# RECONCILING THE MASSACHUSETTS AND FEDERAL INDIVIDUAL MANDATES FOR HEALTH INSURANCE:

# A COMPARISON OF POLICY OPTIONS

DECEMBER 2012

FOUNDATION
MASSACHUSETTS

Linda J. Blumberg and
Lisa Clemans-Cope

## ABOUT THE AUTHORS

Linda Blumberg is a Senior Fellow and Lisa Clemens-Cope is a Senior Research Associate in The Urban Institute's Health Policy Center.

The authors are grateful for insights and suggestions from Katharine Nordahl and Nancy Turnbull.

# EXECUTIVE SUMMARY

The 2006 Massachusetts health reform law successfully increased insurance coverage and improved access to care and self-reported health status among state residents. This success was derived in part from the law's well-designed individual mandate, which requires that most residents enroll in health insurance coverage meeting minimum standards or pay a fine if affordable coverage is available to them and they do not enroll. An individual mandate is also a component of the federal Patient Protection and Affordable Care Act (ACA), though it differs from the Massachusetts mandate in many design components. The federal individual mandate will become effective in January 2014, raising complex questions related to the potential interaction of the two coverage requirements and their effects on Massachusetts residents.

This report analyzes the state's three basic policy options with regard to its individual mandate: the state can eliminate its mandate, maintain the mandate in its current form, or maintain but modify its mandate to increase consistency with the ACA. We analyze these options through their ability to satisfy a set of core objectives. These objectives include minimizing complexity for residents, maximizing political acceptability, limiting the administrative burden on the state, minimizing impacts on state revenue, and minimizing disruption to the state's current system, which has effectively increased insurance coverage and ensured a minimum level of benefits across all insurance markets since 2006. Comparing the options requires a detailed understanding of similarities and differences in the four main policy components of both the state and federal mandates. These components are the *specific benefit requirements* both for coverage that satisfies the mandate and for which parts of the insurance market these rules apply to, *affordability standards* applying to the coverage requirement, *exemptions* to the requirement, and the *level of penalties* imposed for noncompliance with the coverage requirement.

- **Eliminate the state mandate.** The first option, repealing the state requirement once the federal mandate is in effect, would be the least complex policy option for residents, since there would be only one set of rules—the federal rules—for them to follow. This approach would also eliminate the possibility of duplicative penalties, making it politically attractive. The option would decrease the administrative burden on the state relative to today, but it would eliminate all state revenues from the individual mandate penalties (currently about $22 million per year). Repealing the state mandate would nullify the state's own minimum creditable coverage (MCC) benefit standard that currently applies to all state residents. This option would therefore create the most disruption to the current system, as it would risk potential changes in the type of coverage offered by employers and held by residents, particularly for large employer and self-insured plans, most of which will be exempt from the bulk of benefit standards criteria under the ACA. In addition, lower penalties for households in some income ranges under the federal rules could potentially decrease overall rates of insurance coverage.
- **Keep the state mandate**. This option would be complicated for residents since it imposes two separate sets of rules on households. This option would be politically challenging, since some residents would face double penalties. The state administration of this option would be similar to current state law, and state revenues would be similar to those under current state

law. This approach minimizes disruption of the current system, as it maintains strong incentives for residents to enroll in coverage and for residents and employers to comply with the MCC standards. A modification of this second option would be to maintain the state mandate structure but reduce any state individual mandate penalties by the amount that the tax unit owed to the federal government for the ACA's individual mandate penalties. This strategy, while reducing state revenues, would improve political acceptability by ensuring that no resident would pay more in aggregate than the greater of the federal or state penalty amount. However, the computation of penalties and verification of the appropriate amounts could be burdensome for households and state enforcement.

- **Modify the state mandate**. The state could modify its mandate to increase consistency with the ACA. Increased consistency between the state and federal affordability standards, exemptions, and penalty levels could reduce confusion for Massachusetts residents. At the same time, changes in state rules are likely to create political resistance among those who would pay more as a consequence. In particular, the effect on equity across income levels of replacing the state affordability standard with the national one could be significant, and would be strongly related to whether the state supplements federal premium subsidies. However, since coverage rates in the state are high, the number of people affected by changes in the state's exemption and penalty rules is likely to be relatively small. This option would impose somewhat greater administrative burdens on the state, and could significantly reduce state revenues associated with the mandate. It is also possible that residents who face a lower penalty under federal rules might choose not to buy health insurance, though the magnitude of this effect is hard to predict. Importantly, this option would allow the state to keep its MCC benefit standards for all non-exempt adults, thereby both limiting disruption to the current system and preserving the current perceived sense of fairness across all residents and employers, regardless of employer size or self-insured status.

In choosing a policy approach for combining federal and state rules, the state faces competing priorities, especially until 2017, when the state can request a waiver to modify federal rules related to the mandate. Nevertheless, the federal penalties in the early years of full federal implementation of the ACA are lower than in later years, and the high rates of coverage in Massachusetts imply that a relatively small number of residents will experience significant effects of the new federal penalties early on. This suggests that Massachusetts could benefit from maintaining some of the state's individual mandate structures, at least in the first years of the ACA's implementation, to ensure greater stability in its coverage rates and in the standardized level of benefits provided through its private insurance markets. The flexibility starting in 2017 could allow the state to move toward a single set of rules, possibly incorporating the state's current MCC standards. Such an approach would, however, require the state to take steps to reduce the burden on residents of complying with multiple overlapping provisions during the transition period. No matter what choices the state takes to reconcile the state and federal individual mandates, the level of uncertainty in both consumer responses and in how the federal law will be carried out means that any choices are likely to require ongoing evaluation and possible adjustment.

# INTRODUCTION

The fundamental elements of the 2006 Massachusetts health reform law focused on expanding affordable health insurance coverage in the state. A central feature of the law is the individual mandate, which requires that most residents enroll in health insurance coverage meeting minimum standards or pay a fine if affordable coverage is available to them and they do not enroll.[1] An individual mandate is also a component of the Patient Protection and Affordable Care Act (ACA), the federal reform whose fundamental building blocks are the same as those of the law already implemented in Massachusetts. In January 2014, the federal individual mandate will take effect, raising complex questions related to the potential interaction of the two requirements and their impact on Massachusetts residents.

Since the state reforms were implemented, insurance coverage has increased and access to care has improved, as has self-reported health status.[2] The success of the Massachusetts law derives in part from the well-designed individual mandate that helps limit adverse selection—the disproportionate enrollment of higher-cost individuals in particular insurance markets. A requirement that most people have health insurance works together with the additional insurance market reforms to guarantee access to insurance coverage for everyone, regardless of health experience, and to prohibit premium discrimination against those in bad health. Without such a requirement, residents would tend to wait to enroll in coverage until they got sick or anticipated health needs, driving premiums up to unsustainable levels. An individual mandate keeps most people in the system consistently, whether they are young or old, healthy or sick, allowing insurers to charge premiums consistent with the costs of an average population, significantly increasing stability in coverage and costs.

This paper delineates the ways in which the state and federal individual mandates differ and presents an analysis of three basic options available to the state with regard to its individual mandate when the federal mandate takes effect:

- Eliminate the state mandate,
- Leave the state mandate in place in its current form, and
- Modify the state mandate to integrate the two.

This last option could allow the state to maintain some of the advantages of its own requirement while reconciling key differences between the state and federal laws.

1 Other key elements of the state reform include establishment of a health insurance purchasing pool for individuals and small employers, expansion of Medicaid eligibility, financial assistance for purchasing health insurance and reduced cost sharing for those with modest incomes, and requirements on employers to make a fair and reasonable contribution toward the cost of health insurance coverage for their employees. The federal Patient Protection and Affordable Care Act shares these building blocks.

2 Sharon K. Long, Karen Stockley, and Heather Dahlen. 2012. "Massachusetts Health Reforms: Uninsurance Remains Low, Self-Reported Health Status Improves as State Prepares to Tackle Costs." *Health Affairs*, vol. 31 no. 2, pp. 444–451.

The choices made regarding the Massachusetts individual mandate and its structure will have implications for the types of private health insurance purchased in the state and the consistency of benefit standards across the state's insurance markets. This in turn will have an impact on how insurance protects the state's consumers. These decisions not only will affect state revenues, particularly the collection of state penalties for noncompliance with the current requirements, but also will have implications for the state government's administrative burden associated with enforcement and collection of the penalties. The chosen approach will impact consumer costs in a number of ways: through the size and frequency of penalties imposed by state and federal governments combined, through differences in the coverage chosen to meet the mandate rules and associated differences in premiums and out-of-pocket costs, and through the administrative costs and confusion associated with residents' compliance with one or two sets of rules.

