The Individual Mandate: Theory & Practice

August 21, 2014

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• Slides available at

  www.shadac.org/IndividualMandateWebinar
Introduction & Overview
About SHARE

State Health Access Reform Evaluation (SHARE)

• National Program of the Robert Wood Johnson Foundation
• Part of the Foundation’s Coverage Team
• Operates out of the State Health Access Data Assistance Center (SHADAC)
• 33 research grants awarded since 2008
• 2014 grants to launch in October
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SHARE Webinar on Adverse Selection and an Individual Mandate: When Theory Meets Practice

by Martin Hackmann, Jonathan Kolstad, and Amanda Kowalski

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August 2014
Did the Massachusetts Reform Mitigate Adverse Selection?

Overview of Massachusetts Reform and the ACA
Methods and Data
Results
  Coverage
  Costs
  Premiums
Welfare Implications
Implications for National Reform
Forthcoming and Prior Research
**Key Provisions**

**Massachusetts Reform and ACA**

**Massachusetts Reform, April 2006**
- Individual mandate
  - Penalty is up to 50% of basic plan by months without coverage
- Employers mandated to provide coverage
  - >10 FTEs
- Medicaid expansions
  - Up to 100% of FPL for adults
  - Up to 300% of FPL for children
- Subsidized private plans through exchanges
  - Subsidies up to 300% of FPL
- Insurance exchange
  - Administered by the “Connector”
  - Benefit tiers Bronze-Gold and Young Adult Plans (YAPs)

**National Reform, March 2010**
- Individual mandate
  - Penalty is higher of 2.5% of income or $2,085
- Employers mandated to provide coverage
  - >50 FTEs
  - >200 FTEs automatically enroll
- Medicaid expansions
  - Up to 133% of FPL
- Subsidized private plans through exchanges
  - Subsidies up to 400% of FPL
- Insurance exchanges
  - State level administration
  - Benefit tiers Bronze-Platinum and Catastrophic
- Cost control measures

Reference: Kaiser Family Foundation
Methods: Did the Massachusetts Mandate Mitigate Adverse Selection?

- Under theory of adverse selection, the sickest people sign up for coverage first
- Reform in Massachusetts allows us to examine mandate as a practical response to adverse selection
- We know that the initial market was adversely selected if
  - Coverage increased
  - Insurer costs decreased on average (indicates that lower-cost individuals signed up for coverage)
Methods: Did the Massachusetts Mandate Decrease Markups?

- Markups are the difference between what the insurer charges in premiums and pays in costs.
- We know that markups decreased if
  - Premiums decreased by even more than costs.
Methods: Did Decreases in Adverse Selection and Markups Improve Consumer Welfare?

- Under adverse selection and markups, there is a welfare loss because consumer willingness to pay for insurance is higher than what it would cost insurers, but consumer willingness to pay for insurance is lower than the offered price.
- Getting more low-cost people into the pool and charging consumers premiums closer to costs improves welfare.
Methods: Use Changes in Coverage, Costs, and Premiums to Draw Graph and Estimate Shaded Regions and Optimal Penalty

- Arrive at changes in coverage, costs, and premiums by comparing MA to synthetic control group of other states before and after reform.
- Shaded region is welfare gain, graph also gives optimal penalty.
Data

- **SNL Financial Database: 2004-2011**
  - Compiled from National Association of Insurance Commissioners reports
  - Detailed data at the firm-market-year level on
    - Enrollment in member-months
    - Costs to Insurers
    - Premiums
  - Universe of insurers in the individual market
  - Drop insurers that offer Commonwealth Care Plans

- **National Health Interview Survey (NHIS)**
  - Allows us to express insurance coverage in percentages
  - Restrict the sample to individuals 18-64 earning more than 300% of the FPL to avoid
    - Medicaid expansions
    - Commonwealth Care plan expansion
    - Variation in tax penalty
Results: Coverage Increased

- Coverage increased by 21.7 percentage points, starting from 70% in individual market
- 78% from adverse selection, rest due to lower markups
Insurer expenditures decreased by $459 per person per year (8.7% of pre-reform base of $5,271), indicating adverse selection.
Results: Premiums Decreased

