

EXAMINING THE EFFECTIVENESS OF THE  
INDIVIDUAL MANDATE UNDER THE  
AFFORDABLE CARE ACT

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HEARING  
BEFORE THE  
SUBCOMMITTEE ON OVERSIGHT  
OF THE  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
ONE HUNDRED FIFTEENTH CONGRESS  
FIRST SESSION

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**TUESDAY, JANUARY 24, 2017**

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
SUBCOMMITTEE ON OVERSIGHT,  
*Washington, DC.*

The Subcommittee met, pursuant to call, at 2:26 p.m., in Room 1100, Longworth House Office Building, Hon. Vern Buchanan [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]



## **WAYS AND MEANS**

CHAIRMAN KEVIN BRADY

### **Chairman Buchanan Announces Hearing on Examining the Effectiveness of the Individual Mandate Under the Affordable Care Act**

House Committee on Ways and Means Subcommittee on Oversight Chairman Vern Buchanan (R-FL) today announced that the Subcommittee will hold a hearing on Examining the Effectiveness of the Individual Mandate under the Affordable Care Act. The hearing will take place immediately following a brief Subcommittee Organizational Meeting on Tuesday, January 24, 2017 at 2:00 PM in Room 1100 of the Longworth House Office Building.

In view of the limited time to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

#### **DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, February 7, 2017**. For questions, or if you encounter technical problems, please call (202) 225-3625.

#### **FORMATTING REQUIREMENTS:**

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the

Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

**Note:** All Committee advisories and news releases are available at <http://www.waysandmeans.house.gov/>

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Chairman BUCHANAN. The Subcommittee will come to order.

Welcome to the Ways and Means Subcommittee Oversight hearing on Examining the Effectiveness of the Individual Mandate Under the Affordable Care Act. My focus today is on affordability.

In Florida, 65 percent of our counties only have one carrier offering insurance to individuals in 2017. The State went from eight carriers in 2014. Today, we have five carriers, almost half, in 2017. In Manatee and Sarasota Counties, two counties I represent in my district, individuals went from being able to choose from among three different providers down to two. This happened in just a single year. In addition to less options to choose from, the average monthly premium Floridians enjoyed under the ACA increased by 19 percent this past year, according to the Florida Office of Insurance Regulation.

Let me pause and look back 4 years ago when the Affordable Care Act was just beginning to be implemented in 2013. Then, the HHS secretary released a report stating the goal of Affordable Healthcare Act is to increase competition and transparency in the markets for individuals and small group insurance leading to higher quality, more affordable products. Fast forward 4 years later, 2017, what we are seeing not only in Florida but across the country is a decrease in competition, an increase in premium costs. This increase cannot continue. It is not sustainable.

We are here today to understand why the individual mandate, which today I think those fees that we are paying in over \$3 billion was a key component. The ACA is failing to stabilize the health insurance marketplace. This discussion is important not so that members on our side of the aisle or the other side of the aisle can score political points, but that, so we can focus on the facts. We need facts because there are real people's lives that are being impacted.

When I talk to people in my district, it is clear to me that they are struggling. Although I mentioned some statewide and county-level statistics, those numbers touch the lives of real people in Florida in terms of Florida families. We cannot stand idly by as health insurance under the Affordable Care Act becomes less and less affordable for our constituents. I hope this hearing serves as the first step to fixing what is broken. I look forward to listening to our witnesses and learning from the past so that we can develop better solutions for the future.

I now yield to the distinguished Ranking Member Mr. Lewis for the purpose of an opening statement.

Mr. LEWIS. Again, Mr. Chairman, thank you. I want to thank you again and congratulate you on your new role as chairman of the Oversight Subcommittee.

The two Democratic Members of the Subcommittee have now arrived. They didn't get lost in the tunnel. So they are here. Joe Crowley of New York and Danny Davis of Illinois.

Mr. Chairman, I hope we can continue our tradition of strong oversight of the Administration as we have in past Congresses. I would also like to thank each witness for being here this afternoon.

Let me begin by saying what I have said at countless other hearings. The Affordable Care Act works. It works. Now, I want to be crystal clear for the record. The topic of today's hearing is a Republican idea. In fact, Governor Romney called it the ultimate conservative idea because it was based in personal responsibility. The individual mandate became a core part of the health care law. There is not a family in this country that has not been touched by sickness or injury. By sickness or injury.

I have said it before and I will say it again. I believe in my heart of hearts that health care is a basic human right. It is not a privilege for the wealthy. It should not be reserved for the people that insurance companies have decided worthy of the risk.

This Committee has a mission, an obligation, and a mandate to think of those that have been left out and left behind. We cannot forget the 100 million Americans with preexisting conditions. We cannot forget the struggle of those people whose care costs more than the insurance limit. We cannot forget the seniors in the doughnut hole who were unable to afford their medicine.

I know that we can come together to make health care more affordable, more accessible for every person in our great country. I speak for the members on this side of the aisle who are ready to do the good work, the people's work.

We must be mindful not to harm the marketplaces where Americans buy insurance. We must protect children from being kicked off of their parents' plan. We must ensure that a woman is not charged more simply because she is a woman.



Mr. Chairman, today we face a moral issue. In the coming weeks and months, we should come together to improve the law and not destroy it. At stake are not just the detail of policy but the fundamental principles of justice and the very character like our great Nation.

Thank you, Mr. Chairman. And I yield back.

Chairman BUCHANAN. Thank you, Mr. Lewis.

Without objection, other Members' opening statements will be made part of the record.

Today's witness panel includes three experts. First, John Graham is a senior fellow at the National Center for Policy Analysis. Tom Miller is a resident fellow at the American Enterprise Institute. And finally, Dr. John E. McDonough is a professor of practice at the Department of Health Policy and Management at Harvard TH Chan School of Public Health.

The Subcommittee has received your written statements and they will be all made part of the formal hearing record. You will each have 5 minutes to deliver your oral remarks. We will begin with Mr. Graham. You may begin when you are ready.

**STATEMENT OF JOHN R. GRAHAM, SENIOR FELLOW AT THE  
NATIONAL CENTER FOR POLICY ANALYSIS**

Mr. GRAHAM. Thank you, sir.

Chairman Buchanan, Ranking Member Lewis, my name is John R. Graham of the National Center for Policy Analysis. I will take my short time today to emphasize some of the commentary I brought up in my written comments, which I have already submitted to you and which I drafted before President Trump issued his executive order, which I think makes the individual mandate of even more pressing concern.

Will it be enforced by the next HHS secretary? If it is not enforced, will it cause ObamaCare to collapse? Or perhaps some of us might say collapse more or faster than we have seen it collapsing already.

Politically, it is very easy to go after the individual mandate. It is the least popular part of ObamaCare. However, it counterbalances the most popular part of ObamaCare, the protection against being underwritten for preexisting conditions.

I think my message today could be worry not. Although the individual mandate is also—is bad politics, I would also assert it is bad economics or at least weak economics. Now, this is a very different message than we have heard for many, many years. It is true that it can properly be characterized as a conservative idea. And the high water mark of that was what we call RomneyCare in the Massachusetts health reform. The idea which is meant to appeal to conservatives is that this is—demonstrates individual responsibility. We have a problem that hospitals' emergency rooms are jammed with patients who are not paying their bills, and so we have an uncompensated care crisis. Fair enough.

Further, if people are encouraged to buy more insurance, they are more likely to get preventative and timely care and not have to go to the emergency room in the first place. Well, that would be fine. But the reality on the ground is it would only work if the mandate or the uninsured crisis was concentrated among high-in-

come households. If it was folks like Bill Gates or Warren Buffett who were crowding the emergency rooms. I am sorry. I should update that given the current Administration. Peter Thiel or Sheldon Adelson were crowding the emergency rooms. But they are not. It is low-income people who are largely uninsured. They cannot bear to pay the fee or tax or penalty or whatever we want to call it for violating the mandate.

So although it is appealing to conservatives to think that this imposes individual responsibility, in fact what its real effect is to give cover to significant growth in government spending and government programs, which is fine in some people's minds but not for conservative minds, I would suggest.

Now, whatever we want to call it—the law, as you know, calls it a penalty. CMS healthcare.gov now calls it a fee. But whatever we want to call it, it is inefficient in a very mechanical sense. A recent memo from the Internal Revenue Service points out that 6-1/2 million people paid the fine in 2015, but 12.7 million were exempted for various reasons. Again, emphasizing the point that most people whom you think you are affecting with a mandate cannot afford to pay it.

How much was raised from the mandate? \$3 billion. Now, to me that sounds like a lot of money. But as you know, in the health care system that is nothing. We spent \$3.2 trillion on health care in this country in 2015. If we compare the Congressional Budget Office score to—about ObamaCare, the Affordable Care Act in 2010 versus the update in March 2016, it shows there is a slight reduction in anticipated revenue from the tax or penalty from the people who do not obey the mandate. But this is not because more people are getting private coverage and exercising their responsibility.

In the original CBO score, the CBO estimated, this is back in 2010, that the Affordable Care Act would leave 22 million uninsured in 2016 through 2019. Recently, that has been upped to 27 million. Those with employer-based coverage, according to the original estimate, was 163 million. In the new estimate, it is down to 159 million. Sorry. Down to 152 million.

In 2010, the Congressional Budget Office estimated ObamaCare exchanges would enroll 21 million people in 2016, and we know where that has gone, increasing to 24 million in 2019. It is down to an estimate of 20 million people in 2019 under the current law, according to the latest CBO estimate.

Who is getting insured? It is Medicaid. And the Medicaid dependency, the estimates according to the CBO, have gone up by about one-third. So the coverage through ObamaCare is not through enforcing any kind of individual mandate. It is through more government dependency on Medicaid, which is costing us far more than we are getting from an individual mandate.

Chairman BUCHANAN. Thank you.

[The prepared statement of Mr. Graham follows:]

"Obamacare's Individual Mandate is Economically Inefficient and Does Not Improve Access to Health Care"

Statement of John R. Graham

Senior Fellow

National Center for Policy Analysis

Committee on Ways and Means

Subcommittee on Oversight

"Examining the Effectiveness of the Individual Mandate Under the ACA"

Hearing on Tuesday, January 24, 2017 at 2 p.m. in Room 1100 Longworth House Office Building.

Chairman Buchanan, Ranking Member Lewis, and Members of the Committee, I am John R. Graham, Senior Fellow at the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector. I welcome the opportunity to share my views and look forward to your questions.

The individual mandate is Obamacare's least popular feature. It was the subject of the 2012 lawsuit asserting Obamacare was unconstitutional: Never before had the federal government forced any resident to buy a good or service from a private business. The people lost that argument. Nevertheless, Republicans have pledged to eliminate the individual mandate. This commitment remains good politics. Perhaps counterintuitively, it is also good economics.

According to last November's [Kaiser Family Foundation Tracking Poll](#), only 35 percent of respondents have a favorable view of the individual mandate. The proportion drops to just 21 percent among Republicans, and just 16 percent among Trump supporters.<sup>1</sup>

However, getting rid of the individual mandate also poses a political dilemma: It balances a very popular provision of Obamacare. Recall the theory of the individual mandate is to prevent free-riding: Americans should be responsible for maintaining continuous health coverage so they do not become a burden on taxpayers when they become sick.

If you bought a house and did not invest in homeowner's insurance, few citizens would urge the government to require insurers to issue you a policy *after* your house was destroyed by fire. We all understand the market for homeowner's insurance could not function under such a law.

However, we seem to have a blind spot with respect to this problem when it comes to health insurance. In the same poll, 69 percent of respondents support prohibiting insurers from denying coverage because of a person's medical history. The proportion is 63 percent among Republicans, and 60 percent among Trump supporters.

This appears to support the academic economic argument for the individual mandate alongside a means-tested tax credit for buying health insurance: Without them, people will wait until they become sick to buy health insurance. President Obama and his allies came to accept the academic argument without recognizing its political costs.

Further, as was discussed back in 2009 and 2010, the individual mandate has been described as a "conservative" or even "Republican" idea. Championed by an influential conservative think tank, it was integral to Governor Mitt Romney's 2006 health reform in Massachusetts. Characterized as a feature of individual responsibility, the individual mandate would give bipartisan political cover to a significant growth of government spending and control over health insurance.

Of course, history shows it did not achieve that cover. Fortunately, evidence shows the individual mandate is also bad economics, despite academic claims. Whatever we label the

punishment for disobeying the mandate - a “fine” or a “tax” - it is a very, very inefficient way to finance health care. (Although the Centers for Medicare & Medicaid Services refers to a “fee,” the Affordable Care Act names it a “penalty,” which is the word used in this testimony.)

In many other insurance markets, politicians do not become overly concerned with the risk of free-riders. If a person does not buy homeowner’s insurance, and his house burns down, most would agree he was irresponsible. However, no politician would commit taxpayers to rebuild and refurnish his house.

Health care is different. Americans receive treatment, especially at hospitals, whether we can pay or not. The argument from individual responsibility claims some people do not buy health insurance voluntarily, then get rushed to hospitals’ emergency rooms. The hospitals suffer a burden of so-called uncompensated care, which the text of the Affordable Care Act asserted added one thousand dollars to the average premium of insured people (because hospitals raise charges to cover uncompensated care).

