The Affordable Care Act's Mandatory Health Insurance Requirement and Penalties and the Causes of Its Abolition

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On my honor as a University Student, I have neither given nor received unauthorized aid on this assignment as defined by the Honor Guidelines for Thesis-Related Assignments

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INTRODUCTION

The US healthcare system ranks first in the world in science and technology and sixth overall in the FREOPP World Index of Healthcare Innovation (with dimensions of Quality, Choice, Science & Technology, and Fiscal Sustainability), but issues with affordability and accessibility mean that the benefits of advanced American medicine are not felt equally (Roy, 2021). To combat the expensiveness of healthcare and provide greater accessibility, particularly to low-income patients, Congress enacted the Affordable Care Act (ACA) in 2010. In addition to expanding Medicare for seniors and establishing a taxpayer-subsidized Medicaid program for the poor, the ACA also included a provision to punish anyone who chose to not have a health insurance plan (either public or private), forcing them to pay penalties. However, in 2019, the health insurance mandate was lifted, eliminating the penalty for being uninsured but leaving the rest of the ACA intact (Rosenbaum, 2011). This research paper investigates the question: how did changes in social, economic, and political attitudes result in the repeal of the federal mandatory healthcare insurance requirement in 2019?

METHODS

This research paper is a literature review of sources from 2010, when the ACA was first put into place, to 2019, when the health insurance mandate was lifted. Analysis of the ACA individual mandate draws from studies, editorials, and legal documents to analyze the reasons for the lifting of the mandate and applies the STS framework of Actor-Network Theory to the topic. First, the social influences are investigated to study how the mandate affected societal actors and what their responses were to the penalties. Next, the economic impacts of the mandate and its potential benefits or detriments are explored. Lastly, the political factors are examined to analyze how rhetoric and public opinion led to the abolition of the penalties. This essay ties each of these

together to create a comprehensive picture of the ACA and the mandate and how relationships between individuals and institutions shape public policy and the utilization of technology in medicine.

BACKGROUND

The original reason for the ACA being implemented was to combat the expensiveness of healthcare and health insurance in the country and reduce the number of uninsured patients. Individuals in high-risk groups or that have preexisting conditions may find it difficult or impossible to obtain affordable health insurance, and many low-income and part-time jobs do not offer health insurance plans as part of their employment benefits. Additionally, the marketing of prescription drugs has elevated demand and further increased treatment costs (Silvers, 2013). In 2009, before the ACA went into effect, 15.4% of patients were uninsured, and 19.4% of patients had been uninsured at some point in the previous year. Accessibility of health insurance also varied by ethnic and racial groups, with 31.2% of Hispanic patients being uninsured, which was far more than any other group (Cohen et al., 2019). In addition to providing a subsidized healthcare plan through the ACA, the penalties sought to coerce people into buying a plan to reduce the number of uninsured patients and increase the effectiveness of the program.

The current healthcare and insurance system in the United States is a hybrid between public and private options. Of the two, 66.0% of patients have private health insurance, while 34.7% have government insurance (either Medicare or Medicaid). As of 2021, 8.3% of patients were uninsured, which represents 28.3 million people (Berchick et al., 2019; Kiesler-Starkey & Bunch, 2022). Cutting-edge technology and medicine have been a staple of US healthcare, but this has also been one of the largest drivers of costs to patients (Goyen & Debatin, 2009). The cost of research and production of new drugs and devices have further exacerbated healthcare

inequalities due to the subsequent price of these treatments. As a result, minority groups and certain regions of the country are at a higher risk of poorer healthcare utilization and treatment outcomes (Chang et al., 2023). While the ACA was created to address these issues, many of these problems remain to the present day.

