The impact of the $0 individual mandate penalty

What state characteristics
will influence costs when
the mandate is gone?

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History of the individual mandate

The requirement that every American have healthcare coverage or pay a financial penalty was one of the key provisions of the Patient Protection and Affordable Care Act (ACA). Also known as the "individual mandate," this provision of the law [1] required each person to either:

- Maintain qualifying minimum essential health coverage
- Qualify for an exemption
- Make a shared responsibility penalty payment through income taxes for any months without either coverage or an exemption

Among the provisions of the ACA, the individual mandate was one of the most controversial, initially because some questioned its legality, and others questioned its effectiveness at driving insureds into the insurance pool. The U.S. Supreme Court settled the issue of the mandate's legality in 2012, ruling that attaching a financial penalty to a failure to purchase health insurance did not run afoul of the U.S. Constitution. This decision, however, did not settle the issue of the individual mandate's effectiveness. While the amount of the financial penalty was not insignificant (the greater of 2.5% of income or $695 per individual for the 2018 benefit year),[2] it was far less than the cost of purchasing health insurance coverage and thus for many Americans did not provide an adequate incentive to sign up. Before this issue could be fully adjudicated, the Tax Cut and Jobs Act[3] (TCJA), enacted by Congress in late 2017, reduced the financial penalty to $0 beginning with the 2019 benefit year, effectively eliminating the individual mandate.

Understanding the impact of this change on the health insurance risk pool[4] is important to both insurers offering ACA-compliant products and state policymakers evaluating alternatives to the individual mandate. In particular, health insurers—that are now in the process of setting rates for 2019—need to understand how elimination of the individual mandate penalty will affect future enrollment rates, which have a significant impact on rate projections. In particular, how many fewer consumers elect to purchase health insurance now that the financial penalty has been eliminated and how does the change affect the risk pool? Furthermore, some states are considering implementing state-based individual mandates, in some cases in conjunction with a Section 1332 State Innovation waiver. Understanding the actual strength of the federal individual mandate can help these policymakers evaluate and design these state-based options.

The significance of the individual mandate

In theory, removing the individual mandate penalty will result in lower enrollment levels in the individual market[5] due to reduced incentives for individuals to purchase health insurance. As enrollment in the individual market declines, the morbidity of the individual market risk pools will increase because healthy members are more likely to exit the insurance market than are their less healthy counterparts. This change in the risk profile of the individuals remaining in the risk pool will contribute to premium increases in 2019 and beyond.

The actual change in morbidity for each risk pool will vary based on the composition of that risk pool. To help inform assumption selections by health insurers and policymakers responding to changes in the individual mandate, the authors used Milliman's Healthcare Reform Financing Model (HCRFM) to model the effects of multiple variables, with particular focus on identifying those factors with the greatest and least impact on morbidity once the mandate penalty is removed.

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1   IRS. Individual Shared Responsibility Provision. Retrieved May 17, 2018, from https://www.irs.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision.

2   Andrews, M. (February 27, 2018). Your 2018 health plan must comply with ACA rules or you risk tax penalties. NPR. Retrieved May 17, 2018, from https://www.npr.org/sections/health-shots/2018/02/27/588950615/your-2018-health-plan-must-comply-with-aca-rules-or-you-risk-tax-penalties.

3   The complete text of the legislation is available at https://www.congress.gov/bill/115th-congress/house-bill/1.

4   The "risk pool" refers to the aggregation of all insured lives in a given market such as individual, small group, etc.

5   Enrollment in other markets such as group and Medicaid is less likely to change. For further discussion, see http://www.milliman.com/insight/2018/The-individual-mandate-repeal-Will-it-matter/.
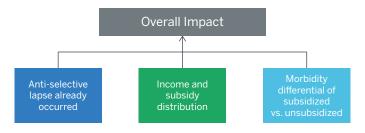
The impact on morbidity of the risk pool of the loss of the federal individual mandate penalty could be influenced by many characteristics of a population, including but not limited to:

- The distribution by federal poverty level (percentage receiving subsidies and the amount of subsidy)
- The proportion of the individual market on state healthcare exchanges
- Affordability (premium and cost sharing compared to income)
- The extent to which individuals were already using exemptions to avoid the mandate
- The historical rate increases and resulting lapses, especially if a state or carrier has already incorporated expected increases for this change in 2018 or earlier rates
- Population health status (morbidity and age/gender mix)
- Consumer knowledge about the mandate
- Outreach efforts to support enrollment by both state and federal governments

Similarly, these same characteristics could influence the effectiveness of any potential state-based individual mandate penalty.[6]

