STATEMENT OF
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HEARING ON THE INDIVIDUAL AND EMPLOYER MANDATES IN THE AFFORDABLE CARE ACT
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

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Good morning Mr. Chairman, Ranking Member McDermott, Members of the Committee. My name is Sabrina Corlette, a Senior Research Fellow and Project Director at Georgetown University's Center on Health Insurance Reforms. I am responsible for directing research and analysis on health insurance, health insurance markets, and implementation of the Patient Protection and Affordable Care Act (ACA). The views I share today are my own, and do not represent those of the faculty, staff, or management of Georgetown University.

I thank you for the opportunity to testify before you today, and for the leadership of this Subcommittee in conducting ongoing oversight of the implementation of the ACA. The hearing today is a timely one, just a few weeks after the 5 year anniversary of the law, and shortly before the close of the first tax filing period.

Given that we have just marked the 5-year anniversary, it is important to spend some time taking stock of how the law's reforms have affected people's access to affordable, adequate health coverage. On just about every dimension, the progress has been remarkable. In my testimony, I will thus focus on:

1) The functioning of the health insurance market, pre-ACA and the rationale for the ACA's reforms, including the individual and employer mandates
2) The impact of the ACA's reforms on access to affordable, adequate health coverage and the economy as a whole

The Health Insurance Marketplace, Pre-ACA

To understand how the ACA has affected health coverage and health insurance markets, it is important to understand what the world looked like before the law was passed. Having decent health coverage is essential to the health and financial vitality of American families. People without health insurance are significantly less likely to receive necessary care, and a lack of meaningful coverage has resulted in medical debt being a primary cause of personal bankruptcies.[1]

On the eve of the law's passage in 2010, approximately 50 million non-elderly Americans were uninsured,[2] and approximately 10 million Americans under age 65 obtained their health insurance through the individual market, meaning they did not have coverage through their employer or public programs such as

Medicare and Medicaid.[3] The people who buy health insurance on their own can be self-employed entrepreneurs, farmers and ranchers, early retirees, part-time workers, widows, and young people "aging off" their parents' plans. Yet, as *Business Insider* magazine put it, before enactment of the ACA, the individual insurance market was a "basket case."[4]

Before the ACA, the individual insurance market was an inhospitable place, particularly for people with less than perfect health.[5] That's a lot of us. According to one estimate, between 50 and 129 million non-elderly Americans have at least one pre-existing condition that would threaten their access to health care and health insurance.[6] These include a wide range of conditions, from back pain and prior sports injuries to chronic illnesses such as diabetes and asthma, as well as diseases like cancer. But, before the reforms in the ACA, in most states applicants for health insurance could be denied a policy because of their health status, or charged more in premiums based on their health and gender, along with a number of other factors. Insurers were also allowed to issue policies that didn't cover critical services like pharmacy, maternity, or mental health benefits. And before enactment of the ACA, insurers could – and did – drop (rescind) an individual's coverage if they got sick, and often imposed annual and lifetime dollar limits on covered benefits.[7]

Health insurance was, and is, a very expensive product, and it is particularly expensive for people trying to buy coverage through the individual market. Unlike those with employer-sponsored coverage, people buying on their own must pay the full cost of their premium, and their payments are not pre-tax. And, unlike those with employer coverage, there was no one to help subsidize the premium costs. According to one national survey, before the ACA, 31 percent of people buying insurance on their own spent 10 percent or more of their income on premiums, compared to only 13 percent of people with employer-based coverage.[8] The same national survey found that 70 percent of people with health problems reported it "very difficult" or "impossible" to find an affordable health plan, compared to people in better health.[9]

More often than not, a common life event causes people to lose coverage or enter the individual market – losing or changing jobs, an illness, a divorce, a birthday, or a move. Prior to the ACA, consumers had some protections to help them transition to new coverage, although these protections were often inadequate. "Safe harbors" under federal law included COBRA, which allows those who lose access to job based coverage to continue their coverage in their former employer's plan for 18-36 months, and HIPAA, which was designed to help people obtain a health insurance policy after their COBRA coverage ends. However, these safe harbors have often not been helpful because premiums are priced out of reach, or the coverage offered was inadequate. The failure of these safe harbors, and the inhospitable nature of the individual market led to the phenomenon of "job lock," in which people were tied to jobs they would otherwise leave, in order to maintain their access to affordable health insurance coverage.

