Individual Mandate

REPORT OF THE INDIVIDUAL MANDATE WORKING GROUP

NOVEMBER 1, 2018

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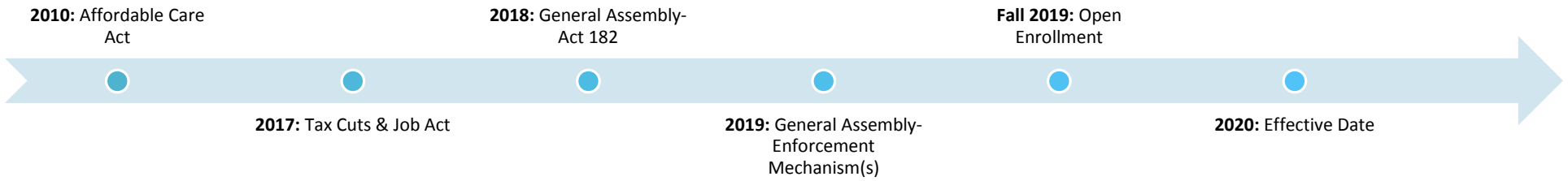
Introduction: Individual Mandate Timeline



- **2010:** Affordable Care Act (ACA) established an "individual mandate" requiring most Americans to have a basic level of health insurance beginning January 2014
- **2017:** Tax Cuts and Jobs Act (TCJA) removed the penalty associated with the federal individual mandate effective 2019
- **2018:** General Assembly passed Act 182 establishing an individual mandate in Vermont and a Working Group to provide recommendations regarding administration and enforcement of the individual mandate[1]
- **2019:** Pursuant to Act 182, enforcement mechanism(s) "should be enacted" to inform Vermonters' coverage decisions during fall 2019 open enrollment[2]
- **2020:** Individual mandate effective in Vermont[3]

[1] Section 3 of Act 182 of 2018
[2] Ibid, Section 2
[3] Ibid, Sec. 5

Introduction: The Working Group

Membership

- Agency of Human Services (Adaline Strumolo)
- Department of Financial Regulation (Emily Brown)
- Department of Tax (Doug Farnham)
- Green Mountain Care Board (Robin Lunge)
- Office of the Health Care Advocate (Mike Fisher)
- Blue Cross and Blue Shield of Vermont (Sara Teachout)
- MVP (Susan Gretkowski)

Meetings

- Seven Meetings; Members also did research and proposal development outside of public meetings
- Facilitator approach: Agendas and meetings led by most relevant organization
- Public Comments: accepted at each meeting; online; public comment period on the draft report (September 28 – October 12)

Introduction: The Working Group

Resources

- Staff from membership's organizations: including insurers' actuarial departments
- State Health and Value Strategies: Jason Levitis[1]
- Colleagues in other states
- Federal Issues Working Group resources[2]

Principles & Process

Recommendations should:

- Focus on maintaining Vermont's low uninsured rate
- Strive to be practical: balance the complexity of health care policy, administrative burden and Vermonters' best interests
- Include alternatives to present different perspectives/priorities

[1] Jason Levitis is a health policy expert focusing on the Affordable Care Act's (ACA's) tax provisions and state innovation waivers. He provides technical assistance to states in partnership with State Health and Value Strategies. He is also a nonresident fellow at the Brookings Institution and a senior fellow at Yale Law School's Solomon Center for Health Law and Policy. Until January 2017 he led ACA implementation at the U.S. Treasury Department.
[2] The Federal Issues Working Group is a stakeholder group of Vermont organizations that responds to changes in federal health care policy

Introduction

The Working Group was unable to come to consensus on an enforcement mechanism as well as two exemptions. This report attempts to provide a fair and balanced presentation of approaches.

- There was consensus that there should be a continued focus and additional emphasis on outreach about health care coverage as a key mechanism to maintain and increase coverage and that improved monitoring and timeliness of data on the uninsured was a good idea.
- Not all members of the Working Group, however, believed that these efforts alone are sufficient to maintain and increase coverage.
- Several members of the Working Group believe that a financial penalty, modeled largely on the federal penalty, with some Vermont modifications is an appropriate enforcement mechanism for a state individual mandate. This is similar to the approaches used in NJ and DC.
  - This subgroup agrees that there should be a flat affordability exemption similar to DC, but does not agree on the income level.
  - Blue Cross Blue Shield of Vermont objects to exempting members of health care sharing ministries.
- The Green Mountain Care Board did not take a position.

What is a mandate

What is a mandate: Overview and Goal

The federal individual mandate and associated enforcement mechanism was one component of an overall strategy in the Affordable Care Act for achieving widespread health insurance coverage. Act 182 of 2018 created this Working Group to recommend administration and enforcement of a state individual mandate to have health insurance beginning in 2020. Goals of an individual mandate include:

- **Increase Enrollment:** require enrollment for those who can access coverage, while exempting those who cannot.
- **Adequate Coverage**: create a uniform standard for health insurance to ensure that Vermonters have certain services and limits on cost-sharing.
- **Lower Premiums:** spread risk throughout a larger population, enabling lower premiums for everyone.
- **Market Stability:** ensure that people maintain coverage over time, not just when they have health needs.

What is a mandate: Components

What is the mandate in Vermont

- A state requirement to have health insurance, which begins in 2020

What qualifies as health insurance

- Most health care coverage qualifies, with the exception of insurance plans that are not meant to provide complete coverage. This is called "minimum essential coverage." The recommendation is to maintain the federal definition of minimum essential coverage in effect on Dec. 31, 2017, with a process at the Department of Financial Regulation to expand the definition if necessary.

Who is required to have health insurance in Vermont

- Most Vermonters unless they qualify for an "exemption." The recommendation is to adopt the exemptions defined in federal law, with some modifications to reflect state administration or policy preferences.[1] The administration of exemptions is tied to the enforcement mechanism.