The federal rules will take effect on January 1, 2014, and cannot be modified under the law until at least 2017, when states can apply for a five-year waiver of certain health insurance requirements, including the individual mandate. Such waivers will be made conditional on the state's demonstrating both that its alternative approach leads to coverage at least as comprehensive as its choice of Essential Health Benefits under the ACA and that the waiver does not increase the federal budget deficit. Thus, although only state policies can be modified before 2017, the state should take into account the potential for modifying federal requirements after the initial three-year period of 2014–2016.

The Commonwealth's chosen policy approach for combining federal and state rules requires decision makers to balance an array of competing objectives, not all of which can be satisfied simultaneously. These include:

- Simplicity: Ensuring that the rules are clear and as simple as possible for the public to understand and comply with;
- Political feasibility: Maximizing political acceptability, for example, by prioritizing perceived fairness of penalties assessed and the impact on large and small employers in terms of the benefits their employees are likely to demand;
- Ease of implementation by state: Preventing an increase in the state's administrative burden in implementing the policies associated with the mandate;
- Impact on state revenues: Maintaining current state revenues of about $22 million annually; and
- Minimizing disruption to the state's current system, which has effectively increased insurance coverage and ensured a minimum level of benefits across all insurance markets since 2006.

As we describe possible policy approaches regarding the state mandate once the federal mandate is implemented, we assess their implications for each of these policy objectives. First, however, we describe the Massachusetts coverage requirement and the policies that underlie it and delineate how they differ from those included in the ACA.

# COMPONENTS OF THE INDIVIDUAL MANDATES AND HOW MASSACHUSETTS AND FEDERAL LAW DIFFER

Four policy components interact to form the individual mandate requirements in both the Massachusetts law and the federal law: the type of coverage required, the affordability standard, exemptions to the requirement, and the level of penalties imposed for noncompliance. Each is discussed here in turn. These policy components are summarized in Exhibit 1.

**EXHIBIT 1. POLICY COMPONENTS OF THE INDIVIDUAL MANDATE**

| POLICY COMPONENT | NATIONAL ACA | MASSACHUSETTS |
|---|---|---|
| TYPE OF COVERAGE REQUIRED | • To avoid the federal penalty related to the individual mandate under the ACA, nonexempt residents must maintain minimum essential coverage (MEC).<br>• Fully insured products sold to small employers and nongroup insurance products sold to residents must include Essential Health Benefits.<br>• Employer self-insured plans and large-group plans satisfy MEC without any requirement that they include Essential Health Benefits. Public insurance coverage (e.g., Medicaid and Medicare) also satisfies MEC.<br>• Those with grandfathered plans are exempt from the Essential Health Benefits requirement. | • To avoid the state penalty related to the MA individual mandate, all adults must enroll in minimum creditable coverage (MCC), regardless of the source of coverage.<br>• No exemptions from the MCC requirement are granted for grandfathered plans.<br>• MCC is automatically satisfied by public insurance coverage, student health coverage, and young adult plans held by eligible residents. |
| AFFORDABILITY STANDARD TO DETERMINE WHO IS SUBJECT TO THE COVERAGE REQUIREMENT | • Affordability exemptions are granted to those for whom the premium for the lowest-cost coverage option exceeds 8% of family income. | • Affordability exemptions vary with income, requiring lower shares of income to be spent for health insurance by those with lower incomes. The state's affordability schedules also vary by household configuration (single, couple, or family).<br>• For all those with incomes below 400% of the federal poverty level (FPL), the MA affordability schedule is more progressive than the ACA's affordability standard. |
| EXEMPTIONS TO THE COVERAGE REQUIREMENT | • Populations exempted: those with incomes below the income-tax-filing threshold, undocumented immigrants, Native Americans, those with religious objections, incarcerated people, those certified as having other economic hardships, and those who are without coverage for less than three consecutive months during the year (the exemption applies only to the first gap in coverage). | • Populations exempted: children, those with religious objections, those demonstrating financial hardship who are granted a Certificate of Exemption, and those who are without coverage for less than 90 days during the year. |

*continued*

**EXHIBIT 1. POLICY COMPONENTS OF THE INDIVIDUAL MANDATE** *continued*

| POLICY COMPONENT | NATIONAL ACA | MASSACHUSETTS |
|---|---|---|
| **LEVEL OF PENALTIES IMPOSED FOR NONCOMPLIANCE WITH THE COVERAGE REQUIREMENT** | • The federal penalty is determined as the greater of two values:<br>1. A flat dollar amount that in subsequent years increases with the cost of living, or<br>2. A percentage of the household's taxable income that is in excess of the tax-filing threshold equal to 1%, 2%, and 2.5% in 2014, 2015, and 2016 and beyond, respectively.<br>• If all MA residents were uninsured once the federal reforms were fully implemented and the penalties were fully phased in, approximately three-quarters of them would face a higher federal individual mandate penalty than a state penalty. | • The state penalty increases with income for the lowest-income groups. For those with incomes above 300% of the federal poverty level, the penalty also varies with age. The 2012 penalties are:<br>– Half the cost of the lowest-priced Commonwealth Care plan for those with incomes at or below 300% of the poverty level.<br>– Half the cost of the lowest-priced Commonwealth Choice plan for those with incomes above 300% of the poverty level. |

**Type of Coverage Required to Satisfy the Mandate.** Both Massachusetts and the ACA require that coverage meet particular standards in order to satisfy the individual mandate; however, their standards differ appreciably. The main differences arise in requirements for private insurance coverage.

To avoid the federal penalty under the ACA, residents who are not exempt from the federal individual mandate (as described below) must maintain minimum essential coverage (MEC). MEC does not include specific benefit requirements beyond the requirement that the plan primarily cover medical benefits. Several types of coverage are deemed automatically compliant with the MEC standard: government-sponsored insurance programs (Medicaid, Medicare, the Children's Health Insurance Program [CHIP], the veterans' health care program TRICARE, and coverage through the Peace Corps), self-insured and large-group employer-sponsored insurance (ESI),[3] and grandfathered plans (plans in effect on the date of enactment).[4] Beginning January 1, 2014, fully insured products sold to small employers and nongroup insurance products must include Essential Health Benefits as defined in the federal law and as implemented in each state in order to satisfy the MEC standard.[5] However, self-insured plans and large-group plans satisfy MEC *without* any requirement that they include the Essential Health Benefits. Thus virtually any large-group employer plan and any self-insured plan (regardless of employer size) will satisfy MEC under the

3 The ACA defines large-group, as of January 1, 2014, as 101 employees or more; however, states are permitted to define large-group as anywhere from 51 to 100 employees or more from January 1, 2014, until January 1, 2016. As of January 1, 2016, all states must be in compliance with the 101 employees or more definition.

4 In addition, the Secretary of Health and Human Services can deem other health benefits coverage, e.g., coverage through a state health benefits risk pool, as meeting MEC.

5 Center for Consumer Information and Insurance Oversight. 2011. "Essential Health Benefits Bulletin," December 16. http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

ACA. Those with grandfathered plans are also exempt from the Essential Health Benefits requirement and additional rules under the ACA as well.[6]

The Massachusetts law, however, requires *all* adults not exempt from the individual mandate requirement (as described below, children are not covered by the requirement) to enroll in minimum creditable coverage (MCC), regardless of the source of coverage. MCC includes requirements that a plan include at least some level of coverage for particular categories of medical services: ambulatory patient services, diagnostic imaging and screening, emergency services, hospitalization, prescription drugs, maternity and newborn care, medical/surgical care, mental health and substance abuse services, prescription drugs, and radiation therapy and chemotherapy. In addition, the MCC requirements, among other things, limit maximum annual deductibles and out-of-pocket spending for in-network care and prohibit limits or caps for prescription drug benefits and particular illness or annual benefits.[7] The Massachusetts MCC requirement is automatically met by public insurance coverage, by student health plan coverage, and by young adult plans held by eligible residents.[8] However, beyond public coverage and young adult plans, in order to meet the individual mandate requirements set forth by the state and thereby avoid any penalty, the coverage held by an adult must at least satisfy MCC.[9] The MCC requirements apply to all adults covered by private health insurance from any source, regardless of group size, self-insured plan status, or nongroup plan status. Massachusetts does not designate plans as "grandfathered," as the federal law does, so those with coverage pre-dating the 2006 reforms come under the MCC requirement as well.