At the same time, the number of "underinsured" individuals was rising dramatically before enactment of the ACA, such that, in 2013 there were twice as many as there were in 2003. Those purchasing insurance on their own were more than twice as likely to be underinsured as those who had coverage through an employer-based plan.[10] In general, someone is considered underinsured when they have insurance but because of high deductibles, high co-payments, or non-covered benefits, the insurance offers inadequate financial protection for the health care services people need.[11]

Coverage prior to the ACA's reforms could be inadequate for many reasons, including:

- *Pre-existing condition exclusions*, in which insurers were permitted to permanently exclude from coverage any health problems that a consumer disclosed on their application for a policy. For example, if an applicant had a history of asthma, it was not uncommon for the insurer to carve out his or her entire upper respiratory system from the plan's covered benefits.
- *Limited benefits.* Insurers selling health insurance in the individual market often sold "stripped down" policies that did not cover benefits such as

maternity care, prescription drugs, mental health, and substance use treatment services.[12]

- *Limited coverage.* Prior to the ACA, it is estimated that about 102 million people were in plans with a lifetime limit on benefits and about 20,000 people hit those limits every year. And 18 million people were in plans with annual dollar limits on their benefits.
- *High out-of-pocket costs*. Before the ACA, individual market policies often came with extremely high deductibles - $10,000 or more was not uncommon – and high cost-sharing. One study in California found that individual policies paid for just 55 percent of the expenses for covered services, compared to 83 percent for plans sold to small businesses.[13]

The ACA includes numerous reforms intended to address the rising number of uninsured in this country and the shortcomings in the individual market. These set minimum federal standards for an individual's access to affordable and adequate health insurance, with state flexibility to enact stronger consumer protections if they wish. These reforms include:

- *Improved Access to Coverage.* The ACA required insurers to provide coverage to people who apply for it, regardless of their health status. In addition, the ACA prohibits insurers from rescinding the coverage of consumers who submit medical claims, except in the case of clear fraud by the policyholder. And of course, in those states that have adopted it, low-income people can now benefit from the ACA's Medicaid expansion.
- *Improved Affordability of Coverage.* The law provides for premium tax credits and cost-sharing reductions to help make coverage more affordable. Currently 87 percent of people enrolled through the health insurance marketplaces are receiving financial assistance.[14] In addition, the law prohibits insurers from charging people more in premiums based on their health status or gender, and limits the amount they can charge based on a person's age.
- *Improved Adequacy of Coverage.* The ACA prohibits the use of pre-existing condition exclusions and sets a minimum benefit standard, called "essential

health benefits." The law also sets a new minimum level of coverage such that enrollees, on average, would not pay more than 40% of costs, and limits the total amount of out-of-pocket spending consumers must incur, currently at $6,600 per year for an individual. These new standards help ensure that insurance does what it is supposed to do: provide real financial protection.

The ACA's Individual Mandate: Critical to the Sustainability of Insurance Reforms

The ACA's individual responsibility requirement, often referred to as the individual mandate, has been by far the most controversial element of the law. However, its origins date back to Republican health reform proposals in the 1990s. It is essential to any comprehensive health reform plan to keep premiums affordable and sustain meaningful coverage. Because the law prohibits insurers from discriminating against people with pre-existing conditions, a mechanism is needed to prevent people from waiting until they get sick before signing up for insurance. If that were allowed, only those needing health care services would sign up, and the cost of insurance would be very high. As one expert has put it, "You basically can't have a functioning insurance market if people can buy insurance on their way to the hospital."[15] We need only to look at two real-life examples to illustrate why the mandate is needed:

- *Washington state insurance reforms*. In 1996, Washington adopted insurance reforms similar to those in the ACA, but without an individual mandate. As a result, the state experienced a 25 percent reduction in individual market enrollment and a decline in the number of comprehensive plans offered. The largest carrier in the market raised premiums by 78 percent.[16]
- *New York insurance reforms*. New York passed reforms in the early 1990s requiring insurers to accept all applicants, even those with pre-existing conditions. The result? Just a few years after passage, enrollment in the individual market was as much as 50 percent lower than when reforms began, and New York had the highest individual market premium rates in the country.[17]

And in fact, once the ACA's individual responsibility requirement was put into effect in New York rates dropped by an average of 50 percent.[18]

But you don't have to look only to states' experiences to understand the implications of repealing the individual mandate. The Congressional Budget Office has estimated that just a 5 year delay in the individual mandate would result in 13 million more people being uninsured and premium increases of 10-20 percent.[19]

