Premium Increases for “Young Invincibles” Under the ACA and the Impending Premium Spiral

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Executive Summary

Crucial to the success of the Affordable Care Act’s (ACA) health insurance exchanges is the participation of 2.7 million uninsured 18-35 year olds, sometimes referred to as the “young invincibles.” With lower than average incomes and generally good health, “young invincibles” are more likely to forego health coverage than others, or be attracted to plans offering basic coverage at minimal prices. Due to the ACA’s sweeping market reforms, rates for low-premium plans have increased exponentially between 2013 and 2014. In fact, on average, a healthy 30 year old male nonsmoker will see his lowest cost insurance option increase 260 percent.

18-35 year olds typically utilize fewer health care services than other populations, and as such, their premiums are needed to subsidize the costs of caring for more expensive enrollees. The administration admits that without these “young invincibles” the exchanges may well fail. However, unreasonable premium increases and an ineffectual subsidy-penalty system appear likely to discourage young people from signing up, threatening the stability of the insurance market.

As can be seen in the following map, premiums for a healthy 30 year old will increase in all fifty states and the District of Columbia – from a low of 9 percent in Massachusetts to a high of 600 percent in Vermont.
Premium subsidies will do little to defray increased rates for young people, while penalties for noncompliance appear paltry when compared to the costs associated with coverage. A cost-benefit analysis reveals that the cost of purchasing subsidized insurance is up to 10 times greater for this population than the cost of the mandate penalty. Premium spiral may be eminent, as many will find it financially advantageous to forego coverage, potentially limiting the actual number of “young invincibles” entering the exchange system to well below the administration’s goal of 2.7 million.

**Introduction**

The Obama Administration estimates they need the participation of nearly 2.7 million 18-35 year olds in order for state-level health insurance exchanges set up by the Affordable Care Act (ACA) to work as intended.¹ The enrollment of these low cost young adults, a group commonly referred to as “young invincibles,” is essential, as they are required to subsidize the costs of insuring the elderly and chronically ill. The term “young invincible” is a health policy buzzword used to describe young, generally healthy individuals who remain uninsured due to optimism bias: the perception that insurance is not a sensible investment since they are

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¹ Julie Pace and Jim Kuhnhenn, *Obama declared health care law ‘is here to stay’*, Associated
unlikely to need expensive medical treatment. Studies have also shown that a portion of this young, uninsured population cannot afford insurance at pre-Affordable Care Act rates. Whatever the cause, convincing this previously uninsured group of individuals to enroll in insurance plans is critical to the success and stability of the exchanges.

Given their youth, health status, and average income, this demographic is most likely to be attracted to plans offering basic coverage with affordable premiums that, under the exchange regulations, will require greater cost-sharing and perhaps cover more limited networks and services. Under the Affordable Care Act, the plans offering the lowest acceptable coverage (with an actuarial value of 60-70 percent) are categorized as bronze plans.

However, a comparison of the monthly premium for the least expensive bronze plan offered in each state-level exchange to the least expensive plan offered in 2013 reveals that premium rates are set to increase exponentially in 2014 under the exchange system, with a 30 year old single person expecting an average premium increase of 260 percent. The catalysts for these excessively large increases include guaranteed issue and community rating, amongst other ACA provisions. Prior state-level experiences reveal that guaranteed issue and community rating policies can result in a market-destabilizing phenomenon known as premium spiral.

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3 See e.g. S. R. Collins, R. Robertson, T. Garber, and M. M. Doty, Young, Uninsured, and in Debt: Why Young Adults Lack Health Insurance and How the Affordable Care Act Is Helping, The Commonwealth Fund, June 2012.


Premium spiral begins when guaranteed issue and community rating policies raise premiums, particularly for the young, who cross-subsidize high-risk beneficiaries. In response to rising costs, young healthy enrollees opt out of coverage, seeing the investment as financially disadvantageous given their low medical costs. The insurance risk pool becomes disproportionately older and sicker, further increasing prices and driving insurers out until the system becomes unsustainable. In order to avoid this “death spiral,” the Obama Administration put the individual mandate in place. The financial mechanisms meant to encourage enrollment, low-income subsidies and noncompliance penalties, however, seem unlikely to entice “young invincibles” into the exchange system.