**Affordability Standard.** Both the state and federal laws establish affordability standards whereby those unable to obtain insurance coverage deemed affordable by the respective statute are not subject to a penalty for remaining uninsured. The two affordability standards are not structured in the same way, however. Under the ACA, affordability exemptions to the coverage requirement are granted to those for whom the premium of the lowest-cost coverage option exceeds 8 percent of family income. Thus the federal affordability standard is a flat share of income, regardless of the income level of the household. For those with access to employer-sponsored insur-

---

6 Under the ACA, grandfathered plans are exempt from new rules regarding allowable deductibles for small-group plans, coverage of preventive services without cost sharing, a prohibition on taking health status into account when setting premiums, and limitations on premium age rating. Grandfathered plans do have to comply with the ACA's prohibition on lifetime dollar limits on coverage and with the requirement to offer coverage of dependent children to age 26; fully insured plans have to comply with the required minimum loss ratio regulations.

7 MCC Requirements Fact Sheet: Minimum Creditable Coverage (MCC) Requirements. 2012. https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/What%2520Insurance%2520Covers/MCC%2520Background/MCCRequirements.pdf

8 Code of Massachusetts Regulations, 956: Commonwealth Health Insurance Connector Authority. 2009. https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Regulations/documents/MCC%2520Regulation_956%2520CMR%25205%252000.pdf. The ACA includes availability of catastrophic plans in the individual market for adults under age 30 and for those deemed to have no affordable coverage available to them. These plans must provide the EHB, with at least three primary-care visits reimbursed prior to applying the deductible, which can be set as high as the Health Savings Account out-of-pocket maximum in 2014, and which will grow according to an index in succeeding years.

9 Health Connector. "Minimum Creditable Coverage Requirements." https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/What%2520Insurance%2520Covers/MCC%2520Background/MCCRequirements.pdf

ance, the lowest-cost employer-based premium available to them is used to determine whether affordable coverage is available. For those without access to employer-based coverage and who are ineligible for public insurance, the lowest-cost bronze plan available through the exchange in the resident's area is used as the benchmark for affordable coverage. If the household is eligible for premium tax credits through the exchange, the value of that credit is taken into account when computing whether affordable coverage is available.

The affordability standard under Massachusetts regulation, which determines who is subject to the coverage requirement, varies with income, requiring lower shares of income to be spent for health insurance by those with lower incomes.[10] In addition, the state's affordability schedules vary by household configuration (single, couple, or family). Although not required by statute, the schedules are currently linked to the premiums charged those of differing incomes and family configurations in Commonwealth Care, the state's subsidized insurance program for moderate-income residents without access to employer-sponsored insurance. Instead of standards pegged to particular incomes relative to the poverty level, the standards are dollar amounts determined by the Connector Board and consistent with available coverage through the Connector for subsidized or unsubsidized insurance.

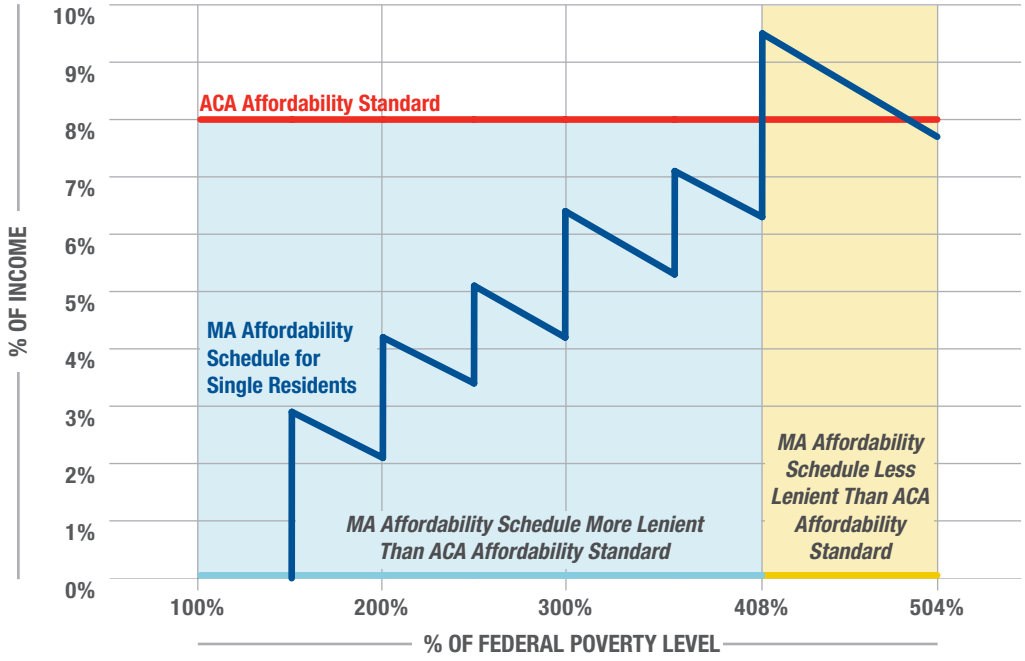
Exhibit 2 demonstrates how the federal affordability standard compares with the current Massachusetts standard for single residents, defined as either individuals who have no dependents or married individuals who file taxes separately and have no dependents.[11] (Similar information for couples and families is provided in the appendices to this report). For all of those with incomes below 400 percent of the federal poverty level (FPL), Massachusetts' affordability schedule is more progressive than the ACA's affordability standard (as signified by the pink bar along the axis measuring income relative to poverty). Thus Massachusetts currently requires that the state's residents who are not exempt from the coverage requirement pay less as a share of income than would be required under federal law in order to avoid a penalty. In general, for those with incomes above 400 percent of the FPL, the state requires that non-exempt residents pay a higher share of income than would be required under federal law in order to avoid a penalty.[12] In Massachusetts (in 2012), coverage is deemed affordable for all single residents with incomes above 504 percent of the FPL, couples with incomes above 588 percent of the FPL, and families with incomes above 625 percent of the FPL, while the 8 percent standard holds for all incomes under the ACA.

10 The affordability schedule by income group and family type for 2012 can be found at: https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/Individual/Affordability%2520Calculator/Connector%2520Affordability%2520Info%2520Sheet.pdf

11 Affordability Schedule and Premium Tables, Calendar Year (CY) 2012, Memorandum to Health Connector Board of Directors, July 20, 2012. https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/What%2520Insurance%2520Covers/Affordability%2520Background/2012/AffordabilityandPremiumScheduleFinal.pdf

12 One exception is that some individual Massachusetts residents with incomes just below 504 percent of the FPL would be required to pay slightly less as a share of income than under federal law to avoid a penalty.

**EXHIBIT 2. NATIONAL ACA PREMIUM AFFORDABILITY STANDARD VERSUS MA PREMIUM AFFORDABILITY SCHEDULE FOR SINGLE RESIDENTS IN 2012**




Source: Affordability Schedule and Premium Tables, Calendar Year (CY) 2012, Memorandum to Health Connector Board of Directors, July 20, 2012. https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/What%2520Insurance%2520Covers/Affordability%2520Background/2012/AffordabilityandPremiumScheduleFinal.pdf

**Exemptions from Penalties for Reasons Other than Lack of Affordable Access to Insurance.** The federal law includes an array of exemptions from the individual mandate and any penalties for noncompliance. Populations exempted by the federal law include those with incomes below the income-tax-filing threshold, undocumented immigrants, Native Americans, those with religious objections, incarcerated people, those certified as having other economic hardships, and those who are without coverage for less than three consecutive months during the year (the exemption applies only to the first gap in coverage). Massachusetts law exempts all children and those with religious objections, those demonstrating financial hardship who are granted a Certificate of Exemption, and those who are without coverage for less than 90 days during the year.

**Level of Penalty for Noncompliance.** As indicated above, the force behind the individual mandate is not, as the name might suggest, that residents are compelled to enroll in health insurance coverage. Rather, the requirement is that the resident must pay a penalty to the government if the mandate applies to them but they choose not to enroll in coverage. Both the federal requirement and the state requirement are structured in this way, but the level of the penalty differs between the two.

The federal penalty is determined as the *greater* of two values:

1. A flat dollar amount that is equal to $95, $325, and $695 per individual in 2014, 2015, and 2016 respectively and that will increase with the cost of living in subsequent years;[13] or
2. A percentage of the household's taxable income that is in excess of the tax-filing threshold equal to 1 percent, 2 percent, and 2.5 percent in 2014, 2015, and 2016 and beyond, respectively.

