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State individual mandates

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EDITOR'S NOTE

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I. Introduction

On December 22, 2017, President Trump signed major tax legislation that eliminated the penalties associated with the Affordable Care Act's individual mandate, effectively repealing the requirement that most Americans maintain qualifying health coverage. Repealing the mandate, also referred to as the individual shared responsibility provision, is expected to lead to substantially higher individual-market health insurance premiums and rates of uninsurance. The tax law makes mandate repeal effective after 2018. With open enrollment for 2019 coverage set to begin November 1, states are considering whether and how to respond.

One policy response that has gained increased attention is a mandate at the state level. Massachusetts enacted a mandate as part of its 2006 health reform package, and it remains in effect today.¹ New Jersey and the District of Columbia (D.C.) recently enacted mandate legislation with rules closely resembling the federal rules, taking effect in 2019.² Vermont has enacted a mandate effective 2020, but without an enforcement mechanism; the legislation empanels a working group to develop recommendations.³ Several other states have been considering mandate options.⁴

Enacting a state mandate is a straightforward way for states to avert the negative consequences of federal mandate repeal. It also offers states other advantages: it can help discourage the spread of insurance coverage that does not meet designated standards, facilitate state outreach to the uninsured, and serve as a source of revenue to finance other state policies aimed at improving insurance markets.

The key elements of mandate legislation are: (1) the coverage that qualifies; (2) the amount of penalties for not maintaining coverage; and (3) the exemptions available. States must also consider the administrative mechanisms they would use to collect mandate penalties and grant exemptions and reporting requirements to support compliance.

¹ For a summary of the Massachusetts mandate, see "[The Massachusetts Individual Mandate: Design, Administration, and Results](#)," *Massachusetts Health Connector*, November 2017. See also Audrey Morse Gasteier, "[With the Federal Individual Mandate Gone, States Might Step Up: Lessons From Massachusetts](#)," *Health Affairs Blog*, January 16, 2018.

² For New Jersey legislation, see New Jersey State Legislature, "[New Jersey Health Insurance Market Preservation Act](#)". Bill No. A3380. For D.C. legislation, see District of Columbia Council, "[Fiscal Year 2019 Budget Support Act of 2018](#)," Act Number A22-0442.

³ Vermont General Assembly, [Vermont House Bill 696](#).

⁴ See, for example, Dania Palanker, Rachel Schwab, and Justin Giovannelli, "[State Efforts to Pass Individual Mandate Requirements Aim to Stabilize Markets and Protect Consumers](#)," *To the Point* (blog), Commonwealth Fund, June 14, 2018; Rachel Bluth, "[A Health Plan 'Down Payment' Is One Way States Try Retooling Individual Mandate](#)," *NPR*, March 8, 2018; and Stephanie Armour, "[States Look at Establishing Their Own Health Insurance Mandates](#)," *The Wall Street Journal*, February 4, 2018

Federal law and Massachusetts law offer somewhat different models for each of these elements. While each model has advantages, this paper recommends taking the federal model as the baseline to provide continuity for stakeholders and to simplify implementation. Such a mandate can be enacted using a common drafting method known as “conformity” with federal law, which defines state law by reference to federal law, with adaptations for state context. This approach simplifies drafting and permits states to adopt the federal government’s regulations and sub-regulatory guidance⁵ as a starting point to expedite implementation.

From this starting point, a state may adapt the law based on its needs and policy preferences. This paper discusses a range of changes states may elect, including some specific provisions of the Massachusetts law.⁶

II. Rationales for creating state individual shared responsibility provisions

Enacting a state mandate may help states achieve a range of policy objectives. Some of these objectives coincide with those of the federal mandate, and some are relevant to state mandates alone. This section of the paper discusses several of these objectives in turn.

A. Averting Premium Increases and Reductions in Coverage from Federal Mandate Repeal

The primary motivation for states to enact a mandate is to replace the federal mandate and its support for health insurance markets and coverage.

Pre-ACA markets were characterized by (1) insurer practices that disadvantaged consumers with preexisting health conditions or who developed serious health conditions,⁷ (2) substantial populations who chose to go without coverage or could not afford it, and (3) substantial volumes of unpaid medical

⁵ The term “guidance,” as used in this paper, refers to both regulations and other rulemaking documents issued by administrative agencies. For example, in addition to regulations, the IRS promulgates notices, revenue rulings, and revenue procedures.