Utilizing a cost-benefit analysis to compare the costs of the increased bronze level premiums net any subsidies to the costs of the penalties, it becomes clear that in the majority of instances, the cost of the bronze level insurance premiums far exceed the costs of the penalties, except for those with incomes 133% of the federal poverty level. Despite cost-defraying subsidies, the combination of costly premiums and ineffective penalties for noncompliance will likely keep many “young invincibles” from enrolling in the exchanges, and could result in a form of premium spiral.

**Methodology**

This paper focuses on the health insurance premiums for a 30 year old single male nonsmoker. As someone categorized as a “young invincible,” this individual would most likely be interested in purchasing a bronze-tier plan, offering compliant coverage, but at the lowest price possible within the exchanges. The 2014 publically released premium data differ in their age ratings, and therefore must be standardized so that each reflects the premium cost for a bronze-tier plan being purchased by a 30 year old single male. Using the Centers for Medicare and Medicaid Service’s (CMS) default federal standard age curve, base premium rates and rates not fitting into this paper’s parameters were converted into a uniform set of data. For the purposes of this paper, the following conversion equation is used: \( ARP = BR(PR) \). The premium ratio factor used to compute the cost of a premium for a 30 year old man was 1.135.

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6 Adjusted rate price (APR) = Base rate (BR) x Premium ratio (PR).
The January 2013 rates used in this study are derived from a July 2013 report developed by the U.S. Government Accountability Office (GAO). The report compiles annual base premium rates for each state, presenting the minimum, median, and maximum premium rates for individuals, families, and couples of varying ages. The GAO compiled the rates using information from the Center for Consumer Information and Insurance Oversight (CCIIO). As the base rates for single men aged 30 are available in this report, there was no need to use the CMS age curve formula to create a demographically constant set of data.

To compare the two sets of base premium data, the 2014 post-ACA rates were compared with the actual 2013 rates. These numbers are displayed below both as a difference in actual dollars and as a ratio to one another.

Results

Of the 51 states studied, all experienced health insurance rate increases, with 44 of those states experiencing triple digit percentage increases in premiums for the lowest-priced coverage. Pre-ACA premiums average $62.00 monthly, while post-ACA premiums average $187.08 per month, a $125.08, or 202 percent, increase. The average percent change between 2013 and 2014 minimum level plan monthly premiums is 260 percent, reflecting a nearly 3 to 1 ratio between the two sets of premiums.

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The maximum increase is 600 percent (a $332.69 increase in Vermont) and the minimum increase is 9 percent (a $19.79 increase in Massachusetts). The increase in Massachusetts, however, is an outlier when compared to the remaining results – that state’s insurance market has been subject to ACA-like reforms since 2006, bloating the premium for the lowest-cost pre-ACA policy to nearly $214, making it the highest of the 2013 premiums analyzed in this study. The median increase is 237 percent (between South Carolina’s 227 percent increase and California’s 247 percent increase) and the majority of the increases range between 200 and 300 percent. States with the top five highest percent changes are (in order starting with the highest): Vermont, Georgia, Nebraska, Arkansas, and Wisconsin. Vermont, Wyoming, Mississippi, Alaska, and Indiana all experience the highest actual dollar amount changes between 2013 and 2014.

**Catalysts for Premium Increases**

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8 It should also be noted that as Massachusetts’ premiums increased, the public received less for its money. A 2013 study commissioned by the Commonwealth of Massachusetts Center for Health Information and Analysis found that from 2009-2011, as premiums increased by 9.7 percent, the value of benefits decreased 5.1 percent.
Some have likened this sort of analysis to comparing apples and oranges. They assert that the health insurance plans of the past are no longer comparable to insurance plans post-ACA. Despite the differences between coverage in 2013 and 2014, prices for bargain-basement policies, most attractive to the “young invincibles” needed to support the system, have risen exponentially. As the choice of the “apple” has been foreclosed and replaced with the more expensive “orange,” it is important to compare the costs of the two and study the catalysts behind any increased costs. The following section discusses seven major factors driving this dramatic increase in premiums for the most basic plans.

**Health Insurance Tax (HIT)**

The ACA imposes an excise tax on insurance plans with an $8 billion cost the CBO expects to be passed to the consumer in the form of premium increases. According to the Joint Committee on Taxation, the total cost of the Health Insurance Tax (HIT) is projected to exceed $100 billion by 2024. Global consulting firm Oliver Wyman projects that these increases will result in premium increases upwards of 2.3 percent within the first year of the tax’s implementation. Over the next decade, the HIT is estimated to cost the average individual $2,171 and family $5,140 in additional premiums.