How is a mandate enforced

- As noted in Slide 6 above, there is not consensus in this area.
  - There was consensus that there should be a continued focus and additional emphasis on outreach about health care coverage as a key mechanism to maintain and increase coverage and that improved monitoring and timeliness of data on the uninsured was a good idea.
  - Not all members of the Working Group, however, believed that these effort alone are sufficient to maintain and increase coverage.
  - Several members of the Working Group believe that a financial penalty, modeled largely on the federal penalty, with some Vermont modifications is an appropriate enforcement mechanism for a state individual mandate.

[1] There is not consensus on the affordability or religious conscience exemption. See Exemption section for details.

What we know about Vermont

Item	All returns	Federal Income Tax Returns: 2016 Data[1, 2] Size of adjusted gross income: Under $1 [1]	$1 under $10,000	$10,000 under $25,000	$25,000 under $50,000	$50,000 under $75,000	$75,000 under $100,000	$100,000 under $200,000	$200,000 under $500,000	$500,000 under $1,000,000	$1,000,000 or more
FPL Level	1		<84%	84% - 210%[1,2,3]	210% - 421%[2,3]	421% - 631%	631% - 842%	842% - 1684%	1684% - 4209%	4209% - 8418%	>8418%
	2		<62%	62% - 156%[1,2,3]	156% - 312%[2,3]	312% - 468%[3]	468% - 624%	624% - 1248%	1248% - 3121%	3121% - 6242%	>6242%
	3		<50%	50% - 124%[1,2,3]	124% - 248%[1,2,3]	248% - 372%[2,3]	372% - 496%[3]	496% - 992%	992% - 2480%	2480% - 4960%	>4960%
	4		<41%	41% - 130%[1,2,3]	103% - 206%[1,2,3]	206% - 309%[2,3]	309% - 412%[3]	412% - 823%	823% - 2058%	2058% - 4115%	>4115%
# of Vermont returns	325,860	5,850	50,030	61,570	82,690	46,050	30,140	38,750	9,050	1,210	520
	100%	**2%**	**15%**	**19%**	**25%**	**14%**	**9%**	**12%**	**3%**	**0%**	**0%**
# of returns w/ penalty	10,590	**	** 30	3,160	5,070	1,480	470	290	70	** 10	**
$ of penalty	$7,346,000	-	$ 18,000	$ 1,607,000	$ 2,967,000	$ 1,328,000	$ 573,000	$ 570,000	$ 225,000	$ 58,000	-
	3.2%		**0%**	**30%**	**48%**	**14%**	**4%**	**3%**	**1%**	**0%**	**0%**

Program Eligibility Thresholds

- [1]Medicaid: up to 138% FPL
- [2]Vermont Premium Assistance: up to 300% FPL
- [3]Federal Premium Tax Credit: up to 400% FPL

- Categories not broken down by household size, makes definitive conclusions more difficult
- $10,000 - $25,000: Many family sizes should be eligible for Medicaid
- $25,000 - $50,000: Some family sizes should be eligible for Medicaid, federal Advance Premium Tax Credit or Vermont premium assistance.

[1] 2016 Report on Individual Income and Tax Data, Vermont

[2] As a result of confusion about the federal tax rules, the figures above include substantial numbers of erroneous payments by Medicaid-eligible families who were in fact exempt. The issue was detected, and the IRS took steps to correct it, including refunding payments, but the results of those efforts are not reflected above.

What we know about Vermont

Item	All returns	under $10,000	$10,000 under $25,000	$25,000 under $50,000	$50,000 under $75,000	$75,000 under $100,000	$100,000 under $200,000	$200,000 under $500,000	$500,000 or more
		Federal Income Tax Returns: 2015/2016 Vermont Data[1, 2] Delta between 2015 and 2016 Size of adjusted gross income							
FPL Level	1	<84%	84% - 210%[1,2,3]	210% - 421%[2,3]	421% - 631%	631% - 842%	842% - 1684%	1684% - 4209%	4209% - 8418%
	2	<62%	62% - 156%[1,2,3]	156% - 312%[2,3]	312% - 468%[3]	468% - 624%	624% - 1248%	1248% - 3121%	3121% - 6242%
	3	<50%	50% - 124%[1,2,3]	124% - 248%[1,2,3]	248% - 372%[2,3]	372% - 496%[3]	496% - 992%	992% - 2480%	2480% - 4960%
	4	<41%	41% - 130%[1,2,3]	103% - 206%[1,2,3]	206% - 309%[2,3]	309% - 412%[3]	412% - 823%	823% - 2058%	2058% - 4115%
# of returns subject to penalty	-2,290	-10	-920	-950	-270	-80	-80	0	0
% change	**-18%**	**-25%**	**-23%**	**-16%**	**-15%**	**-15%**	**-22%**	**0%**	**0%**
$ of penalty	$ 1,242,000	$ 9,000	$ 520,000	$ 581,000	$ 137,000	$ 13,000	$ -48,000	$ 20,000	$ 10,000
% change	**20%**	**100%**	**48%**	**24%**	**12%**	**2%**	**-8%**	**10%**	**21%**

Program Eligibility Thresholds

- [1]Medicaid: up to 138% FPL
- [2]Vermont Premium Assistance: up to 300% FPL
- [3]Federal Premium Tax Credit: up to 400% FPL

- Penalty increased from 2015 ($325/adult) to 2016 ($695/adult)

[1] 2016 Report and 2015 Report, Individual Income and Tax Data, Vermont

[2] As a result of confusion about the federal tax rules, the figures above include substantial numbers of erroneous payments by Medicaid-eligible families who were in fact exempt. The issue was detected, and the IRS took steps to correct it, including refunding payments, but the results of those efforts are not reflected above.

What we know about Vermont

Table One: Maintenance Population[1] Approximate Percent of Members Projected to Drop Coverage							
Income Range	Age Band						
	LT18	**18-26**	**26-35**	**35-45**	**45-55**	**GT55**	**Total**
Below 200% FPL	8%	7%	5%	5%	4%	2%	4%
200% to 250% FPL	12%	12%	11%	11%	8%	4%	8%
250% to 300% FPL	13%	11%	10%	10%	8%	3%	7%
300% to 400% FPL	11%	11%	9%	9%	7%	3%	7%
Above 400% FPL	41%	38%	40%	37%	27%	13%	25%
Total	25%	13%	10%	11%	10%	5%	9%

Table One: Maintenance Population Demographics of population projected to drop coverage as a result of removing the individual mandate penalty.

