วารสารเศรษฐศาสตร์และกลยุทธ์การจัดการ
ปีที่ 8 ฉบับที่ 2 กรกฎาคม – ธันวาคม 2564

Journal of Economics and Management Strategy
Vol. 8, No. 2, July – December 2021

The Effectiveness (or Lack Thereof) of the Individual Mandate

Jirakit Taechachokevivat[1] Pantira Tangjitthaweechai[2] and Thana Sompornserm[3]

Received: January 8, 2021
Revised: April 22, 2021
Accepted: April 30, 2021

ABSTRACT

There are two main objectives of the study: 1) to determine the effect of the individual mandate on various aspects of healthcare in the United States from 2010 to 2019, using insurance coverage, insurance premium, overall welfare, the crowding out of private insurance, overall healthcare spending, government spending, and healthcare quality as indicators; and 2) to identify the effect of the individual mandate of the ACA on different income groups in the United States. The results showed that, in terms of coverage rates, most studies suggest that the mandate increases coverage rates, although one study suggests there is no effect of the mandate on coverage rates. Evidence also points out that the individual mandate can decrease insurance premiums, increase welfare, and prevent a crowding out effect. However, the results also revealed that the mandate can increase overall healthcare spending, has an ambiguous effect on government spending, and has no effect on the healthcare quality in the United States. Overall, the benefits of an individual mandate appear to outweigh their costs.

Keywords: Affordable Care Act, Obamacare, Individual Mandate, Health Insurance

Introduction

The Affordable Care Act, or Obamacare, was a federal statute enacted in 2010 with the primary purposes of "increasing the number of the insured, improving the quality of care, and reducing the costs of health care" (Manchikanti, Helm, Benyamin & Hirsch, 2017). Although this is the case, the policies incorporated in the ACA are primarily directed towards expanding coverage for the uninsured.

[1] Undergraduate Student, Faculty of Economics, Kasetsart University, Email: jirakit.tae@ku.th
[2] Undergraduate Student, Faculty of Economics, Kasetsart University, Email: pantira.ta@ku.th
[3] Assistant Professor, Faculty of Economics, Kasetsart University, E-mail: fecotns@ku.ac.th

Contradicting evidence can be observed when looking at the effectiveness of Obamacare. Although the statute was widely praised for increasing the number of the insured by over 20 million people, the 6 million who lost their insurance from it (possibly a result of the cancellation of insurance plans that did not meet the new coverage requirements) usually go unnoticed. Those in the working class and middle class who earn more than 400% of the federal poverty level (FPL), who do not receive any help from the provisions, ended up worse off, with uneven access to healthcare and a steadily declining percentage of workers obtaining health benefits from their employers (Manchikanti et al., 2017). Furthermore, data shows that, "as ACA provisions have taken effect, GDP and employment growth have slowed sharply", with the estimated cumulative loss by the end of the decade exceeding $1.2 trillion and "lost growth in work hours per person has removed the equivalent of 800,000 full-time jobs from the economy" (Mulligan, 2016). A 2012 estimate shows that "the ACA should be expected to increase federal spending obligations by more than $1.15 trillion over the upcoming decade and to worsen cumulative federal deficits by somewhere between $340 and $530 billion over the same period" (Blahous, 2012). This implies that the achievements of Obamacare came at a very steep cost, and its desirability and effectiveness still remain in question.

The causes of the effects from Obamacare are difficult to identify, as it is the largest healthcare reform in the United States since Medicare and Medicaid in 1965, consisting of many major provisions, with the statute totaling more than 2,500 pages and regulations exceeding 70,000 pages (Manchikanti et al., 2017). Investigating all the provisions and their consequences would prove to be a monumental task. Therefore, this study instead opted to evaluate in detail one of the major provisions of Obamacare. Out of all the major provisions, the individual mandate was deemed "the law's most controversial provision", requiring "people either to have insurance coverage or to pay a penalty" (Wilensky, 2012). The mandate faced such a large degree of resistance that, "immediately after the legislation's passage, 13 states filed lawsuits challenging the constitutionality of the requirement" (Hamel & Nairn, 2011). The main legal concern against the mandate is its constitutionality, whether Congress has the rights to force people to purchase health insurance against their free will. However, perhaps what garnered the most public outrage is its "assault" on people's freedom of choice, something valued very deeply by Americans (Hamel & Nairn, 2011). Eventually, the decision to lift the mandate penalty was passed in the Tax Cuts and Jobs Act of 2017, and it became effective in 2019 (Gruber & Sommers, 2019). The controversy and discussion around the individual mandate led to its selection as the provision of interest for this study.

The individual mandate should contribute to the Affordable Care Act's goal of increasing insurance coverage in the United States by providing an incentive to purchase health insurance through the mandate penalty (Hamel & Nairn, 2011). In addition, mandates should "reduce the welfare loss from adverse selection in insurance markets", according to economic theory, although "recent empirical work on adverse selection finds relatively little welfare loss, suggesting otherwise" (Hackmann, Kolstad, & Kowalski, 2015). Such contradictions, along with the strong opposition to the policy, call for further investigation into the policy in order to determine the effectiveness and the desirability of the individual mandate in the United States. Additionally, the individual mandate could also be investigated through comparisons between the case of the United States' individual mandate and the healthcare and insurance system in another country, whether it would be in terms of its necessity, applicability, or anticipated effects. This would give a better illustration of the effect of the individual mandate in contexts other than the United States'. This study uses the case of Thailand as a comparison to the United States' case.