If the government imposes an individual mandate to maintain health insurance or pay a penalty, there will be a significant reduction in uncompensated care, and this hidden tax should come off our premiums. Also, being insured should increase the likelihood of being treated by a doctor early in the development of a problem, and avoiding the emergency department altogether.

Unfortunately, the consequences of the individual mandate are quite different in the real world. The only way the individual mandate would solve the problem of uncompensated care is if high-income people were the ones receiving uncompensated care. They are not. It is low-income people who dominate the uninsured. So, increasing the number of people with health insurance requires far more tax credits flowing out to subsidize their coverage than revenues from penalties. This drives health costs up.

The net cash flows are complicated because neither health insurers nor hospitals and other providers would tolerate tax credits being paid to individuals directly. This would impose significant credit risk throughout the health system. As a result, the Affordable Care Act pays tax credits to insurers, which reduces net premiums due from beneficiaries.

Nevertheless, a [recent report](#) from the IRS demonstrates the confusion.<sup>2</sup> For 2015:

- According to forms submitted with individuals’ tax returns, about 5.8 million taxpayers received *advance* payments of premium tax credits.
- However, according to forms submitted to the IRS by Obamacare’s exchanges, 7.3 million taxpayers received advances.
- The IRS figures the difference (about 1.5 million people) comprises taxpayers who have not filed the appropriate form with their tax returns.

- About 2.4 million taxpayers claimed more tax credit in their tax return than they had received in advance.
- About 3.3 million taxpayers reported they had received too much in advance and had to refund some. The total was \$2.9 billion.

As for the individual mandate:

- About 12.7 million taxpayers filed for an exemption from the mandate. (There are a number of grounds for exemption, including self-declared “hardship”).
- About 6.5 million taxpayers reported a total of \$3.0 billion in penalties due for not maintaining coverage.

Recall U.S. health spending in 2015 was \$3.2 *trillion*, so the penalties comprise an utterly trivial share of health care financing.<sup>3</sup> Even within Obamacare, revenue from penalties were never very significant. According to the Congressional Budget Office’s original score of the Affordable Care Act, the individual mandate was estimated to raise \$17 billion over ten years (2010 through 2019), only 2 percent of Obamacare’s \$1 trillion dollar source of funds.<sup>4</sup> In the March 2016 baseline, the CBO updated its estimate of revenue from penalties.<sup>5</sup> For the four years included in both the 2010 and 2016 estimates (2016 through 2019), the estimate dropped one fifth from \$15 billion to \$12 billion.

However, this is not because more people are expected to pay for their own insurance. On the contrary, more are expected to be uninsured or fall into Medicaid, a welfare program fully funded by taxpayers. The changes are significant:

- In 2010, CBO estimated Obamacare would leave 22 million uninsured in 2016 through 2019. In 2016, CBO estimated Obamacare will leave 27 million uninsured through 2019 – an increase of almost one quarter.
- In 2010, CBO estimated Obamacare would leave 163 million with employer-based health benefits in 2016 and 159 million in 2019. In 2016, CBO estimated Obamacare will leave only 155 million with employer-based plans. The number will decrease to 152 million in 2019.
- In 2010, CBO estimated Obamacare exchanges would enroll 21 million people in 2016, increasing to 24 million in 2019. In 2016, CBO estimated Obamacare’s exchanges will enroll only 13 million people this year, and 20 million in 2019.
- In 2010, CBO estimated Obamacare would result in 52 million Americans remaining or falling into dependency on Medicaid or the Children’s Health Insurance Program, the welfare programs jointly funded by state and federal governments that subsidizes low-income households’ health care, in 2016. CBO estimated that figure would drop slightly to 51 million in 2019. In 2016, CBO estimated 68 million will be dependent on the

program this year through 2019 – an increase of almost one third in the welfare caseload.

If there is any positive to this news, it is that Obamacare's exchange spending will be less than initially estimated. Because the estimated number of people enrolling in Obamacare's exchanges has been cut almost in half, the estimate of taxpayer dollars handed out to insurers in the exchanges has also been reduced. The initial estimate for the 2016-2019 period was \$394 billion, which has been dialed back to \$243 billion in the March 2016 update.

Of course, those 16 million more welfare dependents will be a burden on taxpayers. Because of differences in the way CBO reports Obamacare's effect on Medicaid and the CHIP in its 2010 and March 2016 estimates, it is not easy to calculate the change in Medicaid and CHIP spending due to Obamacare.

Nevertheless, this month's CBO estimate alone indicates \$64 billion, almost one quarter of the \$279 billion the federal government will spend on Medicaid and SCHIP this year, is due to Obamacare's Medicaid expansion.<sup>6</sup>

This is broadly reminiscent of the experience of Massachusetts' 2006 reform. In its 2007-2008 *Progress Report*, the state noted 97,000 uninsured residents (58 percent of the uninsured) were assessed a (very small) penalty in 2007.<sup>7</sup> However, of the 434,000 who became newly insured through March 2008, 72,000 were enrolled in the fully subsidized MassHealth program and 176,000 in the partially subsidized Commonwealth Care. Although, a majority of enrollees in Commonwealth Care did not actually pay any premium. The proportion paying premium increased from 20 percent in August 2007 to 42 percent in 2013 the last year before Obamacare.<sup>8</sup> For most beneficiaries, Commonwealth Care was wholly welfare.

State and federal spending attributable to Massachusetts health reform almost doubled from \$1.0 billion in 2006 to \$1.9 billion in 2011. The reform drove up health spending. Hospitals' emergency department use increased by 17 percent in the two years after the reform was implemented.<sup>9</sup>

The reform also gave the insurance commissioner political power to dictate insurance premiums. The commissioner refused 235 of 276 rate hikes for April 2010 and demanded that plans rebate premiums that had already been paid.<sup>10</sup> The result is that Massachusetts' health plans hemorrhaged cash, and a senior regulator described the situation as a "train wreck."<sup>11</sup>

Similarly, the average Obamacare premium hike for 2017 was 25 percent, demonstrating an individual mandate does not reduce premium growth by making everyone pay their fair share.<sup>12</sup> A friendly 2014 analysis published by the U.S. Department of Health & Human Services estimated Obamacare would reduce uncompensated care costs by \$5.7 billion that year.<sup>13</sup> However, Medicaid and Obamacare tax credits cost the federal government alone \$38 billion in 2014. It makes no sense to spend \$38 billion to save \$5.7 billion.

The preponderance of evidence on government forcing more money into the health system shows it does not increase preventive or primary care and reduce emergency department use. Plenty of evidence, reaching as far back as the Canadian province of Quebec's guaranteeing universal coverage in 1971 shows emergency departments see more patients, not fewer, after such a reform.<sup>14</sup>

What such reforms do achieve is to feed more unaccountable money into hospitals and other health services facilities. If we look back in a straight line from December 2016 to January 2008, the high-water mark of employment before the Great Recession started destroying jobs, we can see the United States added 6.87 million nonfarm civilian jobs. (This is the net figure, passing over the millions of jobs lost and re-gained through the recession.) However, 2.59 million jobs are in health services, which grew by one fifth (20 percent). All other nonfarm jobs grew only 3.42 percent, adding 4.29 million jobs. Health services accounted for 38 percent of all jobs added from the January 2008 peak through the end of last year.<sup>15</sup>

The evidence shows an individual mandate to maintain health insurance is not an appropriate government measure to induce residents to take responsibility for their health. Rather, it gives cover for a dramatic increase in government spending on a health-services sector that shows no productivity improvements.

<sup>1</sup> "Kaiser Health Tracking Poll: November 2016," The Henry H. Kaiser Family Foundation, December 1, 2016. Available at <http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-november-2016/>.

<sup>2</sup> John A. Koskinen, letter to Congress regarding 2016 tax filings related to Affordable Care Act provisions, Internal Revenue Service, January 9, 2017. Available at <https://www.irs.gov/pub/newsroom/commissionerletteracafileseason.pdf>.

<sup>3</sup> "National Health Expenditures 2015 Highlights, Centers for Medicare & Medicaid Services, December 6, 2016. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>.

<sup>4</sup> "Cost estimate for the amendment in the nature of a substitute for H.R. 4872, incorporating a proposed manager's amendment," Congressional Budget Office, March 20, 2010. Available at <https://www.cbo.gov/publication/21351>.

<sup>5</sup> "Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables From CBO's March 2016 Baseline," Congressional Budget Office, March 2016. Available at <https://www.cbo.gov/sites/default/files/recurringdata/51298-2016-03-healthinsurance.pdf>.

<sup>6</sup> In 2010, CBO's total estimate of 52 million dependents in 2016 comprised a baseline of 35 million plus 17 million more due to Obamacare's expansion. This month, CBO's estimate of 68 million comprised a baseline of 57 million dependents if Obamacare had not passed, plus 11 million due to Obamacare's expansion.

<sup>7</sup> "Massachusetts Health Care Reform: 2007/2008 Progress Report," Commonwealth Connector, 2008, page 8. Available at [https://www.mahealthconnector.org/wp-content/uploads/progress-reports/2007\\_2008ProgressReport.pdf](https://www.mahealthconnector.org/wp-content/uploads/progress-reports/2007_2008ProgressReport.pdf).

<sup>8</sup> "Report to the Massachusetts Legislature, Implementation of the Health Care Reform Law, Chapter 58, 2006-2008," The Massachusetts Health Care Connector Authority, October 2, 2008, page 20. Available at <https://www.mahealthconnector.org/wp-content/uploads/annual-reports/ConnectorAnnualReport2008.pdf>; "Report to the Massachusetts Legislature, Implementation of Health Care Reform, Fiscal Year 2013,"



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Massachusetts Health Connector, January 2014, page 9. Available at <https://www.mahealthconnector.org/wp-content/uploads/annual-reports/ConnectorAnnualReport2013.pdf>.

<sup>9</sup> Liz Kowalczyk, "ER visits, costs in Mass. Climb," *Boston Globe*, April 24, 2009. Available at [http://archive.boston.com/news/local/massachusetts/articles/2009/04/24/er\\_visits\\_costs\\_in\\_mass\\_climb/](http://archive.boston.com/news/local/massachusetts/articles/2009/04/24/er_visits_costs_in_mass_climb/).

<sup>10</sup> "Patrick-Murray Administration's Division of Insurance Announces Decision on Rate Increase Submissions by Health Insurers," press release, Massachusetts Division of Insurance, April 1, 2010.

<sup>11</sup> Robert Weisman, "State Acts to Oversee 3 Insurers," *Boston Globe*, June 11, 2010.

<sup>12</sup> "Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace," U.S. Department of Health & Human Services, October 24, 2016, page 5. Available at <https://aspe.hhs.gov/sites/default/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf>.

<sup>13</sup> Thomas DeLeire, Karen Joynt, and Ruth McDonald, "Impact of Insurance Expansion on Hospital Uncompensated Care Costs," U.S. Department of Health & Human Services, September 24, 2014, page 1. Available at <https://aspe.hhs.gov/pdf-report/impact-insurance-expansion-hospital-uncompensated-care-costs-2014>.

<sup>14</sup> John R. Graham, "Least Surprising Health Research Result Ever: Medicaid Increases ER Use," *Health Policy Blog*, National Center for Policy Analysis, January 16, 2014. Available at <http://healthblog.ncpa.org/least-surprising-health-research-result-ever-medicare-increases-er-use/#sthash.16xwCVfS.ltbX25u8.dpbs>

<sup>15</sup> John R. Graham, "Obamacare's Voodoo Employment Economics Threatens Reform," National Center for Policy Analysis, forthcoming.

Chairman BUCHANAN. Mr. Miller, you are up next.

**STATEMENT OF THOMAS MILLER, RESIDENT FELLOW,  
AMERICAN ENTERPRISE INSTITUTE**

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

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

Most arguments in favor of the individual mandate usually present it as a necessary, though far less popular, means to more laudable ends. Well, they certainly got the last part right. The individual mandate touches exposed nerves and offends core principles in ways that other elements of the modern regulatory state do not. The individual mandate has consistently remained the most intensely unpopular provision of the new health care law since it first took shape.

One of 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. But shifting costs less transparently is not the same as actually reducing them.

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. Trying to force people to buy insurance they cannot afford or pay much more for such coverage than it actually appears worth to them remains politically and economically difficult.

As a consequence, 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 rather than a more polarizing command. Because the penalties for failing to comply with the mandate are rather modest in proportion to the average—likely average premium cost of required coverage, millions of individuals have calculated that it is much less expensive to pay the penalty than to purchase mandatory insurance.

Projections for compliance versus penalty payment under the individual mandate by the Congressional Budget Office consistently have overestimated the degree of compliance. In practice, the Internal Revenue Service has reported noticeably higher numbers of individual mandate penalty payers despite lower amounts of actual revenue collected. CBO also has tended to be on the high side of claims that the Affordable Care Act would rapidly and substantially increase coverage in the new law's exchanges for individual coverage as well.