⁶ Model state legislative language reflecting this approach and presenting the various policy options is available at <http://shvs.org/resource/model-legislation-for-state-individual-mandate/>.

⁷ These practices included, for example, exclusions for pre-existing conditions, charging higher premiums to those with a history of high health expenses, and using technicalities to [retroactively cancel coverage](#) for those who incurred unexpectedly large health care expenses once enrolled.

bills incurred by the uninsured that were ultimately borne by providers, governments, or other actors in the health care system.⁸

The ACA included several measures to address these problems. It prohibited insurer practices harmful to individuals with high medical costs, like denying them coverage, charging them higher premiums, and cancelling their coverage without good cause. Because these protections alone tend to increase premiums, the ACA included several measures to make coverage more affordable and keep healthy people in the insurance pool. Specifically, it created subsidies to help low- and moderate-income consumers purchase individual-market health insurance. It created well-defined enrollment opportunities to make it harder to enroll only when sick. And it imposed an individual mandate to deter free-riding. Taken together, these measures created a market that made adequate health coverage broadly available and affordable.

Repealing the federal mandate weakens this structure. Mandate repeal is expected to reduce enrollment, especially among the healthy. Insurers respond to this “adverse selection” by increasing premiums, which will further reduce enrollment.

Consistent with this logic, the Congressional Budget Office (CBO) estimates that federal mandate repeal will increase premiums in the individual market by about 10 percent and increase the number of uninsured individuals by millions beginning in 2019, rising to around 9 million more uninsured once the effects are fully felt.⁹ Urban Institute researchers reach similar conclusions, projecting that nationwide enactment of state mandates modeled on the federal one would reduce premiums by an average of 11.8 percent and lead to 7.5 million fewer uninsured.¹⁰ (The Urban paper also provides state-by-state breakdowns of these estimates.) An estimate of the impact on California’s market alone, based on a survey about responses to mandate repeal, suggests it will increase premiums 5 to 9 percent.¹¹

⁸ Teresa Coughlin et al., “[An Estimated \\$84.9 Billion In Uncompensated Care Was Provided In 2013: ACA Payment Cuts Could Challenge Providers](#),” *Health Affairs*, May 2014. See also Teresa Coughlin et al., “[Uncompensated Care for the Uninsured in 2013: A Detailed Examination](#),” *Kaiser Family Foundation*, May 30, 2014.

⁹ Congressional Budget Office, “[Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028](#),” May 2018. The 9 million figure is derived from that report’s statement that CBO’s current estimate of “the reduction in health insurance coverage [due to mandate repeal] is about one-third smaller” than estimated in its November 2017 report. The earlier report showed a reduction of 13 million in 2025, 2026, and 2027 (the end of its estimating window). See Congressional Budget Office, “[Repealing the Individual Health Insurance Mandate: An Updated Estimate](#),” November 2017. Two-thirds of 13 million is about 8.7 million. The new report also found a reduction in health insurance coverage of 4 million in 2019.

¹⁰ Linda Blumberg et al., “[How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs?](#)” *Urban Institute*, July 20, 2018.

¹¹ Hsu et al., “[Eliminating the Individual Mandate Penalty in California: Harmful But Non-Fatal Changes in Enrollment and Premiums](#),” *Health Affairs Blog*, March 1, 2018. See also Matthew Fiedler, “[How Did the ACA’s Individual Mandate Affect Insurance Coverage?](#)” *The Brookings Institution*, May 2018.