The penalty amount is capped at the national average premium of bronze-level qualified health plans available through state exchanges for the relevant household size.

The Massachusetts penalty for those with incomes below 300 percent of the federal poverty level is related to the lowest-priced plan offered in Commonwealth Care. For those with incomes at or above 300 percent of the poverty level, the penalty is related to the lowest-cost plan in the Commonwealth Choice program, the unsubsidized coverage available to individual and small-group purchasers through the Connector. The penalty increases with income for the lowest-income groups. For those with incomes above 300 percent of the poverty level, the penalty also varies with age. The 2012 penalties are:

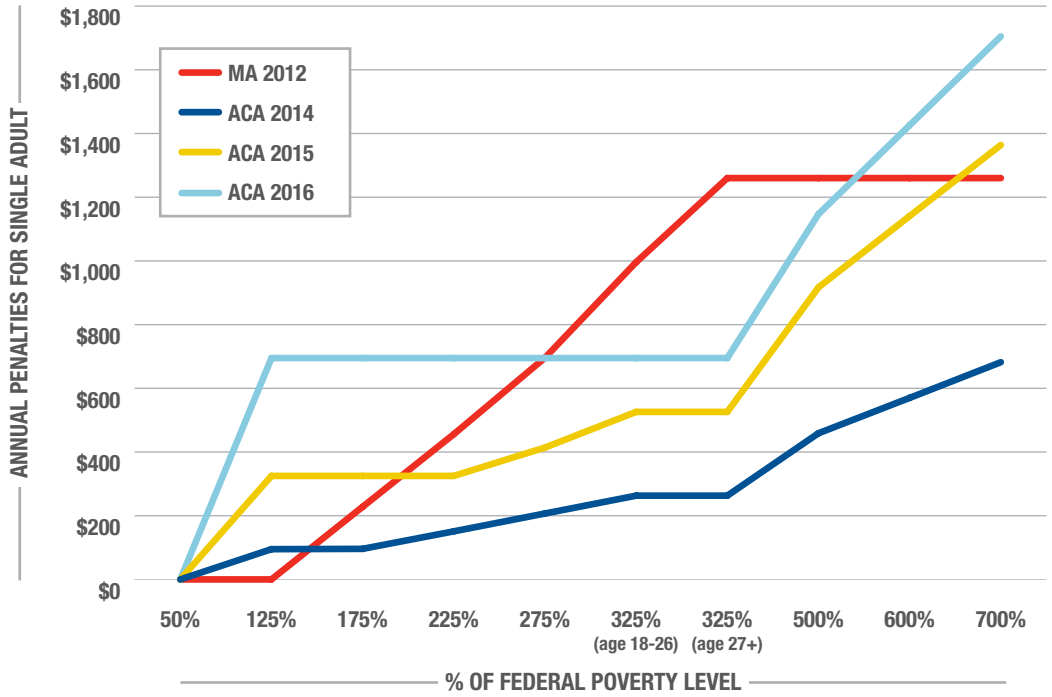
- Half the cost of the lowest-priced Commonwealth Care plan for those with incomes at or below 300 percent of the federal poverty level:
  - $0 for individuals in families with incomes of up to 150 percent of the federal poverty level;
  - $228 per adult per year for those with incomes of 151 to 200 percent of the federal poverty level;
  - $456 per adult per year for those with incomes of 201 to 250 percent of the poverty level; and
  - $696 per adult per year for those with incomes of 251 to 300 percent of the poverty level.
- Half the cost of the lowest-priced Commonwealth Choice plan for those with incomes above 300 percent of the federal poverty level:
  - $996 per year for individuals aged 18–26 earning more than $32,676 (half the premium of the lowest-priced young adult insurance plan excluding prescription drug coverage);
  - $1,260 per year for individuals 27 and older earning more than $32,676 (half of the lowest-priced bronze-level coverage including prescription drug coverage).

In some cases, the federal penalty for going without coverage will be higher than the state penalty, and in other cases, the reverse will be true. Exhibit 3 compares the federal individual

13 The penalty for dependents under 18 years of age is half of the flat dollar amount penalty for an adult, and the flat dollar amount for a family is capped at three times the flat dollar penalty for one adult.

mandate penalties for a single adult at different income levels in 2014, 2015, and 2016 with the Massachusetts penalties in 2012. Simulations with the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) suggest that the potential federal penalty (in 2016 when fully phased in) will exceed the potential state penalty for 74 percent of Massachusetts families. In other words, if all residents became uninsured once the federal reforms are fully implemented and the penalties are fully phased in, approximately three-quarters of them would face a higher federal individual mandate penalty than a state penalty. The likelihood that the federal penalty will be higher than the state penalty is greater for those with incomes below the state's median than it is for those with incomes above the median (87 percent versus 61 percent, respectively).

**EXHIBIT 3. NATIONAL ACA INDIVIDUAL MANDATE PENALTIES FOR TAX YEARS 2014, 2015, AND 2016, AND MASSACHUSETTS INDIVIDUAL MANDATE PENALTIES FOR TAX YEAR 2012 (ANNUAL PENALTIES FOR SINGLE ADULTS)**




Source: TIR 12-2: Individual Mandate Penalties for Tax Year 2012, accessed October 15, 2012. http://www.mass.gov/dor/businesses/help-and-resources/legal-library/tirs/tirs-by-years/2012-releases/tir-12-2.html

Note: Penalty amounts are based on noncompliance for the entire year. MA penalties for couples who do not comply with the individual mandate rules will equal the sum of single penalties for the two spouses, regardless of dependents. MA penalties will increase over time as well, but since the size of the increases is not known at this time, they are not shown here.

# MASSACHUSETTS POLICY OPTIONS ONCE THE FEDERAL INDIVIDUAL MANDATE IS IN PLACE

As the state prepares for full implementation of the ACA in January 2014, state policymakers are considering whether and how to change provisions related to the Massachusetts coverage requirement. An array of options exists, including complete repeal of the state requirement, preservation of the state requirement as it is currently structured, and modification of the state mandate's structure. We present these options below and discuss their advantages and disadvantages.

## COMPLETE REPEAL OF THE MASSACHUSETTS INDIVIDUAL MANDATE

Repealing the state requirement once the federal mandate is in effect would provide the simplest way to reconcile differences between the state and federal laws. This straightforward approach could bolster public support for the remaining elements of the state law. While public support for the 2006 Massachusetts law is currently high—63 percent of Massachusetts residents polled in 2011 said that they supported it[14]—support might ebb in response to two separate mandate requirements that appear redundant. In addition, two sets of rules operating simultaneously could cause confusion among Massachusetts residents. Perhaps more important, the duplicative requirements could increase penalties for noncompliance to levels not envisioned under either statute.

However, repealing the state mandate would also eliminate the revenue the state obtains from its penalty. The Massachusetts Department of Revenue reported that the penalty provided over $21 million in revenue to the state in Fiscal Year 2011 and over $22 million in Fiscal Year 2012.[15] The state uses these funds to support the Commonwealth Care Trust Fund. In addition, repeal would eliminate the state requirement that adult residents obtain insurance coverage meeting the standards delineated in the MCC rules. As explained above, the MCC standard applies much more broadly than the federal Essential Health Benefits standard and extends to all those with private coverage, regardless of whether the coverage is obtained as a fully insured or self-insured product and whether it is purchased through a small group, through a large group, or in the nongroup market.

Even if Massachusetts repeals the state mandate and the related benefit standards, the state will retain these benefit standards for certain plans through provisions of the ACA. The ACA gives states flexibility in choosing the benchmark for the Essential Health Benefits that are required of individually purchased plans and fully insured small-group plans. The Massachusetts Depart-

14 Robert J. Blendon, Gideon Gil, Gillian K. Steel Fisher, Johanna R. Mailhot, and Kathleen J. Weldon. 2011. Harvard School of Public Health/Boston Globe. Massachusetts Health Reform Law 2011. May 24–26. http://www.hsph.harvard.edu/news/press-releases/files/blendon_topline_6.6.11.pdf

15 Amy A. Pitter. Commonwealth of Massachusetts Department of Revenue. Monthly Report of Collections and Refunds, June 2012. Run date: 8/17/2012. http://archives.lib.state.ma.us/bitstream/handle/2452/127813/ocn425960269-2012-06.pdf?sequence=1

ment of Insurance has selected the state's largest small-group plan, which is also the state's largest HMO plan, as the benchmark for its Essential Health Benefits. By choosing the most popular small-group plan, Massachusetts policymakers ensured that a plan consistent with the benefits in the current MCC will be subsumed into the state's Essential Health Benefits benchmark plan. From 2014 on, this standard will continue to apply to individually purchased plans in Massachusetts as well as small-group fully insured plans.[16] Without the Massachusetts mandate and its MCC standard, however, plans offered by large employers (now defined as firms of 51 or more workers but increased to 101 or more workers as of 2016 unless the state opts to expand the definition of the small-group market sooner) and self-funded group plans would not be required to comply with a particular benefit standard.[17] The combination of the Massachusetts state individual mandate and the MCC benefit standards currently creates a strong incentive for large-group and self-funded plans to provide a plan with at least the MCC benefits. Without that combination, there would be no way to encourage large-group or self-funded plans to choose MCC benefits, and some might reduce benefits below the current MCC standards.