Objectives

1. to determine the effects of the individual mandate of the ACA on various aspects of healthcare in the United States during the period of 2010 to 2019

2. to identify the effect of the individual mandate of the ACA on different income groups in the United States.

Methodology

The methodology of the study is a review and comparison of literature on the individual mandate and the ACA. The majority of the literatures studied are quantitative analyses of different effects of the individual mandate and the ACA. The findings from these literatures are then compiled and compared in order to draw a conclusion on the effectiveness of the mandate.

A number of indicators are used to identify the effects of the individual mandate on various aspects of the US healthcare system. These indicators are the number of the uninsured (or coverage rates), insurance premium, welfare, crowding out effect, overall healthcare spending, government spending, and healthcare quality.

The number of the uninsured in the U.S. is an important indicator for the effectiveness of the individual mandate, as lowering the number of the uninsured in the country is the primary objective of the Affordable Care Act and the individual mandate. A significant lowering of the number of the uninsured will imply that the mandate is able to achieve this objective.

Another objective of the individual mandate is to keep insurance premiums low, as it entices both healthy and unhealthy people to maintain insurance coverage. This should protect the insurance market against issues such as premium spirals. If insurance premium falls when the mandate is implemented or rises when the mandate is lifted, it implies that the mandate is able to suppress the rise in premiums.

In terms of welfare, when the uninsured falls ill and "fall back on subsidized parts of the system, such as charitable care", this support is either paid for by taxpayers when the public sector is involved or "individuals pay extra when they cover their own medical bills or buy their own insurance", achieved through "higher hospital charges and higher insurance premiums for those who are insured", creating inefficiencies and an equity problem (Steuerle, 1994). An individual mandate should reduce the number of the uninsured, lowering welfare loss. In addition, problems can also arise from adverse selection within the insurance market. In theory, an individual mandate should reduce the welfare loss caused by these issues, hence the change in welfare could be used as an indicator of the effectiveness of the individual mandate.

For the crowding out effect, the increase in government support through other ACA provisions could crowding out private insurance provision. The individual mandate penalty should raise the value of current coverage plans such as employer-sponsored insurance and potentially prevent the crowding out of private provision from government expansions in healthcare.

Evaluation of the costs of the mandate is also necessary. If the individual mandate significantly raises the overall healthcare spending, its costs may outweigh its benefits. In addition, the government may incur large increases in its spending with the implementation of the mandate, whether it would be from direct costs such as administrative and enforcing costs, or indirect costs such as increased government spending in Medicaid or premium subsidies due to increased coverage resulting from the mandate. If the costs to the government increases by too large of a margin, the costs of the individual mandate may outweigh the benefits.

One of the main goals of the ACA is to improve the quality of care in the U.S. Although the policies introduced by the act, especially the individual mandate, does not directly target

this objective, it should still be measured. Whilst the mandate may not contribute much in terms of quality of care, observing the change in the United States' healthcare quality may be able to provide a better perspective on the effectiveness of the ACA as a whole.

Lastly, a review of literature on the Thai healthcare and insurance framework will be conducted. The review will provide insight on the implications of the individual mandate if it was implemented in Thailand, be it in terms of the effect on the economy, the role of the government, or the impact on the general population. Such an insight is needed to make comparisons between the United States' individual mandate and the potential of the individual mandate in Thailand.

Theory and Academic Principal

To understand the effects of the individual mandate, it is necessary to recognize how the mandate penalty is calculated. Eibner and Saltzman (2015) stated that "the individual mandate is a requirement of the ACA that most citizens and legal residents of the United States have health insurance. People who do not have health insurance must obtain it or pay a penalty". The mandate penalty is an annual amount, and the actual amount to be paid is then prorated on the basis of the number of months the payees were without coverage. As for the calculation of the penalty, "the penalty for noncompliance is calculated as the greater of either a percentage of applicable income, defined as the amount by which an individual's household income exceeds the applicable tax filing threshold for the tax year; or a yearly flat dollar amount assessed on each taxpayer and any dependents. The total dollar amount assessed on a taxpayer (for themselves and any dependents) is capped at 300% of the annual flat dollar amount" (Rosso, 2020). Since 2019, "the annual penalty has been reduced to zero, which has effectively eliminated the penalty" (Rosso, 2020)

Effects on the Indicators

Insurance coverage is considered one of the most important indicators for the mandate's effectiveness. However, conflicting evidence is present in terms of the mandate's effects on the number of the insured. These evidence can be separated into whether the estimate is made prior to the mandate taking effect or after the mandate has taken place.

Effect on Coverage Rates

Prior to the mandate taking effect, Shiels and Haught (2011) suggested that the individual mandate, along with other provisions of the ACA, would increase insurance coverage by 7.8

million people, compared to when other provisions are implemented without the mandate, suggesting that the implementation of the mandate has a positive impact on coverage rates.

During the effective period of the mandate, an estimate by Frean, Gruber, and Sommers (2016) suggested that they were able to estimate 60 percent of the coverage gains resulting from the Affordable Care Act, with none of the increase being accounted for by the individual mandate, suggesting that the individual mandate had little to no impact on coverage rates. This was rationalized through factors such as low levels of mandate penalty and the model's inability to capture behavioral factors. In contrast, the Congressional Budget Office (2017) estimated that, if the mandate penalty were lifted, insurance coverage would fall continuously from years 2019 to 2027, suggesting a large positive impact of the individual mandate on coverage rates. This is consistent with the findings of Eibner and Nowak (2018), who found that the removal of the individual mandate penalty would result in a decline in enrollment (ranging from 2.8 million to 13 million people, depending on people's response to the repeal).