These predictions have been borne out by 2019 rate announcements, with many issuers pointing to mandate repeal as a key driver of higher premiums, even as other factors helped drive premiums down.¹²

A state mandate can avert or reverse these effects by standing in for the federal mandate. For example, New Jersey’s insurance department estimates that its individual mandate reduced issuers’ 2019 premium requests by about 7 percent relative to what they would have been without the mandate.¹³

B. Limiting the Spread of Association Health Plans, Short-Term Plans, and Other Substandard Coverage

States imposing a mandate choose which coverage qualifies and which does not. Imposing a fee on individuals without designated coverage discourages the sale and purchase of coverage that does not qualify. This influence may be especially valuable in limiting the reach of substandard coverage – coverage that fails to comply with one or more of the ACA’s consumer protections or other insurance regulations. Substandard coverage can put consumers at risk and segment the market for health coverage, increasing premiums for ACA-compliant coverage.¹⁴

Two types of substandard coverage are currently of particular concern: association health plans (AHPs)¹⁵ and short-term limited-duration coverage (short-term plans).¹⁶ On October 12, 2017, President Trump released an Executive Order¹⁷ instructing the Departments of Health and Human Services, Labor, and the Treasury (collectively, “the Departments”) to consider loosening the rules governing the sale of these products. The Labor Department responded with regulations – finalized on June 19, 2018 – expanding the circumstances under which small employers and self-employed

¹² See, for example, Sabrina Corlette, [“The Effects of Federal Policy: What Early Premium Rate Filings Can Tell Us About the Future of the Affordable Care Act,”](#) *CHIRblog*, May 21, 2018. See also Fiedler, Matthew, [“How Would Individual Market Premiums Change in 2019 in a Stable Policy Environment?”](#) The Brookings Institution, Aug. 1, 2018.

¹³ See New Jersey Department of Banking and Insurance, [“NJ Department of Banking and Insurance Releases Proposed 2019 Rate Changes Submitted by Health Insurers,”](#) July 27, 2018.

¹⁴ For a detailed discussion of substandard coverage and how states regulate it, see Kevin Lucia et al., [“State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market,”](#) *The Commonwealth Fund*, March 29, 2018.

¹⁵ For additional information on AHPs, see K. Lucia and S. Corlette, [“President Trump’s Executive Order: Can Association Health Plans Accomplish What Congress Could Not?”](#) *To the Point (Blog)*, The Commonwealth Fund, Oct. 10, 2017.

¹⁶ For additional information on short-term plans, see D. Palanker, K. Lucia, and E. Curran, [“New Executive Order: Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market,”](#) *To the Point (Blog)*, The Commonwealth Fund, Oct. 11, 2017.

¹⁷ Trump, Donald, [“Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States,”](#) *whitehouse.gov*, October 12, 2017.

individuals may purchase coverage through an AHP.¹⁸ On August 1, 2018, the Departments finalized regulations extending the maximum duration of short-term plans from three months to 364 days and permitting renewals or extensions for up to three years.¹⁹

Both AHPs and short-term plans are exempt from key consumer protections applicable to the individual and small-group markets. AHPs are exempt from the ACA's essential health benefits requirement and some of its restrictions on setting premiums based on factors like age and gender. They are also generally exempt from state insurance regulations relating to disclosure and solvency; likely as a result, they have a history of fraud and insolvency.²⁰ Short-term plans are generally exempt from all the ACA consumer protections, including the prohibitions on underwriting, denying coverage, lifetime and annual limits, and rescissions when an enrollee gets sick.

These weaker standards generally allow short-term plans and AHPs to be sold more cheaply than conventional health insurance, for several reasons: (1) the plan terms can be less generous; (2) less generous terms discourage individuals with costly health care needs from enrolling; and (3) these plans may take additional steps to keep out high-cost individuals, including simply refusing to offer them coverage in the case of short-term plans. This leads to a departure of healthier enrollees from ACA-compliant markets, which raises premiums for ACA-compliant coverage. Independent modeling bears out this concern, generally finding an individual-market premium impact in the mid-single digits, though point estimates vary.²¹ The resulting segmentation may benefit consumers with modest

¹⁸ Department of Labor Final Rule, "Definition of "Employer" under Section 3(5) of ERISA — Association Health Plans," Citation Pending, [released for public inspection](#) on June 19, 2018.

¹⁹ Departments of the Treasury, Labor, and HHS, "[Short-Term, Limited-Duration Insurance](#)," 83 FR 38212, August 3, 2018 (released for [public inspection](#) August 1, 2018). The Executive Order also instructs federal agencies to consider loosening the rules governing health reimbursement arrangements (HRAs), but such guidance has yet to be issued.