Rather than reexamine the flawed foundations of its previous assumptions, CBO appears to have recently doubled down on them. The CBO estimates are flawed in overstating baseline assumptions for future growth in the ACA's version of individual market coverage, exaggerating the response rate of those subject to the mandate before and after its possible repeal, misestimating Medicaid coverage effects, and setting unrealistic parameters for future health policy changes. In fact, the most significant force behind the size and shape of insurance coverage gains has been large taxpayer subsidies primarily through the expanded Medicaid program.

Enrollment rates for the ACA exchanges are highly sensitive to one's income and premium tax subsidy level. Enrollment by younger and healthier risks, which is supposed to be the primary target of the individual mandate, has failed to reach expected levels. There are a variety of alternative policy remedies that could be pursued if the individual mandate is either limited further or repealed. They include extension of HIPAA-like protection against health status risk rating to individuals in the nongroup market who maintain continuous qualified insurance coverage while switching between health plans. Or imposing penalties in the form of higher insurance premium surcharges when eligible individuals fail to obtain or maintain minimum qualified coverage during annual open enrollment periods. Or tightening eligibility verification further for special enrollment periods between annual open seasons in ACA exchanges. Or enabling default enrollment in minimum qualified coverage costing no more than the value of applicable Federal taxpayer subsidies for insurance. Or providing a different mix of taxpayer subsidies for obtaining and maintaining qualified insurance coverage in the individual market that are more generous to younger and healthier individuals who have declined coverage thus far. Or as a last resort for some and a first resort for others, actually enabling and incentivizing insurers to offer coverage that is less expensive and more attractive to potential uninsured customers.

Thank you, Mr. Chairman. I look forward to your questions.

Chairman BUCHANAN. Thank you, Mr. Miller.

[The prepared statement of Mr. Miller follows:]



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

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

**Thomas P. Miller, J.D.**  
Resident Fellow in Health Policy Studies

January 24, 2017

The American Enterprise Institute (AEI) is a nonpartisan, nonprofit, 501(c)(3) educational organization and does not take institutional positions on any issues. The views expressed in this testimony are those of the author.

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.<sup>i</sup>

The penalties for failing to comply with the mandate also are rather modest in proportion to the likely average premium cost of required coverage.<sup>ii</sup> 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”<sup>iii</sup> 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.<sup>iv</sup>

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.<sup>v</sup> 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.<sup>vi</sup>

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.<sup>vii</sup>

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,<sup>viii</sup> and that enrollment by younger and healthier risks – the primary targets of the individual mandate -- has failed to reach expected levels.<sup>ix</sup>

#### 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.<sup>x</sup>
- 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!

<sup>1</sup> Patient Protection and Affordable Care Act, 2010, section 1501(g)(2)(A) and (B)(i-ii)).

<sup>ii</sup> 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.

<sup>iii</sup> 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.

<sup>iv</sup> 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>.

<sup>v</sup> 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.

<sup>vi</sup> 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>.

<sup>vii</sup> 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").

<sup>viii</sup> 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>.

<sup>ix</sup> 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/obamacares-failure-and-moving-health-care-policy-in-a-new-direction/print/>.

<sup>x</sup> 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.

Chairman BUCHANAN. Dr. McDonough, it is your testimony.

**STATEMENT OF JOHN E. MCDONOUGH, DRPH, MPA, PROFESSOR OF PRACTICE, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD TH CHAN SCHOOL OF PUBLIC HEALTH**

Mr. MCDONOUGH. Thank you, Chairman Buchanan and Ranking Member Lewis and Members of the Committee.

Chairman BUCHANAN. Turn your mike on.

Mr. MCDONOUGH. Pardon me. Thank you.

Thank you, Chairman Buchanan, Ranking Member Lewis, Members of the Committee. I am John McDonough from the Harvard Chan School of Public Health. I would just note from my bio in my statement that I, between 2008 and 2010, was a staff person for the Senate Committee on Health, Education, Labor, and Pensions, and worked on the writing and passage of the Affordable Care Act. So I am a former Senate staff person in recovery. And I think most of you will understand that that is unfortunately a terminal, lifelong preexisting condition that I just can't shake as much as I might try.

So thank you for the honor of speaking before you. I have a written statement, and I will just highlight my six main points in it and then engage in conversation on whatever matters you find of value talking with me about.

First, the individual mandate, so-called the individual responsibility requirement of the ACA, is a core mechanism to ensure a healthy risk pool and more stable premiums in a guaranteed issue market that bans the practice of medical underwriting and preexisting condition exclusions in the individual health insurance market. It is core and it is recognized, and is not the only way to address it, but it is an essential component of the law. What we in Massachusetts where I was involved in the passage of the Massachusetts health reform law refer to as the three-legged stool.

Secondly, to eliminate the mandate and to leave in place guaranteed issue is a sure and proven formula for major disruption in the individual health insurance market nationally. And that is a concern that I think is neither speculative nor hypothetical. We have seen it played out in a number of States over the past 25 years.

Thirdly, I would mention, as Dr. Graham has also mentioned, that between the late 1980s and the latter part of the last decade, the individual mandate was largely a policy idea that was championed by conservatives, starting with Professor Mark Pauly and Stuart Butler in the late 1980s. And only in the latter part of the last decade was it embraced and accepted by Democrats. Its roots are entirely based on the notion of individual responsibility and shared responsibility as Governor Mitt Romney stated repeatedly during the Massachusetts health reform experience.

Fourthly, there are other ways to get at the intent and purpose of the individual mandate. It is not that mechanism or anything else. One mechanism is in late enrollment penalties. Another mechanism is referenced in Speaker Ryan's Better Way plan in terms of continuous coverage requirements. I would caution that I think that if you compare the individual mandate and continuous coverage requirements, I would regard the continuous coverage re-



quirements as far more onerous and punitive in terms of consumers and would urge caution before you go too far down that path.

Fifthly, I find no empirical evidence that suggests that the individual mandate has anything to do with the stresses that have been experienced in the State and Federal health insurance exchanges over the 2007 enrollment and now carrying-out period. There are other causes that I think more effectively explain those problems that are going on in those markets and be happy to talk with you about those.

And finally, I would only suggest that the suggestion that the size of the individual mandate penalty should be increased to enhance the uptake of individual health insurance is a mistaken notion. I think far more at the core in terms of enhancing enrollment would be to address the lack of adequate affordability in the health insurance exchanges right now, particularly for consumers between 250 and 400 percent of the Federal poverty level.

Those are my main points, and I look forward to further conversation. Thank you.

Chairman BUCHANAN. Thank you, Doctor.

[The prepared statement of Dr. John E McDonough, DrPH, MPA follows:]

**Comments for the Record**  
**U.S. House Committee on Ways and Means,**  
**Subcommittee on Oversight**  
**Hearing on Health Insurance Individual Responsibility**

Tuesday, January 24, 2017

By Dr. John E. McDonough

Harvard TH Chan School of Public Health

Chairman Buchanan, Ranking Member Lewis, and members of the Subcommittee on Oversight, my name is John E McDonough and I am a professor of practice in the Department of Health Policy and Management at the Harvard T.H. Chan School of Public Health in Boston, Massachusetts. I hold a doctoral degree in public health and a master's degree in public administration. Formerly I worked between 2008 and 2010 as a senior advisor on national health reform for the U.S. Senate Committee on Health, Education, Labor and Pensions where I participated in the writing and passage of the Affordable Care Act (ACA). Between 2003 and 2008, I served as executive director of Health Care for All, Massachusetts' leading consumer health advocacy organization where I was deeply involved in the passage and implementation of the 2006 Massachusetts Health Reform Law. Between 1985 and 1997, I served as a member of the Massachusetts House of Representatives where I held many health policy positions of responsibility, including co-chair of the committees on health care and insurance.

I am here to offer testimony on the ACA's "requirement to maintain minimum essential coverage" (Section 1501, 42 USC 18091), as well as a similar provision enacted as part of the 2006 Massachusetts health reform law that served as a model for Title 1 of the ACA. Though popularly – or unpopularly – known as the "individual mandate," that term is not used in either federal or state statutes to describe the "individual responsibility" provisions of the law. I advance six points, outlined below:

- The individual mandate is a core mechanism to ensure a healthy risk pool and more stable premiums in a guaranteed issue market that bans the practices of medical underwriting and pre-existing condition exclusions in insurance contracting in the individual market.
- To eliminate the mandate and leave in place guaranteed issue is a sure and proven formula for major disruption in the individual health insurance market nationally, a concern that is neither speculative nor hypothetical.
- Between the late 1980s and 2009, the individual mandate was largely an idea championed by both conservative and moderate Republicans until former President

Barack Obama endorsed it in June 2009.

- Other mechanisms could be used to replace the individual mandate, such as late enrollment penalties or the proposed “continuous coverage” requirement advanced in Speaker Paul Ryan’s “Better Way” health proposal, though the latter requirement would be far more punitive towards individual consumers than the ACA’s individual mandate.
- No empirical evidence I can find suggests that the individual mandate is the cause of the stresses recently experienced during the 2017 enrollment cycle in many of the federal and state health insurance exchanges. Other causes more effectively explain these recent problems.
- Finally, the suggestion that the size of the individual mandate’s tax penalty should be increased to enhance the uptake of individual health insurance is misguided. More effective would be increasing premium and cost sharing subsidies for income eligible consumers to more closely mirror affordability levels in the Massachusetts health insurance system.

I will elaborate on these in turn.

First, the individual mandate is a core mechanism to ensure a healthy risk pool and more stable premiums in a guaranteed issue market that bans the practices of medical underwriting and pre-existing condition exclusions in insurance contracting in the individual market.

In the 2006 Massachusetts and 2010 U.S. health reform laws, the individual mandate was recognized as an essential component of a “three-legged stool” to expand health insurance coverage, especially in the private individual (non-group) health insurance market. The other two legs are: first, guaranteed issue of individual health insurance to all qualified persons regardless of medical history or current health status; and second, premium and cost sharing support/subsidies to make the purchase of health insurance affordable for those who would otherwise be unable to afford the cost of coverage. Like a stool, all three of the legs are necessary for the structure to stand reliably.

The “three-legged stool” structure, including the individual mandate, has proven effective in the achievement of a principal goal of both the Massachusetts and U.S. health reform laws, that is the lowering of the numbers of persons without insurance. In Massachusetts, the rate of uninsured dropped from 7.7% in 2006 to 2.5% in 2015.<sup>1</sup> In the U.S. the number of uninsured Americans has dropped from 48.6 million in 2010 to 28.6 million in 2015.<sup>2</sup> The U.S. uninsurance rate, now between 8-9%, is the lowest it has even been recorded in the nation.

Research studies have reached differing conclusions on the precise impact of the individual mandate itself in achieving these reductions in rates and numbers of uninsured. For example, in a 2015 RAND Research Brief, Eibner and Saltzman found that the absence of the ACA mandate would lead to a 20% drop in individual market enrollment, and a 27% drop in

enrollment among young adults.<sup>3</sup> On the other hand, Frean et al in a 2016 Working Paper for the National Bureau of Economic Research, found only “small and inconsistent effects of the individual mandate in 2014 and 2015 with minimal policy impact.”<sup>4</sup>

Regardless of the empirical evidence, the health insurance industry as well as health insurance experts have been clear for nearly three decades that some form of a coverage obligation is essential to provide a balanced risk pool and to provide necessary confidence that guaranteed issue can be maintained in a financially sustainable manner. A December 7 2016 letter to Speaker Paul Ryan and Leader Nancy Pelosi from the American Academy of Actuaries describes this dynamic well:

“A sustainable health insurance market depends on enrolling enough healthy people over which the costs of the less healthy people can be spread. To ensure viability when there is a guarantee that consumers with pre-existing conditions can obtain health insurance coverage at standard rates requires mechanisms to spread the cost of that guarantee over a broad population. The ACA’s individual mandate encourages even the young and healthy to obtain coverage.”<sup>5</sup>

Among health insurance and health policy experts, widespread consensus exists that to maintain guaranteed issue without any pre-existing condition exclusions requires some enforceable mechanism to provide a robust and diverse risk profile among eligible consumers.

Second, to eliminate the mandate and leave in place guaranteed issue is a sure and proven formula for major disruption in the individual health insurance market nationally, a concern that is neither speculative nor hypothetical.

The experiences of states between the early 1990s and today demonstrates that the concern about the workability of guaranteed issue without some enforceable mechanism such as an individual mandate is a legitimate and essential issue. Eight states adopted guaranteed issue, most during the 1990s. When the damage from guaranteed issue without some form of mandate became evident, some states abandoned the protections, while other states accepted the damage to their individual market risk pool and continued the practice.