Table Two: Recruitment Population Demographics of population uninsured in 2014; federal individual mandate penalty was in effect.

Table Two: Recruitment Population[2] Uninsured Rate by Age and FPL (2014)									
Breakdown by Age									
Age	**0-17**	**18-24**	**25-34**	**35-44**	**45-64**	**65+**	**TOTAL**		
% uninsured	1.0%	4.6%	**11.0%**	5.1%	3.7%	0.3%	**3.7%**		
Change from 2012 to 2014	-1.5%	-6.9%	-7.2%	-2.1%	-2.5%	0.0%	**-3.1%**		
Breakdown by FPL									
FPL Level	**Below 139%**	**139%-150%**	**151%-200%**	**201%-250%**	**251%-300%**	**301%-350%**	**351%-400%**	**Above 400%**	**TOTAL**
% uninsured	5.0%	3.2%	**5.8%**	**5.7%**	4.2%	5.4%	2.0%	2.0%	**3.7%**
Change from 2012 to 2014	-4.6%	-11.4%	-7.4%	-2.3%	-5.4%	-1.1%	-1.7%	-1.3%	**-3.1%**

[1] Lewis & Ellis Individual Mandate Report: considers financial determinants and does not include non-financial considerations such as risk aversion, health status, pending legislation (Act 182 of 2018) or compliance accountability.
[2] Vermont Household Health Insurance Survey 2014: 2018 results not available at time of report submission. 2018 results expected to be roughly similar to 2014, with a slightly lower uninsured rate overall and a statistically lower rate for those with Incomes <139% FPL.

What we know about Vermont

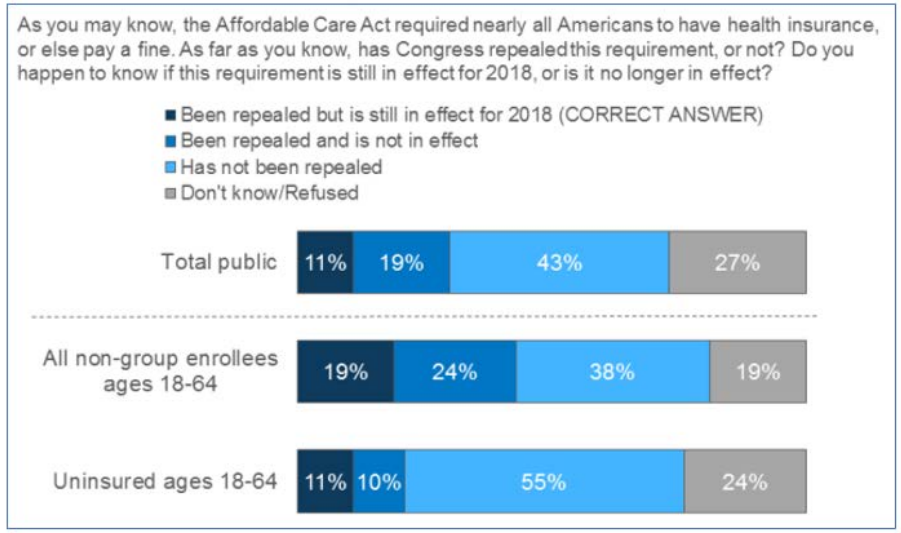
2019: In their individual and small group filings, BCBSVT and MVP each requested a 2.0% rate increase due to the elimination of the federal penalty, approximately a $9.8 million impact on overall total premium. The approved rates allowed for a 1.6% increase, resulting in an overall total premium impact of approximately $7.9 million.

Impact on 2019 Individual and Small Group Premiums

Carrier	# of Lives	Filed		Approved	
		Rate	Premium Impact	Rate	Premium Impact
Blue Cross/Blue Shield[1]	52,591	2.00 %	$ 6,954,599	1.60%	$ 5,563,679.15
MVP[2]	25,223	2.00 %	$ 2,891,984	1.60%	$ 2,313,587.42
			$ 9,846,583		**$ 7,877,266.58**

Beyond 2019: The status of the individual mandate penalty is unclear to many Americans at this time. As individuals develop a clearer understanding of the federal penalty's status over time, enrollment and premiums may be impacted.

Public Confusion regarding status of the Individual Mandate[3]



*Source: Kaiser Health Tracking Poll - March 2018: Non-Group Enrollees

[1] Blue Cross and Blue Shield of Vermont 2019 Individual and Small Group Filing
[2] MVP 2019 Vermont Health Connect Filing
[3] Kaiser Health Tracking Poll- March 2018: Non-Group Enrollees

What we know from studies

The Working Group reviewed 47 pieces of literature on the topic of the Individual Mandate.[1]

Efforts to conceptualize and measure the impact of an individual mandate, particular to the United States and the Affordable Care Act are:

1. New and relatively few in number.
2. Based largely on the overall impact of the individual mandate policy, with a small minority extrapolating the impact of the individual mandate penalty as enforcement mechanism.
3. The literature consulted for this review presents substantial evidence that the ACA and Massachusetts health care reforms as larger policy packages are correlated with a decrease in the national and Massachusetts uninsured rates, emphasizing the significant impact of Medicaid expansion and premium subsidies.
4. There is a range of estimates, based on empirical research and analysis, for the impact of a mandate with a penalty. There is little evidence about the impact of a mandate without a penalty.

[1] A full list of literature is available in the Resources section.