After the mandate was removed, a study by Gruber and Sommers (2019) found a "taste of compliance" effect, where they suggest that the mandate did not directly increase coverage rates but influenced it indirectly by inducing people to obtain coverage in order to avoid the idea of not being in compliance with the law (not to avoid the penalty), implying a positive effect of the individual mandate on coverage rates, although the magnitude is difficult to measure.

Overall, the reasonings behind the positive effects include the "taste of compliance" effect and the fact that the mandate encourages healthier people, who are less likely to seek insurance coverage, to obtain insurance coverage. This would also restrain premium increases in the market, making it easier for people to obtain insurance coverage or maintain coverage.

Effect on Insurance Premiums

The next indicator of interest is the insurance premium. Prior to the mandate becoming effective, Shiels and Haught (2011) estimated that, without the mandate, the implementation of the ACA and all its other provisions would lead to a premium spiral, increasing premiums of nongroup insurance by 12.6 percent before leveling out, compared to the case where the mandate was implemented alongside the other provisions of the ACA. This implies that the mandate has a positive effect on insurance premiums, keeping it from rising and making it easier for people to obtain/maintain insurance coverage.

The Congressional Budget Office (2017) also estimated that, if the mandate were repealed, average premiums in the nongroup market would rise by approximately 10 percent

in most years of the decade relative to the baseline projection, implying a positive effect of the mandate on insurance premiums. This estimation is consistent with the study of Eibner and Nowak (2018), who estimated that there would be a rise in premiums (by 3 to 13 percent for the bronze plans, depending on people's response to the repeal) if the mandate penalty were lifted.

All three studies found positive effects of the individual mandate on insurance premiums, with the main focus being on the nongroup insurance premiums. The predicted rise in insurance premium is mainly attributed to there being less incentive for healthy people to seek insurance coverage.

Effect on Welfare

The next indicator is the level of welfare. Although no study has been done on the ACA's individual mandate, studies on the previously implemented individual mandate of the Massachusetts reform by Hackmann, Kolstad & Kowalski (2015) shows that welfare increased by 4.1 percent as a result of the reduction of adverse selection. Estimates by the CBO show that the ACA's individual mandate would entice more healthy people to seek coverage, lowering premiums, which would reduce welfare loss from adverse selection. Although there is no direct evidence of the increase in welfare as a result of reduction in adverse selection from the ACA's individual mandate, it is a possibility and should be kept in mind.

Effect on the Crowding out of Private Insurance

The crowding out effect, or the impact on private insurance provision, is another indicator that should be considered. The provisions of the ACA may lead to private insurance provision being crowded out of the market, as it may entice those already covered by private insurance to switch over to programs like Medicaid when the coverage requirements were expanded. Research by Abraham, Royalty, and Drake (2016) and Sommers, Shepard, and Hempstead (2018), as studied by Gruber and Sommers (2019), found that there was no evidence of crowding out of private insurance (especially in employer-sponsored insurance) in the case of the ACA. The individual mandate was cited as one of the reasons for this, as it increased the value of employer-sponsored insurance, leading to people opting to maintain their coverage, hence there being no observable crowding out effect. This implies a positive effect of the mandate in terms of the crowding out effect.

Effect on Overall Healthcare Spending

The estimations of the effects of the individual mandate on overall healthcare spending of the U.S. yielded mixed results. Two estimations were made prior to the implementation of

the mandate. The first estimation, by Buettgens, Garrett, and Holahan (2010), found that the implementation of the individual mandate along with other provisions of the ACA, would result in a $53.1 billion increase in the overall health system spending of the U.S. On the other hand, if the mandate was not implemented along with the other provisions, overall health system spending is estimated to decrease by $10.2 billion. This implies that the mandate would increase overall health system spending. The reason behind this may lie partly in the predicted increase in coverage driven by the mandate. DeCristofaro (2010), also estimated that the mandate would increase overall health system spending of the United States, although on a smaller scale (a projected increase of $7 billion to $26 billion). The reasoning behind this is that, with the expansion of government provisions, it would shift the burden towards the government through increases in Medicaid spending and premium subsidies but not increase overall health system spending by much.

Effect on Government Spending

In terms of government spending, prior to the mandate taking effect, Buettgens, Garrett, and Holahan (2010) estimated that government spending would be used more efficiently if the mandate was implemented, with the estimated government spending per newly insured person falling to $2,451 instead of the $4,795 without the individual mandate, implying that the mandate would have a positive effect on government spending on a per capita basis. However, on the aggregate level, DeCristofaro (2010) estimated that government spending would increase by $12 billion to $62 billion, or 1.2 to 6 percent. This implies a negative impact of the mandate on government spending, as it raises the fiscal burden of the government.

After the mandate has taken effect, Eibner and Nowak (2018) studied the effect of lifting the mandate on the government budget deficit. The study estimated the range of change in the government budget deficit to be from an $8 billion reduction to a $3.6 billion increase in 2020, depending on how consumers respond to the repeal, with the decline in the deficit attributable to declines in insurance coverage (which would reduce spending on programs such as Medicaid).