- Premiums decreased by $1,368 per person (23.3 percent of pre-reform base of $5,871), reflecting less adverse selection and lower markups.
Reform made participants in individual market better off by $299 per person per year – approximately $63.5 million overall per year spread over 212,000 individuals

80 percent of welfare gain from reductions in adverse selection (likely from mandate)

Remaining 20 percent from decreased markups (likely from introduction of exchange, changes in individual/small group market)
Results: Summary

- Coverage increased, insurer costs decreased, premiums decreased
- Reform made participants in individual market better off by $299 per person per year
- Optimal minimal individual mandate penalty would be at least $1,462 (penalty under national reform is greater of $2,085 or 2.5% of household income)
Implications for National Reform

- MA already had community rating and guaranteed issue regulations, which are established by national reform
- The individual mandate mitigated adverse selection in the presence of these regulations
- National market would have had adverse selection similar to pre-reform Massachusetts had the Supreme Court struck down the mandate while keeping these regulations
- Other states could have different experiences
Forthcoming and Prior Research

- **ACA**

- **Massachusetts**
Forthcoming and Prior Research

- **ACA**

- **Massachusetts**
Nancy Turnbull

Senior Lecturer
Harvard University
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The Individual Mandate: Some Thoughts from the Ground in Massachusetts

Nancy Turnbull
Harvard School of Public Health
Board Member, Health Connector
## Comparison of Massachusetts and US Health Care Reform Laws

<table>
<thead>
<tr>
<th>Policy</th>
<th>Massachusetts</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Coverage for the Poor</strong></td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td><strong>Subsidized Coverage for moderate income</strong></td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td><strong>Reforms to private insurance market</strong></td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td><strong>Health Insurance Exchange</strong></td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td><strong>Individuals must buy insurance</strong></td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td><strong>Employers must provide or pay penalties</strong></td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>
Differences between Massachusetts and Federal Reform relevant to impact of IM

- Separate program of subsidized coverage: Commonwealth Care
  - ≤300% FPL
  - Not eligible for Medicaid or ESI

- Not part of the individual market and risk pool
  - Program run and financed by state (and feds)
  - Separate standardized products and carriers
  - Sliding scale subsidy

- This population will be part of individual market under ACA in other states (and now in Massachusetts)
  - How will this affect premiums and selection?
## Preserving Better Subsidies and Coverage
### Key Policy Goal in MA Response to ACA

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>100-133%</td>
<td>$11,490-$15,282</td>
<td>$19-25</td>
<td>$0</td>
</tr>
<tr>
<td>133%-150%</td>
<td>$15,282-$17,235</td>
<td>$38-57</td>
<td>$0</td>
</tr>
<tr>
<td>150-200%</td>
<td>$17,235-$22,980</td>
<td>$57-121</td>
<td>$40</td>
</tr>
<tr>
<td>200-250%</td>
<td>$22,980-$28,725</td>
<td>$121-193</td>
<td>$78</td>
</tr>
<tr>
<td>250-300%</td>
<td>$28,725-$34,470</td>
<td>$193-272</td>
<td>$118</td>
</tr>
</tbody>
</table>

Note: Actuarial value of APTC silver plan ~70% ; actuarial value of ConnectorCare plans ~97%. With cost-sharing, AVs in ACA are 94% at 100-150% FPL; 87% at 151-200%, and 73% at 201-250%.
Two-Thirds of Increase in Coverage In Massachusetts Has Been Among People who are **Not** Subject to An Individual Mandate Penalty (But Who Are Eligible for Free Health Coverage)

Change in Total Coverage by Source: 2006 vs 2012 (~430,000 people)

- Medicaid: 43%
- Unsubsidized Through Exchange: 20%
- CommCare: No Premium: 8%
- CommCare: Premium: 20%
- Other (7%)
- Employers (2%)

What impact on premiums in individual market??
From IM Atheist to IM Agnostic: My Spiritual Conversion

Increase in People with Coverage by Type of Coverage: June 2006 vs December 2008

- Public: 59% of gain
- Employer: 33%
- Individual: 8%
- Private Coverage: 41% of gain

December 2008

+421,000 people
From IM Atheist to IM Agnostic: What a Difference a Recession Makes