What qualifies as health insurance

MINIMUM ESSENTIAL COVERAGE

What qualifies as health insurance: Overview and Goal

- Act 182 of 2018 establishes the Vermont individual mandate in 32 V.S.A. §10452 and includes a definition of what qualifies as health insurance, called "minimum essential coverage." The Act directs the Working Group to review minimum essential coverage (MEC) and suggest recommendations.
- Act 182 adopted the federal definition in 26 U.S.C. §5000A and related regulations, as in effect on December 31, 2017. This includes coverage provided by employers, the military, Medicare, and Medicaid.[1]
- The goal of minimum essential coverage is to create a uniform standard for health insurance to ensure that Vermonters have certain services and limits on cost-sharing. Insurance coverage may be more comprehensive than this standard.

[1] Limited Medicaid coverage, such as Ladies First, would not qualify.

What qualifies as health insurance:
Minimum Essential Coverage- Federal Definition

Qualifies	Does Not Qualify
Employer Sponsored Coverage	Americorps
Individual Market Health Insurance • Any metal level plan purchased through the Health Insurance Marketplace • Student Health Plans • "Grandfathered" non-ACA compliant plan that has been in force since March 23, 2010 or earlier	Coverage consisting solely of excepted benefits • Accident and disability policies • Stand alone vision care or dental care • Worker's compensation • Critical illness or specific disease policies
Medicare	Short Term Limited Duration Insurance (STLDI)
Medicaid	
Children's Health Insurance Program (CHIP)	
VA Coverage	
Tricare	

What qualifies as health insurance: Recommendations

The Working Group recommends the following:

- Modify 32 V.S.A. §10451 to ensure that the federal guidance in effect on December 31, 2017, is incorporated into the MEC definition and not subsequent federal updates or changes.
  - Suggested amendment: (3) "Minimum essential coverage" shall have the same meaning as in 26 U.S.C. § 5000A~~, as amended, and as in effect on December 31, 2017,~~ and any related regulations and federal guidance, as in effect on December 31, 2017.

- Provide the Department of Financial Regulation (DFR) authority to consider and deem new forms of coverage or health insurance products as MEC, using the criteria established in federal law and guidance.

- The Working Group does not recommend adding or excluding other forms of coverage to the MEC definition.

What qualifies as health insurance: Considerations

Maintaining the federal MEC definition will:

- Provide consistency to policyholders with existing MEC
- Maintain high standards for health insurance coverage satisfying the state individual mandate
- Ensure individuals will not be subject to different state and federal definitions regarding MEC

What qualifies as health insurance:
Process Highlights

The Working Group considered two issues in making its recommendations:

1. Adding AmeriCorps health insurance coverage to the state MEC definition. The Working Group did not ultimately adopt this modification because these individuals are very likely to be exempt from the enforcement mechanism, if any.
2. Whether the definition should explicitly exempt or include association health plans (AHP).
   - The Working Group looked at whether coverage offered by AHPs should be considered MEC
   - As currently proposed under Department of Financial (DFR) rules, fully insured AHPs would be required to offer coverage that meets the federal coverage requirements for MEC
   - Self-insured AHPs were not discussed as DFR rules are not yet published

Who is required to have health insurance

EXEMPTIONS

Who is required to have health insurance: Overview and Goal

- This section considers who should and should not be required to have health insurance. Act 182 directs the Working Group to develop recommendations for “exemptions” from compliance with the individual mandate. If an individual is eligible for an exemption, any enforcement would not apply to them.
- The goal is to encourage enrollment for those who can access coverage, while exempting those who cannot.
- People may not be able to access coverage for reasons of eligibility for health insurance, religious conscience, hardship, or affordability.

Who is required to have health insurance: Recommendations

The Working Group explored exemptions from a policy perspective, agnostic of enforcement mechanism. The Working Group recommends the following:

- Adopting the federal exemptions in effect in statute, regulation and guidance as of December 31, 2017, and as applicable in Vermont, with some modifications and caveats detailed in the next slide.

- Determining the administration of exemptions if the legislature enacts an enforcement mechanism. To the extent exemptions are administered, the Working Group recommends the following:
  - Honor all federal exemptions issued to individuals based on the criteria above.
  - Review exemptions at point and time of enforcement (i.e. retrospectively), including hardship applications through a state application process.
  - Do not establish a program to grant prospective exemptions. The United States Department of Health and Human Services (HHS) is continuing to issue exemption certificates at this time. The Working Group also determined that both federally and in Massachusetts, very few prospective exemptions were requested. Accordingly, the administrative burden of a prospective approach did not seem to be advisable.

Who is required to have health insurance:
Recommendations- Modifications from ACA

Affordable Care Act (ACA) Exemption	Initial Recommendation for Vermont Modification	How to Obtain
Short coverage gap Individuals should be exempt if they went without coverage for *less than three* consecutive months during the year.	Proposed Vermont modification would extend it to *3 months or less*, bringing the exemption in line with allowable Short Term Limited Duration Insurance time period.	Point of enforcement
Citizens living abroad and certain non-citizens Exempt US citizens who spend most of their time in a foreign country and non-US citizens. These individuals are generally not eligible for health care in Vermont.	The ACA addresses citizenship but not state residency. Proposed modification is to also exempt non-VT residents.	Point of enforcement
Incarceration exemption Exempts individuals who are in jail, prison or similar penal institution or correctional facility after the disposition of charges	None	Point of enforcement
Religious Conscience Exemption Exempts members of federally-designated and approved religious sects and health care-sharing ministries pursuant to 26 U.S.C. §5000A(d)(2)(A) and (B). This is a narrow exemption-that only applies to a limited group, such as the Amish. Health care-sharing ministries must be approved by HHS and have been in existence since 1999.	Most Working Group members recommend maintaining the ACA interpretation. BCBSVT recommends removing members of health care-sharing ministries from this exemption. GMCB does not have a position.	Point of enforcement
Hardship Exempts people who have experienced circumstances that prevented them from obtaining coverage. Examples may include: homelessness, eviction, foreclosure, fire, flood, bankruptcy, domestic violence, death of a close family member, or unpaid medical bills.	CMS has issued guidance with a variety of hardship exemptions, some of which apply in Vermont. Initial recommendation is to issue Vermont-specific guidance including individualized affordability issues and a list of events that are presumed to cause a hardship.	State application; or use of HHS exemption certificate
Income is below the income tax filing threshold Exempt if income is below the income tax filing threshold.	The ACA exemption is based on IRS tax filing threshold. Proposed modification is to base on Vermont tax filing threshold.	Point of enforcement
Affordability exemption Exempts people for whom health care coverage is considered unaffordable.	See enforcement section for options. The Working Group does not have consensus on a recommendation.	Point of enforcement