Overall, it can be seen that, if the mandate is successful in increasing insurance enrollment and coverage, there will be a subsequent increase in government spending as a result of increases in the provisions to the insured.

Effect on Healthcare Quality

The last indicator is the U.S. healthcare quality. Prior to the provisions of the ACA coming into effect, the healthcare quality of the United States has been constantly falling in terms of

ranking compared to its peers. This result is contradictory to its health expenditure per capita, which is highest among the 11 nations it was compared to. By 2014, when the major provisions of the ACA came into effect, the healthcare quality of the United States was ranked last among the 11 countries (Davis, Stremekis, Squires, & Schoen, 2014, as stated in Manchikanti et al., 2017)

By 2019, the United States' relative healthcare quality still has not improved by much, if it did improve at all. While the U.S. "spends more on health care than any other country", they "are not achieving comparable performance" with "poor health outcomes, including low life expectancy and high suicide rates" compared to their peer nations (Tikkanen & Abrams, 2020). Although on absolute terms, there may be improvements on many fronts, the U.S. is improving at a rate much slower than their peers and also at a much higher cost, suggesting large inefficiencies in the process. In addition, Tikkanen and Abrams's (2020) analysis shows that the U.S. has "the highest rates of avoidable mortality because of people not receiving timely, high-quality care", showing that there are still key deficiencies in the U.S. healthcare system. Table 1 shows a summarization of the effects of the individual mandate on the indicators.

Effect of the Individual Mandate on Different Income Groups

The implementation of the individual mandate resulted in different effects in different income levels. Particularly, the mandate hasn't gone down well with those in the "working and middle class" who "earn more than 400% of the federal poverty level (FPL), who constitute 40% of the population and don't receive any help" but are subject to the penalty if they fail to enroll under an eligible insurance coverage (Manchikanti et al., 2017). The new and expansive coverage requirements introduced by the ACA caused many insurance policies to fail to meet the standard, leading to their cancellation. Some policies reduced existing areas of coverage to be able to meet and support the new requirements. The requirements also drove up premiums, reducing affordability. This led "those with incomes below 133% of the federal poverty level" to move into Medicaid, while "those with incomes between 133% and 400% of the federal poverty level were able to purchase highly subsidized insurance in newly created Health Insurance Exchanges". However, "those with incomes over 400% of the Federal Poverty Level were not subsidized and faced substantial insurance premiums and out-of-pocket expenses" (Manchikanti et al., 2017). Former President Bill Clinton had a word on this issue, stating that "all of a sudden, 25 million more people have health care and then the people who are out there busting it … wind up with their premiums doubled and their coverage cut in half" (Clinton, 2016, as cited in Manchikanti et al., 2017). Yet, opting out of the insurance coverage would also subject them to a penalty.

On the other hand, Straw (2017) estimated that, by repealing the mandate, "millions of low- and moderate-income people losing health insurance would be harmed" and that "overall, low- and moderate-income people would lose much more than they'd gain from repeal" (para. 4-6). These people, whose income are under 400 percent of the FPL, and are eligible for Medicaid or premium tax credits, are mostly able to "get coverage for less than the cost of the penalty", and are not negatively affected by the mandate penalty, and perhaps may even be helped by it, as implied by Straw. At the same time, "those with incomes below 100 percent of the poverty line who aren't eligible for either Medicaid or premium tax credits — are exempt from the mandate" (Straw, 2017). As such, they are unaffected by the mandate.

For those with higher income, as "health insurance coverage rises sharply with income", and insurance premiums are unlikely to take up a significant portion of their income, it is unlikely that they will have to consider dropping the coverage as premiums rise (Tax Policy Center, Urban Institute & Brookings Institution, n.d.). As such, they are affected by the mandate to a much lesser degree than those immediately above the 400% FPL. Table 2 shows a summarization of the effects of the individual mandate on the different income groups.

Further exploring the previously mentioned issue of the impact of the ACA on healthcare affordability and economic inequality, a similar issue is observed when inspecting the ACA in its entirety. Overall, the provisions, standards, and requirements of the ACA "has led to increasing premiums and reduced affordability" (Manchikanti et al., 2017). However, the ACA has also provided measures to help offset this cost. One of such measures is the ACA's cost-sharing reductions (CSR). Cost-sharing is the act of sharing the cost of covered health care services between the insured and the insurance company, requiring the insured to make out of pocket payments in the form of copayment, deductibles, or coinsurance (Norris, 2020). The ACA's CSR was introduced with the purpose of keeping healthcare costs affordable, with it providing both cost-sharing subsidies "designed to reduce the portion of a claim that an insured will have to pay" and lower out-of-pocket maximums (Norris, 2020). However, the eligibility is based on income, with those eligible for CSR benefits required to be "between 100 percent and 250 percent of the federal poverty level", and the benefits are only applied to the Silver insurance plans (Norris, 2020). However, in the fall of 2017, "the Trump administration stopped funding cost-sharing reductions", causing most insurers to add the CSR costs to the premium for Silver plans, making them disproportionately expensive (Norris, 2021). This spurred another problem, as the premium subsidy, which is another one of the ACA's measures to make coverage more affordable, is based on the benchmark cost of Silver plans. The increase in costs for Silver plans

resulted in disproportionately large premium subsidies, with some enrollees being able to obtain Gold or Bronze plans for $0, or for free. Similar to the CSR, eligibility for premium subsidies is normally based on income (those eligible should have incomes between 100% to 400% of the federal poverty level). However, for 2021 and 2022, "subsidy eligibility is based on the cost of the benchmark plan relative to the person's income" (Norris, 2021).