**Exchange Usage and Administration Fees**

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Both federally facilitated and state operated exchanges are allowed to charge insurance companies user fees in order to sell their products in the exchanges. It is currently estimated that such fees, which are likely to be passed along to the customers, could cause federal exchange level premiums to increase by up to 3.5 percent. These monthly fees can be adjusted beyond 2014 to amounts “specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.” State operated exchanges are also allowed to charge their own user fees to consumers, in some cases totaling $540 annually.

**Essential Health Benefits**

Beginning in 2014, non-grandfathered health plans are required to cover essential health benefits (EHB), a broad range of services fitting into 10 categories of coverage, some of which are not included in policies today. The expansive categories require coverage of ambulatory services, behavioral health care, outpatient prescription drugs, maternity and newborn care, and preventative and wellness services, amongst others. According to the CMS, the package of essential health benefits to be offered by all health plans is expected to “be equal in scope to a typical employer health plan.” Independent estimates of the impact of the required essential health benefits on the premiums found in the individual market

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15 31 U.S.C. § 9701(a); 45 C.F.R. § 156.50(b).
18 West Virginia Offices of the Insurance Commissioner, *West Virginia Health Benefit Exchange: Financial Sustainability Overview*, slide 17 (June 11, 2012), available at http://bewv.wvinsurance.gov/LinkClick.aspx?fileticket=hJnhICt7GxA%3D&tabid=112&mid=481 (discussing a maximum projected per member per month user fee of $45.02, or $540.24 annually).
19 42 U.S.C. § 300gg(6)(a) (“A health insurance issuer...shall ensure that such coverage includes the essential health benefits package required under section 18022(a) of this title.”).
20 *Id.* at § 18022(a)-(b).
have varied, but all states expect some level of increase. Premium increases associated with coverage of the essential health benefits have ranged from 0.13 percent in Rhode Island to 33 percent in Maine, with most states expecting single digit increases.

**Minimum Actuarial Values**

The ACA also drives premium increases by implementing minimum actuarial values for health insurance policies. Actuarial value (AV) refers to the true value of the insurance plan, reflecting the percentage of covered costs the plan is expected to pay for the average enrollee. Section 1302(d)(2)(A) of the Act specifies that the AV be calculated based upon the costs of the EHB being offered to a standardized population. Plans are grouped into four categories based upon their AV, with each category covering a greater share of the average enrollee’s medical expenses: bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent). The bronze tier, a centerpiece of the individual mandate and likely a popular choice amongst young enrollees, establishes the minimum actuarial value of 60 percent for all plans in the exchange system. This figure represents a higher value than many of the health insurance plans being offered in the individual market today. In fact, more than half the plans currently available on the individual market would not meet the bronze tier AV threshold, with 12 percent of plans having an AV between 35 percent and 49 percent. As these plans are forced to simultaneously...

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26 Id. at § 18022(d)(1)(A)-(D).

cover a more extensive range of services and pay a higher percentage of the costs associated with those services, premiums are expected to rise.

**Age-Band Compression**

The ACA’s new age-band compression provision contributes to premium increases for younger individuals. Age-bands are used to regulate the costs of health insurance, attempting to ensure relative affordability for all. Currently, all 50 states have age-band systems with at least a 5:1 ratio, meaning that an older enrollee’s premium cannot be more than five times that of a younger enrollee in the same plan. The ACA, however, alters this ratio, compressing it to 3:1. In order to offset the high costs associated with insuring the elderly, premiums for the healthiest segment of enrollees, those between the ages of 18 and 49, will need to increase. According to a study conducted by Oliver Wyman, the implementation of the 3:1 ratio will increase premiums 45 percent for individuals 18-24 years old and 35 percent for those 25-29. The switch to a more compressed age-band rating will likely push these younger enrollees out of the system, resulting in instability for the exchanges as the risk profile becomes unbalanced.