Who is required to have health insurance: Considerations

If the legislature enacts an enforcement mechanism, the recommended approach to exemptions would:

- Largely, maintain consistency with the Affordable Care Act so Vermonters who are currently exempt will remain so
  - Most of the Working Group members recommend maintaining the ACA's narrow interpretation of the religious conscience exemption which is specific to members of federally-designated religious sects and health care-sharing ministries. This would maintain the status quo.
  - BCBSVT recommends removing these ministries from the exemption, because they do not offer insurance to their members.
- Modify some exemptions where it is practical and logical for state-level administration (e.g. non-residents)
- Align with state policy where applicable (e.g. short term limited duration insurance)
- Minimize, to some extent, potential administrative burden

Who is required to have health insurance: Process Highlights

- The Working Group considered all the exemptions under the ACA including implementing regulations and guidance.
- The Working Group heard testimony and received public comment related to the religious conscience exemption, including a request to expand the exemption to include Christian Scientists, similar to Massachusetts.

How is a mandate enforced

ENFORCEMENT MECHANISM

How is a mandate enforced: Legislative Charge

Act 182 of 2018 Sec. 2. PENALTY FOR FAILURE TO MAINTAIN MINIMUM ESSENTIAL COVERAGE; LEGISLATIVE INTENT

"It is the intent of the General Assembly that the individual mandate to maintain minimum essential coverage established by this act should be enforced by means of a financial penalty or other enforcement mechanism and that the enforcement mechanism or mechanisms should be enacted during the 2019 legislative session in order to provide notice of the penalty to all Vermont residents prior to the open enrollment period for coverage for the 2020 plan year."

How is a mandate enforced: Overview and Goal

As noted earlier, the Working Group was unable to come to consensus on an enforcement mechanism. **Therefore, this section first outlines area of consensus among the group. It then details two sets of options regarding enforcement.**

Despite the lack of consensus, the common goals among Working Group members are to:

- Encourage people to purchase and maintain health insurance coverage and to help keep the number of uninsured individuals low.
- Spread risk and lower premium costs through widespread enrollment in health insurance coverage, among both healthy and less healthy individuals.
- Stabilize the health insurance market.

How is a mandate enforced:
Consensus Overview

The Patient Protection and Affordable Care Act (ACA) established multiple policies to support health care coverage for more Americans:

- Insurance market reforms, including guaranteed issue, community rating, and a ban on preexisting condition exclusions
- Subsidies to make health insurance coverage affordable and Medicaid expansion
- Individual mandate

With ACA implementation, the uninsured rate in the United States has fallen.

There is a range of information about whether any one policy is more or less responsible for this reduction in uninsured.

Therefore, it is important to continue to emphasize the importance of coverage through outreach and to continue to monitor the market for enrollment changes.

How is a mandate enforced:
Consensus Overview

There is consensus that there should be a continued focus and additional emphasis on outreach about health care coverage as a key mechanism to maintain and increase coverage and that improved monitoring and timeliness of data on the uninsured is a good idea.

Not all members of the Working Group, however, believe that these efforts alone are sufficient to maintain and increase coverage.

The following slides detail two sets of options regarding enforcement[1].

1. Some members of the Working Group believe that a financial penalty, modeled largely on the federal penalty, with some Vermont modifications is an appropriate enforcement mechanism for a state individual mandate.
2. Some members do not support a financial penalty to enforce the mandate and instead recommend enhanced outreach and monitoring of the uninsured.

[1] The Green Mountain Care Board did not take a position.

Modified Federal Penalty

Modified Federal Penalty: Overview

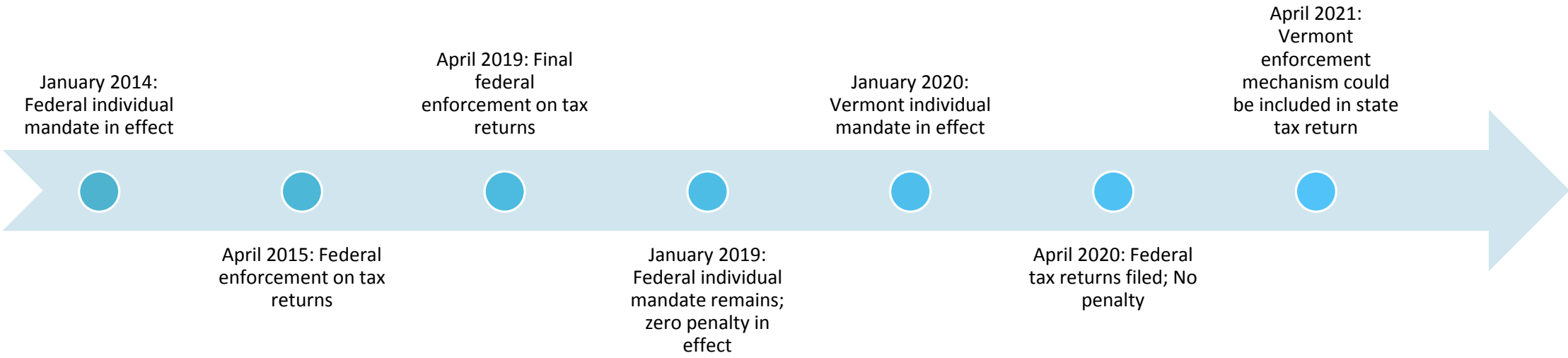
A Vermont income tax penalty at the 2018 federal level ($695 or 2.5% of income over filing threshold with a cap; prorated for months uninsured and ½ for children) administered though the state income tax structure with the following recommended modifications:

- Use taxpayer Adjusted Gross Income to measure household income for federal poverty level (FPL) calculations for simplicity
- Provide a flat exemption for families below a certain income in the range of 200-400% FPL
  - The Working Group discussed using the Dr. Dynasaur qualification threshold (317% FPL approximately) but did not reach consensus on this level
- Use federal calculation for the affordability exemption (no more than 8.3% of household income) for families above the threshold
- Cap the penalty amount at the lowest-cost state Bronze plan, not the national average
  - Under the ACA, the national average of the lowest cost bronze plans is used as a cap, but the federal government is not expected to continue to do this calculation after 2018.