In both the case of the CSR and premium subsidies, the eligibility criteria are based on income levels. Therefore, while the ACA has made healthcare affordable for some, particularly those eligible for benefits or subsidies, it has made healthcare less affordable for many others, especially the working and middle class above the 400% FPL level. This, again, brings about the issue of inequality, as millions in the low-income group (under the 400% FPL level) enjoy the benefits from ACA provisions while millions more above the 400% FPL level are suffering from rising premiums and less affordable healthcare, with the impact being the most prominent at the cutoff point of the subsidy.

Table 1 Summary of the effects of the individual mandate on the indicators

Indicators	Period	Results	Effects
Number of Uninsured (Coverage Rate)	Prior to the Implementation	Shiels and Haught (2011): The mandate would increase insurance coverage.	Positive
	After the Implementation	Frean, Gruber, and Sommers (2016): The mandate has little to no impact on insurance coverage.	No Effect
		Congressional Budget Office (2017): The mandate has increased insurance coverage.	Positive
		Eibner and Nowak (2018): The mandate has increased insurance coverage.	Positive
		Gruber and Sommers (2019): The mandate has increased insurance coverage. - Through an indirect effect happening through the "taste of compliance" effect	Positive
Insurance Premium	Prior to the Implementation	Shiels and Haught (2011): The individual mandate would lower insurance premiums (especially in the nongroup market).	Positive
	After the Implementation	Congressional Budget Office (2017): The individual mandate lowered insurance premium (especially in the nongroup market).	Positive
		Eibner and Nowak (2018): The individual mandate lowered insurance premium (in the bronze plan).	Positive

Table 1 (Continued)

Indicators	Period	Results	Effects
Welfare	After the Implementation	Hackmann, Kolstad & Kowalski (2015): It is possible for the individual mandate to increase welfare. - The increase in welfare is a result of the reduction in adverse selection in the insurance market.	Positive
Crowding Out Effect	After the Implementation	Gruber and Sommers (2019): The individual mandate is partially responsible for the absence of the crowd out of private insurance provision. - Results from the works of Abraham, Royalty, and Drake (2016) and Sommers, Shepard, and Hempstead (2018).	Positive
Overall Healthcare Spending	Prior to the Implementation	Buettgens, Garrett, and Holahand (2010): The individual mandate would increase overall healthcare spending of the U.S.	Negative
		DeCristofaro (2010): The individual mandate would increase overall healthcare spending of the U.S. by a small margin.	Negative
Government Spending	Prior to the Implementation	Buettgens, Garrett, and Holahand (2010): The individual mandate would reduce government spendings on a per capita basis. - An increase in efficiency of government spending.	Positive
		DeCristofaro (2010): The individual mandate would increase overall government spending.	Negative
	After the Implementation	Eibner and Nowak (2018): The individual mandate may have a positive or negative effect on government spending (federal budget deficit). - The resulting effect depends on the reaction of consumers to the removal of the mandate penalty.	Ambiguous
Healthcare Quality	After the Implementation	Tikkanen and Abrams (2020): The Individual mandate had little to no significant impact on the healthcare quality of the United States.	No Effect

Table 2 Summary of the effect of the individual mandate on different income groups

Income Level Group	Effects
Low income group under the 133% FPL line	If they are eligible for Medicaid or premium tax credit - Able to move into Medicaid - Positively affected by the mandate
	If they are not eligible for Medicaid or premium tax credit - Exempted from the mandate penalty - Unaffected by the mandate
Low income group between the 133% and 400% FPL line	Able to purchase highly subsidized insurance in newly created Health Insurance Exchanges - Positively affected by the mandate
Working and middle class above the 400% FPL line	Not supported by the provisions.
	Faces the mandate penalty in the case of failure to obtain insurance coverage.
	Faces increased premium and less coverage as insurance companies attempt to meet the new requirements implemented by the ACA
	Negatively affected by the mandate
The upper class (high income)	Are usually covered by insurance coverage, and are unlikely to drop the coverage due to increase in premiums as it does not take up a significant portion of their income - Unaffected/negatively affected by the mandate, but to a much lesser degree than the middle class.

Sources: Manchikanti et al. (2017); Straw (2017); Tax Policy Center, Urban Institute & Brookings Institution (n.d.)

Discussion

The Legal and Political Side of the Individual Mandate and the Affordable Care Act

The unconstitutional nature of the individual mandate has brought with it a great degree of public outrage and calls for the mandate to be repealed. Lawsuits were immediately filed in 13 states against the mandate as soon as the legislation was passed, challenging its constitutionality. Although the mandate became ineffective in 2019 as a result of the Tax Cuts and Jobs Act of 2017, this was not the end of the story. In February 2018, “a group of 20 states, led by Texas, sued the federal government” in an attempt to bring down the entire ACA, while “another 17 states, led by California, were permitted by the trial court to intervene in the case and defend

the ACA" (Musumeci, 2020). Later, two states on the Texas side withdrew from the case while four more states joined in on defending the ACA. The ACA's future was threatened when, "in December 2019, the U.S. Court of Appeals for the 5th Circuit affirmed the trial court's decision that the individual mandate is no longer constitutional because the associated financial penalty no longer 'produces at least some revenue' for the federal government" (Musumeci, 2020). Furthermore, it was argued that "the rest of the ACA is not severable from the mandate and should therefore be invalidated" (Kaiser Family Foundation, 2020). At the time of writing, the constitutionality of the ACA is being reviewed by the Supreme Court in the *California v. Texas* case.