²⁰ Kevin Lucia and Sabrina Corlette, "[Association Health Plans: Maintaining State Authority is Critical to Avoid Fraud, Insolvency, and Market Instability](#)," *The Commonwealth Fund*, January 24, 2018.

²¹ For example, the CMS Office of the Actuary (which operates independently from CMS's political leadership) estimated that finalizing the short-term rules would increase premiums in the ACA-compliant individual market by about 6 percent by 2022: CMS Office of the Actuary, "[Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule](#)," April 6, 2018. A report by Avalere estimated that the AHP proposed rule would increase ACA-compliant premiums by 3.5 percent in the individual market and by 0.5 percent in the small group market: Avalere, "[Association Health Plans: Projecting the Impact of the Proposed Rule](#)," February 28, 2018. The Urban Institute estimates that the combination of the short-term proposed rule and individual mandate repeal would cause premium increases of 18.2 percent in states that do not restrict short-term plans, compared to 8.3 percent in states that effectively prohibit substandard short-term plans and 12.8 percent in states that substantially restrict them: Linda Blumberg et al., "[The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending](#)," *Urban Institute*, February 2018. CBO estimates that together the short-term and AHP rules, if finalized, would increase ACA-compliant premiums between and 2 and 3 percent, but CBO does not break down the impact between the individual and small group markets: Congressional Budget Office, "[Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028](#)," May 2018. All of these increases are on top of the increases that would normally occur due to inflation, normal changes in utilization, etc.

health care needs. But it is generally harmful to those with pre-existing conditions, who may have to pay more for coverage or see their needs fall into benefit gaps.²² Individuals with no history of illness may also be harmed if they enroll in such coverage and then unexpectedly have substantial health care needs and find the coverage capped, needed services excluded, or their plan insolvent. In addition, consumers may be unaware of the ways in which these plans are less comprehensive than ACA-compliant plans.

A state mandate can limit the reach of non-ACA-compliant coverage by effectively increasing its price by the amount of the penalty. This makes ACA-compliant plans comparatively more attractive, which helps keep their premiums from rising due to additional adverse selection. The New Jersey and D.C mandates both are not satisfied by AHPs that fail to meet specified standards. And both of these plus the federal and Massachusetts mandates are not satisfied by substandard short-term coverage.

A state mandate may be used in similar fashion to limit the reach of other substandard coverage. This may include:

- Health care sharing ministries, which are generally not treated as insurance by states and therefore not subject to either state or federal health insurance regulation;²³
- Grandfathered plans, which are exempt from several key ACA market reforms.²⁴ The Massachusetts' mandate generally excludes these plans;²⁵
- Substandard employer-sponsored coverage, for example employer coverage that lacks prescription drug coverage.²⁶ The Massachusetts' mandate generally excludes this coverage.

Using a mandate in this way may be particularly important to curb the growth of substandard AHPs, because states may lack other effective options for limiting them. States have historically had substantial authority to regulate AHPs, and the final AHP regulations appear to preserve that authority. But two risks remain. First, the proposed AHP regulations sought comment on the federal

²² The American Academy of Actuaries summarizes these concerns in its comment letter on the AHP proposed rule, warning that the rule would allow AHPs to “offer lower premiums to healthier and/or younger enrollees, deteriorating ACA markets and raising ACA premiums as healthier groups leave ACA plans for AHP plans.” See American Academy of Actuaries, “[Re: Definition of “Employer” Under Section 3\(5\) of ERISA—Association Health Plans](#),” March 5 2018.

²³ See JoAnn Volk et al., “[Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets?](#)” Commonwealth Fund, August 8, 2018.

²⁴ “[Grandfathered Insurance Plans](#),” *Health insurance rights & protections, healthcare.gov*

²⁵ Linda Blumberg and Lisa Clemens-Cope, “[Reconciling the Massachusetts and Federal Individual Mandates for Health Insurance: A Comparison of Policy Options](#),” *Urban Institute*, December 2012.