As of 2012, only five states (Maine, Massachusetts, New Jersey, New York, and Vermont) required individual market health insurers to guarantee issue all products to all residents. These five states maintained their guaranteed issue requirements despite a collapse in participation by individual consumers in the face of growing unaffordable health insurance premiums. The impact was most dramatically evident in New York State where participation in the individual market dropped from 752,000 covered lives in the early 1990s when guaranteed issue was first adopted to about 34,000 covered lives in 2009.<sup>6</sup> Massachusetts saw a similar form of insurance “death spiral” when it adopted guaranteed issue in its individual health insurance market in 1996 without an accompanying mandate, only seeing the non-group market return to viability after implementation of the state’s individual mandate in 2007.<sup>7</sup> Other states, notably New Hampshire, Kentucky, and Washington repealed or restricted their

guaranteed issue rules once the market impact became clear. Four states (Michigan, Pennsylvania, Rhode Island, and Virginia, plus the District of Columbia) in 2012 still required their Blue Cross Blue Shield carrier to act as insurer of last resort, an increasingly unworkable formula as the cost of care for clients in the individual markets became increasingly unsustainable.<sup>8</sup>

Though guaranteed issue and the related banning of medical underwriting and pre-existing condition exclusions remain among the most popular features of the ACA, with public promises to retain it from President Trump, House Speaker Ryan, and Senate Majority Leader McConnell, the certain danger of maintaining guaranteed issue without an enforceable mandate of some form is neither speculative nor hypothetical. The Congressional Budget Office released a report as recently as January 17 concluding that “eliminating the mandate penalties and the subsidies while retaining the market reforms would destabilize the nongroup market and the effect would worsen over time.”<sup>9</sup>

Third, between the late 1980s and 2009, the individual mandate was largely an idea championed by both conservative and moderate Republicans until former President Barack Obama endorsed it in June 2009.

The policy idea of a mandate on individuals to purchase health insurance as a mechanism to achieve near-universal coverage was introduced in the American health policy sphere in the late 1980s by Professor Mark Pauly of the University of Pennsylvania’s Wharton School as an alternative to single-payer or employer mandate proposals to reach the same goal.<sup>10</sup> The idea was advanced and promoted by the Heritage Foundation, and especially by Dr. Stuart Butler, in the same period.<sup>11</sup> In the years 1993-1994 when the President Bill Clinton promoted national health reform legislation, Senators Robert Dole, John Chafee and Charles Grassley, along with 19 other Republican members of Congress as co-sponsors, advanced a proposal to establish a national mandate on most Americans to purchase health insurance as an alternative to the Clinton Administration’s approach.<sup>12</sup> In the late 1990s, Louisiana Senator John Breaux became the first prominent Democrat to embrace the concept of the individual mandate.

In 2004, Massachusetts Governor Mitt Romney proposed legislation to establish a statewide individual mandate that drew support from overwhelming Democratic majorities in the State Senate and House of Representatives, from U.S. Senator Edward Kennedy, and from President George W. Bush whose Administration provided key financing for the program. The legislation was signed into law on April 12, 2006 in a ceremony in Boston’s historic Faneuil Hall. Seated on the stage was a representative of the Heritage Foundation which consulted with Governor Romney on structuring the individual mandate and creating the Massachusetts Health Insurance Connector Authority, the first governmental example of a health insurance exchange, another concept championed by the Heritage Foundation.<sup>13</sup>

The Massachusetts law incorporated the “three-legged stool” concept that is the organizing idea behind Title 1 of the ACA: systemic insurance market reform including guaranteed issue, an individual mandate to purchase health insurance, and premium/cost sharing subsidies to

make the buying of insurance affordable. When Governor Romney left his position in January 2007 to begin his first campaign for the Republican nomination for U.S. President, full implementation of the law was left to his successor, Gov. Deval Patrick. During Romney's 2008 campaign, he received the endorsement of Sen. James DeMint who noted in his letter of support that as Governor, Romney had "passed innovative health care reforms."<sup>14</sup>

During the 2008 campaign for the Democratic nomination for U.S. President, leading candidates Hillary Clinton and John Edwards both advanced health care reform proposals that included an individual mandate, while candidate Barack Obama did not. Indeed, President Obama did not officially endorse inclusion of an individual mandate in health reform legislation until June 2009, well after the Congressional process had started in earnest. It was in this period that many Congressional Republicans began to distance themselves from the individual mandate. Exemplifying this change was Senator Charles Grassley who stated on Fox News in June 2009: "When it comes to states requiring it for automobile insurance, the principle then ought to lie the same way for health insurance because everybody has some health insurance costs, and if you aren't insured, there's no free lunch. Somebody else is paying for it."<sup>15</sup> Three months later, in September 2009, his views had shifted: "Individuals should maintain the freedom to choose whether to purchase health insurance coverage or not."<sup>16</sup>

Democrats embraced the individual mandate concept in the 2000s in good faith to find common ground on universal coverage with Republicans and conservatives on a key structural feature championed by the latter groups. But as the ground shifted for Democrats leading them to support the mandate was a practical way forward, the ground shifted for Republicans compelling them to abandon a policy they had themselves promoted for nearly two decades.

Fourth, other mechanisms could be used to replace the individual mandate, such as late enrollment penalties or the proposed "continuous coverage" requirement advanced in Speaker Paul Ryan's "Better Way" health proposal, though the latter requirement would be more punitive towards individual consumers than the ACA's individual mandate.

Several mechanisms have been proposed to replace the ACA's individual mandate in replacement legislation. One of these is a "late penalty" fee such as the ones included in Medicare Parts B and D.<sup>17</sup> The alternative most often advanced in recent months is the proposal that guaranteed issue only be applied to individuals who maintain "continuous coverage" of their health insurance policies within defined limits. This proposal received prominent backing in the House Republican Leadership's "A Better Way" health proposals released this past June 2016:

"Our plan also proposes a new patient protection for those Americans who maintain continuous coverage. ... If an individual experiences a qualifying life event, he or she would not be charged more than standard rates – even if he or she is dealing with a serious medical issue. ... However, making the decision to forego coverage during this one-time open enrollment period will result in the forfeiture of continuous coverage

protections and lead to higher health insurance coverage costs for that individual for a period in the future.”<sup>18</sup>

Individuals and families unable to avoid undefined coverage gaps permitted under the Better Way plan would be subject to medical underwriting and pre-existing condition exclusions for, as mentioned above, “a period in the future.” Those individuals with any pre-existing conditions found to be relevant by health insurance companies for underwriting purposes would be denied coverage. Under the Better Way plan, their recourse for denied insurance applicants would be to seek coverage from newly re-established state high risk pools. The experience with state high risk pools has been mixed at best. Pools first established in the 1970s were chronically underfunded, often with long waiting lists and high premiums, with coverage limits that were banned by the ACA, such as lifetime and annual benefit caps, waiting periods, and limited benefits.<sup>19</sup>

Beyond these concerns is the issue of just how many individuals would be newly subjected to what I refer to as the “medical underwriting circle of hell.” The current estimate of uninsured Americans by the CDC is 29 million, while the CBO estimates that as many as 32 million Americans potentially losing their insurance under Republican repeal legislation vetoed by President Obama one year ago. While we can hope that any ACA repeal will be accompanied by a robust replacement law that will fully cover all who may otherwise lose coverage, no such guarantee exists today. This new era of insurance industry medical underwriting will subject at least tens of millions of Americans to renewed medical underwriting. By comparison, in 2015 an estimated 7.5 million Americans paid the ACA individual mandate assessment on their tax return.<sup>20</sup>

Even though the health insurance industry has been vocal in advocating for changes to the ACA in line with its priorities, including for example repeal of the health insurance industry tax and adjustment to special enrollments periods, no leading industry voices have been urging the Congress or Administration to re-impose medical underwriting and pre-existing condition exclusions. My conversations with insurance industry executives reveal no desire to return to that sordid work. Americans take pride that the days of classifying our fellow citizens according to their medical histories are in the past, and they show no desire to return to them.

Fifth, no empirical evidence I can find suggests that the individual mandate is the cause of the stresses recently experienced during the 2017 enrollment cycle in some federal and state health insurance exchanges. Other causes more effectively explain these recent problems.

It is well known that many of the federal and state health insurance exchanges have experienced turbulent times leading up to 2017 enrollment year characterized by rising premiums and market disruption. Some suggest that problems with health exchanges in this period demonstrate a fatal marketplace meltdown, justifying calls to scrap the ACA’s private insurance coverage structure and replace it with something new. It is a legitimate question – whether exchanges face fundamental dysfunction or temporary and fixable disruption. Regardless of one’s conclusions on this question, no convincing evidence ties the disruption to

the individual mandate. A related and legitimate question is whether the mandate's financial penalties are high enough – a question I will address in the next and final section.

Regarding the state of the ACA exchanges, a December 22 2016 "RatingsDirect" report from S&P Global concludes:

"S&P Global Ratings expects U.S. health insurers to report improved underwriting performance in the individual market in 2016 versus 2015. Although most insurers will still report an underwriting loss for 2016, the losses will be smaller than in 2015. This means the changes made to network design and premium pricing are gaining traction, though more still needs to be done. For 2017, we expect continued improvement, with more insurers reporting close to break-even or better results for this segment."

S&P also believes that premium hikes for 2018 "will be well below the 2017 hike."<sup>21</sup> Despite the controversies over the future of the ACA and premium increases, signups in the 2016-17 open enrollment period were the most robust since the launch of the marketplaces in 2013-14.<sup>22</sup>

A noteworthy development involves the state of Alaska where, last spring, alarms sounded when premiums were projected to rise by more than 40% in the state's individual health insurance market. Rather than accept the increases, the Republican-controlled state legislature passed a law to establish a reinsurance mechanism for the individual market, a move that rapidly lowered premium increases to about 7%. The ACA included three recognized mechanisms to moderate premium growth: risk adjustment, reinsurance, and risk corridors. Under the ACA, the latter two expired after the first 3 years at the end of 2016, and the risk adjustment has been subject to controversial limitations imposed by the Congress. These developments significantly exacerbated the 2016-17 turmoil in the ACA markets.

Beyond this, variation exists among the 51 state and federal exchanges, and a pattern emerges. Most states that have actively worked to make their exchanges succeed by meeting the needs of their citizens outperform exchanges where state political leaders have been antagonistic or apathetic to their success.

Sixth and finally, finally, the suggestion that the size of the individual mandate's tax penalty should be increased to enhance the uptake of individual health insurance is misguided. More effective would be increasing premium and cost sharing subsidies for income eligible consumers to more closely mirror affordability levels in the Massachusetts health insurance system.

Numerous commentators, inside and outside of the insurance industry, have suggested that the individual mandate is too weak to be effective and that the monetary penalty should be increased to provide a greater incentive to motivate individuals to purchase coverage.<sup>23</sup> The penalty for non-purchase of health insurance under the ACA applies to individuals and families deemed able to afford the cost. For 2017 and beyond, the penalty is \$695 (adjusted for inflation in future years) or 2.5% of income, whichever is higher, for a full year without



coverage. Under Massachusetts health reform, once fully implemented, the tax penalty for non-coverage reached a maximum of approximately \$900 per year. Though different, the two sets of individual mandate penalties were fairly close in financial impact for non-coverage.

Once implemented, Massachusetts health reform triggered a major drop in the state's uninsurance rate from 7.7% in 2006 to 2.5% in 2015, and the rate had dropped to below 3% by 2008. Far more significant for Massachusetts than the size and scope of the individual mandate penalty was – and is – the extent of premium and cost sharing subsidies available to eligible consumers. The Massachusetts affordability formula for eligible consumers using the state's exchange is far more generous, as Table 1 below demonstrates:

<b>Income Relative to Poverty (%)</b>	<b>MA – Required contribution to subsidized single coverage as share of income (%)</b>	<b>ACA – Required contribution to subsidized coverage as share of income, 2015 (%)</b>
100	0	2.01
150	0	4.02
200	2.1	6.30
250	3-4	8.10
300	4.2	9.56
350	No Cap	9.56
400	No Cap	9.56
Over 400	No Cap	No cap

Source: Urban Institute<sup>24</sup>

While not strictly comparable to Massachusetts, the current uninsurance rate for the U.S. is 8.6%.<sup>25</sup> Rather than increasing the size of the individual mandate tax penalty, more effective would be to address the reality that the affordability formulas for premium and cost sharing subsidies in the ACA is not generous enough for many families in the target income categories, most importantly for households with incomes over 250% of the Federal Poverty Line.

### **Conclusion**

Though the individual mandate is the most controversial and unpopular aspect of the ACA, it is a foundational element that enables the ACA to provide coverage to tens of millions of Americans who would otherwise be uninsured. It is also a key feature that permits the highly popular guaranteed issue rule to function effectively. Removing the individual mandate by itself would have negative consequences for the health security of many tens of millions of Americans and would move our nation backwards in terms of addressing the key challenges we face in continuously improving our nation's health and health care.

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Chairman BUCHANAN. I want to thank all of you. It is excellent testimony. We now proceed to questions and answer session. For the purposes of today's hearing, I will hold my question until the end.

I will now recognize the gentleman from Pennsylvania, Mr. Meehan.

Mr. MEEHAN. Thank you, Mr. Chairman and the Ranking Member. And I am going to look forward to working with both of you and the full Committee on this important agenda before us. And there couldn't be a more appropriate place to start than with this particular issue.