The effect of the ACA is far-reaching, and if the act were struck down, most if not all of its provisions would be eliminated, and the American healthcare system would be significantly impacted. Expanded eligibility for health coverage is one key category of provisions of the act, with the expansion resulting in 12 million newly eligible enrollees as of June 2019, 9.2 million people in the Health Insurance Marketplace receiving premium tax credits as of February 2020, and 10.7 million having effectuated coverage through the Health Insurance Marketplace as of the first quarter of 2020 (Kaiser Family Foundation, 2020). Federal minimum standards for private health insurance is another key category of provisions of the act, with 54 million people having "a pre-existing condition that would have been deniable in the pre-ACA individual market" (Kaiser Family Foundation, 2020). Other key provision categories include "other provisions affecting employers/group health plans", "consumer assistance", "other Medicaid provisions", "Medicare provisions", and "additional provisions" (Kaiser Family Foundation, 2020). All of these provisions could be lost if the ACA were abolished. 21 million people are at the risk of losing their insurance coverage, 60 million beneficiaries of Medicare could face changes to medical care and higher premiums, and the cost of care for the uninsured could rise by up to $50.2 billion (Abelson & Goodnough, 2021). The fate of the ACA and millions of Americans now reside in the hands of the Supreme Court.

The Individual Mandate in the Context of Thailand

Although the individual mandate proved to be, to a certain degree, an effective policy in increasing insurance coverage and lowering insurance premiums, as well as provide various other benefits, this may only apply to the specific case of the United States. Different results may occur when the individual mandate is implemented in other countries. Drawing comparisons to Thailand in terms of the potential effect if the individual mandate was implemented may give a clearer picture on how the individual mandate may perform in contexts other than the U.S. The application of the individual mandate in Thailand can be limited, given the circumstance

of its insurance and healthcare system. Despite sustained periods of political instability and an under-performing economy, Thailand's policy on universal health coverage (UHC) has made good progress since its inception in 2002, which covered its population of approximately 66.3 million people (Sumriddetchkajorn et al., 2019).

The Constitution of the Kingdom of Thailand (1998) directed that "a person shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from public health centres of the State, as provided by law..." (Chularat, 1998). This decree was met with the "Universal Health Coverage Project" issued in 2001 during the Thaksin government. The program ensured that all Thai citizens are able to access health services with the cost of treatment of only 30 baht per illness. "The basis is that every Thai citizen is entitled to the 30-baht scheme, but if that citizen is already covered in another way, the other coverage will be used first," explained Atipong Pathanasethpong, a doctor at Khon Kaen University hospital. The 30-baht health coverage scheme covers approximately 48 million out of the 69 million population, with the remaining population being insured through other means such as through their employers or the civil servants medical benefit scheme (Chia, 2020). The 30-baht health coverage scheme would later be adjusted so that coverage is provided free of charge, under the Universal Coverage Scheme (UCS). Thailand's national health insurance is covered by three schemes, which are the UCS, the Civil Servants' Medical Benefit Scheme, and the Social Security Scheme.

It can be seen that Thailand's population has insurance coverage one way or another, provided through the various schemes or through private or employer-sponsored coverage. The largest intended effect of the individual mandate is to increase insurance coverage, as well as to reduce the negative effects of the policies implemented alongside it such as the crowding out effect, or negative effects in the market such as adverse selection and premium spirals. In the context of Thailand's healthcare system, where universal health coverage is provided through the UCS, there exists no need for an incentive to increase insurance coverage. Insurance premiums are also not a concern, as the most-basic coverage is provided free of charge. A comparison between the healthcare and insurance systems of Thailand and the United States is shown in Table 3.

Table 3 Comparison of the healthcare and insurance systems between Thailand and the United States

Characteristics	Thailand	The United States
Major Government Insurance / Healthcare Schemes	Universal Coverage Scheme	Medicare
	Civil Servants' Medical Benefit Scheme	Medicaid
	Social Security Scheme	Affordable Care Act
Universal Healthcare Coverage	Yes. All Thai citizens are covered under the three schemes. They can also choose to seek employer-sponsored insurance and private insurance.	No. U.S. citizens who are not covered under government schemes, employer-sponsored insurance, or private insurance are left uninsured.
Healthcare Costs as a Percentage of GDP	3.793 percent as of 2018 (World Bank, n.d.a)	16.885 percent as of 2018 (World Bank, n.d.b)

The fundamental differences between the healthcare and insurance systems of Thailand and the United States imply that the applications of the individual mandate may be very limited in Thailand. Although there may be less opposition to the individual mandate in Thailand, as the notion of freedom of choice is not as strong as that of the United States, the costs incurred from the mandate through monitoring, administration, and enforcing costs may be higher than the benefits it can provide. In addition, issues of transparency, as well as corruption, have always riddled the Thai society. Implementing a policy that is not very beneficial but would create large opportunities for corruption may not be advisable. Hence, if there are no fundamental changes in the healthcare and insurance systems of Thailand, it is unlikely that an individual mandate or a similar provision will be implemented. This, by no means, implies that the healthcare system of Thailand is perfect. There are many flaws within the current Universal Coverage Scheme, and improvements can be made in many areas to enhance the quality of care and standard of living in Thailand. However, an individual mandate is unlikely to be one such improvement.

