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Issue Brief

Eliminating the ACA's Individual Mandate:

How Would California Fare?

The Tax Cuts and Jobs Act, a federal tax law passed late in 2017, will eliminate the financial penalties imposed on people who do not maintain creditable coverage as defined under the Affordable Care Act (ACA) from 2019 onward. This paper describes ACA provisions encouraging enrollment in health coverage, explores the potential impact of the elimination of federal penalties, and discusses why California may wish to impose state-based penalties to promote enrollment.

Context

Prior to the passage of the ACA, obtaining health insurance was entirely voluntary and contingent on personal circumstances. Most people who were offered employer-sponsored coverage accepted it, paying a modest premium share. Many others enrolled in public programs such as Medi-Cal or Medicare with no, or low, premiums. Californians without access to employer-sponsored insurance and ineligible for public programs could only obtain coverage by purchasing it themselves through the individual market. Features of this market, described below, meant that people without other coverage options were more likely to remain uninsured.

Participation in the market for individual health insurance can be tenuous for both consumers and health plans. Individual consumers, bearing the full cost of premiums, may avoid the administrative burden and financial cost of enrollment until they need health care. For health plans, the costs to identify and attract new enrollees are high, partly because changing circumstances lead people to move in and out of the individual market frequently.

Prior to the ACA, in California and in most states, health plans could deny coverage or charge higher premiums for individuals judged likely to use more services based on their health conditions or age. Many consumers were thus excluded from the individual market, either explicitly or because premiums were prohibitive.

A primary policy goal of the ACA was to provide expanded and more stable access to health coverage. The ACA acknowledged the diverse paths by which people obtain health insurance and it built on, rather than overturned, those arrangements. The law imposed new responsibilities on, and provided new opportunities to, both consumers and health plans.

Key requirements imposed by the ACA include:

- Health plans were required to sell to all consumers regardless of health status ("guaranteed issue"). Benefits had to meet minimum standards and less product variation was allowed.
- Consumers were required to obtain health insurance that met specific standards ("individual mandate"); if they did not, they faced tax penalties.
- The ACA provided sliding-scale premium subsidies and cost-sharing reduction payments on behalf of low- and modest-income consumers who enrolled through Covered California, California's health insurance marketplace.
- States were allowed to expand Medicaid eligibility to people in households earning up to 138% of the federal poverty level (FPL), with the federal government providing additional funding. Taking advantage of this option, California made Medi-Cal available to millions of previously ineligible low-income childless adults.

Taken together, these provisions were intended to stabilize and expand the individual market and make more affordable coverage options available to many consumers. Cost barriers were greatly reduced, particularly for lower-income consumers, and an obligation to maintain coverage was imposed. In turn, health plans could anticipate substantial enrollment growth but had to assure access to all consumers and comply with new benefit designs that supported comparison shopping.

Why Penalties?

The effectiveness of policies that require or prohibit particular actions depends on the monetary and nonmonetary costs of compliance, the penalties associated with noncompliance, and the timeliness of enforcement.[1]

Although it can be difficult to isolate the impact of penalty size and structure from other policy provisions, these examples illustrate how higher penalties and effective penalty enforcement can advance policy goals:

- The 2006 Massachusetts health reform law imposed an individual mandate with penalties that, compared to penalties under the ACA, were (1) larger at most income levels; (2) progressive (penalty amounts increased with income); and (3) age-adjusted, providing costlier populations a greater incentive to maintain coverage.[1] Uninsured rates have fallen and adverse selection has declined, resulting in lower premiums across the entire individual market.[3]
- Most states require drivers to maintain automobile insurance, but types of penalties and enforcement processes vary. Stricter state-level enforcement results in fewer uninsured motorists.[4]

How Much?

Under the ACA, in 2017 the penalty for not maintaining health insurance was 2.5% of family income with both a minimum and a maximum. The minimum penalty was $695 per adult plus $347.50 per child, up to $2,085 for a family. The maximum penalty was set at the national average premium for a bronze plan.[5] The penalty was prorated for people uninsured for a portion of the year and waived for those who were uninsured for less than three months.[6] Exemptions for hardship and other circumstances were available.[7]

Who Paid?

In California, 778,000 households paid ACA penalties totaling $373 million in 2015. The vast majority of these penalties were paid by households whose adjusted gross income was less than $75,000.[8] Most of them could likely have enrolled in subsidized plans through Covered California with no, or low, premium contributions.[9]

Low- and modest-income Californians forgo coverage for a variety of reasons, including struggles to afford even subsidized premiums. If California implements state penalties, directing the resulting funds toward additional subsidies could be justified as part of an overall strategy to maximize the number of covered Californians.