One of the concerns that I hear back in my district frequently is the frustration of everyday Americans with Federal Government mandates telling people this is the way you are going to live your lives. It would be bad enough if that was all that there was to it. But the fact of the matter is we are talking about something which, notwithstanding the opening statement of my good friend the Ranking Member, the ACA does not work. And I was pleased to see Mr. Miller talk about the concept of exposed nerves from the Federal mandates that are happening. And we hear words about mandate, coercion. Those are the kinds of things that I think are affecting people.

And then you look at the facts. We have had this program. Premiums have been rising by double digits for the very people that Mr. McDonough talked about in the hardest places to be able to pay. One-third of the counties now have only a single insurer. The exchanges are consisting largely now of older and less healthy people.

And I look at my own district in Pennsylvania. And we have taken the time to ask people to weigh in. Premiums for ObamaCare plans of Pennsylvania are up 33 percent in 2017. Each year there is fewer to choose from. In 2016, there were 13 plans. Next year, there will be eight. Now listen to the individuals in their own words. Mike from Boyertown shared with me his concern, the cost of our health care insurance. "We have coverage from healthcare.gov and our rates are increasing from \$1,600 to \$2,600 a month." These are working class people. "Only six plans are available, and the lowest cost one is still over \$2,000 per month just for my wife and I." Fred from Lansdale wrote, "I received my annual health insurance rate increase for 2017 yesterday. My rates went up from \$2,500 to over \$3,750 per month. Per month. Last year's increase was devastating. This year's increase is even more overwhelming. I am self-employed. I only had a few short years ago. This news is devastating to my family."

People are voting with their feet in this. The CBO just came out and released its most recent, just this week. Expects a sharply lower number of participants in the Affordable Care Act for exchanges in 2017. CBO said the number of participants in the exchange was expected to be 10 million in 2017. So clearly, we have been sold a bill of goods. It isn't working.

Mr. Miller, what conclusions can you draw from this kind of revised estimate?

Mr. MILLER. Well, it is not working according to plan is the short answer. To connect this up with the subject of today's hear-

ing, one of this—this reflects, in effect, an overinvestment in a set of policies that did not come together and work as promised. And part of what you are seeing in the higher premiums and the restricted availability of plans, the losses in plans, is everybody was supposedly saying it is all going to work like clockwork. Everybody is going to go into the exchanges. That is what CBO projected. They weren't talking to the people on the ground. And so we have got a different experience in practice than the one that was proposed to us in theory.

Now, we can keep trying to implement that theory saying sooner later it will work out. That seems to be what CBO is mostly projecting. On the other hand, we can try to say we need to take this into the shop and change the mix around. And we need to get back to having health care coverage that actually matches what people are willing to pay for and can pay for.

Mr. MEEHAN. I am so glad you said that about taking it into the shop. Because here is the big misnomer in this whole discussion. This idea that somehow there is this Republican effort to just drop the thing and leave everybody on the street, instead of the real genuine effort which is to take something that isn't working and try to get it to work better.

We only get 40 percent of the people who are eligible for these exchanges into it. And yet we need about 72 percent to make them work. So how do we incent that other 30 percent to get in? Is it by mandates or is it by working on the kinds of things which are being put in place to lower the cost, to make better availability, to make their—allow the programs to be the kinds of things in which they have a choice to find the insurance that fits them? Isn't that the better way to get that remaining 30 percent so we can get the kind of exchanges that can actually work?

Mr. MILLER. We have tried the weak punitive approach or we know what is best. We might want to try some positive incentives to find out what in fact—where the market is.

Mr. MEEHAN. Mr. Chairman, thank you. I yield back.

Chairman BUCHANAN. I now want to recognize the distinguished Ranking Member, Mr. Lewis, for any question he might have.

Mr. LEWIS. Thank you very much, Mr. Chairman.

Dr. McDonough, one of the things I am most proud of in today's law is that because of the ACA, Americans with preexisting conditions are able to get insurance. Can you discuss why the individual mandate is so necessary?

Mr. MCDONOUGH. So thank you for the question, Representative. The concept of guaranteed issue, which means that insurers must issue coverage to applicants regardless of their prior medical history, regardless of their current medical status, is one of the most popular features of the Affordable Care Act. It is a policy that was implemented in various States starting in the 1990s. About eight States in particular. Five States implemented it. All eight States implemented it without an individual mandate. And all States, when they did it, saw significant substantial disruption in their individual health insurance market because people were going in and purchasing coverage when they felt they need it and

then dropping out of the market when they got whatever services they needed.

And so it was a damaging risk pool that created what some refer to as an insurance death spiral where premiums go up, and as premiums go up, more people drop out. We saw that in Massachusetts, New York, New Jersey, Vermont, and other States. Kentucky, New Hampshire. Some States did guaranteed issue without a mandate. And when they saw the impact, they withdrew and they stopped guaranteed issue. Other States, like Massachusetts and New York, did it and had damaging impacts in the market and kept the policy in place.

But guaranteed issue is one of the most popular features of the law. Americans don't like the idea that to get coverage you can only get it if you don't have any adverse medical history that would disqualify you from coverage. And they don't like the individual mandate. And they usually don't understand that there is a link between the two of them. And that guaranteed issue can't function effectively in an environment without some kind of coverage responsibility, some kind of shared responsibility on the part of individuals. So that is where it comes from, and so—the linking together.

And so Massachusetts, in 2006, in its Health Insurance Reform Law, for the first time put together and actually implemented an individual mandate and guaranteed issue together. We saw a dramatic drop in our rate of uninsurance. We saw a stabilization, a stabilization of premiums in the individual market. And it was a strikingly successful experiment in terms of the intended influence on the individual health insurance marketplace. So we saw it at work.

And it was then the design feature that people thought made sense in terms of coming up with the national reform that is the Affordable Care Act. So that's where it came from and that is why it is in there. It is an essential piece. So Americans love guaranteed issue and don't want to lose that. But guaranteed issue without some kind of coverage requirement creates a serious market disruption which people would not want to see.

Mr. LEWIS. Thank you very much, Doctor. Would you talk about the best ways to get people enrolled in insurance and engaged in their health care? Is it better to increase financial assistance or to follow the Republican suggestion such as the Better Way health proposal?

Mr. MCDONOUGH. So the concern that I have with the Better Way health proposal and with some of the other plans that are forward is that, you know, the United States in January 1, 2014, banished medical underwriting from our health insurance market for the first time in our history. And overwhelmingly Americans like that reform. Don't want to go back. And that seems to be fairly bipartisan.

The concern that I see in terms of the suggestion to have guaranteed issue but only for people who can maintain continuous coverage is that there will literally be, in a very short period of time, tens of millions of Americans who will then fall back into the circle of people who will be newly subject to medical underwriting and have their insurance-ability, their ability to buy insurance, rated

based upon their medical history. I think that would be a terribly unfortunate step backward that Americans would not appreciate and have rejected that approach.

Mr. LEWIS. And thank you very much, Doctor.

I yield back.

Chairman BUCHANAN. I now recognize Mr. Smith from Missouri.

Mr. SMITH. Thank you, Mr. Chairman.

Back in December, I held health care roundtables throughout our congressional district in southeast and south central Missouri to just hear from farmers, small business owners, families of the experiences that they have had under ObamaCare. And the message was very consistent. Forcing citizens to buy a product they simply didn't want or suffer a tax penalty is un-American, especially when in many cases that product is too expensive and not adequate.

As the gentleman from Pennsylvania mentioned briefly of the exchanges in his State going from 13 to 8 I think were the numbers, out of the 30 counties in the Eighth Congressional District of Missouri, individuals who are forced under the individual mandate, you know what their options are? Out of 30 counties, 26 of those 30 counties has one choice. Looks like adequate options. Absolutely not. Take the case of Doug from southeast Missouri. He is a 61-year-old divorced cabinetmaker who helps his 20-year-old daughter and ex-wife pay for their health insurance. Doug started a small business just over 3 years ago. He wrote me. This is what he wrote: "My business is beginning to be profitable. However, with startup costs and normal business costs, cash flow, et cetera, there is nothing left of the budget for my personal health insurance. I have been without coverage for 2-1/2 years. I make too much to qualify for subsidies, not that I would take advantage anyway, and do not make enough to pay the premiums after paying for everyone else. The ACA penalty adds injury to insult. Insult because the whole mandated mess is unconstitutional. And injury because I usually have to take out yet another business loan to pay my income taxes after the ACA penalty."

I checked prices for insurance for a 61-year-old man in his county of Missouri, and it is somewhere in the neighborhood of \$900 a month. That is more than the typical rent payment in southeast Missouri and would likely represent one of the largest expenses he would be paying. So who is the policy really helping, I ask? It is definitely not the lower and middle class in southeast Missouri. The mandate targets individuals, but it also hurts the health care facilities and hospitals who help serve them.

During one of our roundtables, the Chief Executive Officer of one of the federally qualified health centers testified that in their area, 37.3 percent of the population they serve are uninsured. But yet everyone is required to have health insurance under the individual mandate.

The mandate was designed to address uncompensated care, but it didn't. Here is the bottom line. ObamaCare's individual mandate has failed. Special enrollment periods and exemptions by the Obama Administration created an environment that goes completely against the idea of a mandate that created an unfair burden on facilities in my district that offer care to low-income individuals.

My question is to Mr. Miller. Your testimony highlighted weak enforcement and weak compliance as challenges with the individual mandate. Can you explain in more detail how the individual mandate harms the low- and middle-income people it was supposedly designed to help?

Mr. MILLER. Well, I am trying to go backwards from where you are talking about. Part of it is because it didn't deliver what it said it was going to do. In terms of the coverage effects you saw, where those people went was primarily into Medicaid to the extent they were lower income. That is what they ended up choosing rather than the exchange-based coverage. And that is where they have ended up. However, insurers along the way have incurred some substantial losses within these exchange markets because their original business plans assumed a different set of enrollment and a different level of compliance with a mandate which was never enforced in that manner. So that the mismatch has created, in effect, a compression of plans and the rising premiums. There are other distinctions along the way.

Some of the statements that have been made about the scope of uncompensated care costs, if you look at the vast historical record, vastly exaggerated. Now, this law has a lot of moving parts. We took away some of the funding for that uncompensated care as—on the assumption it was going to be made up for by the increased enrollment. That didn't match up. We have had behavioral changes which indicate that people who are nominally insured are still going to emergency rooms anyway.

So it is hard to isolate the mandate alone along this broader mosaic of basically a floundering law which has many different theories behind it that don't work out in practice.

Mr. SMITH. Thank you, Mr. Chairman.

Chairman BUCHANAN. I now recognize the gentleman from New York, Mr. Crowley.

Mr. CROWLEY. Thank you, Mr. Chairman. Thanks very much. I appreciate this hearing today.

If I can, I just want to—my good friend, I mean this with all sincerity, from Pennsylvania. I think the world of Pat Meehan and he knows it. He made the reference at the end of his comments where this notion or idea come from that Republicans want to repeal without replacing. And I would just note for the record that we have had 65 attempts to repeal the Affordable Care Act, or ObamaCare, over the last 6 or so years without ever once offering a replacement. Maybe that is where we might get the idea that you simply want—you all simply want to repeal the bill without replacing it. That is just an observation.

Mr. McDonough, my home State of New York provides a valuable example of how the requirement to buy insurance is a critically important aspect of the ACA to provide stability in the individual insurance market. Before the ACA, New York's individual market did not include an individual mandate. So the market did not have enough healthy individuals. As a result, monthly individual premiums reached over \$1,500 and less than 20,000 people had enrolled.

Now as a result of the Affordable Care Act, premiums for individuals are 50 percent lower than they would have been without the



ACA. The number of New Yorkers in the individual market has grown by 270 percent. And plan participation in more—is more robust. Sixteen insurers offer coverage in the individual market and 21 serve the small group market.

Mr. McDonough, would you say that New York's experience with the mandate illustrates just why it is so critical and the dangers that could happen if it is repealed or undermined?

Mr. MCDONOUGH. So thank you, Representative, for that question. I think it is important to recognize that the issues with the Federal and State health insurance exchanges from New York, from Pennsylvania, from Missouri, from all of the different States vary. So there are some States that are going through very significant disruption and very critically high rises in premiums. There are other States like, for example, New York and California, that are doing very well actually in terms of a moderate rate of growth.

There is the striking example that we have of the State of Alaska. Alaska last spring had projections that the premiums in their individual market were going to go up by over 40 percent. In the summer, the Alaska legislature with their governor agreed to create a reinsurance pool within the State individual health insurance market just in Alaska. When they did that, that single act, they brought their projected premium increases from 40 percent down to 7 percent.

So part of the difference, and it is not exclusively this, but it is very much a factor, part of the difference is that States that have aggressively grabbed and worked to take a leadership role in helping this new health insurance market to work and succeed have seen strikingly better results in terms of premium growth and in terms of plan participation than States that have, for their own legitimate reasons, been very hostile to the implementation and have had not only nothing that they wanted to do to help it, but actually worked consciously and proactively to try to undermine the implementation of the law.