The story may be different if the ACA in its entirety is considered. The major provisions of the ACA include expanded eligibility for health coverage, federal minimum standards for private health insurance, other provisions affecting employers/group health plans, consumer assistance, other Medicaid provisions, Medicare provisions, and additional provisions (Kaiser Family Foundation, 2020). If the Thai government were to look at introducing the ACA in Thailand, it would be extremely difficult to identify all of the impacts, as the ACA is a massive healthcare reform, and many of the provisions are related to healthcare programs unique to

the United States, such as Medicare and Medicaid. Nevertheless, if the government is set on introducing the applicable provisions of the ACA to Thailand, it should expect a wide variety of effects, including slowdowns in employment and GDP, as the U.S. case showed that "incentive changes embedded in the ACA … are expected to ultimately reduce employment by 3 percent and GDP by 2 percent" (Mulligan, 2016). It is also expected for the healthcare spending of the government to significantly increase with the provisions it implemented, as well as spending on administrative costs, enforcement costs, and other forms of implementation costs. On the political side, it is expected that the benefits, costs, and legality of the ACA will be intensely debated between the government party and the opposition. In any case, the issue of the ACA in its entirety in the context of Thailand is a topic that requires further study in order to illustrate a clearer impact of the Act if it were implemented.

Conclusion and Policy Implications

The implementation of the individual mandate has incited a great deal of outrage from the public. Immediately the least popular provision from the ACA, cries for its repeal and lawsuits against its implementation were far from rare. The focal point of the opposition of the individual mandate is in its "unconstitutional nature", as freedom of choice is the top priority in America. However, many studies have found that the individual mandate has had a positive impact on many aspects of the American healthcare system. More specifically, many studies have found evidence of a positive effect on coverage rates (although one study suggests there to be no effect), a positive effect on insurance premiums, a positive effect on welfare, and a positive effect in terms of the prevention of a crowding out effect. Despite that, studies have also found that there is a negative effect on overall healthcare spending, an ambiguous effect on government spending, and no effect on the healthcare quality of the U.S. Here, a positive effect refers to an advantageous or beneficial effect to an indicator, while a negative effect signifies that the effect is disadvantageous or harmful.

The effects discovered from these studies show that the individual mandate has been effective to a certain degree in accomplishing its purpose. Evidence of it being an incentive for people to seek insurance coverage, lowering premiums by increasing the number of healthy people in the pool of the insured, lowering adverse selection in the insurance market, and reducing the crowding out of private insurance provision has been found, signifying that it is able to provide many benefits. The higher overall healthcare spending is to be expected when more people are purchasing insurance and are engaged in the healthcare system. The lack of an

effect on U.S. healthcare quality is also to be expected since the mandate does not target the quality of care. Therefore, if one was able to overcome the notion of the mandate being unconstitutional, they will be able to see that it is an effective policy that is able to accomplish its purpose. When weighing the costs and benefits of the individual mandate, the benefits appear to exceed the costs. Hence, the effect of the mandate on the American healthcare system is positive.

Despite the effectiveness of the policy, the individual mandate was rendered ineffective, with the mandate penalty set to zero. It may be difficult for the United States to see the mandate's resurgence due to the negative public opinion surrounding it. Politicians are unwilling to put their popularity at risk by pushing for the reinstatement of the mandate penalty. In addition, the success of a reinstatement would rely largely on the distribution of seats in Congress between the Democrats and the Republicans, as past records have shown that currently, the success or failure of the passage of a policy in the House is largely dependent on how many seats the party supporting the policy has (partly due to the unprecedentedly high party unity in both parties). The potential of the individual mandate making a return relies not only on its effectiveness and the costs and benefits, but the political environment is also crucial. Now, with Joe Biden set to become the next U.S. President, there is a possibility for a resurgence of the individual mandate, as it was a policy spearheaded by the Democrats in the period when Biden was the vice president to Obama. However, this is unlikely to happen in the near future as Biden has to first establish a stable footing in Congress and among the people of America. The negative perception of the individual mandate and its penalty may lead to backlashes from the public if Biden is unable to present a satisfactory cause for its reinstatement. Therefore, although a conclusion can be drawn that the individual mandate is an effective provision, and that its benefits outweigh its costs, there is still substantial negative public opinion surrounding it and its future remains uncertain.

References

Abelson, R. & Goodnough, A. (2021, March 8). If the Supreme Court ends Obamacare, here's what it would mean. *The New York Times*. Retrieved from https://www.nytimes.com/article/supreme-court-obamacare-case.html

Blahous, C. (2012). *The fiscal consequences of the Affordable Care Act*. Arlington, VA: Mercatus Center.