The aforementioned modeling tested a number of these characteristics to determine the sensitivity of the morbidity change (defined as including both changes in health status and demographics). We found that, in general, the morbidity impact was most influenced by:

- Degree of anti-selective lapse that has already occurred in the individual market
- Income distribution and subsidies
- Morbidity differential between subsidized and unsubsidized members

Conversely, our modeling showed that the market level morbidity changes in an environment without the mandate are not sensitive to the following characteristics:

- Age/gender mix of the individual market
- Whether or not a state put a transitional policy in place

In addition to the short-term impact of eliminating the individual mandate penalty, this change could amplify the impact of other changes to rates in 2019 and beyond. For example, enrollees may become additionally sensitive to future rate increases, and thus might be more likely to lapse coverage.

The significant factors

ANTI-SELECTIVE LAPSES TO DATE
The individual market has generally experienced high rate increases in recent years,[7] and has seen issuers exit the market. This is likely to have already caused some healthier and unsubsidized members to forego coverage. To the degree that a given state's individual market has already experienced anti-selective lapses, the impact of eliminating the individual mandate penalty will likely be relatively less because many of those who would likely be affected by elimination of the mandate have already exited the market.

INCOME DISTRIBUTION AND SUBSIDIES
In general, states with a greater proportion of unsubsidized members—consumers with incomes greater than 400% of the federal poverty level (FPL)—and healthier members are more likely to see a more significant financial impact due to removal of the mandate. Unsubsidized and healthier members would be more likely to exit the market if there were no penalty for doing so. Conversely, states with more subsidized and unhealthier members would be likely to see a lessened impact of the mandate penalty removal. In general, subsidized members are more likely to maintain coverage because a portion of their premium (and, in particular for members with incomes less than 250% of the FPL, a portion of their cost sharing), is subsidized. Less healthy members are generally more likely to maintain coverage because they are expected to have higher claim amounts and thus get greater value from their insurance.

MORBIDITY DIFFERENTIAL BETWEEN SUBSIDIZED AND UNSUBSIDIZED MEMBERS
All else being equal, unsubsidized members are generally more likely to exit the market than subsidized members. Therefore, the morbidity differential between subsidized and unsubsidized members will influence the resulting morbidity change. For example, if a given state's unsubsidized members are significantly healthier than its subsidized members, then the resulting morbidity impact is likely to be greater as compared to a state where the morbidity differential between these groups is less significant. Thus, it is important to understand this differential when determining the impact of mandate removal.

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6   Cousart, C. (February 20, 2018). Considering a state individual mandate? What policymakers can learn from Massachusetts' experience and Maryland's proposal. National Academy for State Health Policy blog. Retrieved May 17, 2018, from **https://nashp.org/ considering-a-state-individual-mandate-what-policymakers-can-learn-from-massachusetts-experience-and-marylands-proposal/**.

7   Houchens, P. (May 17, 2018). Commercial health insurance: Overview of 2016 financial results and emerging enrollment and premium data. Retrieved May 17, 2018, from **http://us.milliman.com/insight/2018/ Commercial-health-insurance-Overview-of-2016-financial-results-and-emerging-enrollment-and-premium-data/**.

Less significant factors

AGE/GENDER MIX

One characteristic we observed to have less effect on morbidity was the demographic (age/gender) mix of a population. On a nationwide basis, we observe a material difference in morbidity between younger enrollees purchasing individual ACA coverage relative to the younger population in general. At the same time, we observe an immaterial difference in morbidity between older members purchasing individual ACA coverage and the older population in general. This has resulted in a less significant morbidity differential between younger and older enrollees in the ACA individual market. Therefore, the age/gender mix of a population will be less influential in terms of the resulting morbidity change due to the mandate removal. However, a given state or issuer may have more significant morbidity differences between younger and older members, in which case the age distribution would be more likely to influence the resulting morbidity impact.

TRANSITIONAL POLICY BY STATE

Another characteristic is whether a state allowed transitional policies to continue. We tested the impact of this variable by assuming a state had discontinued transitional policies back in 2014 or 2015 and then allowed the policies to continue into 2019. In both cases, we found no significant impact on morbidity. When states discontinue transitional plans, these policyholders made decisions to join or not join the ACA risk pool some time ago and now react to the mandate removal in many ways similar to the overall ACA risk pool. When states allow transitional policies through 2019, the transitional enrollees do not affect the ACA risk pool results, although the mandate removal may affect the risk profile of the transitional policies themselves. The lack of a mandate could, however, affect a transitional person's purchase decision if transitional policies were ended after 2019.