**Community Rating and Guaranteed Issue**

In their purest form, community rating laws require health insurance companies to charge the same premium to all members of a heterogeneous risk pool, regardless of their demographics, socioeconomic status, and health history. A modified community rating system, as is prescribed in the ACA, gives insurance companies more flexibility in determining

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premiums, allowing demographic factors (such as age within a rate band, as discussed above) to determine a particular pool’s premium.\textsuperscript{32} Factors such as health history and current health status, however, cannot be factored into premium pricing. Either form of community rating force insurers to consider all enrollees as part of a singular risk pool. This runs counter to the traditional risk allocation method, where insurers utilize experience rating, which predicts future costs for a risk pool based upon the insurer’s past spending on that particular group.\textsuperscript{33} Studies have shown that equalizing premiums within low-risk and high-risk pools tends to raise insurance costs for healthy enrollees, as they now must cross-subsidize the coverage of the elderly or chronically ill.\textsuperscript{34} Researchers with the Council of Economic Advisors found that community rating raises the prices of individual and family policies by over 20 percent and 27 percent, respectively.\textsuperscript{35}

Guaranteed issue requirements prohibit health insurance companies from denying coverage to anyone who applies for health insurance, including those individuals with preexisting conditions, those who apply for insurance after the onset of a health condition.\textsuperscript{36} Under guaranteed issue regulations, insurance companies are required to provide insurance products to potentially high-cost and high-risk individuals. The guaranteed issue provision of the ACA represents an attempt to eliminate discrimination against those potential enrollees deemed to be high-risk given their health history or current health status.\textsuperscript{37} Bringing higher cost individuals into the risk pool gives rise to premium increases for the young

\textsuperscript{32} Id.
\textsuperscript{35} Id. at 6.
\textsuperscript{36} 42 U.S.C. §§ 300gg-1(a), 300gg-3, 300gg-4(a).
\textsuperscript{37} Id. at § 300gg-1(a) (“[E]ach health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.”); see also Alec MacGillis, \textit{The Insured: It’s Status Quo, for Now}, in \textit{Landmark: The Inside Story of America’s New Healthcare Law and What it Means for Us All}, 99, 101 (2010) (discussing the denial of coverage for preexisting conditions as discriminatory).
as the system has to accommodate enrollees requiring above-average expenditures. As with community rating, the Council of Economic Advisors found that guarantee issue policies raise the price of an individual health insurance policy by 114.5 percent. For family policies, the price increase was just over 94 percent.

These two market reforms are grouped together due to their interaction, as neither can truly stand alone without creating gross inequalities in the marketplace. For example, in the absence of community rating, guaranteed issue ensures people cannot be turned down for coverage, but does nothing to prevent companies from charging an unaffordable premium. On the other hand, without guaranteed coverage, insurers using community rating would be required to set standard premiums, but would retain the autonomy to deny coverage for high-risk applicants. Despite the dangers to the marketplace posed by guaranteed issue and community rating, the two reforms are generally implemented in tandem.

**Premium Spiral or the “Death Spiral”**

Guaranteed issue and community rating are the greatest sources of premium increases under the ACA, especially for young, healthy purchasers. In the past, the premium-ballooning characteristics inherent to guaranteed issue and community rating led to a phenomenon known as premium spiral. By changing the general dynamics of the insurance market, notably the market's ability to adjust premiums and decline coverage based upon risk, guaranteed issue and community rating lead to an unstable system.

In a guaranteed issue and community rating system, healthy individuals are perversely incentivized to wait to enroll in coverage until there is a true need. Because of guaranteed issue, they cannot be denied coverage and can simply enroll during the next open enrollment period if their anticipated medical costs rise to the point where it is financially advantageous to carry coverage. Community rating has a similar affect, incentivizing younger, healthier individuals to wait until they are older or less healthy to enroll, as those high-risk groups have access to cross-subsidized premiums. With increased numbers of high-risk enrollees

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taking advantage of guaranteed coverage, insurance companies are faced with higher expenditures, fueling increases in premiums. As premiums rise, healthier individuals without expected medical needs flee the system, leaving the risk pool lopsided and increasingly unstable. Several states have experienced a variation of this hypothetical, all experiencing some level of market instability as the result of guaranteed issue and community rating policies. Effects on the insurance markets in those states included increased premiums, decreased enrollment, and fewer insurance plans in the market.

To mitigate the instability associated with guaranteed issue and community rating, the Obama Administration developed the individual mandate. Some contend that without an individual mandate requiring all uninsured citizens to purchase coverage, guaranteed issue and community rating could destabilize both the ACA and the country’s individual and small group insurance market, while leaving the employer-sponsored market relatively untouched. Princeton economics professor Dr. Uwe Reinhardt echoed this sentiment, stating that the “imposition of community-rated premiums and guaranteed issue on a market of competing private health insurers will inexorably drive that market into extinction, unless these two features are coupled with . . . a mandate on individual[s] to be insured.”