So there is a real difference there. And I think it is worth understanding that you can make differences happen here. States need to be part of the solution. And the States that have done that have made a real difference. Sorry for too much time in that answer.

Mr. CROWLEY. That is all right.

Mr. Chairman, I have a letter from the Department of Financial Services in New York State which oversees the insurance industry in the State. I would just ask that we include that for the record to the Committee.

Chairman BUCHANAN. Yeah, that is fine.

Mr. CROWLEY. I just wanted to say, listen, this is incredibly complicated, all the parts that go into making the Affordable Care Act work itself. We talked about, you know, the mandates. We haven't talked about other aspects that have—in the whole, that make it actually work or in theory work. So, listen, I understand the frustration. We have been frustrated for the last 6 years. We haven't found any partners to actually improve the Act as opposed to just repealing it.

I think my colleagues on the other side of the aisle realize now, as does the new President, how difficult it is to take away the sweets. It is the vegetables, I think, my colleagues have had a dif-

ficult time swallowing in order to get to the sweets first. But I think they are learning that. And I yield back.

Chairman BUCHANAN. I now recognize the gentleman from Arizona, Mr. Schweikert.

Mr. SCHWEIKERT. Thank you, Mr. Chairman. And those of us with a sweet tooth, we will work on that. And, Mr. Chairman and fellow Members and obviously the panel, being from Arizona, when you use the term “disruption,” we’re one of the epicenters of it. You know, if it wasn’t for almost a charitable gift by I think our Blue Cross Blue Shield going into a couple counties, I would have had counties—remember, my State has only 15 counties. So our counties are huge. They would have had no offering.

So could I beg of you, and this is going to be a little different, but this is something staff and I have been trying to hunt for years. Could we do a little math together? I need some help on something. What I am hunting for is—and we have even had researchers from Kaiser and other people try to help us. And the Administration has been willfully difficult, and maybe it is because the way the data sets are collected. Maybe it is obfuscation. Maybe it is perfectly innocent.

If I go back at the end of fiscal year 2016, we functionally have had what? Three years out there where there was product offered. How many of our brothers and sisters gained coverage that either did not have coverage before or who were not Medicaid eligible? And when I say did not have coverage before, truly had gone long term. Not where they had 3 days between jobs and we called them uncovered. But how many—I mean, what is the real number? How many folks now have coverage by the end of fiscal year 2016 that did not have any either access to coverage or weren’t Medicaid eligible? And can anyone give me an honest number? This is an open—I mean, this is a fly ball for whoever can pitch it back.

Mr. MILLER. I don’t usually like to do this in a hearing. I may have to quote Jon Gruber. And I only do that every couple of years. Because even a stopped clock may be right a couple of times a day.

Based on those recent calculations, approximately 60 percent of the coverage gains came from Medicaid. There is a little bit of a dispute as to how much of that is expansion Medicaid and how much of that is old Medicaid.

Mr. SCHWEIKERT. Look, we have 2 minutes and 30 seconds to play here. So, okay, let’s say it is 60 percent of the population gained it through Medicaid. Then of the remaining 40, I have seen some numbers out there that say a substantial portion of that had either access to or had coverage at some time before. And my—

Mr. MILLER. Some of that is old Medicaid. There is a provision where if you go into the hospital, you can get signed up for Medicaid. That is under old Medicaid as well as new Medicaid. There were States who were already expanding before 2014. It makes that old Medicaid.

Mr. SCHWEIKERT. So is it—

Mr. MILLER. Some of it came from the individual exchanges, though. That is a fact.

Mr. SCHWEIKERT. Okay. So who—

Mr. MILLER. But probably about only about half of the exchange coverage more or less are actually net uninsured getting coverage.

Some of them were people who got pushed out of the other part of the individual market.

Mr. SCHWEIKERT. And, look, I understand this is a little difficult and there is a lot of moving parts here. As someone just said, it is complicated. So are we now down to 7 million?

Mr. MILLER. We could be down to 6 or 7 million. And, again, these are fuzzy numbers because we pretend that our data is excellent and you can raise four or five different surveys and get different numbers and make different assumptions.

Mr. SCHWEIKERT. In the next minute and 30 seconds, let's pretend we are accountants. Okay. So over the beginning of this law till the end of 2016, how much has been spent? And when I say "spent," I mean by the Federal Government, the State government, individual premiums, losses from insurance companies, others. What is my total dollar amount? Because I have seen numbers at, you know, \$500 billion. I mean, I have seen some really interesting numbers that if you do a true all-in math, and I am—you see where I am going. For 3 years of coverage, my all-in cost to help 7 million, I could almost do that in the top of my head. Someone is going to correct me later. \$68,000 per life? I mean, I am buying their health coverage, and I could have probably bought them a really nice car.

So something's wrong. And just if we take a step backwards, whether it be the individual mandate or just the basic math of if we all agreed we want to help our brothers and sisters out there, our total dollars per total life coverage, something is horribly wrong in what we are doing. Am I being unfair?

Mr. MCDONOUGH. I would just respond, Mr. Schweikert, by saying that I think that 6 million is a significant understatement. And I don't want to put out a number that I can't defend.

Mr. SCHWEIKERT. Okay. I would be elated if you could do me one of the grandest favors of all. Because we really—and my staff is back there laughing at me. I have spent a couple years of my life looking for this number, and talking to really smart people like yourself. Help me find real math. Because I come from a world of the math is the math is the math. But right now I am looking at numbers where I could have bought their coverage and bought them a nice car. Something's horribly wrong in what we're doing.

Thank you. And I yield back, Mr. Chairman.

Mr. MCDONOUGH. Happy to do that, sir.

Chairman BUCHANAN. I now recognize the gentlewoman from Indiana, Mrs. Walorski.

Mrs. WALORSKI. Thank you, Mr. Chairman.

President Obama promised over and over again, if you like your doctor, you can keep your doctor. If you like your health plan, you can keep your health plan. And despite these repeated pledges, we know now that these statements were completely untrue. In fact, in the fall of 2013, millions of Americans started receiving plan cancellation notices. PolitiFact ranked President Obama's statement as its lie of the year in 2013. But it wasn't just the immediate loss of plans. People are still losing them. For example, in Indiana last year, four insurers left the exchange, leaving Hoosiers with fewer options. That is 50 percent loss of our own plans. Recently, I heard from a constituent of mine from Starke County in Indiana.

He has had two open heart surgeries at Mayo Clinic that requires him to be on blood thinning and other medications, as well as periodic checkups. He had a private health insurance plan that he liked. Covered his medical needs. But in 2015, it was knocked out by ObamaCare. He was forced to buy a health care policy on the marketplace, but unfortunately discovered at an annual checkup at Mayo Clinic that his doctors were not in the network. And because of that and because they were out of State, they were out. He was forced to pay thousands of dollars out of pocket for the visit, in addition to thousands more out of pocket for the prescriptions. When he appealed to the Indiana Department of Insurance, he was told there was no marketplace insurance plan that would cover his doctors at Mayo Clinic as a Hoosier living in the State of Indiana.

He recently learned that his marketplace plan through UnitedHealthcare won't offer individual market plans for his area in 2017. He was forced back into the marketplace again to find a new health care plan that still will not cover his out-of-state doctors. It reinforces to me that for many Americans, this law is not working as promised.

And Mr. Miller and Mr. Graham, I wanted to direct this to you. Isn't it true that the individual mandate was supposed to increase competition on the exchanges by ensuring that people sign up, thereby encouraging insurance carriers to offer more choices and broaden those networks?

Mr. GRAHAM. That was the stated objective. And as you have described it, it has not been the case. So I agree, I guess, would be my answer.

Mrs. WALORSKI. Mr. Miller.

Mr. MILLER. As I like to say, it seemed like a good idea at the time. Although, unlike Mr. McDonough's testimony, it has been a bad idea for many of us for a long period of time on the conservative Republican side of the aisle, just to rewrite history a little bit, going back to the 1990s.

What was proposed wasn't executed. And it wasn't going to work that way because of the grand design, in theory, did not reflect the reality on the ground. Some people gained under this arrangement. There is no question about that. If you were a low-income person suddenly getting substantial subsidies for coverage, you might not be crazy about that coverage, but you will say you came out ahead. There are other people in that market, though, who had something that they were comfortable with or at least were ready to settle for. They were told that is not good enough. These are the folks who got moved out of other parts of the individual market and ended up with less effective choices and ones they didn't want. And that is what you are mostly hearing from among your constituents.

Mr. GRAHAM. And that is not going to turn around on its own. I think President Obama's Council of Economic Advisers just before they left asserted that the insurers have now got it figured out, everything is under control. The first 3 years you had the training wheels on board and—but now we are good to go. That doesn't make any sense. You know, the last year, from 2016 to 2017, you had by far the worst premium increase, 25 percent nationwide average. It is not getting better, it is getting worse. It is like the in-

surers are having more and more trouble every year they stay in the exchange.

Mrs. WALORSKI. Well, I guess my follow-up is, when insurance networks have become so narrow that individuals like my constituent, and there is many of those in Indiana, I just talked about one. When they lose access to their doctors, what does that say about the individual mandate's effectiveness to begin with?

Mr. GRAHAM. I think it says you are on the route to Medicaid for everybody where there is very poor access to care in many cases. So folks like—I know some of the Members have given testimony from their constituents. The whole structure is so terrible. You know, you earn an income that is—you are not Medicaid eligible so you can't even get the poor access to care that Medicaid offers. You might get some tax credit in the ObamaCare. Maybe you make too much money for that. Hard work to figure all that out, you know. And then the IRS comes after you next year and says you owe money back. So the complexity is far too complex. And I think when you go from one insurer to no insurer, as in Arizona, you were very lucky. I mean, what is a market where there is no insurance offered? It is not a market.

Mrs. WALORSKI. Right. I appreciate it.

Mr. Chairman, I yield back.

Chairman BUCHANAN. I now recognize the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman. And I want to thank all of our witnesses who are being very helpful as we deal with one of the most complex issues and problems that I think we face today as it relates to health care.

I represent the State of Illinois in the seventh district, which contains more hospital beds than any other congressional district in the country. The Affordable Care Act, which also has been beneficial to the four major medical center operations, medical schools that we are all so fortunate to have, the Affordable Care Act has greatly improved access to care for tens of millions of Americans. Enrollees now have access to medical homes, in general no longer have to rely solely on hospital emergency rooms, and have the comfortability of knowing that when they need care, it is available there for them.

Today, more than 1 million Illinoisians have health insurance coverage as a result of ACA, either due to the law's Medicaid expansion or its health insurance marketplace, and the majority of whom were uninsured prior to September 2013 when the ACA's coverage expansions were first implemented. Because of ACA the Nation's insurance uninsured population has dropped dramatically to less than 11 percent currently from nearly 17 percent in 2013.

If Congress repeals health insurance coverage, Illinois would sustain a potential loss of \$11.6 billion, \$13.1 billion in annual economic activity, and about 95,000 jobs lost. Ultimately, any attempt to repeal the ACA should be accompanied with an appropriate and responsible replacement plan that, at a minimum, ensures access to coverage for the more than 20 million U.S. residents who now have coverage as a result of the law.

If Congress does not make repeal of coverage contingent on adoption of an ACA replacement plan, then lawmakers should also cor-

respondingly repeal the significant hospital payment cuts that help pay for ACA's coverage expansions. This is important for Illinois's hospitals and health systems which, to date, have had to absorb the more than \$1 billion in Medicare reimbursement cuts to pay for the cost of the law's coverage expansion. For example, Northwestern Medical has seven hospitals alone, including Northwestern Memorial Hospital. They have absorbed more than \$273 million in Medicare cuts since 2011.

Mr. McDonough, can you see institutions sustaining those kind of cuts and expenditures and continue to provide the level of care and service that they currently provide?

Mr. MCDONOUGH. Thank you, Mr. Davis. And no, I don't see that. I think there is a real difference across the country right now in terms of the financial health of hospitals, frankly between States that have expanded Medicaid under the ACA and States that have not. The States that have expanded along with the robust expansions through the marketplace have seen much greater financial health. And in States that have not expanded, there has been a far higher rate of hospital closure and of serious financial dilemma facing hospitals and other medical providers in those States. So it is a real difference and an indicator of what may come were there to be total repeal. Sorry.

Mr. DAVIS. Thank you.

Thank you, Mr. Chairman.

Chairman BUCHANAN. I now recognize the gentleman from Florida, Mr. Curbelo.

Mr. CURBELO. Mr. Chairman, thank you very much for holding this hearing. It will be my honor to serve under you in this Congress and with my colleagues here, especially Ranking Member Mr. Lewis, who I was proud to welcome to my community recently to celebrate Dr. Martin Luther King Day. And I also want to thank the witnesses for their testimony today.

Dr. McDonough, we share someone in common, Dr. Julio Frenk was the dean at your school. He has since moved up in the world, transferring to the University of Miami where he serves as president, which happens to be my alma mater.