Modified Federal Penalty: Considerations

Pros	Cons
Familiar to public and government officials	Administrative burden and new cost to state
Policy continuity with the Affordable Care Act, which maintains the ACA's policy integrity and allows the state to leverage federal guidance, etc.	Penalizes Vermonters who fail to purchase health insurance coverage
Studied actuarial impact	Trade offs exist between complexity and the desire to protect individuals from negative consequences
Provides revenue to offset administrative costs and potentially increase subsidies	Impacts relatively few individuals compared with the level of administrative effort
Increases information available to do outreach to individuals without coverage	Limited impact as a solution to address remaining uninsured
Similar to other states' efforts (MA, NJ, DC)	Proponents of a financial penalty could not find consensus on an affordability threshold, choosing rather to provide a range for policymakers to consider

Modified Federal Penalty: Timeline



Modified Federal Penalty: Administration

Administer the penalty as part of the state income tax system and:

- Allow taxpayers to attest on the income tax form that they have coverage that meets MEC or that they have circumstances meeting an exemption with audits to determine compliance
  - State hardship exemptions will require an application and documentation to determine if the circumstances meet the state guidance on a case-by-case basis. This would require collaboration between Tax and the Department of Vermont Health Access (DVHA).
- Authorize Tax and DVHA to share information for outreach and enrollment purposes
- Provide that the state will discontinue enforcement if the federal penalty is reinstated in the future to avoid double payment of a penalty (similar to MA)
- Subject to federal permission, offer a special enrollment period for individuals impacted by the penalty, which allows them to enroll in health insurance immediately to avoid payment in the subsequent year
- Use any revenue generated by a penalty toward efforts to support coverage (see slide 46 for examples)

Increased Outreach and Monitoring of the Uninsured

Increased Outreach and Monitoring: Overview

Continued focus and additional emphasis on outreach about health care coverage as a primary mechanism to maintain and increase coverage

- Emphasize the responsibility Vermonters have to maintain health care coverage – that not having insurance negatively impacts the greater community; promote a "taste for compliance," leveraging Vermont's socially responsible culture.
- For 2019, concentrate on increases in premium subsidies, relative value of non-silver plans, and option for unsubsidized members to enroll in reflective silver plans outside of the marketplace; the positive impact of subsidies on the uninsured rate has been documented.
- Utilize DVHA's In-person Assister Program and the marketplace's 200 Assisters to continue to engage uninsured Vermonters, help them enroll in coverage, and provide data that will inform future enrollment assistance efforts.

Improve monitoring and timelines of data on the uninsured

- Utilize an annual survey, such as the Behavioral Risk Factor Surveillance System (BRFSS), to monitor any changes in Vermont's uninured rate, both overall and by specific demographics.
- DVHA will monitor, and report on, enrollment data collected through the marketplace.

Increased Outreach and Monitoring: Considerations

A financial penalty would be costly to administer and may disproportionately impact economically vulnerable Vermonters. The harm created by implementing a penalty could outweigh any positive impact it will have on Vermont's healthcare market.

There is no agreement in the literature that the individual mandate with a penalty strongly influences people's coverage decisions. Studies address the overall impact of the individual mandate policy, with a small minority extrapolating the impact of the penalty as an enforcement mechanism.

What is clear in the research is that the policy package of subsidies, guaranteed issue, and a requirement to have coverage work together to increase enrollment. Some authors cite a stronger influence from subsidies and Medicaid expansion.

Therefore, this recommendation is to continue to focus on emphasizing the importance of coverage for Vermonters through outreach and continue to closely monitor the market for attrition or other trends that could warrant further action.

Increased Outreach and Monitoring: Considerations

Pros	Cons
Does not penalize Vermonters and families or exacerbate the benefits cliff	No state-based enforcement mechanism to replace federal one
Focuses on other means of encouraging enrollment and stabilizing marketplace	Actuarial predictions that additional families leave the marketplace
Does not require implementation of a complex, new cost program, impacting a small population	Insurance premiums increased by 1.6% in 2019 for the impact of the penalty repeal
Saves resources required to implement complex program	
Monitoring may facilitate more nuanced policy decisions for Vermont	
Uses strong incentives that are already in place to encourage enrollment (ie APTC)	

How is a mandate enforced: Process Highlights

The Working Group used information gathered by the ad hoc Federal Issues Working Group, information from every state with an individual mandate (Massachusetts, Washington DC, and New Jersey), and information from other states actively researching an individual mandate (Maryland, Washington).

- MA is the only state with an individual mandate that pre-existed the ACA and therefore had experience implementing and administering the program at the state level.
- DC and NJ recently enacted state-level mandate programs that are closely modeled on the ACA-with some state-specific adjustments.
- MD considered designing a state program, modeled on the ACA, but with a system for using the penalty payments to offset premium costs of uninsured individuals who subsequently enroll in health insurance coverage. The program administration was complex and the legislation was ultimately not enacted.
- WA state, which does not have an income tax, was consulted on ideas for how to enforce a mandate without the use of the income tax system.
- Former Treasury official, Jason Levitis provided information about the ACA individual mandate design and administration federally.
- The Working Group also utilized IRS Vermont income tax data to determine how many resident taxpayers paid the federal penalty in 2015 and 2016.
- The working group heard testimony from the provider community regarding the volume of uncompensated care and possible reasons to go uninsured.