Providing low-income individuals with an affordable healthcare plan would counteract the problem of accessibility, but the penalties under the mandate carried a broader utilitarian purpose to the ACA. Because of the cost of treatment and the uncertainty of payment, many practices (primary care physicians, outpatients, etc.) would make uninsured patients pay at the time of service or not take them in at all (O'Toole et al., 2001). The Emergency Medical Treatment and Active Labor Act (EMTALA) passed in 1986 requires hospitals to treat patients in emergency situations regardless of insurance coverage or even payment (Zibulewsky, 2001). As a result, hospitals lose roughly $35 billion each year due to the treatment of uninsured patients, a cost which is then passed on to other patients, insurance companies, or taxpayers (Institute of Medicine (US) Committee on the Consequences of Uninsurance, 2003). Additionally, having an expensive procedure done is not only physically demanding on the patient, but may also leave the patient with a large amount of debt. In June 2020, 17.8% of Americans had medical debt collections (Kluender et al., 2021). While debt itself carries massive negative consequences for the economy, health-related work losses account for $260 billion lost annually (Mitchell & Bates, 2011). Therefore, the institution of penalties as part of the ACA was also intended to protect hospitals and reduce overall healthcare spending nationally.

STS FRAMEWORK: ACTOR NETWORK THEORY

Actor Network Theory (ANT) is a tool used by researchers and scholars in the field of Science and Technology Studies (STS) to investigate how relationships between both human and

non-human actors (i.e., technologies and institutions) create social or other consequences. In ANT, the focus is entirely on the networks, rather than the individual actors themselves, and nothing exists that is not a part of the network. Although labeled a theory, ANT is more accurately described as a lens or a tool for analyzing systems, as opposed to a concrete theory of how they work (Latour, 1996). As it relates to technology, the importance of networks is seen through the vast classifications and standards in place to ensure that new technologies are easily integrated into the existing system (Bowker & Star, 1996). These standards are often made by governments or other organizations, which connects the idea of standards and regulations to the topic of this research paper through the significance of the healthcare mandate under the ACA. Public policy and medical technology and institutions are intertwined through the creation and enforcement of standards and regulations, and examining the changes in these policies is the purpose of this paper.

The analysis conducted within the paper leverages ANT as a framework for examining the complex and multidimensional relationships that exist within a network, exploring them from social, economic, and political perspectives. A tenant of ANT is the fluidity of reality, meaning that networks are dynamic and constantly evolving, and a network may be examined from multiple perspectives at once (Cresswell et al., 2010). This paper looks at a major shift in the healthcare network in the United States with the abolition of the health insurance mandate, acknowledging the dynamic nature of actor-networks. The social perspective analyzes the factors contributing to the continued prevalence of uninsured individuals and the personal reasons why someone may choose to be without or be unable to afford insurance, even with the ACA. The economic lens examines how hospitals and patients are financially impacted by the mandate and how monetary consequences for actors result in policy changes. Lastly, the political angle

explores how public opinion, political rhetoric, and cultural values influenced the alleviation of the mandate and larger pushes to repeal the ACA in its entirety. ANT gives a big-picture, contextualized view of the ACA, hospitals, insurance companies, and others' relationships to show that none are working in isolation from the rest.

ANT has already been applied to the field of healthcare by STS scholars, usually focusing on specific technologies or community characteristics in how they relate to medicine. The metered dose inhaler (MDI) or Medihaler, for example, ran into issues between timely treatment of an asthma attack and the controlling of a potentially dangerous substance (Prout, 1996). Therefore, the Medihaler had to navigate government regulations, user training and competence, and manufacturing and distribution within the organization of the healthcare system. The Medihaler was not limited to purely engineering consequences, but also had to face political and social ones as well in a broader actor-network. ANT has also been postulated as a tool to not only analyze a given actor-network, but also to then construct a more ideal system of collecting, processing, storing, and distributing medical data to doctors and nurses (Bilodeau & Potvin, 2018). Communication technology provides a literal network for examination, and the management of records and resources efficiently and responsibly is essential for the operation of a quality and trustworthy healthcare facility. Previous work in applying ANT to the healthcare field gives a template for the structuring and analysis of the ACA and the insurance mandate that occurs in this essay.