Buettgens, M., Garrett, B., & Holahan, J. (2010). Why the individual mandate matters. *Timely Analysis of Immediate Health Policy Issues*. Retrieved from http://www.urban.org/sites/default/files/publication/29456/412280-Why-the-Individual-Mandate-Matters.PDF

Chia, J. (2020). *The history of Thailand's Universal Healthcare Coverage, and its uncertain future*. Retrieved from https://www.thaienquirer.com/12090/the-history-of-thailands-universal-healthcare-coverage-and-its-uncertain-future/

Chularat, A. (1998). *Constitution of the Kingdom of Thailand*. Retrieved from http://www.nhrc.or.th/getattachment/c80b0c99-f47e-41ca-b861-84003ccada7d/.aspx

Congressional Budget Office. (2017, November). *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (Report No. CBO-53300). Retrieved from https://www.cbo.gov/publication/53300

DeCristofaro, A. H. (2010). *Require Individuals to Obtain Coverage* (Report No. TR-562/1). RAND Corporation. https://www.rand.org/pubs/technical_reports/TR562z1/analysis-of-individual-mandate.html

Eiber, C., & Nowak, S. (2018). *The effect of eliminating the individual mandate penalty and the role of behavioral factors*. Retrieved from https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors

Eibner, C. & Saltzman, E. (2015). *How does the ACA individual mandate affect enrollment and premiums in the individual insurance market?* Retrieved September 12, 2020 from https://www.rand.org/content/dam/rand/pubs/research_briefs/RB9800/RB9812z4/RAND_RB9812z4.pdf

Frean, M., Gruber, J., & Sommers, B. D. (2016). *Premium subsidies, the mandate, and Medicaid expansion: Coverage effects of the Affordable Care Act*. Working Paper 22213. Cambridge: National Bureau of Economic Research

Gruber, J., & Sommers, B. D. (2019). The Affordable Care Act's effects on patients, providers, and the economy: What we've learned so far. *Journal of Policy Analysis and Management*, *38*(4), 1028-1052. Retrieved from https://doi.org/10.1002/pam.22158

Hackmann, M. B., Kolstad, J. T., & Kowalski, A. E. (2015). Adverse selection and an individual mandate: When theory meets practice. *American Economic Review*, *103*(3), 1030-1066. Retrieved from http://dx.doi.org/10.1257/aer.20130758

Hamel, R., & Nairn, T. (2011). Ethical perspectives on health care reform - The individual mandate: A rancorous moral matter. *Health Progress*, *92*(4). Retrieved from https://www.chausa.org/publications/health-progress/article/july-august-2011/ethical-perspectives-on-health-care-reform---the-individual-mandate

Kaiser Family Foundation. (2020). *Potential impact of California v. Texas decision on key provisions of the Affordable Care Act*. Retrieved from https://www.kff.org/health-reform/issue-brief/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act/

Manchikanti, L., Helm, S., II, Benyamin, R. M., & Hirsch, J. A. (2017). A critical analysis of Obamacare: Affordable care or insurance for many and coverage for few? *Pain Physician*, *20*, 111-138. Retrieved from https://www.painphysicianjournal.com/current/pdf?article=NDMwMg%3D%3D&journal=104

Mulligan, C. B. (2016, June 27). *Has Obamacare been good for the economy*? Retrieved from https://www.manhattan-institute.org/html/issues-2016-has-obamacare-been-good-economy-9022.html

Musumeci, M. (2020). *Explaining California v. Texas: A guide to the case challenging the ACA*. Retrieved from https://www.kff.org/health-reform/issue-brief/explaining-california-v-texas-a-guide-to-the-case-challenging-the-aca/

Norris, L. (2020). *The ACA's cost-sharing subsidies*. Retrieved from https://www.healthinsurance.org/obamacare/the-acas-cost-sharing-subsidies/

Norris, L. (2021). *Will you receive an Obamacare premium subsidy*? Retrieved from https://www.healthinsurance.org/obamacare/will-you-receive-an-obamacare-premium-subsidy/

Rosso, R. J. (2020). *The individual mandate for health insurance coverage: In brief*. Retrieved September 12, 2020 from https://fas.org/sgp/crs/misc/R44438.pdf

Sheils, J. F., & Haught, R. (2011). Without the individual mandate, the Affordable Care Act would still cover 23 million; Premiums would rise less than predicted. *Health Affairs*, *30*(11), 2177-2185. Retrieved from https://doi.org/10.1377/hlthaff.2011.0708

Steuerle, C. E. (1994). Implementing employer and individual mandates. *Health Affairs*, *13*(2), 54-68. Retrieved from https://doi.org/10.1377/hlthaff.13.2.54

Straw, T. (2017). *Repealing individual mandate would hurt, not help, low- and moderate-income people*. Retrieved from https://www.cbpp.org/blog/repealing-individual-mandate-would-hurt-not-help-low-and-moderate-income-people

Sumriddetchkajorn, K., Shimazaki, K., Ono, T., Kusaba, T., Sato, K., & Kobayashi, N. (2019). Universal health coverage and primary care, Thailand. *Bulletin of the World Health Organization*, *97*, 415-422. doi: 10.2471/BLT.18.223693

Tax Policy Center, Urban Institute & Brookings Institution. (n.d.). *Who has health insurance coverage*? Retrieved September 13, 2020 from https://www.taxpolicycenter.org/briefing-book/who-has-health-insurance-coverage

Tikkanen, R. & Abrams, M. K. (2020). *U.S. Health care from a global perspective, 2019: Higher spending, worse outcomes*? Retrieved from https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019

Wilensky, G. R. (2012). The shortfalls of "Obamacare". *The New England Journal of Medicine*, *367*(16), 1479-1481. Retrieved from http://doi.org/10.1056/NEJMp1210763

World Bank. (n.d.a). *Current health expenditure (% of GDP) – Thailand*. Retrieved March 18, 2021 from https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=TH

World Bank. (n.d.b). *Current health expenditure (% of GDP) - United States*. Retrieved March 18, 2021 from https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=US