The ACA Remains Critical for Insurance Coverage and Health Funding, Even without the Individual Mandate

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Enacted in 2017, the Tax Cuts and Jobs Act eliminated the individual mandate penalties of the Affordable Care Act (ACA). Now, a case before the US District Court for the Northern District of Texas about the individual mandate could open the door to ending the ACA.[1] Our analysis shows that if the entire law were eliminated, the number of uninsured people would increase by 17.1 million, or 50 percent, in 2019; this estimate reflects coverage losses over and above the losses associated with setting the individual mandate penalties to $0.

The plaintiffs in *Texas v. United States* claim that eliminating the penalty ends the individual mandate. They argue that the individual mandate is essential to the ACA, that the law cannot operate or be sustained without it, and that, thus, the entire ACA should be eliminated.

Although eliminating the individual mandate has adverse effects on insurance coverage, these negative outcomes would only be exacerbated by eliminating the ACA's remaining components. Even without the individual mandate penalties, the ACA supports health care in all states with substantial federal dollars. Eliminating the law would significantly reduce investment in Americans' health.

Other ACA provisions that affect the Medicare program, payment and delivery system reforms, support for community health centers, and preventive care initiatives would be eliminated if the ACA were fully repealed. We do not analyze the elimination of those provisions here.

We estimate the impact of a complete repeal of the coverage provisions of the ACA, comparing that with insurance coverage and health care spending under current law. The current law estimates include the repeal of the individual mandate penalties and other recent policy changes, including the shortened

annual open-enrollment period and the reduced funds for outreach and enrollment assistance. It does assume guaranteed issue and community rating. Our analysis does not include the effects of the expansion of short-term limited-duration policies or association health plans because rules on these policy changes are not finalized.

Under current law, 12.4 percent of the nonelderly population, or 34.1 million people, will be uninsured in 2019 (table 1). Another 148.7 million people will have employer-sponsored insurance, and 68.9 million people will have insurance through Medicaid or the Children's Health Insurance Program (CHIP). Approximately 14 million people will have nongroup insurance coverage, including those receiving federal tax credits to reduce their premiums and those who buy policies with their own funds.

TABLE 1

Health Insurance Coverage Distribution of the Nonelderly under Current Law and Full Repeal, 2019

	Current Law (ACA), 2019		Full Repeal, 2019		Difference	
	People (1,000s)	Share of US total	People (1,000s)	Share of US total	People (1,000s)	Percentage-point
Insured	*240,186*	*87.6%*	*223,047*	*81.3%*	*-17,139*	*-6.2%*
Employer	148,665	54.2%	150,155	54.7%	1,491	0.5%
Nongroup (with tax credits)	7,999	2.9%	2,589	0.9%	-5,410	-2.0%
Nongroup (without tax credits)	6,005	2.2%	7,845	2.9%	1,841	0.7%
Medicaid/CHIP	68,944	25.1%	53,883	19.6%	-15,060	-5.5%
Other (including Medicare)	8,574	3.1%	8,574	3.1%	0	0.0%
Uninsured	*34,130*	*12.4%*	*51,269*	*18.7%*	*17,139*	*6.2%*
Total	**274,316**	**100.0%**	**274,316**	**100.0%**	**0**	**0.0%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. The results take into account that Massachusetts and New Jersey have state-enforced individual mandate policies in 2019.

The Impact of Full ACA Repeal

If the ACA were invalidated (effectively repealed), the number of uninsured people would increase to 51.3 million, an increase of 50 percent, or 17.1 million people. Medicaid/CHIP enrollment would fall by 15.1 million through the elimination of the ACA's Medicaid expansion. This would increase uninsurance among the low-income population.

The number of people with private nongroup insurance would drop 25 percent, from 14.0 million to 10.4 million. Some of those who previously had tax credits would keep nongroup coverage, but they would pay the full premiums. Although 3.6 million fewer people would have private nongroup coverage, those retaining private nongroup coverage would likely have policies that cover fewer benefits and require more out-of-pocket spending for services because of the elimination of the ACA's minimum benefit and actuarial value standards. These policies would be substantially less accessible to people with current or past health problems because of the elimination of guaranteed issue and modified community rating rules.

Finally, if the ACA were fully repealed, federal spending on acute care for nonelderly people would be substantially reduced. Federal spending on Medicaid and Marketplace premium tax credits would fall from $392.1 billion to $245.5 billion in 2019, a loss of $146.6 billion in federal support to finance health care. This represents a decline of 37.4 percent compared with current ACA-related spending. The decline in federal Medicaid spending alone would total $81.6 billion. The elimination of tax credits would reduce federal spending by $65.0 billion.

TABLE 2

Reduction in Federal Spending with Full ACA Repeal, 2019

Millions of dollars

	Medicaid/CHIP	Tax credits	Total federal spending
Current law (ACA)	327,098	65,024	392,122
Full repeal	245,547	0	245,547
Difference	*81,551*	*65,024*	*146,575*

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. The results take into account that Massachusetts and New Jersey have state-enforced individual mandate policies in 2019.

