

“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

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“Examining the Effectiveness of the Individual Mandate Under the ACA”

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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.¹

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 show 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.² 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.³ 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.⁴ In the March 2016 baseline, the CBO updated its estimate of revenue from penalties.⁵ 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.⁶

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 2007.⁷ 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.⁸ 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.⁹

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.¹⁰ The result is that Massachusetts' health plans hemorrhaged cash, and a senior regulator described the situation as a "train wreck."¹¹

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.¹² 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.¹³ 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.¹⁴

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.¹⁵

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.

¹ "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/>.

² 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/commissionerletteracafilingseason.pdf>.

³ "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>.

⁴ "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>.

⁵ "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>.

⁶ 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.

⁷ "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.

⁸ "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,"

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

⁹ 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/.

¹⁰ "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.

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

¹² "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>.

¹³ 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>.

¹⁴ 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>

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