How is a mandate enforced:
Additional Options Considered

The Working Group considered several other enforcement mechanisms in depth, but ultimately decided **not to pursue these further**. These include:

- Attestation of coverage or exemption on the state income tax return without a financial penalty for noncompliance.
- A state-specific penalty with a larger affordability exemption and progressive structure (Office of Health Care Advocate Proposal - see Resource Slides for details.)
- Tax credit or deduction tailored to the currently uninsured population (e.g. 26-34 with incomes between 150-250% FPL). This demographic is unlikely to have tax liability, so refundable credit more likely to be effective. Provides another point of contact with the uninsured if they are tax filers.
- With any tax-based option, offer special enrollment period around tax filing to encourage the purchase of insurance.
- Premium surcharge of 2% per year for every year uninsured, which would be charged when insurance is purchased. Difficult to administer with the Advance Premium Tax Credits and Vermont Premium Assistance; also difficult to calculate years without insurance because individuals change insurers. (Australia)
- A state penalty program, modeled on the federal penalty, but with a system for using the penalty payments to offset premium costs of uninsured individuals who subsequently enroll in health insurance coverage. The program administration was complex and administratively challenging. (MD)

How is a mandate enforced:
Additional Options Considered

The Working Group also **brainstormed** alternative enforcement options, none of which warranted exploration**.** The Working Group **does not recommend** that these options be pursued further:

- Discount on premiums for the uninsured
- Non-income tax penalty or fee: auto license, cell phone, public utilities, bank account
- Waiting periods or delayed effective dates for the uninsured
- Exit fee for dropping insurance or a maintenance of coverage discount
- Have an annual State Lottery for health insurance coverage as an awareness campaign for the importance of coverage, to encourage enrollment, and to identify families in need of insurance
- Waiver of a small penalty or provide a small reward if someone without insurance applies for coverage

Other mechanisms to enhance enrollment

Other Mechanisms to Enhance Enrollment

An individual mandate is not the only way to enhance enrollment in Vermont. The Working Group briefly discussed additional ideas for how to increase or maintain coverage, but did not pursue them further because they are outside the scope of the project.

These include:

- Increasing subsidies to make premiums for health insurance more affordable
- Age rating the individual and small group market
- Changes to special enrollment policy
- Reinsurance for the individual and small group market

Public Comments

Summary of Public Comments

Public Comments on Draft Report:

- 18 Public Comments submitted by people or organizations
- Comments could be submitted at each Working Group meeting, by email or by phone
- The Public Comment period on the draft report was September 28 – October 12, 2018

Summary of Public Comments on Draft Report (18)[1]:

- Support for maintaining exemption for healthcare sharing ministries (13)
- Support for creating a religious exemption for individuals holding beliefs inconsistent with the requirement to have medical health insurance, and who do not use medical health care during the prior tax year. (1)
- Opposition to a state-based individual mandate/recommendations for alternatives to an individual mandate penalty (4)
  - Of these 4 comments, 2 were opposed due to affordability concerns

Full text of all public comments available here.

[1]For the purposes of summarizing public comments, each comment was categorized based on its primary topic.

Resources

Research, Data, and Other Materials

Data:

- Agency of Human Services
  - Vermont Household Health Insurance Survey 2012 & 2014
  - Selected excerpts from the 2014 VHHIS
- Department of Vermont Health Access
  - Health Coverage 1st Quarter 2018
  - Bronze Plans 2018
- Agency of Administration: Vermont Employer Health Benefits Survey
- Department of Tax: Comparison of Income Tax Brackets to Federal Poverty Levels pending final review at Tax
- Joint Fiscal Office: Premium Comparisons
- IRS Data
  - 2016 Report on Individual Income and Tax Data, Vermont
  - 2015 Report on Individual Income and Tax Data, Vermont
  - Federal Exemptions Data 2014, 2015 & Preliminary 2016
- Lewis and Ellis: Individual Mandate Study
- Rand Report: Economic Incidence of Health Care Spending in VT

Research, Data, and Other Materials

Policy Papers and Research:

- The Commonwealth Fund:
  - State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market
  - The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors
  - First look at health insurance coverage in 2018 finds ACA gains beginning to reverse
- Congressional Budget Office:
  - Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028
  - Repealing the Individual Health Insurance Mandate: an updated estimate
- Health Care Advocate Report: The Cost of Health Insurance: Quantifying the Vermont Affordability Crisis
- New England Journal of Medicine: The Importance of the Individual Mandate — Evidence from Massachusetts
- Urban Institute: How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs?

Research, Data, and Other Materials

Policy Papers and Research:

- Baicker, K., Congdon, W. J., Mullainathan, S. (2012). Health insurance coverage and take-up: lessons from behavioral economics. *The Millbank Quarterly*, *90*(1), 107-134
- Barnet, J. C., Berchick, E. R. (2017). Health insurance coverage in the United States: 2016. U.S. Census Bureau, Current Population Reports
- Bauhof, S.,Carman, K. G., Wuppermann, A. (2013). *Financial literacy and consumer choice of health insurance*. RAND Working Paper.
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- Blumberg, L. J., Garrett, B., Holahan, J. (2016). Estimating the counterfactual: how many uninsured adults would there be today without the ACA? *Inquiry*, *53*.
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Research, Data, and Other Materials

Policy Papers and Research:

- Collins, S. R., Rasmussen, P. W., Doty, M. M., Beutel, A. (2015). *Americans' experiences with marketplace and Medicaid coverage: findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015*. Commonwealth Fund.
- Courtemanche, C., Marton, J., Ukert, B., Yelowitz, A., Zapata, D. (2017). Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid expansion and non-expansion states. *Journal of Policy Analysis and Management*, *36*(1), 178-210.
- Feidler, Matthew, USC-Brookings Schaeffer Initiative for Health Policy, "How Did the ACA's Individual Mandate Affect Insurance Coverage?"
- Frean, M., Gruber, J., Sommers, B. D. (2016). Disentangling the ACA's coverage effects – lessons for policy makers. *New England Journal of Medicine*, *375*(17), 1605-1608.
- Frean, M., Gruber, J., Sommers, B. D. (2017). Premium subsidies, the mandate, and Medicaid expansion: coverage effects of the Affordable Care Act. *Journal of Health Economics*, *53*, 72-86.
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- Glied, S, & Jackson BA. (2017). The future of the Affordable Care Act and insurance coverage. *American Journal of Public Health*, *107*(4), 538-540.
- Hibbard, J. H., & Peters, E. (2003). Supporting Informed Consumer health care decisions: data presentation approaches that facilitate the use of information in choice. *Annual Review of Public Health*, 24, 413-433.