RESULTS AND DISCUSSION

Social Influences

When analyzing the individual mandate, it is impossible to decouple the mandate from the rest of the ACA. Because the mandate was intended to encourage participation in the ACA, the goals and successes of the ACA must be considered when determining the effectiveness of the individual mandate. The main goal of the ACA individual mandate was to decrease the number of uninsured Americans by making the choice to remain uninsured less favorable, and it was seemingly successful at achieving this goal. When the ACA was expanded in 2014 and the individual mandate was phased in, the number of uninsured Americans plummeted from 44.4 million in 2013 to 35.9 million in 2014 then to 29.1 million in 2015 (Tolbert et al., 2023). A study which isolated patients (ages 26-64) with >400% of the Federal Poverty Line (FPL) income group found that the percentage of uninsured patients fell from 5.53% to 3.41% due to the individual mandate (Fiedler, 2018). The >400% FPL demographic was selected because they are eligible for Medicaid, but ineligible for tax credits or other benefits that would have influenced their decision more heavily. The ACA changed the size and composition of the insured and uninsured populations in the United States. Obamacare increased the number of insured Americans, and the individual mandate influenced which Americans chose to buy insurance when they otherwise would not have. The evolution of actors is important in understanding the context in which the individual mandate existed and was repealed.

Besides the individual mandate, there are other factors that could have contributed to the observed decrease in the uninsured population. Between 2014 to 2015, 24% of the increase in coverage was attributed to marketplace tax credits (applicable to lower income patients), and 36% was attributed to Medicaid enrollment or newly or previously eligible people (Eibner & Nowak, 2018). The same report also acknowledged other influences, such as a taste for compliance, media coverage, inertia in decision making, and other policy changes that occurred

with the ACA expansion. The taste for compliance suggests that people will enroll in insurance because the mandate exists, regardless of the size of the penalty. In other words, the patient wants to follow the rules, and he is enrolling in insurance not because he is afraid of paying a penalty. In fact, some studies conducted on the subject have found no evidence to suggest that increasing the size of the penalty changes the response to the mandate (Frean et al., 2017). While 84% of the population was aware of the mandate, a limited understanding of the way the penalty was calculated and was implemented could have contributed to the unresponsiveness of the public to penalty size changes (Eibner & Nowak, 2018). Lastly, inertia in decision making means that once someone has made a decision, they stand by their decision, even when circumstances change. As a result, if the mandate changes or is eliminated, a person with insurance will keep it regardless. The attitudes of the patient population influence how they respond to the mandate, and their individual experiences shape their opinions and reactions to the ACA and its provisions. The policy decisions made by Congress, such as the size of the penalty, tax credits, and minimum benefit requirements shape people's perspective on the ACA, affecting the favorability of the program. They are also designed to elicit beneficial outcomes for the country, and if a provision, such as the individual mandate, is having minimal influence on the effectiveness of the ACA, then that provision is more likely to be altered or removed.

Whether or not an individual has insurance coverage is also affected by their employment status. Employers offering health insurance to their employees has been a widespread practice for a long time, but with the passing of the ACA, it was now mandatory for employers with 50 or more full-time employees. Since most Americans receive their coverage from their employers, this limits the potential effect of the individual mandate on reducing the number of uninsured. Despite the employer mandate with the ACA, however, there has not been an increase in

Americans receiving their healthcare from employers. Instead, the percentage of people covered by their employer dropped slightly from 60% in 2008 to 59% in 2016 (Manchikanti et al., 2017). The lack of change in the number of people insured by their employers could be because the people gaining insurance through Medicaid are not working full-time jobs and, therefore, not covered by the employer mandate. The relationship between employers and employees within the healthcare network of the United States altered the scale of the influence of the ACA on the number of insured Americans. It limited the relevant population within patient group since most Americans are not buying individual health insurance plans, so the individual mandate is not applicable. While the government's enactment of the ACA targeted the broad category of uninsured Americans, the actual composition of the affected patient population actor is smaller and more specific, narrowing the scope of the ACA's individual mandate. Acknowledging the other actors and relationships that exist within the network gives a better perspective on what changes occurred and which are attributed to the individual mandate.