Additionally, there is some uncertainty about how the Essential Health Benefits requirement will operate after 2015, as the proposed federal regulatory approach applies only to the first two years of the ACA's full implementation. Thus the state's ability in later years to maintain an MCC-like standard through an Essential Health Benefits benchmark plan is not clear.

It is also unclear, however, how attractive it would be for large employers and self-funded plans to reduce their benefits in the absence of an MCC standard, and whether the 2006 state reforms led to significant changes in benefits relative to what was being provided prior to implementation of the MCC-related benefit requirements. If plans were already providing these benefits, by and large, prior to the state's reform, or if consumers have found value in the benefits provided since, there is likely to be little impetus for those plans to change the benefits they offer in 2014, even if employers have greater flexibility to make changes. However, ever-increasing health care costs could lead to benefit reductions over time in the absence of MCC, particularly if new cost-containment efforts prove unsuccessful.

Federal ACA regulations have yet to clarify whether a state can choose to require all health plans operating in its small-group and nongroup markets to provide the specific benefits of its chosen Essential Health Benefits benchmark, as opposed to allowing plans in those markets to provide benefits that are merely actuarially equivalent to the chosen benchmark plan. If the state does not have that option, then eliminating the state's individual mandate and associated MCC requirement could affect the types of coverage provided in small firms and the individually purchased market as well as in large and self-insured firms. For example, MCC requires that coverage have no limits or caps on prescription drug coverage, whereas the federal Essential Health Benefits prohibits only dollar limits on such coverage, allowing caps on the number of prescriptions cov-

16 The EHB exemption for grandfathered plans under the ACA should be irrelevant in Massachusetts, since previously purchased plans in the small-group and individual markets are already consistent with MCC and, by extrapolation, with the new EHB benchmark plan.

17 The ACA does, however, require large-group and self-funded plans to comply with a number of other requirements, including prohibitions on lifetime and annual dollar limits on benefits, a prohibition on rescissions of coverage except in cases of fraud, and first-dollar coverage of certain preventive benefits.

ered. Also, the MCC requirements include some cost-sharing limits that are not necessarily consistent with the ACA's limits, and Essential Health Benefits definitions do not address cost-sharing issues, although small-group and nongroup plans are required to comply with the actuarial value levels defined elsewhere in the law.[18] For example, "according to minimum creditable coverage (MCC) standards, if a health benefit plan includes deductibles or co-insurance for in-network core services, the plan must set out-of-pocket maximums for in-network covered services that do not exceed $5,000 for an individual and $10,000 for a family." These amounts are much lower than the cost-sharing limits that are likely under the ACA. For example, while the ACA specifies that the out-of-pocket limit for covered services for a family of four with income of 250 percent of the FPL ($57,625 in 2012) would be one-half of the Health Savings Account (HSA) law limit, or $5,950 using the 2012 HSA limit, a federal bulletin describing likely federal regulations suggested that maximum out-of-pocket limits for individuals with income between 250 and 400 percent of FPL are not likely to be reduced from the HSA limits, and would thus be set at the full HSA limit, which is $11,900 for a family in 2012.[19]

Additional consequences of dropping the MCC flow from the fact that Massachusetts does not currently regulate the definition of stop-loss coverage—the reinsurance that small employers must typically purchase in order to reduce the risk of self-insuring their employees. The state also does not prohibit employers below a particular size from purchasing stop-loss coverage. Therefore, without a state MCC standard in place, small employers in Massachusetts might have an increased incentive to self-insure, thereby avoiding the ACA's Essential Health Benefits requirement and allowing healthier small employers to opt out of the modified community rating pool in the state's SHOP exchange. An ability to avoid the ACA's Essential Health Benefits requirement (which, as noted previously, could largely replicate the MCC standard for small employers) could increase the incentive to exit the fully insured small-employer risk pools. With self-insurance being most attractive to healthier small groups, such a dynamic could trigger a worsening of risk in the fully insured market, resulting in an increasing average premium for those remaining in the merged market. Options to mitigate this threat in the absence of a state MCC standard include prohibiting stop-loss for some or all small employers and limiting the incentive for small employers to self-insure by ensuring that the "minimum attachment point" for reinsurance is not set so low as to create an incentive to exit the fully insured market.[20]

In summary, we consider how eliminating the Massachusetts individual mandate relates to each of the policy objectives delineated earlier:

---

18 Fully insured, non-grandfathered small-group and nongroup plans must have an actuarial value of 90 percent, 80 percent, 70 percent, or 60 percent unless they are a catastrophic plan for those up to age 30. Deductibles for these plans cannot exceed $2,000 for individuals and $4,000 for families in 2014.

19 CCIIO, Actuarial Value and Cost-Sharing Reductions Bulletin. http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.

20 Some states regulate employer stop-loss insurance by establishing "minimum attachment points." A minimum attachment point is based on enrollment at time of contract and expected claims cost per enrollee, and can refer to individual enrollees' claims or to the group's claims in aggregate. The employer must incur claims equal to the minimum attachment point before being reimbursed by its stop-loss insurance. Higher minimum attachment points increase the risk an employer must bear in order to self-insure, dissuading more small employers from doing so. See also Mark A. Hall. "Regulating Stop-Loss Coverage May Be Needed to Deter Self-Insuring Small Employers from Undermining Market Reforms." *Health Affairs*, February 2012, vol. 31 no. 2, pp. 316–323. http://content.healthaffairs.org/content/31/2/316.full

1. Simplicity for the public: This approach ranks high on simplicity, leaving one set of federal rules in place for households to learn and follow.

2. Political acceptability: This approach is politically attractive in that it eliminates the possibility of double assessments. Horizontal equity (i.e., equity across households with the same income) would be similar to that under current law; however, the vertical equity achieved by the progressive affordability standard across income levels under the state's mandate would be eliminated. As for political acceptability to employers, small employers may feel it is unfair that small-group plans have to comply with Essential Health Benefits while large employers and self-funded employers will no longer be compelled to offer coverage meeting the standards delineated in the MCC rules.

3. Ease of state administration: This approach would decrease the current administrative burden on the state by eliminating the need to monitor and enforce compliance with the components of the state mandate.

4. Impact on state revenues: Eliminating the state mandate would also eliminate all revenues collected by the state under the current policy.

5. Minimizing disruption of the current system: This approach ranks the lowest for this objective among the policy options described. It risks potential changes in the type of coverage offered by employers and held by individuals, particularly among large employers and small employers that could be affected by increased incentives to self-insure. Lower penalties for households in some income ranges under the federal rules could potentially decrease overall rates of insurance coverage as well, depending upon how household decisions are made.

### MAINTAIN THE MASSACHUSETTS INDIVIDUAL MANDATE AS CURRENTLY STRUCTURED, OPERATING SIMULTANEOUSLY WITH FEDERAL REQUIREMENTS

Keeping the state's individual mandate in place alongside the federal mandate beginning in 2014 would avoid all of the concerns detailed above that are associated with the elimination of the MCC standard. However, the potential for double penalties could be widely perceived as being unfair or overly punitive. The different penalties and their application under different circumstances—for example, an individual could satisfy the federal requirements but still face a state penalty—could create significant confusion, particularly if the federal government pursues strong public outreach and education related to the federal law as 2014 approaches. Relying on federally provided information, some households might believe they are complying with all relevant laws when in fact they are not meeting state requirements. Explaining the intersection of the two sets of rules and their components to a broad audience is likely to be challenging.

Specifically, relating to the five policy objectives:

1. Simplicity for the public: This approach ranks low, as it imposes two separate sets of rules on households, leading to potential confusion and complexity in compliance.