The Individual Mandate: A Cost-Benefit Analysis for the Young Invincible

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40 *Id*. Each of the eight states experienced at least one significant negative consequence as a result of the implementation of community rating and guaranteed issue market reforms. Premium increases were seen in Maine, Massachusetts, New Jersey, and New York. Five states – Kentucky, Maine, Massachusetts, New Jersey, and Washington – experienced a “flight” of insurers from their markets. Decreased enrollment, likely as a result of increased premiums or decreased plan options, occurred in New Hampshire and Vermont.

41 42 U.S.C. § 18091(a)(2)(I); see Peter J. Smith, *Federalism, Lochner, and the Individual Mandate*, 91 B. U. L. Rev. 1723, 1727 (2011) (discussing the damage these provisions would do to the insurance market in the absence of the individual mandate).

The ACA utilizes a penalty versus reward system to enforce the individual mandate and attempt to avoid the effects of premium spiral. If a person complies with the mandate, they are potentially rewarded with access to federally financed subsidies that will mitigate the impact of increased insurance premiums. On the other hand, if a person does not carry applicable coverage, they receive punishment in the form of tax penalties, which are deducted from their federal income tax refund.

“Young invincibles” choosing to comply with the individual mandate will find themselves facing high premium costs for the bronze-tier plans, the most basic and attractive plans for that cohort. The exchanges will provide subsidies for coverage through the state-level health insurance exchange based upon a person’s household income as compared to the federal poverty level (FPL). In states declining to adopt the Medicaid expansion option in the ACA, those with incomes between 100 percent and 400 percent of the FPL are eligible for subsidies. In states opting to expand, the range is 133 percent to 400 percent. The subsidies come in the form of refundable tax credits and are available to recipients prior to filing their income tax returns. Credits are calculated based upon the difference between the maximum percentage of income an individual is required to spend on coverage and the premium for the second-lowest priced silver “benchmark plan” that the individual is eligible to purchase. The maximum percentages of income range from 2 percent up to 9.5 percent depending on the individual’s income relative to the FPL.

For those opting to go without health insurance, the individual mandate provides for penalties meant to induce compliance. Beginning next year, those failing to purchase insurance in accordance with the mandate will pay the greater of a $95 fine or 1 percent of their household income that is

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43 26 U.S.C. § 5000A.
44 22 U.S.C. § 18071(c)(1)-(2).
45 See 22 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (expanding Medicaid eligibility to individuals with family incomes at or below 133% of the federal poverty level).
46 Id.
47 22 U.S.C. § 18082(c)(2)(A) (“The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of [the Internal Revenue Code] to the issuer of a qualified health plan on a monthly basis”).
49 Id. at § 36B(b)(3)(A)(i).
in excess of their tax filing threshold. Penalties are slated to reach upwards of $695 or 2.5 percent of household income by 2016 and will be adjusted beyond that date. The penalty is capped annually at an amount equal to the national average premium for bronze level plans available through the state exchanges.

Confronted with these two options, it is likely that “young invincibles,” as well as many other uninsured people, will engage in a cost-benefit analysis to decide their compliance with the individual mandate. In their 2007 study, Glied, Hartz, and Giorgi found the performance of a given mandate varies depending on a number of factors, including the affordability of compliance and the size of any potential penalties. Table 2 lists the costs associated with both compliance and noncompliance, factors likely to be weighed against one another by the uninsured. The premium costs, subsidies, and penalties associated with different levels of income are listed. For the purposes of this chart, we assume that the person purchasing insurance is a 30 year old, single male “young invincible” from state that has expanded Medicaid. As a young, healthy individual, our subject is interested in purchasing the bronze level plan, as he will only use medical services occasionally and is likely more concerned with saving his income.