The decisions for the enforcement of the ACA's individual mandate penalties altered the relationship between the government and the people and the scale of the changes observed in each actor. The Internal Revenue Service (IRS) enforced the individual mandate penalties through deductions from a person's tax refund for the amount that was owed. Americans who were in violation of the mandate and did not pay, however, would not be criminally prosecuted or be liable for additional penalties (Mach, 2015). Additionally, in 2016, the IRS would still process "silent returns," which are when someone does not indicate their insurance status on their tax forms (Thomson Reuters Tax & Accounting, 2017). Therefore, if an individual merely left that section blank on the tax forms, he would not be required to pay the penalty. The lack of strong enforcement for the individual mandate weakened the influence it had over potential enrollees.

The decision by the government to not enforce the individual mandate allowed for the circumvention of the provisions they had put in place, and as a result, the mandate demanded less respect, and people were less likely to adhere. What is the purpose of having a law if it is not being enforced? The strength of the relationship between the actors of the government and the relevant patient population is dependent on the government's ability to create, implement, and enforce legislation and the patients' motivation to adhere to it.

Economic Influences

The need for economic sustainability within the ACA led to the government making policy decisions to adjust the demographic composition of patients on Medicaid. The individual mandate aimed to decrease the risk and financial burden on insurance policy holders by increasing the pool of patients (Fiedler, 2020). Health insurance companies could no longer deny coverage or raise premiums on people with preexisting conditions, so the cost of healthcare for the riskier, more expensive patients was distributed by raising premiums on healthier, low risk patients. Therefore, young, healthy individuals were less likely to have coverage due to increasing rates (Fiedler, 2018). The mandate was designed to incentivize the young, healthy population into buying health insurance policies in order to pay for the high-risk population, and the observed trend with the ACA expansion (including the implementation of the individual mandate) was that it made healthy people more likely to sign up, but did not affect sicker people or those with preexisting conditions (Eibner & Nowak, 2018). The individual mandate changed the composition of the insured population to make the act more economically feasible. By forcing healthy people who did not need insurance as desperately together with patients with preexisting conditions, the healthy individuals paid for the sick ones, which not only funded the

ACA, but also reshaped the demographics of the enrollees of Obamacare to be more representative of the general population.

There has been a shift in the demographics of hospital patients: more patients have ACA Marketplace (i.e., individual) health insurance plans, as opposed to employer-sponsored, commercial coverage, than hospitals were treating in the past. Between 2013 and 2014, charity care costs, or healthcare provided by hospitals for which they will not be reimbursed, decreased by 40.1% in ACA expansion states and 6.2% in non-expansion states (Cunningham et al., 2015). In a study of several hospitals in both expansion and non-expansion states, average operating margins increased from -4% in 2013 to 2% in 2015 in expansion state hospitals, whereas in non-expansion state hospitals, average operating margins remained negative during this timeframe (Felland et al., 2016). The demographic makeup of patients in hospitals changed because of the ACA, and the increase in the percentage of patients with insurance was financially beneficial for hospitals. Developments in patient populations in the wake of the ACA also highlighted differences in performance between expansion and non-expansion states' hospitals. Variation in patient demographics and hospital operating margins exemplify state-level differences in the healthcare systems there due to the variances in network relationships, such as those between the government or patients and hospitals, within each state. Consequently, the effectiveness of the ACA depends also on the state and local governments and hospital systems instead of being uniform across the entirety of the US.