2. Political acceptability: The approach ranks low on this measure as well, as it will lead to double penalties for some families, reducing perceived fairness relative to today. This approach does not differ from the current approach in terms of equity across and within levels of income.

3. Ease of state administration: Administration would be similar to that under current Massachusetts law, except that some additional interactions related to public confusion are likely to occur.

4. Impact on state revenues: State revenues are unlikely to change appreciably.

5. Minimizing disruption of the current system: This approach ranks high in maintaining the strong state incentives to enroll in coverage and comply with the MCC standards, as it leaves current Massachusetts requirements in place in their entirety.

## MAINTAIN THE MASSACHUSETTS MANDATE STRUCTURE BUT REDUCE STATE PENALTIES BY ANY AMOUNT PAID FOR FEDERAL PENALTIES

This policy option differs from the previous one in that it reduces any state individual mandate penalties an individual or family owes by the amount that the tax unit owes to the federal government for the ACA's individual mandate penalties. Residents for which the federal penalty exceeds the state penalty would only face the federal penalty. Those whose state penalty exceeds the federal penalty would pay the federal penalty and pay the state the amount by which the state penalty exceeds the federal penalty. In the latter case, federal plus state payments equal the original computed state penalty.

Under this approach, if the resident enrolls in coverage that satisfies the federal requirements but does not meet Massachusetts requirements (e.g., the policy purchased does not satisfy the MCC standard), the resident owes the full state penalty. In this way, the state's standards would not be undermined, and no one would pay more in aggregate than the greater of the federal or state computed amount.

While this strategy addresses the issues of fairness and maintenance of state standards, confusion over having two sets of individual mandate rules would likely occur. Taxpayers would still need to compute penalty amounts for both the state and federal penalties on their tax forms, and they would have to compute the federal amount before the state amount to accurately determine the amount owed. In addition, this approach is likely to significantly reduce the revenue currently collected by the state through the penalty.

Assessing this approach on the five policy objectives:

1. Simplicity for the public: This approach does not score high marks on this measure, as it includes two separate sets of rules with which individuals are expected to become familiar and comply. In addition, considering that state penalties can be offset with federal payments, computing the appropriate penalty amounts is likely to be somewhat confusing for taxpayers.

2. Political acceptability: The approach is more political acceptable than the second option, above, because it ensures that no household would be required to pay the full federal penalty plus the full state penalty at its current level.

3. Ease of state administration: Offsetting state penalty amounts with federal amounts increases perceived fairness for households, but it creates additional administrative complexity for state agencies, particularly the Massachusetts Department of Revenue. State penalty

amounts calculated on state income tax forms would have to be validated using information from filers' federal penalty payments, a process not necessary today.

4. Impact on state revenue. State revenue from noncompliance penalties can be expected to decline significantly under this approach.

5. Minimizing disruption of the current system. This option maintains the full requirements associated with the state's individual mandate: Those not obtaining coverage that meets the MCC standards would pay the same amount in penalties as they do under Massachusetts law prior to the ACA, although in some instances at least part of the penalty amount would be paid to the federal government. Thus the strength of financial incentives to comply with state rules remains the same, and there should be no noticeable difference in household coverage decisions under this approach.

## MAINTAIN THE MASSACHUSETTS INDIVIDUAL MANDATE BUT MODIFY ONE OR MORE OF ITS COMPONENTS

If the state's individual mandate is preserved in order to maintain the MCC standards, any number of the 2006 law's other component parts—the affordability standard, the exemptions, the level of the penalties—could be modified to be consistent with the ACA mandate. Such increased consistency could reduce resident confusion, particularly as more information regarding federal reform and its requirements is disseminated as 2014 approaches.

**The Affordability Standard.** In general, adopting the federal affordability standard would require more Massachusetts residents to obtain coverage or pay a penalty than does current state law alone. Those with incomes below 300 percent of the federal poverty level who are not eligible for Medicaid face higher premium spending as a percentage of income thresholds before coverage is deemed unaffordable according to the federal standard than they do under the current state standard. When 2012 Massachusetts Commonwealth Care and Commonwealth Choice premiums are used to compute state affordability thresholds, most individuals with incomes between 138 and 400 percent of the FPL face maximum premium contributions of less than 8 percent of income (the federal standard). The differences in the maximum payments are large for those at the lower end of that income group. Exhibit 4 shows the percentage point differences between the federal and state schedules defining the maximum percent of income to be spent on premiums. For example, individuals with incomes of 250 percent of the FPL could pay up to 4.6 percentage points more of their income for premiums under the federal standard than under the state standard; couples and families at 250 percent of the FPL could, respectively, pay up to 3.1 and 4.1 percentage points more of their income under the federal standard.

**EXHIBIT 4. COMPARISON OF FEDERAL ACA AND MA PREMIUM AFFORDABILITY SCHEDULES IN 2012 BY FAMILY CONFIGURATION (PERCENTAGE POINT DIFFERENCE IN % OF INCOME)**

| SINGLES | | COUPLES | | FAMILIES | |
|---|---|---|---|---|---|
| % FPL | PERCENTAGE POINT DIFFERENCE IN AFFORDABILITY STANDARDS BY % INCOME | % FPL | PERCENTAGE POINT DIFFERENCE IN AFFORDABILITY STANDARDS BY % INCOME | % FPL | PERCENTAGE POINT DIFFERENCE IN AFFORDABILITY STANDARDS BY % INCOME |
| 100.0% | 8.0% | 100.0% | 8.0% | 100.0% | 8.0% |
| 150.0% | 8.0% | 150.0% | 8.0% | 150.0% | 8.0% |
| 150.1% | 5.1% | 150.1% | 3.8% | 150.1% | 4.6% |
| 200.0% | 5.9% | 200.0% | 4.8% | 200.0% | 5.5% |
| 200.1% | 3.8% | 200.1% | 1.8% | 200.1% | 3.1% |
| 250.0% | 4.6% | 250.0% | 3.1% | 250.0% | 4.1% |
| 250.1% | 2.9% | 250.1% | 0.5% | 250.1% | 2.1% |
| 300.0% | 3.8% | 300.0% | 1.8% | 300.0% | 3.1% |
| 300.1% | 1.6% | 300.1% | -0.5% | 300.1% | 0.1% |
| 360.0% | 2.7% | 374.0% | 1.2% | 398.0% | 2.0% |
| 360.1% | 0.9% | 374.1% | -1.1% | 398.1% | -1.4% |
| 408.0% | 1.7% | 446.0% | 0.4% | 511.0% | 0.7% |
| 408.1% | -1.5% | 446.1% | -2.6% | 511.5% | -2.6% |
| 504.0% | 0.3% | 588.0% | -0.1% | 625.0% | -0.7% |

Source: Affordability Schedule and Premium Tables, Calendar Year (CY) 2012, Memorandum to Health Connector Board of Directors, July 20, 2012. https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/What%2520Insurance%2520Covers/Affordability%2520Background/2012/AffordabilityandPremiumScheduleFinal.pdf

The effect that changing the state affordability standard to the national one would have is strongly related to the decision (not discussed here in detail) of whether the state will supplement the federal premium subsidies, since these are less generous than the current subsidies available through the Commonwealth Care program for those with incomes between Medicaid eligibility and 300 percent of the FPL. If the state adopts the Basic Health Plan (BHP) option for those with incomes at or below 200 percent of the FPL, enrollees in this coverage option would have low premium costs, with those premiums subsidized by federal funds. In such a circumstance, if the state decides to provide additional subsidies for premiums and/or cost sharing beyond that provided by the federal government, the money would be targeted to those with incomes between 200 and 300 percent of the FPL without access to employer-based coverage.[21] Such additional

21 All states' decisions regarding the BHP option have been complicated by the fact that the federal government has yet to issue regulations detailing specifics of how the program will work, most importantly how the federal payment for BHP enrollees will be determined. It remains unclear when such regulations will be issued. Therefore, if the BHP option is not chosen or is not available owing to a lack of federal guidance, in order to maintain current levels of subsidization for Commonwealth Care enrollees, Massachusetts would have to finance additional assistance for low-income exchange enrollees with incomes below 200 percent of the FPL as well.

subsidies, combined with a BHP similar in nature to Commonwealth Care, would substantially reduce the practical effect of raising the state's affordability threshold to 8 percent across all income groups. However, those with access to employer-based insurance whose income falls below 400 percent of the FPL would still face affordability thresholds higher than those currently in place in Massachusetts. In order to avoid a penalty, these individuals could be required to enroll in employer-based coverage that would have been deemed unaffordable under current rules. New policies that provide state-financed subsidization of coverage for such individuals could be considered as well, in order that these individuals not face higher financial burdens under the federal affordability guidelines. While providing subsidies to low-income individuals with employer offers would increase horizontal equity within the system, treating those in similar financial situations more similarly, such a change would make more people eligible for generously subsidized coverage than are eligible today and would increase state government costs.