Research, Data, and Other Materials

Policy Papers and Research:

- Kaiser Foundation (2017). *Key facts about the uninsured population*.
- Karpman, M., Long, S. K., Zuckerman S. (2016) *Taking stock: health insurance coverage under the ACA as of March 2016*. Urban Institute.
- Korminski, G. F., Nonzee, N. J., Sorenson, A. (2017). The Affordable Care Act's impacts on access to insurance and health care for low-income populations. *Annual Review of Public Health*, *38*, 489-505.
- Long, S. K. (2008). On the road to universal coverage: impacts of reform in Massachusetts at one year. *Health Affairs*, w270.
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- McDonough, J. E., Rosman, B., Butt, M., Tuck, L., Howe, L. K. (2008). Massachusetts health reform implementation: major progress and future challenges. *Health Affairs*, *27*(4), w285-w297.

Research, Data, and Other Materials

Policy Papers and Research:

- Rothschild, M., & Stiglitz, J. (1978). Equilibrium in competitive insurance markets: an essay on the economics of imperfect information. *Uncertainty in Economics*, 259-280.
- Saltzman, E. A., Eibner, C., & Enthoven, A. C. (2015). Improving the Affordable Care Act: an assessment of policy options for providing subsidies. *Health affairs, 34*(12), 2095-2103.
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- Shartzer, A., Long, S. K., Karpman, M., Kenney, G. M., & Zuckerman, S. (2015). QuickTake: insurance coverage gains cross economic, social, and geographic boundaries. Washington, DC: Urban Institute.
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Policy Papers and Research:

- Steinbrook, R. (2008). Health care reform in Massachusetts – expanding coverage and escalating costs. *New England Journal of Medicine*, *358*(26), 2757-2760.
- Tyler, T. R. (1997). Procedural fairness and compliance with the law. *Swiss Journal of Economics and Statistics*, *133*(2/2). 219-249.
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- VanGarde, A, Yoon, J, Luck, H, Mendez-Luck, C. A. (2018). Racial/Ethnic variation in the Impact of the Affordable Care Act on insurance coverage and access among young adults. *American Journal of Public Health*, *108*(4), 544-549.
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- Zhu, J., Brawarsky, P, Lipsitz, S., Huskamp, H., Hass, J. S. (2010). Massachusetts health reform and disparities in coverage, access, and health status. Journal of Internal Medicine, 25(12), 1356-1362.

Research, Data, and Other Materials

Affordable Care Act Individual Mandate Resources:

- Taxpayer Advocate Service Information on Exemptions
- Congressional Budget Office Cost Estimate: March 2018
- IRS Forms Related to the mandate:
  - Form 1095-B (form, instructions): Used by all coverage providers not specifically assigned to Form 1095-A or 1095-C, including issuers outside the Marketplace, Medicare, Medicaid, other govt programs, small employers that self-insure, and others
  - Form 1095-A (form, instructions): Used by Marketplaces to report individual Marketplace coverage. (Issuers themselves are not required to report on Marketplace coverage.)
  - Form 1095-C (form, instructions): Used by large employers (at least 50 FTEs) that self-insure. Coverage information is in Part III of the form
  - Form 8965 (form, instructions): Used to claim exemptions (and the instructions include the penalty calculation rules, though the penalty itself is reported on Form 1040)
  - Form 1040 (form, instructions): Line 61 includes a checkbox to report full-year coverage or a space to report a penalty payment
- Summary of Federal Exemptions prepared by Department of Vermont Health Access staff:
  - ACA Affordability Standards and ACA Exemptions

Research, Data, and Other Materials

Other State Information:

- District of Columbia:
  - Health Benefit Exchange Authority Website for DC

- Massachusetts:
  - Massachusetts Affordability Schedule
  - Proposed Affordability Schedule (presentation for Vote- provides background)
  - The Massachusetts Individual Mandate: Design, Administration, and Results
  - Laws and Rules regulating the individual mandate
    - Title XVI, Chapter 111M: Individual Health Coverage
    - Title XXII Chapter176Q: Commonwealth Health Insurance Connector
    - 956 CMR: Commonwealth Health Insurance Connector Authority
  - Reconciling the Massachusetts and Federal Individual Mandates for Health Insurance

Example of a Vermont Specific Penalty with a Larger Exemption and Progressive Structure

The following example provides for a Vermont specific penalty with a larger affordability exemption and a progressive penalty structure, as compared to the recommended modified federal penalty. The Office of the Health Care Advocate (HCA) initially proposed this approach as an alternative to the modified federal penalty. However, the HCA supports the recommended modified federal penalty detailed in slides 32-36.

The state-specific penalty design would enforce the individual mandate while addressing three major issues: avoiding penalizing individuals for failing to purchase health insurance when the premiums and out-of-pocket deductibles are unaffordable; making the penalty more progressive; and increasing administrative simplicity.

- Flat exemption from the penalty for all families below 400% FPL
- Penalty amount is a progressive percentage of household income ranging from 0.5% for those above 400% FPL to 2.0% for the highest income families with no overall cap; prorated for the number of months uninsured
- Additional affordability exemption based on the lowest-cost state GOLD level plan as a percentage of household income to address out-of-pocket cost concerns (between 400-500% FPL = 12.56% and above 500% FPL = 16%)