Mr. Chairman, although enrollment in the ACA is relatively high in Florida, particularly in the Miami-Dade metropolitan area, choices continue to decrease and premiums continue to rise. This year, the counties in my district have lost insurance carriers. Monroe County lost one carrier and Miami-Dade lost two carriers participating on the exchange. I have heard people in my district about how the current system has reduced their choices and increased their out-of-pocket costs.

Emily, my constituent, explained that she is paying over \$700 per month for a plan with a deductible that is over \$6,000. But still she has been unable to find a doctor in her area who will accept her insurance. Even though she has insurance, her options are severely limited and premiums continue to increase.

Mr. Miller, I have a question for you. These examples that you have heard here today, and I think it is important that we raise them because statistics are fundamental to understanding what is happening in the world, but these real life human examples matter also. Do you believe that these examples are isolated, unique to our

districts or are these the types of things that are happening all over the country?

Mr. MILLER. Well, there is a battle of warring anecdotes and everybody has to have their respective horror story, and you can get them on both sides. In the aggregate, though, we know that this is not working out in reaching its residual level. I comment somewhat in light of some of the discussions here that I am surprised that this embrace by folks who are more favorable to the Affordable Care Act of what you might think of as trickle-down economics. Let's first take care of the hospitals, let's first take care of the insurers, and maybe some people on the ground might eventually get some benefit from this.

This was a very interesting academic study of the Medicare expansion population, one showing that it had grown quite larger in terms of the cost per capita for the new adult, newly eligible able-bodied adults, but it hasn't necessarily delivered any more services. There is another study that indicated the Medicaid beneficiaries actually valued the coverage they received at about 20 to 40 cents on the dollar. So we are pumping more money into the system, but it isn't necessarily getting down to the ground level where it is actually improving people's care. And that is because the system is designed not for the beneficiaries at the end of it to be calling the shots, but somewhere along the line we determined what is good for them and what they should receive. And it works for other people in the system; doesn't necessarily deliver that value at the bottom line for the consumers we supposedly care about.

Mr. CURBELO. So, Mr. Miller, are you suggesting that perhaps major health care special interests such as hospital chains, insurance companies and pharmaceuticals were too influential in the drafting of the last health care reform legislation?

Mr. MILLER. The previous Administration had to cut a deal and in some cases they had to give as well as take. And part of that deal was to make sure that they had placated those interests first in order to get the legislation passed.

Mr. CURBELO. Mr. Graham, with regards to the individual mandate, some suggest, well, this is, as we have kind of concluded here, not working very well, perhaps the solution is to raise the penalty and coerce more people into signing up for health insurance. I don't think that would be a very popular measure, and I assume most Members of this Committee and in this House would probably not be predisposed to supporting that kind of measure. What are some alternatives?

Mr. GRAHAM. I think Mr. Miller proposed some good alternatives. I think Professor McDonough's criticisms of those alternatives is also valid. There is a certain population, if you are just going to say you have got to maintain continuous coverage, you have got to—or pay a fine or whatever, there is some level of population that will not pay that. This is just a reality.

You know, when you lose your job, your mortgage payment or your rent comes first and you are going to drop your health insurance premiums. So there will always be some population that has to—you know, I hate to say it—be taken care of, but the social safety net. And I know on your side of the aisle you have talked about high risk pools, things like that.

I would just like to point out that, you know, Massachusetts had a reform that had some good things, some bad some things, the gentleman from New York who has left, every State had all these tools at their disposal. So what I would like to say is if we don't know the perfect answer, the magic bullet, let's let 50 States try and figure it out and learn from them.

Mr. CURBELO. Thank you. I yield back.

Chairman BUCHANAN. I now recognize the gentleman from North Carolina, Mr. Holding.

Mr. HOLDING. Thank you, Mr. Chairman.

I am going to pick up where my colleague, Mr. Meehan, left off. He listed some good testimony regarding the mandate not panning out, producing the numbers. We have got a slide, if we could put up there, of ACA exchange enrollment expectations versus reality. There. And you have done a good job of talking about some of the problems with the mandate. But it is clear that the economic modeling that the Obama Administration was using, they overestimated the strength of the mandate.

So perhaps, Mr. Miller, you could pick up here. Why would the models overestimate the mandate strengths so pretty dramatically there?

Mr. MILLER. I would say the first reason is they relied upon evidence from Massachusetts and Massachusetts' experts, which was unique to Massachusetts as opposed to the rest of the country. And that was built into a lot of the over assumptions of the high yield from the mandate. They also assumed they would have larger effects further up the scale. And the reality is if you subsidize people heavily, as turned out to be the case for basically those below 200 percent of Federal poverty level, you will get a lot of people, even though they are not crazy about the coverage, they will take it because it doesn't cost them much of anything when you add in the cost-sharing subsidies. You've got a lot of complaints about high deductibles. That has differential effects because of the way in which those cost-sharing subsidies in the exchanges tend to mute those out.

So when you were trying to get more people to come into this market who are either younger or had a little bit more money or were healthier, it turned out it was a bad deal for them. There's plenty of work done by some economists at the University of Pennsylvania, Wharton School, which talked about why you just didn't pay for people to take this coverage compared to either paying a penalty or dodging it in one form or another.

So all of this idea that new revenue was going to come in to pay for what we wanted didn't work out that way. And some of that is reflected in the reduced enrollment that was assumed but never materialized because you run out of subsidies to pay for people. And when it turns out that people have to pay for something they don't want, they don't buy it.

Mr. HOLDING. Right. Well, you know, speaking of subsidies, I find it kind of remarkable that according to some estimates that we have seen, that only about 40 percent of the subsidy eligible population signed up on the exchange. Now, this is concerning. I mean, do you find it concerning and why do you think it is?



Mr. MILLER. Well, that reflects the fact that as you move further up the ladder beyond what I just cited, which is about 60 to 65 percent, those subsidies aren't particularly generous. They are there, but they begin to phase out. This is a highly skewed, very progressive, if you want to use that term, approach to subsidizing very low-income individuals, even more so in the Medicaid-eligible population.

So mission accomplished in terms of getting that target population, but it didn't fit into the larger economic model which assumed that somewhere there was something else to pay for this. They tried a lot of other gimmicks in order to do this, but it didn't actually materialize in the way in which it was originally designed. And part of that is because it was a built-in ceiling on how much the individual mandate could ever produce, despite all the theories to the contrary, and also how much money that was actually there to subsidize people. And we found out that we are going to have come up with some other solutions.

Mr. HOLDING. Well, you know, you have got the benefit now of some history; you know, you have got a graph, we have got some real numbers in. And, you know, you mentioned at the top of the hearing in your prepared remarks, you know, the CBO is doubling down on these flawed estimates. I mean, what would the rationale be behind that?

Mr. MILLER. Well, people when they do models have assumptions and they tend to not want to let go of them. There are some things external to what originally started out that are moved around. Certainly, the Supreme Court decision changed some of the projections in terms of Medicaid enrollment. But the ingrained view that somehow the individual mandate was going to draw in all these people and they were going to comply and was going to be enforced didn't work out that way.

Potentially by some, you know, standard you could have about—you know, at one time they had a 30-million target population, and it turned out that only 3 million of those people were actually—you know, were paying into the individual mandate as opposed to staying uninsured. It is the difference between theory and practice. We have learned a lot about theories. We need to go back to reexamining what will work in practice.

Mr. HOLDING. Thank you very much.

Mr. Chairman, I yield back.

Chairman BUCHANAN. We have been joined at this hearing by our fellow Ways and Means Committee Member, Mr. Kelly. As is our custom, he will be permitted to ask witnesses questions. Now that the Members of the Subcommittee have concluded their questioning, Mr. Kelly from Pennsylvania, you are now recognized for 5 minutes.

Mr. KELLY. Thank you, Chairman. And again, thank you for allowing me to participate today.

All three of you are here for a reason. We talked today the purpose of the hearing is to examine if the individual mandate penalty is actually stabilizing health markets. Okay? And we talked about a lot of different things. I have got so many constituents back home that now have a policy, but don't have any health care.

So between premiums being where they are, deductibles being where they are, copays being where they are, I know there is reference made to Medicaid. The question is who all accepts Medicaid as payment? How many actual providers of health care say, no thanks, it doesn't begin to cover my cost of delivery?

So here is what it comes down to. If we are talking about this and if a big part of the individual mandate was going to cover the cost of all these things, the question is did it work? Is there anybody of the three of you that could say this was—it was well intended? I am going to say it wasn't well intended.

And, Mr. Miller, I love the fact it is three versus practice. Again, it is assuming things without looking at reality. People usually don't buy things they don't want and they certainly don't overpay. It is okay if they are being subsidized, but they—out of their own pocket, will say, you know what, thanks, but no thanks. Has this worked at all? Go ahead. I mean, if we are trying to get to an end here, what has it done?

Mr. MILLER. Well, I always try to be a little more balanced in this approach. We had a lot of bad policies incorporated into the Affordable Care Act, not the individual mandate alone. The way I would first put it is the individual mandate, not only did it not work, it didn't save those other bad policies. So we need to reexamine more than just the individual mandate itself.

The reason why coverage may not be attractive to people may be a part of the way in which we tried to standardize coverage in certain ways, which meant that suddenly it no longer appealed to people in the same manner when they were paying more of the cost than they did before and weren't highly subsidized. So we have got a lot of different things to take out of the bottle and reassemble. But the individual mandate itself did not provide some extra boost.

And you can't keep subsidizing people to basically say, come on. Instead, what we got were limited networks, lower actuarial values, and higher deductibles for people who saw the cost and they didn't want that coverage and they are complaining to you about it. That is how we created a new distortion to deal with the old distortions.

Mr. MCDONOUGH. Can I address?

Mr. KELLY. Oh, yes. Please. Sure.

Mr. MCDONOUGH. Thank you for the question. So just the question, does this work? Well, work is obviously in the eye of the beholder. But just let me give you some responses to does this law work.

Mr. KELLY. Can you do that, Mr. McDonough, if it is in the eye of the beholder? Yeah, I have got two or three pages of people back home in my district, they are saying it doesn't work. So in the eyes of a lot of beholders, including the majority of this country, it doesn't work.

Mr. MCDONOUGH. Okay. So lowest rate of uninsurance in the history of the United States. Drop the—

Mr. KELLY. But, sir, listen, I don't want to equate having an insurance policy with having health care. Huge difference.

Mr. MCDONOUGH. Rates of satisfaction among people who have been enrolled in Medicaid and people who have been enrolled in exchange policies, around 80 percent satisfaction. Drop in the rate of

uninsurance among America's children, by 50 percent over the past several years. The rate of financial security and the drop in medical debt experienced by Americans across the country, a substantial drop. Rate of increase in per enrollee Medicare spending is the lowest it has been in the history of the program since it was created in 1965. Those are just five things. We can go on and on.

Mr. KELLY. Where is this study from?

Mr. MCDONOUGH. These are all different studies, sir. I would be happy to share the sources of all of those with you.

Mr. KELLY. Okay. I would like to see that information. And I appreciate that.

Mr. MCDONOUGH. Happy to do that.

Mr. KELLY. Mr. Graham.

Mr. GRAHAM. I think what Professor McDonough stated, those facts are certainly cohere with what I understand of a lot of things, but very little of that has to do with the individual mandate. You know, there has been some Medicare changes going on. Most of the effect of the Affordable Care Act in terms of coverage is Medicaid. And I know I am going to provoke some folks here, but I don't like to include Medicaid as insurance because Medicaid is a welfare program. So as long as we include more Medicaid enrollment as insured, that is like saying more TANF with having a job, it doesn't make any sense, you know.

So if we are going to be coherent or whatever, giving people more welfare benefits, that's fine. If that is what you all want to do, that is your prerogative as the folks who tax and spend, that's what you are going to do. But let's not pretend that we are making people more individually responsible through this mandate. And as you say, for very many people, the small business owner, the self-employed person, it is just driving them crazy, as we have heard from you and so many of your colleagues, trying to figure out what the heck is going on, how to get an affordable plan and—

Mr. KELLY. I know. We are going to continue to work, Chairman, and I appreciate, again, being included. We are going to continue to try to work to make sure that the American people understand. They are not going to lose, by the way, their insurance. I mean, Mr. Trump was sworn in last Friday. I don't think anybody is walking around the country right now and had their insurance pulled away from them, so that is kind of a false narrative. But we have got to find something that makes sense. None of this makes sense to me economically. Why would anybody stay in the insurance business to lose money?

Thank you.

Chairman BUCHANAN. I now recognize myself. We spent a lot of time on the mandate. I want to shift gears a little bit and talk about affordability and access.

My background before I got here, I have been here about 10 years, but before that, 30 years. And I think back 30, 40 years ago, companies paid or people had access to low cost, high quality health care. I thought back a few days ago and I was thinking back 20 years ago when I was chairman of the chamber in our area, we had 2,500 businesses, most of them 15 employees or less. The number one issue, 20 years ago—and this before the ACA to give them—you know, we can talk about that a little bit.

But 20 years ago, the number one issue, we surveyed all our members, was access and affordable health care. And it just seems like it has accelerated to the point of being absurd that typical individuals—it is not unusual in my area in Florida, Sarasota Florida, a couple could be paying \$2,000 a month for health care. That is outrageous. That is more than a car payment and a house payment.

