

The Affordable Care Act's Individual Mandate Helps Make Health Insurance Affordable and Available

By Stan Dorn

The Affordable Care Act's (ACA) individual-coverage requirement—often called the "individual mandate"—makes it possible to ban health insurance companies from discriminating against people with preexisting conditions while keeping insurance markets stable and functional.

The individual-coverage requirement lets the ACA protect people who have preexisting conditions without destabilizing the insurance market

A key feature of the health law is the requirement that insurers cover people with preexisting conditions without charging more or limiting people's benefits. This means that people can get coverage if they have health problems that create an urgent need for insurance and that make their coverage costly. Unless insurance is also obtained by consumers with low health-care costs—namely, relatively young and healthy people—premiums will skyrocket, pricing coverage out of reach for many families.

Several factors can obstruct enrollment of the relatively young and healthy people needed for market stability. Some may find coverage unaffordable. Many struggle to balance health insurance and other essential household expenses, so premium payments may not be a top priority unless they have pressing and costly health-care needs.

For health plans to enroll a diverse membership, including old and young, healthy and sick, the ACA includes an individual-coverage requirement. The ACA's provision of financial assistance with marketplace coverage is also important to enrolling relatively healthy consumers who could not otherwise afford insurance.

The combination of protections for people with preexisting conditions, the individual coverage requirement, and financial help for those who would otherwise have trouble affording insurance is often termed a "three-legged stool." One important reason why the ACA has covered more than 20 million people is that it includes all three legs of the stool.

What would happen if the individual-coverage requirement disappeared?

Millions lose coverage: The nonpartisan Congressional Budget Office (CBO) found that eliminating the individual-coverage requirement in 2019 and the resulting premium spike would end 13 million people's health insurance by 2025, with 4 million immediately losing coverage. Fully 5 million people would no longer obtain Medicaid, since the individual-coverage requirement encourages people of all income levels to apply for insurance; today, that process leads many to discover that they qualify for Medicaid.

Premiums go up: CBO also found that eliminating the individual coverage requirement would raise insurance premiums by 10 percent in the individual market. That would increase health care costs for more than 13 million people who buy insurance on their own, without federal help.

Before the ACA, states' experience showed the need for an individual-coverage requirement

The Affordable Care Act was carefully designed to overcome problems encountered by earlier state efforts that forbade insurance companies from discriminating against people with health problems. These experiences taught state policymakers that, unless relatively young and healthy people are encouraged to enroll and remain covered, insurance quickly becomes unaffordable, and markets unravel.

Before the ACA, when several states barred insurers from discriminating against people with preexisting conditions but did not require individuals to obtain coverage, healthy consumers, facing other financial pressures, often went uninsured. As a result, individual insurance enrolled mainly people with known health problems. Premiums skyrocketed, and many insurance companies stopped offering coverage.

The ACA's individual-coverage requirement exempts low-income people and others who cannot afford insurance

The basic concept behind the ACA's individual coverage requirement is that, to make the health care system fair and functional for everyone, people who can afford insurance should obtain it. Those who fail to do so must pay a penalty on their federal income tax returns. However, the ACA also recognizes that if people cannot afford insurance, they should not be penalized. The following groups thus do not have to meet the individual coverage requirement and are not penalized if they are uninsured:

» people with incomes below the legal requirement for filing federal income tax returns (currently \$10,350 for an individual and \$20,700 for a couple filing jointly);

- » people who have incomes low enough for expanded Medicaid coverage (currently \$16,600 for an individual and \$34,000 for a family of four) and who live in states that have not expanded Medicaid;
- » people who would have to pay more than 8.16 percent of their income to obtain insurance; and
- » people who experience a financial hardship that prevented them from obtaining insurance.

Other exempt groups include people whose religious principles forbid them from buying health insurance.

The individual-coverage requirement helps keep health coverage affordable and available

In passing the ACA, federal lawmakers made a commitment that people with preexisting conditions should be able to buy insurance on the same terms that are offered to other consumers. For that commitment to coexist with health coverage remaining affordable and accessible for everyone—regardless of health status, age, and gender the health insurance system needs mechanisms that encourage relatively young and healthy consumers to enroll. That is why the ACA includes not just insurance reforms that protect people with health problems, but also financial assistance that makes coverage affordable to people with low- and moderate-incomes and an individual-coverage requirement. All three legs of this stool are needed for stable and functional insurance markets to serve millions of families in America who rely on the individual market for coverage.



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