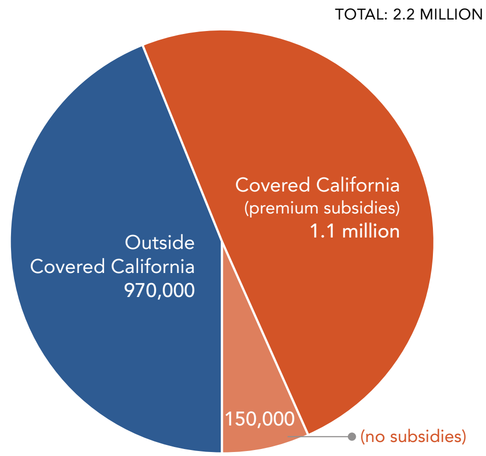
What Will Penalty Elimination Mean for California?

Eliminating ACA penalties related to the individual mandate will have consequences for Californians and for California's individual market. The main result: Fewer people will maintain coverage, and premiums in the individual market will increase.

Between 2013 and 2017, enrollment in California's individual market increased from 1.5 to 2.2 million people. At present about 1.1 million Californians obtain coverage with premium subsidies through Covered California; the remaining individual market enrollees comprise unsubsidized purchasers through Covered California (about 150,000) or through the outside individual market (970,000).[10]

Several connected features of the ACA have contributed to this robust enrollment: guaranteed issue (making individual coverage available irrespective of health status), substantial premium subsidies available via Covered California to low- and modest-income people, strong marketing and outreach efforts, and the individual mandate and threat of penalties imposed at tax time on anyone who does not maintain health insurance for the majority of the previous year. The independent impact of each policy component is hard to discern; instead, as intended under the ACA, all aspects worked together to encourage more people, including younger enrollees and those with fewer health needs, to get and maintain coverage.

Enrollment in California's Individual Market, 2017



Source: Katherine Wilson, analysis of Department of Managed Health Care and California Department of Insurance annual enrollment and Covered California enrollment as of December 2017.

A few observations and data points illustrate how the mandate and penalties affect enrollment:

- In Massachusetts, enrollment doubled following the full implementation of the state individual mandate (which imposed a different penalty structure than that of the ACA — see "Why Penalties?" sidebar). Growth was greater among those without, compared to those with, a chronic illness. Following the mandate, average enrollee age also declined.[11]
- Simulating the impact of eliminating the individual mandate throughout the US, RAND researchers estimated that the insured population would decline by 3% and that individual market enrollment would decline by 20%, with bigger decreases among young adults compared to other age groups.[12]
- In another national analysis, the Congressional Budget Office estimated that repealing the individual mandate would reduce enrollment in the individual market by about 3 million people from a baseline of 17 million, around 18%.[13]
- John Hsu and colleagues surveyed Californians with individual market coverage and found that, absent the penalty, 18% would not have purchased coverage.[14] That decline would translate to an enrollment drop of 378,000 in California's individual market.[15]
- A PricewaterhouseCoopers (PwC) review of data from national and state surveys and microsimulations concluded that Covered California enrollment would decline by between 7% and 28% (90,000 to 350,000 people) if individual mandate penalties were eliminated.[16] For the purposes of early 2019 planning, Covered California's base projection is that enrollment will decline by 12%.[17] That estimate reflects the impact of penalty elimination, as well as other anticipated policy and market shifts.
- In addition to influencing the purchase of individual coverage, eliminating penalties would also lead to erosion in Medicaid enrollment, although it is difficult to estimate by how much. The ACA led to a well-documented "welcome mat" effect through which many people who had long been eligible for Medicaid enrolled only after the law's implementation.[18] Several factors contributed to this outcome, including streamlined enrollment, expanded coverage options and financial

subsidies, greater marketing and outreach, and the imposition of the individual mandate and penalties. A 2015 California estimate attributed a Medi-Cal enrollment increase of 800,000 to this "welcome mat" effect.[19] In its analysis for Covered California, PwC estimated that eliminating penalties would cause Medi-Cal enrollment to decline by 240,000 people in 2019.[20]

- In sum, PwC estimated that penalty elimination could increase the number of Californians without health insurance by between 420,000 and 1,020,000 in 2019.[21]

Results from Massachusetts and from the RAND simulation show that age and health status affect enrollment behavior. In the absence of a mandate and penalties, younger and healthier people are more likely than those with significant health care needs to go without coverage. Conversely, the imposition of penalties increases the likelihood that younger and healthier people will enroll.

These enrollment effects have implications for premiums in the individual market. Health plans set premiums based on expected use of services. If the population (or risk pool) covered is, overall, older or less healthy, plans will raise average premiums. Depending on how much premiums rise and how sensitive enrollees are to price, what could follow is a risk spiral — more and more healthy people opt out because they can't afford rising premiums, and the population that remains grows increasingly expensive to insure.