The decision about whether to offset state penalty liability with federal penalty payments also affects the impact of switching to the federal affordability standard. More Massachusetts residents could face a penalty for choosing not to enroll in "affordable" coverage under federal guidelines than would have faced a penalty under the state affordability schedule. However, if their state penalty is offset by their federal penalty payments, many will be paying the new federal penalty but will owe no additional payments to the state as a consequence of the new affordability schedule.

**Exemptions.** Massachusetts could choose to make the categories of individuals exempt from the state mandate consistent with the categories of those exempt from the federal mandate. For example, Massachusetts could eliminate the state exemption for children and also the state Certificate of Exemption process, opting instead to rely upon federal determinations of financial hardship. Also, the state could exempt undocumented persons, the incarcerated, and Native Americans. None of these changes is likely to have a substantial impact on state coverage or penalty revenue. While the state should consider the impact on residents of losing the state's discretion to grant Certificates of Exemption, any state exemption would not affect federal penalties, and eliminating the state process would reduce administrative burdens on the state.

The state could also make its exemption for those not satisfying the mandate for three months or less consistent with the federal rule. The ACA's exemption applies only to the first three-month lapse in coverage. Creating a consistent set of exemptions would, again, reduce confusion, and the effects on coverage are unlikely to be substantial.

**Penalty Levels.** Massachusetts could choose to make the penalty levels faced by those not complying with its own mandate consistent with those imposed by the ACA. Combining this approach with decreasing the state penalties by the amount of any federal penalties owed would mean that the state would receive revenues only from residents who enrolled in coverage that satisfied the federal mandate but not the state mandate (i.e., if the private coverage in which the person enrolled did not meet MCC requirements). This approach would make only one penalty computation necessary, and confusion would be significantly reduced. It weakens the incentive to comply with MCC when the federal penalty is lower than the current state penalty, but strengthens the incentive when the federal penalty is higher. In addition, this approach would substantially reduce state penalty revenue.

If the state does not decrease its residents' penalty liability by the amount paid for federal penalties, Massachusetts residents whose state penalty equals their federal penalty would pay the amount of the penalty twice—once to the federal treasury and once to the state.

It is unclear whether Massachusetts residents who face lower penalties under the federal schedule than under the current state schedule would change their coverage decisions if the state were to adopt the federal penalty levels and offset any state penalty with the federal penalty amount. Massachusetts is now the only state with a coverage mandate, and thus research is not available to shed light on the extent to which coverage decisions respond to the level of the penalties. If the primary force behind the change in behavior is a cultural shift toward the expectation that almost all residents have coverage, then this change in approach should not substantially decrease coverage in the state.

To summarize in terms of the five policy objectives:

1. Simplicity for the public: Any steps taken to reduce differences between federal and state rules will create clarity and ease the burden of compliance. Even offsetting state penalty payments with federal payments would be simplified if the state's penalty amount was set to match the federal amount.

2. Political acceptability: Changes in the state's affordability standard, exemptions, and penalty levels are likely to create political resistance among those who would be expected to pay or purchase more as a consequence. Some will gain and some will lose, depending upon the changes made, leading to a variety of political responses. For example, while changing the affordability standard to correspond to the federal rules will require more households to buy coverage or pay a penalty than under current Massachusetts law, coverage rates are already high, so the actual number of people affected is likely to be small. However, the current state affordability standard is progressive, increasing vertical equity, as it is linked to the levels of progressive subsidization for those with incomes below 300 percent of the federal poverty level. If that level of subsidization is not continued once the ACA is fully implemented, and if the affordability standard is made less progressive to match federal rules, this is likely to create political opposition from advocates for low-income households. In another example, some residents who do not obtain coverage today would face smaller penalties under federal rules than under state, generating savings for some if the state penalty payments are offset by federal payments, reducing potential opposition from those individuals.

3. Ease of state administration: The changes would require that new rules be written by the Connector Authority and other agencies, staff be retrained, and systems reprogrammed to implement the new approaches. Additionally, as was noted in an earlier option, if state penalties are offset by taxpayers' payments for federal penalties, systems must be established to validate those calculations.

4. Impact on state revenues: Of the options presented in this section, equalizing the level of state and federal penalties would have the largest impact in reducing state revenues, particularly if state penalties are offset by federal payments. Using the federal affordability standard would tend to increase the number of people potentially facing a penalty for remaining uninsured, but the number affected may not be large and thus may not appreciably affect revenues.

Some revenues under these options would be expected to decline, such as revenue from state penalties if these are offset by federal penalties. But some state revenues would remain consistent or increase slightly, for example if the state adopted the federal affordability standard, which would require more residents to obtain coverage or pay a penalty.

5. Minimizing disruption to the current system. While improving consistency between state and federal rules allows the state to maintain its MCC requirement, the strength of the incentives to comply will differ from today if households face different penalty levels, affordability standards, and exemption rules. It is not clear, given limited experience with these types of reforms, how much these modifications to incentives will change individual coverage decisions, but they are likely to lead to at least some changes from the decisions made under current state law. All of the policy options presented and their advantages and disadvantages are summarized in Exhibit 5.

## EXHIBIT 5. MASSACHUSETTS POLICY OPTIONS ONCE THE FEDERAL INDIVIDUAL MANDATE IS IN PLACE

| OPTIONS | ADVANTAGES | DISADVANTAGES |
|---|---|---|
| **REPEAL OF THE MA INDIVIDUAL MANDATE REQUIREMENT** | • Limits confusion for state residents who would otherwise have to comply with two coverage mandates.<br>• Administratively simple. | • State revenue would decrease.<br>• Loss of MCC benefit standards for all non-exempt adults.<br>• Loss of benefit standards of any kind for self-insured and large-group employer plans.<br>• Loss of benefit standards applicable to all private plans, which, in combination with the state's lack of regulation of stop-loss coverage, could potentially increase the incentive to self-insure and opt out of the small-employer exchange. |
| **MAINTAIN THE MA INDIVIDUAL MANDATE AS CURRENTLY STRUCTURED, WITH POSSIBLE OFFSETTING OF STATE PENALTY BY FEDERAL PENALTY AMOUNT** | • Retains MCC benefit standards for all adults not exempt from the state mandate.<br>• Retains MCC benefit standards for self-insured and large-group employer plans.<br>• No double penalties if federal penalty payments offset state payments, and no one would pay more in aggregate than the greater of the federal or state penalty. | • Confusion over two sets of penalties.<br>• Significant reduction in state revenue from reduced state penalty payments.<br>• Double penalties for some if state penalty payments are not offset by federal penalty payments. |
| **MAINTAIN BUT MODIFY THE MA INDIVIDUAL MANDATE ...** | | |
| **... ADOPTING THE FEDERAL AFFORDABILITY STANDARD** | • Limits confusion for state residents who would otherwise have to comply with two affordability standards. | • More state residents would likely pay penalties because fewer would have coverage options deemed unaffordable.<br>• Those who are non-exempt and have incomes <300% FPL could face higher premiums to avoid penalty, particularly if BHP and state subsidies to enhance federal subsidies are not implemented.<br>• Presents administrative challenges for the Connector Authority, other agencies, and the DOR if the system must validate state penalties offset by federal penalties. |
| **... ADOPTING FEDERAL EXEMPTIONS** | • Consistent exemption standards would reduce confusion.<br>• Federal exemption for only the first 3-month lapse in coverage leaves less opportunity for individual to game the system.<br>• Effect on coverage is likely to be minimal. | • Loss of state discretion to grant Certificates of Exemption. |
| **... EQUAL STATE AND FEDERAL PENALTY LEVELS AND OFFSETTING STATE PENALTY WITH FEDERAL PENALTY AMOUNT** | • No double penalties.<br>• Only one penalty computation is necessary.<br>• Effect on coverage is likely to be modest, though uncertainty remains. | • Significant reduction in state revenue from reduced state penalty payments since state penalty is collected only when coverage choice satisfies federal but not state mandate.<br>• Effect on coverage decisions is uncertain—e.g., will fewer of those facing lower penalties under federal rules than under state enroll in coverage? |

# CONCLUSIONS

The Commonwealth of Massachusetts has a variety of possible policy options related to how its individual mandate should be structured after the federal requirement takes effect on January 1, 2014. In this paper, we identify three major policy options for addressing the differences between the state and federal mandates and discuss their advantages and disadvantages, particularly with respect to five specific policy objectives.