The ACA's Employer Mandate: Discouraging Free Riders and Encouraging Shared Responsibility

The ACA's employer mandate is designed to maintain our system of employer-sponsored coverage and to discourage employers from shifting employees into the publicly funded health insurance marketplaces. The underpinning rationale for the provision is that all stakeholders should contribute something to a sustainable, equitable health care system. Those employers that don't offer coverage to their workers are acting as free riders, and they should be required to pay something when their workers receive taxpayer subsidies for health coverage. This is something the American people understand; surveys show that 60 percent of them support an employer mandate.[20] In actual fact, however, very few employers will ever pay a fine under the mandate. Nearly all large firms offer health benefits to at least some employees (98 percent of those with 200 or more employees).[21]

Repealing the employer mandate is estimated to a result in between 200,000 and 1 million individuals joining the ranks of the uninsured, and a loss in federal revenue of $150 billion over 10 years.[22]

<u>The Impact of the ACA's Private Market Reforms</u>

While we are only about 15 months out from the full implementation of the ACA's reforms, the evidence is clear that these reforms are working. First and foremost, the law is meeting its primary objective of expanding health insurance coverage. The uninsured rate at the start of 2015 was 12.9 percent, dropping from 17.1% at the end of 2013.[23] Since the law's passage, approximately 16.4 million Americans have gained health insurance coverage.[24] This means that 16.4 million people are

more likely to receive necessary medical services and gain critical financial security and protection from catastrophic medical costs.

There is also strong evidence that coverage under the ACA is providing better protection than what the market provided before the reforms were effective. A recent national survey from the Commonwealth Fund found declines in the number of people reporting cost-related access problems. For example, the number of people who did not get needed care declined from 80 million people in 2012 to 66 million people in 2014. And the number of people reporting problems paying medical bills declined from 75 million people in 2012 to 64 million in 2014.[25]

At the same time, in spite of dire predictions that the law would cause premium growth to explode, in fact we've seen the opposite. Since the ACA was passed, we have seen the slowest growth in health care prices in 50 years. And the three slowest years of growth in real per capita national health expenditures on record were 2011, 2012, and 2013. In employer-based coverage, the average annual family premium was approximately $1800 lower in 2014 than it would have been if premium growth since 2010 had matched the 2000-2010 average rate of growth.[26] For coverage on the ACA's health insurance marketplaces, premium growth has also been held in check, largely because of robust competition between insurers for market share. For example, one study found an average premium growth of only 2.9 percent for the lowest cost silver-level plans offered on the health insurance marketplaces.[27]

There have also been dire predictions about the ACA's impacts on job growth. Yet here too, the data undermines the rhetoric. The CBO estimates that ACA will reduce the total number of hours worked, by (on net) about 1.5 to 2.0 percent.[28] However, they attribute this small decline to workers *choosing* not to work because of new health insurance options, NOT to employers hiring less people or shifting more people to part time. In other words, unemployment – wanting to work but not being able to find a job – will largely be unaffected by the ACA.[29]

In fact, if you look at job data starting with the month the Affordable Care Act became law, the economy has generated 12 million new jobs over 60 months, the longest streak of private-sector job growth on record. According to the Council of Economic Advisors, over the last 12 months as the Affordable Care Act's main coverage provisions have begun to have their full effect, there are now 3.2 million

new private-sector jobs.[30] There is also no evidence of a rise in involuntary part-time work. In fact, the rate of part-time work has declined since its peak during the Great Recession.[31]

In addition, the ACA is likely to spark an increase in entrepreneurship, as workers are freed from job lock to pursue ideas and start-ups that allow them to optimize their skills and talents. In fact, in partnership with economists at the Urban Institute, my colleagues and I have projected that there will be as many as 1.5 million new entrepreneurs nationally, as a result of the ACA's insurance reforms and new coverage options.

The bottom line? The idea that the ACA is a job killer is thoroughly debunked.

Similarly, in spite of concerns that the ACA will undermine our system of employer-sponsored coverage, there is in fact no evidence to date that employers are reducing offers of coverage. In fact, a tracking poll published at the end of 2014 found that employer offer rates have stayed constant, including among firms that employ low-wage workers.[32]

Conclusion

Thank you for inviting me to testify today about the market reforms in the ACA and the impact for consumers, businesses and the economy as a whole. While there remains considerable uncertainty about the law's long-term impact, early data suggests that the law is meeting its objectives and that concerns about people losing coverage, rising premiums, and job losses are and have been totally unfounded.

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