restrictive community rating imposed by the ACA leads young and healthy individuals to subsidize the care of old and sick individuals through artificially high premiums. Repealing this limit, in theory, should allow premium prices to decline for the younger population, thus removing some of the current financial disincentive to buy insurance. We find that repealing both the individual mandate and the age rating restrictions would result in only 4 million fewer people insured in 2025, compared with expectations under current law, as opposed to the 7 million fewer insured estimated from repealing the mandate alone. Despite the decline in enrollees, spending would increase by $15 billion as the result of increased enrollment among low-income households who would qualify for premium and cost-sharing assistance. This increase in enrollment among low-income households is largely due to higher enrollment among younger households attracted by lower premiums. The combination of these two provisions will lead to much higher variability in premiums, with average premiums increasing for some products and decreasing for others.

4. Allow non-qualified health plans to be sold outside of the Marketplace

Another alternative is to allow non-qualified health plans to be sold outside the Marketplace. Under the ACA, in order to be considered a "qualified health plan" and thus eligible for sale in the health insurance Marketplace, a plan must cover the "essential health benefits" and meet minimum actuarial value requirements. Plans that do not qualify under these rules are prohibited by the ACA. The administration has granted some leeway to the enforcement of these provisions on existing health insurance plans, allowing some individuals currently in non-qualified plans to remain in those plans through the end of 2016. Repealing the mandate and allowing the sale of non-qualified health plans outside the Marketplace, according to our model, would result in 3 million fewer people insured in 2025—5 million fewer people insured through the Marketplace and 2 million more people insured outside the Marketplace. This would result in reduced spending of $193 billion on premium and cost-sharing assistance. While much of the savings are due to fewer people purchasing insurance through the

Marketplace and thus not obtaining subsidies, it is important to note that the 2 million we estimate would purchase plans outside of the Marketplace are doing so without access to the subsidies available inside the Marketplace. This indicates that removing the mandates to cover "essential health benefits" and meet specific actuarial values reduces the cost of coverage and allows individuals the ability to purchase the care they desire without the need for financial assistance from the government.

5. Repeal the age rating restrictions and allow non-qualified plans outside the Marketplace

Finally, we looked at the effect of implementing all of these actions, and, not surprisingly, found positive results. Repealing both the individual mandate and the age rating restrictions while also allowing non-qualified health plans to be purchased outside the Marketplace would result in between 0 and 500 thousand more insured individuals and an increase in spending on premium and cost sharing assistance of $14 billion. The increase in the number insured results from a net of 2.5 million fewer people purchasing coverage through the Marketplace and 3 million more purchasing coverage outside the Marketplace. Again, as in the earlier model repealing the age restrictions, spending increases even though total number of people insured through the Marketplace decreases, because of increased enrollment among low-income, young adults.

Table 1: AAF Modeling of Alternative Policies to the Individual Mandate

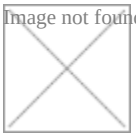
Policy	Effect on Insurance Coverage	Effect on Federal Budget
Repeal the Individual Mandate	7 million fewer insured individuals in 2025	A reduction of $191 billion in federal spending on financial assistance
Repeal the Individual Mandate and Community Rating Restrictions	4 million fewer insured individuals in 2025	An increase of $15 billion in federal spending on financial assistance
Repeal the Individual Mandate and allow non-QHP plans outside of the Marketplace	3 million fewer insured individuals in 2025	A reduction of $193 billion in federal spending on financial assistance
Repeal the Individual Mandate, Community Rating Restrictions, and allow non-QHP plans outside of the Marketplace	Less than 500 thousand more insured individuals in 2025	An increase of $14 billion in federal spending on financial assistance

The Employer Mandate and its Negative Consequences on the Labor Market

In 2014, AAF research revealed significant evidence that the employer mandate and other ACA regulations have been negatively impacting employment and pay. The employer mandate and other ACA regulations have made employers more sensitive to health care costs, which they offset by reducing pay and employment. As a result, since the ACA's passage, the rise in premiums has cost employees an average $935 per year and has reduced employment by 350,544 jobs nationwide.[7]

The employer mandate impacts hiring and employees' hours because, once fully implemented, it will require employers with 50 or more full-time employees to provide health insurance and carries a specific, per-employee

fine for noncompliance.[8] The financial impacts to those that do not provide coverage or for firms that are looking to hire the 50th worker are clear. For example, a 49-employee firm that does not provide coverage and elects to hire their 50th employee now faces a fine of $40,000 per year, which is the $2,000 per employee penalty above the first 30 employees. A small firm can skirt this requirement by switching to part-time workers.[9] The chart below (using 2013 data) reveals that the ACA's definition of "full-time" work as 30 hours per week is at odds with the empirical realities. AAF found that 72 percent of employees in 2013 worked at least 40 hours per week. Further, 50.2 percent worked exactly 40 hours per week. As a result, with the full-time threshold at 30 hours per week, the employer mandate could subject millions of workers to a dramatic reduction in hours.[10]



The employer mandate could be particularly costly for a full-time employee who works 40 hours per week and does not receive health insurance through the employer. If the employer wants to avoid the cost of the mandate and decides to reduce the worker's hours to reclassify him or her as part-time under the ACA, it would cost the employee 11 hours to go from 40 hours to 29 hours per week. If the worker's hourly earnings rate is $24.57 (the December 2014 national average), this means the employee would lose $270.27 per week or $14,054.04 per year.[11]

Despite a mandate to offer coverage, financial incentives are embedded in the ACA that encourage employers to drop health benefits and shift workers onto the health insurance exchanges, as virtually all employers and some low and moderate income employees would be financially better off for doing so. AAF found that there are about 43 million workers for whom it makes sense to drop insurance.[12] While the Congressional Budget Office (CBO) estimated that only 19 million people would receive subsidies, AAF's research suggests that number could easily triple. As a result, the CBO's cost estimate could grow from $450 billion over the first 10 years to $1.4 trillion.[13]

The employer mandate is a key failing of the law, as it will not actually compel employers to add coverage, and it depends on a complicated reporting system that the administration was unable to implement by the deadline set in the legislation. While firms are still trying to understand how this law will fully impact their business, they are making decisions to limit their future financial liabilities, and thus hiring less than they would in the absence of the law.

Conclusion

The individual and employer mandates have and will continue to disrupt both the health insurance market and the labor market. They are only necessary to enforce the ACA's limited and over-regulated choices for consumers, ineffectively pushing people into insurance coverage that does not necessarily meet their needs. By repealing some of the burdensome requirements imposed by the ACA, consumers would find more health insurance options better aligned with their needs and at a price that would allow for the purchase of coverage without depending on federal financial assistance, eliminating the need for such intrusive mandates.

[1] Our estimates on the number of individuals that will pay the penalty and the average value of the penalty are calculated using the county-level demographic information from the American Community Survey and state-wide enrollment statistics from the Department of Health and Human Services.