Conclusion

The removal of the individual mandate penalty will not be an insignificant impact to 2019 rates. However, as is always the case, every state is unique and the changes to the risk pool brought by a zero dollar mandate penalty will vary accordingly. Stakeholders should consider each of the relevant factors outlined above carefully, recognizing that the mandate (and by extension, its effective removal) is just one of many moving parts within the dynamic environment of the individual market. As some states contemplate a state-based mandate, similar considerations will determine the effectiveness, both in terms of how it affects enrollment and how much penalty revenue it might generate. Penalty revenue can be used to stabilize rates or fund other market reform initiatives such as state innovation waivers. Effective and detailed modeling is one step in a necessarily complicated process.

Modeling the impact of eliminating the individual mandate

We used Milliman's HCRFM to estimate the morbidity impact of removing the individual mandate. The HCRFM uses the Current Population Survey (CPS) data supplemented by other data sources (e.g., the Medical Expenditure Panel Survey, the Office of the Assistant Secretary for Planning and Evaluation [ASPE] survey, summarized historical values from actual Unified Rate Review Templates, and Milliman's Model of U.S. Healthcare Expenditures). The HCRFM contains a recalibrated income distribution of the starting census based upon the Public Use Files released for 2016 and 2017 as well as other sources. The HCRFM also contains health status distributions by age and gender using the Milliman Advanced Risk Adjusters™ (MARA™) and the Model of U.S. Healthcare Expenditures.

We used Milliman's commercial Health Cost Guidelines™ (HCGs) to model claim costs. Adjustments were applied to the costs based on the Model of U.S. Healthcare Expenditures and actual historical data from the Unified Rate Review Template. The HCRFM assumes carriers price to meet medical loss ratio (MLR) requirements and then resulting premium amounts are calibrated to publicly available information from Kaiser Family Foundation State Health Facts and data from SNL Financial, ASPE, and other published premium and subsidy estimates.

We simulated various projections in the HCRFM to estimate the morbidity impact of removing the individual mandate. These scenarios contained lapse assumptions, which varied by income and health status levels. Lapse assumptions were based on enrollment data from the Public Use Files, various survey and poll results from sources such as the Commonwealth Fund and Kaiser Family Foundation, and professional actuarial judgment. We compared these results against our baseline projections, which assumed that the individual mandate penalty still applied.

We considered the following factors when determining the impact of the individual mandate repeal:

- The mandate penalty not being large enough to drive consumer behavior.
- Lack of knowledge and confusion about the mandate throughout the marketplace. A Commonwealth Fund study shows that about 60% of adults were aware that the penalty is now $0 for the 2019 benefit year.[8]

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8   Collins, S. R. et al. (May 1, 2018). First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse. Commonwealth Fund. Retrieved May 17, 2018, from http://www.commonwealthfund.org/publications/blog/2018/apr/health-coverage-erosion?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top-stories.

- Lapses that have occurred between 2014 and 2018 due to rate increases and market exits.[9]
- The high proportion of enrollees receiving subsidies. About 83% of exchange enrollees, and about 62% of total enrollees, receive some form of subsidy.[10]

Our modeling did not consider the potential impact of association health plans (AHPs) or short-term limited duration (STLD) policies. Changes to the regulation of these policies are likely to have additional effects on the individual ACA market and could potentially amplify the effects of the removal on the mandate.

The HCRFM uses historical data to project market enrollments, claim costs, and premium levels. Mandate impacts will vary based on emerging information and underlying assumptions regarding future enrollment elections, market dynamics, etc.

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9   Houchens, P. (May 17, 2018). Commercial health insurance: Overview of 2016 financial results and emerging enrollment and premium data. Retrieved May 17, 2018, from http://us.milliman.com/insight/2018/Commercial-health-insurance-Overview-of-2016-financial-results-and-emerging-enrollment-and-premium-data/.

10   CMS.gov (April 4, 2018). 2018 Marketplace Open Enrollment Period Public Use Files. Retrieved May 17, 2018, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html.

Limitations

Andrew Bourg, Stacey Muller, and Fritz Busch are actuaries with Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the American Academy of Actuaries to issue this report and render the actuarial opinion contained herein. This report should not be interpreted as an endorsement by Milliman or the authors of any particular legislation. The report reflects the authors' findings and opinions. The report reflects a current understanding of the ACA and the questions emerging from potential changes to current legislation and regulations. As legislation develops and regulations change, answers may emerge that prompt new questions. We ask that this report be distributed only in its entirety because isolated extracts may be misleading.

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