Table 2: Analysis of Annual Exchange Subsidies, Premiums, and Penalties in 2014-2016

<table>
<thead>
<tr>
<th>FPL</th>
<th>Premium Cap</th>
<th>Income Level</th>
<th>Annual Subsidy</th>
<th>Subsidy Percent</th>
<th>Premium Cost</th>
<th>2014 Penalty</th>
<th>2015 Penalty</th>
<th>2016 Penalty</th>
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<tbody>
<tr>
<td>133 %</td>
<td>3.00 %</td>
<td>$15281.70</td>
<td>$2839.00</td>
<td>100 %</td>
<td>$0.00</td>
<td>$95.00</td>
<td>$325.00</td>
<td>$695.00</td>
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<tr>
<td>175 %</td>
<td>5.15 %</td>
<td>$20107.50</td>
<td>$2390.00</td>
<td>84 %</td>
<td>$449.00</td>
<td>$103.57</td>
<td>$325.00</td>
<td>$695.00</td>
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<tr>
<td>225 %</td>
<td>7.18 %</td>
<td>$25852.50</td>
<td>$1571.00</td>
<td>55 %</td>
<td>$161.02</td>
<td>$325.00</td>
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<tr>
<td>275 %</td>
<td>8.78 %</td>
<td>$31597.50</td>
<td>$653.00</td>
<td>23 %</td>
<td>$218.47</td>
<td>$325.00</td>
<td>$695.00</td>
<td>$695.00</td>
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51 Id. at § 5000A(c)(1)(B).
52 Sherry A. Glied, Jacob Hartz, and Genessa Giorgi, Consider It Done? The Likely Efficacy of Mandates for Health Insurance, 26 Health Affairs 1612, 1618 (November/December 2007).
53 Design and methodology derived from “Analysis of Exchange Subsidies and Enrollee Payments in 2016” in An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, supra note 11, at 29.
Table 2 illustrates that subsidies decline significantly as income rises, even if the increase is marginal. For example, if our subject were to be making 133 percent FPL, 100 percent of his insurance costs would be covered by the premium subsidies. At 175 percent FPL, he would be eligible for a subsidy covering 84 percent of his premium. Should our subject’s income increase to 225 percent of FPL, a salary bump of just over $5,000, his subsidy would drop exponentially to 55 percent. By the time his salary reaches 275 percent of FPL, his subsidy rate would drop to 23 percent. For our subject, any salary above $36,052, or about 314 of percent FPL, would preclude him from receiving premium subsidies.\textsuperscript{54} It is at this level that our subject must pay the full amount for a bronze level insurance plan. Without any premium subsidies, our subject is expected to pay $236.58 per month for his insurance coverage.

In terms of the potential penalties facing our subject, Table 2 illustrates that the penalty as a percentage of income will be more prevalent during the early years of implementation, with the flat dollar penalty being more common by 2016. In 2014, the $95 flat penalty only applies when our subject is making 133 percent of FPL. For each additional income level within the FPL range, he is charged the 1 percent penalty. In 2015, the first three levels – 133 percent, 175 percent, and 225 percent of FPL – are charged the flat penalty of $325, with the remaining four income levels being charged 2 percent of their annual income. Finally, in 2016, the height of the individual mandate penalties, our subject is charged the flat penalty

\textsuperscript{54} It should be noted that subsidies are technically available for individuals and families with incomes up to 400% FPL. Although the cut-off for the availability of subsidies for our subject is 314 percent FPL, this level will vary based upon an individual’s unique circumstances.

\textit{AmericanActionForum.org}
of $695 for all hypothetical income levels except 375 percent and 425 percent of FPL.

Table 3 compares the rewards and penalties of the individual mandate by calculating the costs of subsidized insurance coverage as a percent of the potential penalty for noncompliance. A comparison of this sort is used because consumers will compare the cost of the insurance product in excess of the individual mandate penalty to the amount of the penalty itself.\textsuperscript{55}

**Table 3: Ratio of Premiums Net Subsidies to the Individual Mandate Penalties 2014-2016**

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In 2014, the only person with a financial incentive to “purchase” coverage would be the person making 133 percent FPL. This remains the same in 2015. Only in 2016 does it become financially advantageous for another person, this time making 175 percent FPL, to purchase insurance. For all other income ranges during the coming years, the cost of purchasing subsidized health insurance is far greater than the cost of the mandate penalty, in two instances topping 10 times the cost of the penalty. Across

\textsuperscript{55} Amy B. Monahan, *On Subsidies and Mandates: A Regulatory Critique of the ACA*, 36 J. Corp. L. 781, 794 (July 2011) (discussing the concept of “delta,” the result of a comparison of the benefit of coverage to the difference between premium costs and any penalties).
the next three years, the cost of subsidized insurance is, on average, around 4 times the cost of the penalty.