With respect to the national economy, a major objective of the ACA, and by extension the individual mandate, was to protect against the financial consequences of poor health. After Medicaid expansion, early expanding counties observed an 11% reduction in high-interest payday loans taken out by low-income families. They also saw a reduced incidence of new

medical debt, probability of becoming delinquent on debt, and improved credit scores (Campbell & Shore-Sheppard, 2020). By reducing the number of patients with medical debt, other areas of the economy improve, and hospitals receive compensation for the services they provide. A 2017 report from the Congressional Budget Office (CBO) estimated that if the individual mandate were to be eliminated, federal budget deficits would decrease by $338 billion between 2018 and 2027, the number of people with health insurance would decrease by 4 million in 2019 and 13 million in 2027, and average premiums in the nongroup market would increase by 10% due to healthy people being less likely to buy insurance (Beyer et al., 2017). The repeal of the individual mandate would save the government, and by extension the taxpayer, a substantial amount of money, but the potential increase in the uninsured population could counteract the previous achievements of the ACA. While resulting from changes to healthcare policy, the reduced reliance on payday loans and increasing or reducing taxes affect other areas of the economy and society, and the potential unintended consequences of the ACA and individual mandate's implementation and repeal demonstrate the extent of the network and how healthcare intertwines with other aspects of American society.

Although the ACA has provided health insurance to more people, it has not been successful in making healthcare more affordable. Per enrollee spending across Medicare, Medicaid, and private insurance has continued to rise, with the latter being the most severe, despite efforts of the ACA to control costs (McGough et al., 2023). The individual mandate reduced the effective price of health insurance, however, meaning that because of the penalty, people would still be paying a portion of the cost of an insurance plan regardless. Therefore, despite the absolute cost of the plan being higher, the difference in price between the penalty and the premium makes the latter option more appealing (Fiedler, 2018). The limited economic

benefits felt by patients could have influenced negative opinions on the ACA and led to more resentment of the individual mandate. The mandate was an attempt by the government to modify the behavior of potential enrollees. By implementing a penalty for not having insurance, they made a poor option (having to pay a high premium to cover someone else's medical bills) seem less undesirable, and thus artificially increased the patient pool for insurance.

Political Influences

The fight against the individual mandate, which was one of the most controversial parts of the act, was part of a larger effort to repeal the entire ACA. In 2012, the Supreme Court decided on the constitutionality of the individual mandate in The National Federation of Independent Business, et al. v. Sebelius. The Court ruled that the penalties associated with the mandate were unconstitutional, but Congress did have the authority to implement them as a tax. The Court also ruled, however, that the ACA was also not allowed to be implemented nationwide and that penalties could not be imposed on states that elected not to expand the ACA (Blake, 2012). Another lawsuit brought to the Supreme Court challenged the ACA a second time in 2020. California v. Texas argued that since the penalty had been reduced to zero in 2019, it could no longer be considered a tax, so the entirety of the ACA was then unconstitutional. The Supreme Court ruled that the states could not challenge the act in this way, so the ACA survived (Oyez, 2021). Republicans in Congress have also challenged the ACA, and the House has advanced over 50 bills to repeal the ACA in just the first four years, as well as cut funding for specific programs within it (McIntyre & Song, 2019). The Supreme Court dictated how the ACA was able to be implemented, which affected patients' access to and ability to afford health insurance. Additionally, the constant altering and challenging of the ACA by lawmakers continues to cause

perpetual changes in the laws and how they impact patients, healthcare providers, and the relationship between them.

Government actions on the state level have also shifted actor-network relationships within the context of the ACA and health insurance. In addition to states contesting the constitutionality of the ACA, many states chose not to expand the ACA in their state. By 2020, 14 states had still not expanded the ACA, and of those states, all of them either had Republican governors or Republican-controlled legislatures (Oberlander, 2020). On the other end of the spectrum, despite the mandate penalty being reduced to zero in 2019, five states and Washington D.C. have implemented their own individual mandates (HealthSherpa, 2019). State governments, through their ability to choose participation in the ACA expansion, have impacted their citizens' access to and quality of healthcare in their respective states. The states that have implemented their own versions of the individual mandate have taken on the role the federal government held previously, reestablishing and strengthening the relationship between government, the ACA, and individual patients.