Increase in People with Coverage by Type of Coverage vs June 2006

- Public: 59%
  - December 2008: 8% increase
  - March 2011: 2% increase

- Employer: 33%
  - December 2008: 8% increase

- Individual: 8%
  - December 2008: +421,000 people
  - March 2011: +439,000 people
No Erosion of Employers Offering Coverage

Proportion of Employers Offering Health Insurance

Source: KFF/HNET and Mass DHCFP
Most of the Remaining Uninsured are Not Subject to Any Individual Mandate Penalty… But They Are Likely Eligible for Free Coverage

Details of Uninsured from Mass State Tax Filings: 2011

<table>
<thead>
<tr>
<th>Uninsured Full Year (n=170,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paid penalty</strong></td>
</tr>
<tr>
<td><strong>Nothing affordable</strong></td>
</tr>
<tr>
<td><strong>Income &lt;150% FPL: no penalty</strong></td>
</tr>
<tr>
<td><strong>Appealed penalty</strong></td>
</tr>
<tr>
<td><strong>Religious/other exemption</strong></td>
</tr>
</tbody>
</table>
The biggest gains in coverage have been among young adults.
Significant reductions in the racial coverage gap

Percent of Population Uninsured

Urban Institute, 2005 and MHIS 2010
Importance of Health Insurance Market Reforms in Making Coverage More Affordable

- Non-group/individual and small-group insurance markets combined in Massachusetts in 2007
  - Reduced individual rates significantly with only minor increase for small employers

- Age for eligibility for dependent coverage for health insurance raised to 25 years

- Exchange/marketplace as means to promote new products, make shopping easier and prices more transparent for consumers

<table>
<thead>
<tr>
<th>Insurer</th>
<th>2006: Standard Plan</th>
<th>2008: Gold Plan</th>
<th>2008: Bronze Plan</th>
<th>% change Gold vs. 2006 Plan</th>
<th>% change: 8% annual inflation added to 2006 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>25-year-old</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO Blue</td>
<td>$528</td>
<td>$470</td>
<td>$255</td>
<td>-11%</td>
<td>-23%</td>
</tr>
<tr>
<td>HPHC</td>
<td>$507</td>
<td>$441</td>
<td>$220</td>
<td>-13%</td>
<td>-24%</td>
</tr>
<tr>
<td>NHP</td>
<td>$436</td>
<td>$343</td>
<td>$197</td>
<td>-21%</td>
<td>-32%</td>
</tr>
<tr>
<td>Tufts</td>
<td>$710</td>
<td>$378</td>
<td>$218</td>
<td>-47%</td>
<td>-54%</td>
</tr>
</tbody>
</table>

| **Family (2 kids, 35-year-old parents)** | | | | | |
| HMO Blue | $1248 | $1660 | $902 | +33% | +16% |
| HPHC* | $1533 | $1540 | $767 | 0% | -13% |
| NHP* | $1505 | $1276 | $731 | -15% | -26% |
| Tufts | $1683 | $1330 | $766 | -21% | -31% |

| **Couple in 60s** | | | | | |
| HMO Blue | $1888 | $1879 | $1020 | 0 | -14% |
| HPHC | $2011 | $1853 | $923 | -6% | -20% |
| NHP | $1733 | $1477 | $847 | -15% | -26% |
| Tufts | $2397 | $1587 | $914 | -34% | -43% |
More People Covered But Little Progress on Financial Security Overall

<table>
<thead>
<tr>
<th>Category</th>
<th>2006</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of pocket costs &gt; 10% income</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Has medical debt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems paying medical bills</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>Insured and problems paying medical bills</td>
<td>14%</td>
<td>15%</td>
</tr>
</tbody>
</table>
IM Meets Rising Health Insurance Premiums: How to Respond?

- Let reach of the mandate erode?
- Increase the affordability schedule to maintain reach of mandate?
- Reduce public subsidies?
- Reduce minimum mandated coverage (e.g., reduce actuarial value levels)?
- Take more aggressive public policy action to moderate health insurance premiums?
Question & Answer

Submit questions using the chat feature on the left-hand side of the screen.

Amanda Kowalski  
Nancy Turnbull
The Individual Mandate: Theory & Practice

- Direct inquiries to Carrie Au-Yeung at butle180@umn.edu
- Webinar slides and recording available at www.shadac.org/IndividualMandateWebinar
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