The numbers in Tables 2 and 3 are illustrative of the major deficiencies within the subsidy-penalty system. While subsidies are likely to offset the costs of purchasing health insurance for some individuals, a significant number of people will either receive negligible subsidies or will be ineligible for them altogether. In 2010, 52 percent of the uninsured population was between the ages of 18 and 35.\textsuperscript{56} That same year, 30 percent of the uninsured population was making greater than 250 percent FPL.\textsuperscript{57} If you were to assume that the number of uninsured persons making at least 250 percent FPL is spread uniformly across the population, then at least 28 percent of the uninsured population between the ages of 18 and 35 would receive a subsidy covering less than 40 percent of their insurance premiums.

As “young invincibles” realize that federal subsidies may not cover enough of their premiums to offset the increased cost of insurance, many are likely to consider the penalty a viable and cost-effective option. An American Action Forum poll found that a 30 percent increase in premiums would cause 45 percent of respondents to forego coverage and pay the penalty.\textsuperscript{58} Considering this statistic, triple digit percentage increases in premiums are likely to fuel a rate of noncompliance higher than 45 percent. While penalties for those at the higher end of the income spectrum may incentivize enrollment, “young invincibles” with lower incomes, requiring less extensive medical plans, will find the penalties much smaller than their expected premium costs. As seen in Table 3, for nearly all income ranges over the next three years, it makes better sense financially to pay the penalty and refrain from purchasing a bronze level plan for continuous health insurance coverage. These individuals could then remain uninsured, pay the necessary penalties, and save their income.

\textsuperscript{56} Emily Carrier, Tracy Yee, and Rachel L. Garfield, \textit{The Uninsured and Their Health Care Needs: How Have They Changed Since the Recession?}, Kaiser Commission on Medicaid and the Uninsured 3 (October 2011) (data derived from the Center for Studying Health System Change’s 2003, 2007, and 2010 Health Tracking Household Surveys).
\textsuperscript{57} Id.
Highlighting these potential savings, a recent study found that 3.7 million “young invincibles” will save at least $500 by choosing the penalty over coverage, with another 3 million projected to save $1,000 or more by foregoing coverage.\textsuperscript{59}

One might argue that this strategy is risky, as it is “impossible...to predict with certainty the future financial burden of health care costs.”\textsuperscript{60} The sudden onset of an illness or catastrophic injury has the very real potential to financially ruin an individual or family. Whether based on health realities or faulty biases, “young invincibles” are likely to estimate the health care costs for their immediate future as relatively low. Despite the risks associated with non-coverage, “young invincibles” may not find value in purchasing expensive coverage that they perceive they are unlikely to use. As a result of these factors, we may see significant numbers of young individuals opting to pay the penalty instead of purchasing coverage.

**Conclusion**

Predicting the behavior of a group faced with a mandate has been described as an “inexact science.”\textsuperscript{61} However, after comparing the affordability of compliance to the size of the potential penalties, the probability that “young invincibles” will comply with the individual mandate appears fairly low. First, compliance will be unaffordable for many. A number of provisions in the ACA drive up premium prices for most income levels, but particularly for those who are young. Premium subsidies may help some enrollees, but beyond a certain threshold, these tax credits are too small or are wholly unavailable to a significant portion of the uninsured population. As such, the cost associated with compliance is high.

Conversely, the size of the potential noncompliance penalty is low. In nearly every instance analyzed, it made better fiscal sense to accept the penalty and forego coverage. Purchasing the exchange-offered insurance


\textsuperscript{60} Richard W. Johnson and Corina Mommaerts, *Will Health Care Costs Bankrupt Aging Boomers*, The Urban Institute 1, 21 (February 2010).

\textsuperscript{61} Glied, Hartz, and Giorgi, supra note 52, at 1612.
only made financial sense for those at the lowest end of the FPL range and in that instance coverage came at no out-of-pocket cost to the purchaser since 100 percent of the bronze level premium was covered by the federal subsidy. Otherwise, for some levels of income, the premium costs outweigh the expected penalties by a margin of up to 10:1.

Although an inexact science, the numbers clearly illustrate a problem for the Affordable Care Act, the individual mandate, and the exchange system. Premiums for those required to subsidize the system have risen too much and the mechanisms meant to defray those costs and encourage people to participate in the system are too weak. As such, a significant portion of the uninsured “young invincible” population will purposefully choose to remain without coverage. Should this be the case, the American insurance market will experience widespread premium spiral.