The first approach, repeal of the state mandate, offers the least confusing policy option for Massachusetts residents, who would then be required to comply with only the federal mandate. This approach would also be the least administratively burdensome for state government, which, under most of the other options, would need to coordinate penalty amounts between state and federal tax returns. However, Massachusetts has already achieved the highest rate of insurance coverage in the country under its current individual mandate and subsidization structure. Elimination of the state's mandate could disrupt the coverage gains that have been achieved and benefit standards that have been established over the last six years.

Minimizing changes to the current structure can be achieved through either the second approach, maintaining the state mandate in place in its current form, or the third approach, maintaining the state requirement with modifications. Either approach will increase the likelihood that the high coverage and consistent benefit levels will be maintained once the ACA is fully in place but is likely to create additional complexity for households and state administration, and may impact state revenue collection and political acceptability. In addition to maintaining the state's level of insurance coverage overall, minimizing disruption to the current system means ensuring consistent and comprehensive insurance protection across all of the state's insurance markets. The state's current Minimum Creditable Coverage (MCC) benefit standards have benefit and cost-sharing requirements that differ in important ways from the standards inherent in the ACA's Essential Health Benefits guidelines, which may not ensure that the highest-need, highest-cost consumers receive predictable and adequate insurance protection.[22] Moreover, the MCC standards apply to all insured adults in the state, enhancing consistency and predictability in coverage from the consumer perspective and reducing the incentives for self-insurance among small employers, which could lead to adverse selection in the small-group insurance market. This contrasts with the more limited applicability of benefit standards under the ACA. The more components of the state's own individual mandate that are kept in place over time, the more certain the state is to maintain the character of coverage that Massachusetts has established since 2006.

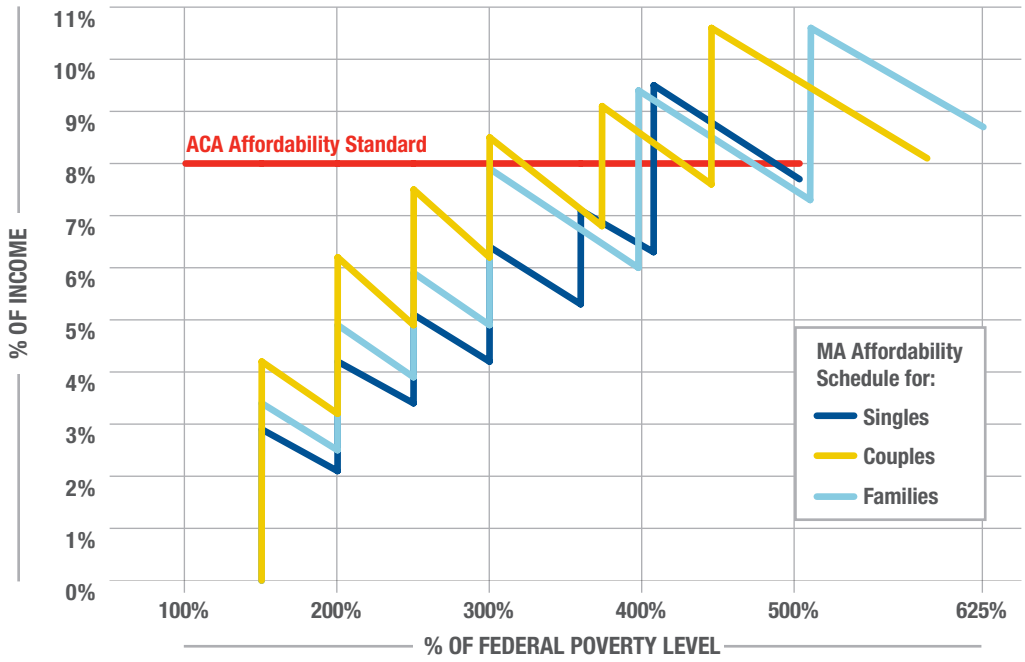
There is no way to perfectly accommodate all of the competing priorities in the short run, since the state must wait three years before it is able to request a waiver of certain federal rules in order to meet state objectives. Nevertheless, the federal penalties are lower in the early years of

22 Lisa Clemans-Cope, Linda J. Blumberg, Judy Feder, and Karen Pollitz. 2012. "Protecting High-Risk, High-Cost Patients: 'Essential Health Benefits,' 'Actuarial Value,' and Other Tools in the Affordable Care Act." *Timely Analysis of Immediate Health Policy Issues*, June. http://www.urban.org/UploadedPDF/412588-Protecting-High-Risk-High-Cost-Patients.pdf

federal implementation of the ACA, and the high rates of coverage in Massachusetts imply that a relatively small number of residents will encounter the penalties. This suggests that Massachusetts could benefit from maintaining some of the state's individual mandate structures in the first years of the ACA's implementation, to ensure greater stability in private insurance markets and to see how coverage and benefit levels are changing in other, similar states, particularly those aggressively implementing reforms. The flexibility starting in 2017 would likely allow the state to move toward a single set of rules, possibly incorporating the state's current MCC standards. Such an approach would, however, require the state to take steps to simplify the burden on residents of complying with multiple overlapping provisions during the transition period. No matter what choices the state makes to reconcile the state and federal individual mandates, the level of uncertainty about both consumer responses and how the federal law will be carried out means that the choices are likely to require ongoing evaluation and consideration.

# APPENDICES

## APPENDIX 1. NATIONAL ACA PREMIUM AFFORDABILITY STANDARD VERSUS MA PREMIUM AFFORDABILITY SCHEDULES BY FAMILY CONFIGURATION IN 2012




Source: Affordability Schedule and Premium Tables, Calendar Year (CY) 2012, Memorandum to Health Connector Board of Directors, July 20, 2012. https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/What%2520Insurance%2520Covers/Affordability%2520Background/2012/AffordabilityandPremiumScheduleFinal.pdf.

## APPENDIX 2. MA PREMIUM AFFORDABILITY SCHEDULES BY FAMILY CONFIGURATION IN 2012

| SINGLES | | COUPLES | | FAMILIES | |
|---|---|---|---|---|---|
| % FPL | % INCOME | % FPL | % INCOME | % FPL | % INCOME |
| 100.0% | 0.0% | 100.0% | 0.0% | 100.0% | 0.0% |
| 150.0% | 0.0% | 150.0% | 0.0% | 150.0% | 0.0% |
| 150.1% | 2.9% | 150.1% | 4.2% | 150.1% | 3.4% |
| 200.0% | 2.1% | 200.0% | 3.2% | 200.0% | 2.5% |
| 200.1% | 4.2% | 200.1% | 6.2% | 200.1% | 4.9% |
| 250.0% | 3.4% | 250.0% | 4.9% | 250.0% | 3.9% |
| 250.1% | 5.1% | 250.1% | 7.5% | 250.1% | 5.9% |
| 300.0% | 4.2% | 300.0% | 6.2% | 300.0% | 4.9% |
| 300.1% | 6.4% | 300.1% | 8.5% | 300.1% | 7.9% |
| 360.0% | 5.3% | 374.0% | 6.8% | 398.0% | 6.0% |
| 360.1% | 7.1% | 374.1% | 9.1% | 398.1% | 9.4% |
| 408.0% | 6.3% | 446.0% | 7.6% | 511.0% | 7.3% |
| 408.1% | 9.5% | 446.1% | 10.6% | 511.5% | 10.6% |
| 504.0% | 7.7% | 588.0% | 8.1% | 625.0% | 8.7% |
| ABOVE 504% | Affordable | ABOVE 588% | Affordable | ABOVE 625% | Affordable |

Note: % FPL indicates household income as a percentage of the federal poverty level. % Income indicates the percentage of income that is deemed affordable for the household to pay in insurance premiums. Affordable indicates that households at that level of income are defined as being able to afford coverage.

Source: Affordability Schedule and Premium Tables, Calendar Year (CY) 2012, Memorandum to Health Connector Board of Directors, July 20, 2012. https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/What%2520Insurance%2520Covers/Affordability%2520Background/2012/AffordabilityandPremiumScheduleFinal.pdf