I read the other day, and I shared this with our people, in the front page of I think it was USA Today, 62 percent of Americans don't have \$1,000 in the bank. I thought to myself when I looked back, you know, you can talk about wages and everything else, that one of the things that is gutting the middle class I think is health care cost. You get the subsidy. You know, maybe it works for you, but people just outside the subsidy, because small businesses and everybody else, they can't afford to provide it. It's \$1,400 for a family of four, \$1,600. So the small business might pick up \$600, \$700. It is getting passed to the workers. And that is why nobody has anything.

So my thought when I first heard about the ACA, I was concerned back then about the cost of health care and I was open-minded, if it bent a curve on health care. But I heard what you said, Doctor. But I can just tell you in our region in Florida, it is not unusual to hear every single day rates going up 20 and 30 percent for small businesses and individuals. That is the reality.

So I guess I would ask any of you, Mr. Miller, Mr. Graham, let's start there, what are we going to do about, or your thoughts, in bending the curve? It is just—and I know it is a big discussion, but I would like to just have maybe 30 seconds each of you just to give me your point.

Mr. MILLER. All right. That is a bigger discussion.

Chairman BUCHANAN. I know it is a big discussion.

Mr. MILLER. So let me simplify. This may not be the politically astute answer.

Chairman BUCHANAN. No. I just want—

Mr. MILLER. If we keep pumping more money into health care, it is going to cost more. Now, if we want to do that, we need to think about that a little bit more surgically. So the approach might be to actually have the individuals supposedly benefiting from this to control those dollars and decide how they want to spend it. That will be a different type of result in terms of better quality health care at a lower price over time. We have tried subsidizing it, we have tried regulating it, we have tried placating everybody in between. We need to get it down to the ground level and decide what people actually want to spend their money on. And that includes trading off health care with better wages. And we need to stimulate economic growth and we need a healthier population. We need a better health care delivery system.

Those are all things well beyond the little games we play with individual mandates and insurance subsidies. That is a bigger discussion, but we need to focus more on that.

Mr. GRAHAM. I would agree with Mr. Miller. And I would point out that all this money going into the ObamaCare exchanges, it really goes to insurance companies, you know. We advocate consumer-driven health care. We don't give any tax credits to individ-

uals that they can spend directly. And I know one of the Members talked about the premium is more than the rent. Well, when I pay my rent, I move in that day and I start living there, you know. I pay for these insurance policies and they don't kick in until I go to the hospital. So if we are going to help people, let's help them pay directly for care. And we had some good experience that that can help reduce some cost.

Chairman BUCHANAN. Doctor, I will give you an opportunity. Take a few seconds and wrap up.

Mr. MCDONOUGH. The major challenge, it seems to me and to many other experts with whom I work, is to change the underlying incentives in terms of the delivery of medical care to move away from a system that rewards providers to do more and more through fee-for-service and, instead, to move toward a system that rewards providers when they actually provide quality, value service. And we have a number of important directions that we are going in.

The Nation is moving in this direction, regardless of what happens to the fate of the ACA. You saw it in the MACRA law, the bipartisan bill that passed the House and the Senate in 2015. That is not a rejection of the direction that the ACA started, it is an enhancement and an acceleration of it. That is going to continue. And I think that is really probably the most important dynamic that is going on right now in terms of moving our system to a different place.

Chairman BUCHANAN. Let me just conclude. In Florida—I was chairman actually in the floor of the chamber down there too—it is the biggest issue. The cost of health care keeps going. It is not just the last 8 years. It has been the last 20 years. It is out of control, out of hand. We have got to find a way we can work together for the betterment of everybody in the country.

I would like to thank our witnesses for appearing before us today. Please be advised that Members have 2 weeks to submit written questions to be answered later in writing. Those questions and your answers will be part of the formal hearing record.

With that, the Subcommittee stands adjourned.

[Whereupon, at 3:45 p.m., the Subcommittee was adjourned.]

[Public Submissions for the Record follows:]



**Statement on  
“The Individual Mandate under the Affordable Care Act”**

**Submitted to the  
House Ways and Means Committee  
Subcommittee on Oversight**

**January 24, 2017**

America’s Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

We appreciate this opportunity to comment on the individual mandate established by the Affordable Care Act (ACA). Our members have strongly supported an approach to health reform that brings everyone into the system. Broad coverage can ensure the availability of affordable coverage options. Health insurance only works when everyone is covered: those who utilize insurance to obtain quality care as well as those who are healthy but have insurance to protect them in case they get sick. Both types of consumers must be insured for coverage to remain affordable.

As the committee examines this issue, we recognize that the individual market has been a challenge for many years – both before the ACA and after. We recognize that certain parts of the ACA have not worked as well as intended, particularly for individuals who purchase coverage on their own. The challenges facing the individual exchange marketplace – which have been well-documented – include significant increases in average premiums in 2017, fewer health plan choices, and lower-than-expected exchange enrollment and risk pool stability challenges in some states. And absent significant and specific improvements to the exchanges this year, 2018 was already likely to be another challenging year.

While these challenges are real and remain, it is also true that the health reform law has expanded coverage to 20 million Americans. These gains have been achieved through Medicaid expansion as well as through the ACA exchange marketplaces (which has been accomplished through financial assistance via premium subsidies and through the individual mandate).

We also recognize that Congress is preparing to consider legislation to substantially change the ACA and that the individual mandate is likely to be repealed as part of this effort. That's why we are so focused on finding the right solutions that can deliver the strong, stable market – and affordable coverage – that we all want to achieve. We believe it is important for Congress to approve continuous coverage incentives – along with additional stabilization solutions – to minimize the impact of eliminating the individual mandate.

Our statement focuses on two topics:

- The rationale for having full consumer participation, in combination with market reforms and financial assistance, as part of a strategy for achieving a balanced risk pool in the individual health insurance market.
- The need for effective policies to encourage continuous coverage and broad consumer participation in the individual health insurance market if Congress passes legislation to repeal the ACA individual mandate and retains all other market reforms.

#### **The Rationale for Full Consumer Participation**

Since January 2014, the ACA has required health plans to offer coverage to everyone, including individuals with pre-existing conditions, and has prohibited any variation in premiums based on a person's health status or medical history. The health reform law also requires everyone to purchase and maintain coverage (or else pay a penalty) in recognition of the fact that, without such a requirement, there otherwise would be a strong incentive for people to wait and purchase insurance only after they get sick or injured.

In 2012, while the U.S. Supreme Court was weighing its decision about the constitutionality of the individual mandate and other ACA provisions, we commissioned studies examining the experience of two states – Washington and Kentucky – that enacted market reforms without an individual mandate or any other mechanism to achieve universal access to coverage. These

studies yielded important lessons about the unintended consequences of health reforms that create incentives for healthy people to forego the purchase of coverage:

- One study<sup>1</sup> examined Washington state’s experiment with guarantee issue in the absence of an individual mandate. According to the study, the reforms Washington state enacted in 1993 resulted in substantial increases in the premiums charged for individually purchased policies, a dramatic reduction in the number of carriers writing policies for individuals in the state, and a 30 percent increase in the number of uninsured.
- Another study<sup>2</sup> explained that the enactment of guarantee issue and community rating reforms in Kentucky, in the absence of an individual mandate, provided a powerful incentive for people to delay purchasing coverage until after they needed medical care. As a result of these reforms, individuals’ insurance premiums skyrocketed, in some cases over 100 percent, and the resulting disruption in the state’s insurance marketplace forced most of the state’s health insurers to leave the market.

In addition to experience in the states, several non-partisan studies have concluded that eliminating the individual mandate would significantly increase premiums and cause serious market disruptions, absent the implementation of additional or alternative policies to promote market stability.

- The Congressional Budget Office (CBO) concluded that “premiums in the non-group market would be roughly 20 percent to 25 percent higher than under current law” as a result of “repealing the penalties associated with the individual mandate.”<sup>3</sup> However, CBO’s analysis did not evaluate the impact of any alternatives to the individual mandate that policymakers may consider.
- The American Academy of Actuaries has cautioned that “eliminating the ACA’s individual mandate, premium subsidies or cost-sharing reductions would increase the likelihood for adverse selection, in which people who are most at risk of high health care costs would be the most likely to enroll, while many healthier individuals decide not to purchase coverage. Premiums for the remaining pool would increase as a result, further

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<sup>1</sup> Lessons Learned: Washington State’s 1993 Experiment with Health Insurance Reforms, May 2012

<sup>2</sup> Unintended Consequences: Kentucky’s Experiment with Health Care Offers Lessons For Nation, May 2012

<sup>3</sup> Congressional Budget Office. “How Repealing Certain Portions of the ACA Would Affect Health Insurance Coverage and Premiums.” January 2017. <https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52371-coverageandpremiums.pdf>



exacerbating adverse selection problems. A premium spiral could result, with fewer and fewer insureds and higher and higher premiums.”<sup>4</sup>

- The Brookings Institution cautioned that eliminating the individual mandate penalties “would likely de-stabilize the market and very possibly cause it to collapse in some regions of the country during the interim period before any replacement is designed.” Moreover, the Brookings authors found that eliminating the mandate penalties would “cause a substantial number of those currently with insurance, especially younger, healthier ones, to drop their insurance, leaving an even sicker pool in place and increasing premiums even further.”<sup>5</sup>

These research findings are well worth considering in the congressional debate on ACA replacement reforms. The clear lesson for policymakers is that any reforms that give healthy people incentives to delay purchasing coverage will lead to unintended consequences—higher costs and fewer choices—for the broader population. It will diminish access to high quality, affordable health insurance. To avoid this outcome, Congress should take steps to encourage continuous coverage and broad participation in the individual health insurance market.

#### **Alternative Approaches to Encouraging Continuous Coverage and Broad Participation in the Individual Health Insurance Market**

We recognize there is significant support in Congress for repealing the individual mandate penalties, as part of a broader ACA repeal bill. However, absent the enactment of alternative incentives to promote continuous coverage, this could create market instability and result in the loss of health insurance coverage for millions of Americans.

To promote a stable individual market during a transition period, incentives are needed to encourage consumers to maintain continuous coverage and minimize movement in and out of the marketplace. We have developed a potential framework of public policies to implement effective continuous coverage requirements, leveraging existing statutes and current health plan practices.

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<sup>4</sup> American Academy of Actuaries. “Consequences of Repealing ACA Provisions or Ending Cost-Sharing Reduction Reimbursements.” December 7, 2016.

[http://actuary.org/files/publications/HPC\\_letter\\_ACA\\_CSR\\_120716.pdf](http://actuary.org/files/publications/HPC_letter_ACA_CSR_120716.pdf)

<sup>5</sup> Brookings Institution. “Why Repealing the ACA Before Replacing it Won’t Work and What Might.” December 13, 2016. <https://www.brookings.edu/research/why-repealing-the-aca-before-replacing-it-wont-work-and-what-might/>

A framework for continuous coverage must begin with a clear definition of requirements, which must be clearly communicated to consumers. We recommend using the existing HIPAA framework as the starting point to define continuous coverage. While HIPAA requires 18 months of creditable medical coverage, we recommend the requirement be set at 12 months as this better reflects coverage trends in the individual market. Creditable coverage should leverage the existing definition of minimum essential coverage (MEC)—a well-defined, existing standard.

Once new rules of the road are in place, all consumers should have the opportunity to enroll in coverage during 2018 open enrollment, regardless of their current coverage status, before any new requirements are put in place. Education and awareness are critical to ensure consumers understand the consequences of waiting to enroll, and these new requirements should be clearly communicated to enrollees during 2017 to encourage enrollment during 2018 open enrollment.

Individuals who apply for coverage after January 31, 2018 (after the close of the 2018 open enrollment period) must meet continuous coverage requirements, defined as 12 months of creditable coverage. Those who do not meet this requirement would face penalties such as a premium surcharge or having to wait six months to enroll—similar to the existing practice for Medicare Parts B and D.

Other policy requirements need to be implemented in tandem to promote continuous coverage and reduce movement in and out of the individual market risk pool. Individual market special enrollment period (SEP) rules should be modified, as appropriate, to reflect continuous coverage policies. SEP rules should be tightened so that a life event is not an opportunity to enroll in coverage for the first time, but to make a needed change to an existing policy (e.g., to add a newborn). SEP rules must be enforced and eligibility should be verified prior to enrollment.

Implementing effective and well-designed continuous coverage incentives is critical to promoting affordable coverage and market stability—especially if the individual mandate is eliminated immediately under partial repeal of the ACA through a budget reconciliation bill. In addition to continuous coverage incentives, additional policies—such as risk pool funding, reforms to the premium subsidies (APTC) and related policies—are necessary to mitigate coverage disruptions and can help promote a more stable transition to alternative insurance coverage reforms.

**Conclusion**

Policymakers in Washington and in state capitols across the country have tried to improve the individual insurance market for many years. This is another opportunity to get it right. And by working together to find the most effective solutions, we can deliver the long-term improvements that the American people deserve.