Researchers have estimated the premium and market implications of eliminating the mandate penalties:

- An analysis of all 50 states and the District of Columbia conducted by Covered California estimated that the elimination of federal penalties could result in incremental premium hikes nationally of 7% to 15% in 2019 and an additional 2.5% to 10% annually in 2020 and 2021.[22] The impact of penalty elimination is influenced by state market conditions and policies.
- A national RAND analysis estimated that premiums would increase by 8% as enrollment among healthier people declined.[23]
- In California, the Hsu analysis found that a decline in enrollment among people with lower annual spending would cause individual market premiums to rise by 5% to 9%.[24]
- PwC estimated that 2019 California individual market premiums would increase by between 5% to 13% as a result of penalty elimination.[25] For the purposes of early 2019 planning, Covered California's base projection is that premiums will increase by 11%.[26]

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Federal premium subsidies are structured to ensure that the second-lowest-priced silver plan will not exceed a fixed share of income (on a sliding scale from 2.01% for people in households at 100% of FPL to 9.56% of household income at 400% of FPL). This means that for lower-income people, premium increases are substantially or entirely backfilled with increases in federal premium subsidy payments. Households above 400% FPL, however, will feel the full force of any premium increase brought about by a worsening risk mix.

Throughout most of California, unsubsidized single individuals in their 40s or older, and unsubsidized married couples at most ages, already face premiums for bronze coverage that exceed the ACA affordability threshold for purposes of the individual mandate (8.13% of annual income).[27] Eliminating penalties would push premiums further out of reach. Unsubsidized people with high medical use already bear out-of-pocket costs as high as 15% of their annual income;[28] premium increases due to penalty elimination would exacerbate their affordability burden. In contrast, healthier people above the subsidy threshold may respond to rising premiums by simply opting out of coverage, with deleterious effects on premiums and affordability for those who remain in the coverage pool.

Why Should California Take Action?

California has made dramatic progress in expanding coverage under the Affordable Care Act. It has established a strong exchange, Covered California, and a stable individual market. As a result, health plan participation and premium levels in California compare favorably to those in other states.[29] The ACA's individual mandate and its associated penalties were part of the broader federal and state policy framework that made those accomplishments possible.

With the elimination of federal penalties in 2019, California's policy leaders, seeking to sustain gains made under the ACA, may wish to impose state-level penalties. The ACA established the precedent that people are responsible for maintaining coverage and showed that it is feasible to report coverage status for purposes of penalty assessment. Maintaining an explicit expectation that people obtain coverage meeting comprehensiveness standards would provide greater predictability for health plans as they forecast enrollment and risk. As a consequence, individual market premiums would be more stable and lower than if penalties were abandoned without replacement. Imposing state penalties would also help sustain a norm of individual responsibility and reinforce a "culture of coverage" across California.

Conclusion

In recent years California has demonstrated strong, innovative leadership in implementing the ACA and taking state policy and administrative action to expand coverage. As a result, in 2018 the share of Californians with health insurance stands at a record high. Many state policy leaders and stakeholders are committed to moving further toward universal coverage. As policymakers consider their options to expand enrollment, they remain aware of threats that could cause erosion in recent coverage gains. The elimination of penalties related to maintaining coverage is one such threat. Replacing recently eliminated federal individual mandate penalties would keep more people covered and increase the stability and affordability of health insurance in the individual market.

Californians and California health plans have largely embraced the shared responsibility features of the ACA, responding through enrollment and marketplace participation to the law's subsidies and cost-sharing assistance, requirements, and penalties. In the face of federal retrenchment on individual penalties, California can respond with its own penalties designed to sustain coverage gains and to support a stable individual health insurance market.

Implementation Considerations

Penalties are an important tool available to California policymakers committed to ensuring that Californians get and keep health insurance coverage. The structure of penalties need not be identical to those imposed under the ACA, and California will likely wish to explore and evaluate many related issues.

What constitutes appropriate grounds to exempt people from paying penalties? Should penalty amounts be linked to premiums? How progressive with respect to income should they be? How should penalty revenues be used? As an example, one proposal under consideration in Maryland would set aside an individual's penalty payment and allow it be used for future premium payments.[30] In another example, Massachusetts has used data collected through its penalty system to tailor and target its outreach to the remaining uninsured.[31]

Actions that would augment the effectiveness of penalties should also be weighed. For example, outreach and communication — to ensure that Californians understand their coverage responsibilities, what state penalties apply if they don't meet those responsibilities, and what coverage and affordability programs are available — will be particularly important following the past year's turbulent and confusing public discourse regarding ACA repeal. Imposing a continuous coverage requirement or an auto-enrollment process in addition to penalties to encourage enrollment may also warrant consideration.[32] In sum, California policymakers can reinstate a component of the ACA yet tailor it to population needs and state policy priorities.

About the Author

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Endnotes

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