Throughout its existence, ACA has been a controversial program, and support or opposition to the act are split along party lines. Per a 2014 poll, only 19% of Democrats opposed the ACA compared to 83% of Republicans, and 56% of Republicans wanted the ACA repealed. Additionally, only 41% of Americans thought healthcare was a responsibility of the federal government. Within the ACA, the individual mandate was the most controversial provision with support for individual mandate being 45% in 2011 (Dalen et al., 2015). Preexisting condition protections, on the other hand, were the most popular. In a 2022 poll on the popularity of the ACA, a quarter of respondents said they had been helped by the ACA, and a fifth of respondents had said they had been hurt by it, citing primarily the increase in costs it caused (Kirzinger et al.,

2024). A person's affiliation with one political party or another, his individual values and beliefs, and the various relationships and influences that molded them all impact one's stance toward the ACA and the individual mandate. The connection between the ACA and political beliefs goes the other way as well. The ACA itself and patients' experiences with it also influence opinions on the act and whether it should continue. Therefore, through the opinions and sentiments of constituents, political networks and social relationships impact how the ACA is received and whether it is modified or repealed in the future. Voters, politicians, and community organizations play an active role in the evolution of the American healthcare system, and despite the ACA being designed to improve medical outcomes, it is also a contentious political issue, which introduces actors outside the traditional idea of the healthcare network.

Limitations and Future Directions

The removal of the ACA individual mandate is a recent event, so not everything is known about the broader implications of the mandate's repeal. By extension, the relative significance of each actor's influence on one another is still unclear. The considerable number of actors at play in the US healthcare system also provides limitations. The complexity of relationships makes them difficult to completely cover in this research paper. It should also be noted that the social, economic, and political subsections are not individual networks. Instead, they are different facets of the same network and are highly dependent upon each other. Lastly, this paper utilizes a literature review for the compilation of research. While other studies and polls are cited, this project did not conduct its own separate interviews or polls.

While the individual mandate is no longer a relevant component of the ACA as of 2019, the larger battle against the ACA continues. The act remains a controversial political topic, and efforts by Democrats and Republicans to either expand or repeal the ACA persist. As such, this

topic is still evolving, and future research should be aimed at evaluating the changing attitudes regarding and effects of the ACA. Other provisions, such as the employer mandate, are also controversial and are still in effect. Finally, the long-term effects of the ACA on healthcare affordability and quality and its broader economic and social impacts will become clearer as time moves forward. Understanding the full scope of the consequences of the ACA and its provisions will aid policymakers make better decisions for the country in the future.

CONCLUSION

This paper explores the changes in the United States healthcare network to create a better understanding of the circumstances under which the ACA's individual insurance mandate was repealed in 2019. The use of Actor-Network Theory allows for the social, economic, and political effects of the ACA and the mandate to be viewed in the context of a relationship between actors. People, groups, institutions, and policies are viewed as actors engaging in a network, and this research paper identifies actors, evaluates the change and evolution of those actors, and describes the relationships between the actors with each other and with the ACA. Actors such as the patient population, large employers, hospitals, insurance companies, and state and federal governments all played a role in the formation of the environment surrounding the abolition of the individual mandate. The individual mandate was just one actor within the much more expansive network of the American healthcare system, and the social, economic, and political factors surrounding its repeal do not exist in isolation. The change in both the actors and the relationships between them led to an evolving environment (social, economic, and political) that resulted in the elimination of the mandate. Changing situations, relationships, and the introduction of new actors will continue to shape the healthcare network in the United States and the policy decisions made for

the country, whether it be for a national healthcare system, such as the ACA, or an alternative solution.

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