Full ACA Repeal Would Harm American Health Care

Despite the repeal of the individual mandate penalties, and despite the various administrative policy decisions since early 2017 that have reduced insurance coverage and increased premiums in the private nongroup insurance market, roughly 240.2 million nonelderly people will have insurance coverage (either private or public) in 2019 under current law.

Without the ACA, the number of insured people would fall to 223.0 million. Medicaid/CHIP enrollment would drop by 15.1 million, and the uninsured would increase by 17.1 million people. States would have less money to support care for people who would lose coverage.

These shifts would decrease revenue for health care providers and increase the financial burdens associated with uncompensated care. Thus, invalidating the entire ACA would cause considerable harm, even compared with the ACA as restructured by recent policy changes.

The Department of Justice Argument

As we were finalizing this brief, the US Department of Justice (DOJ) filed its brief in *Texas v. United States*, a 20-state lawsuit against the Affordable Care Act.[2] DOJ asserts (1) that the individual mandate is no longer constitutional because it is not supported by a tax penalty, and (2) that in striking down the mandate, Congress also effectively struck down the guaranteed issue and community rating provisions, which cannot operate in the absence of the mandate. However, DOJ contends that repeal of the individual mandate penalty does not affect the constitutionality of the rest of the ACA, including the premium tax credits and Medicaid provisions.

DOJ argues that Congress would not maintain the guaranteed issue and community rating provisions without the mandate because the markets could not function with those provisions but without the mandate. But a recent Congressional Budget Office report showed that although the number of uninsured people and the cost of premiums would rise without the mandate, the Marketplaces could still function (CBO 2018). Urban Institute modeling reached the same conclusion, as shown in this brief's estimates of coverage and government spending. In table 1, the "current law" scenario reflects the ACA without the individual mandate but with guaranteed issue and community rating.

If DOJ's position were adopted, insurers could deny coverage to anyone and could charge higher premiums to the sick. This does not seem to be Congress's intent; although it repealed the tax penalty for the individual mandate, it has not eliminated guaranteed issue and community rating provisions. And if those provisions are eliminated, it is not clear how benchmark premiums for Marketplace tax credits would be determined, or how those tax credits would be delivered to eligible enrollees.

Data and Methods

Our analysis uses the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).[3] HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed policy options. The model has been used extensively to estimate the cost and coverage implications of health reforms at the national and state levels and has been widely cited, including in the Supreme Court's majority opinion in *King v. Burwell*.[4]

HIPSM is based on two years of the American Community Survey. The population is aged to future years using projections from the Urban Institute's Mapping America's Futures program.[5] HIPSM is designed to incorporate timely, real-world data when they are available. We regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state. The enrollment experience in each state under current law affects how the model simulates policy alternatives.

Notes

1. Sarah Kliff, "20 States File a New Lawsuit Arguing Obamacare Is Illegal," *Vox*, February 28, 2018, https://www.vox.com/policy-and-politics/2018/2/28/17064444/obamacare-aca-lawsuit-mandate-voxcare.
2. Amy Goldstein, "Trump Administration Won't Defend ACA in Case Brought by GOP States," *Washington Post*, June 7, 2018, https://www.washingtonpost.com/national/health-science/trump-administration-wont-defend-aca-in-cases-brought-by-gop-states/2018/06/07/92f56e86-6a9c-11e8-9e38-24e693b38637_story.html.
3. "The Health Insurance Policy Simulation Model (HIPSM)," Urban Institute, accessed June 12, 2018, https://www.urban.org/research/data-methods/data-analysis/quantitative-data-analysis/microsimulation/health-insurance-policy-simulation-model-hipsm.
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5. Rolf Pendall, Nan Marie Astone, Steven Martin, H. Elizabeth Peters, Austin Nichols, Kaitlin Franks Hildner, Allison Stolte, and Pam Blumenthal, "Mapping America's Futures," Urban Institute, last updated December 1, 2017, http://apps.urban.org/features/mapping-americas-futures/.

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CBO (Congressional Budget Office). 2018. *Federal Subsidies for Health Insurance Coverage for People under Age 65: 2018 to 2028*. Washington, DC: CBO.

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John Holahan is an Institute fellow in the Health Policy Center at the Urban Institute, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, and on developing proposals for health system reform, most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act, including the costs of Medicaid expansion and the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.

Linda J. Blumberg is an Institute fellow in the Health Policy Center, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state and federal levels, and interpreting and analyzing the implications of particular policies. Examples of her work include analyses of the implications of congressional proposals to repeal and replace the ACA, delineation of strategies to fix problems associated with the ACA, analysis of the implications of the *King v. Burwell* Supreme Court case, and a number of studies of competition in ACA Marketplaces.

Matthew Buettgens is a senior research associate in the Health Policy Center, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model. The model has been used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state by state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments, small firm self-insurance under the ACA and its effect on the fully insured market, state-by-state analysis of changes in health insurance coverage and the remaining uninsured, the effect of reform on employers, the affordability of coverage under health insurance exchanges, and the implications of age rating for the affordability of coverage.

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