²⁶ The federal mandate generally recognizes all conventional employer-sponsored coverage. The ACA consumer protections require coverage in the small group market to provide the essential health benefits (EHBs), but plans in the large group and self-insured markets are exempt.

government preempting state regulation using authority granted by ERISA. The final rule did not adopt this approach, but it suggested the Administration would consider doing so if states “go too far in regulating [certain] AHPs in ways that interfere with the important policy goals advanced by this final rule.” Second, even absent additional federal action, an AHP wishing to escape state regulation may assert that state rules are preempted under ERISA because they are inconsistent with the AHP final regulations.²⁷ States and others would likely go to court to challenge preemption under either of these scenarios, but the outcome is difficult to predict. In such a scenario, a state mandate may have a better chance of surviving a preemption challenge than would direct state regulation of AHPs, since a mandate applies to individuals rather than the ERISA-regulated entities themselves, and it is a creature of the state tax code, an area where ERISA jurisprudence has historically shown greater deference.

Using a state mandate in this way would most likely not eliminate the non-qualifying substandard coverage. Short-term plans have never satisfied the federal mandate, yet they continued to be sold and even increased their market share until regulations curtailed them in 2016.²⁸ But it would make these types of coverage less attractive and thereby reduce the risk they pose to consumers and insurance markets.

C. Facilitating Targeted Outreach to the Uninsured

Another benefit of a state mandate is that information about who remains uninsured can be leveraged to notify the uninsured of coverage options. This may include:

- **Direct Outreach to the Uninsured.** If a resident reports being uninsured (either paying a penalty or claiming an exemption), the state can send them a reminder during the next open enrollment season. The notice can describe available coverage options, including contact information for the state Marketplace. The ACA provides for the IRS to do this,²⁹ but the IRS has taken more limited action due to limited funding.³⁰ Such notices may be customized using

²⁷ Katie Keith, “[Final Rule Rapidly Eases Restrictions on Non-ACA-Compliant Association Health Plans](#),” *Health Affairs Blog*, June 21, 2018.

²⁸ Kevin Lucia et al., “[State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market](#),” *The Commonwealth Fund*, March 29, 2018. Until 2016, short-term plans were allowed to last up to 364 days, much as under the proposed regulations. See final regulations at [81 FR 75316](#).

²⁹ See [ACA section 1502\(c\)](#).

³⁰ Instead of sending targeted notices to uninsured individuals, the IRS generally has relied on less direct approaches, like including general notifications in IRS publications and [encouraging returns preparers](#) to notify their clients. See, e.g., IRS, “[Affordable Care Act - Notification of nonenrollment - §1502\(c\): Return Preparer Best Practices](#),” [undated]. See also Treasury Inspector General for Tax Administration, “[Affordable Care Act: Implementation of the Notification Requirement for Individual Filers Not Enrolled in Health Insurance](#),” July 31, 2017.

information on the tax return. For example, the notice could inform the individual that they may be eligible for a substantial Marketplace subsidy based on the income and family size reported on the return.

- **Targeted Outreach to Areas and Groups with High Rates of Uninsurance.** The state can analyze the mandate data to identify geographic areas, age groups, etc., with high rates of uninsurance and then target those concentrations with media or on-the-ground outreach.

Massachusetts employs both of these approaches using information from its mandate, and officials there credit this outreach as an important reason for the success of its health reform and its low rate of uninsurance.³¹ Several states have asked the IRS for the data needed to do this outreach themselves, but to the author’s knowledge, the IRS has refused, likely due to data privacy rules.³² Enacting a mandate of their own allows states to collect and employ this information themselves.

D. Maintaining Federal Health Care Spending in the State

Repealing the federal mandate is expected to substantially reduce federal spending on health care, primarily by reducing enrollment in federally subsidized coverage. These reductions in coverage and spending will be spread across the states. Enacting a state mandate can maintain coverage at higher levels in the state, thereby maintaining the federal dollars flowing into the state.

CBO’s November 2017 analysis of federal mandate repeal included detailed estimates of the ways eliminating the mandate would reduce federal health spending. That analysis found that repeal of the mandate would reduce net federal spending on health care subsidies by about \$380 billion over the 2018-2027 budget window. This primarily reflects a \$185 billion reduction in spending on individual market subsidies³³ and a \$179 billion reduction in federal spending on Medicaid and CHIP due to reduced coverage through those programs, as well as other smaller effects on other forms of coverage and programs.

³¹ For example, see “[Massachusetts’s Experience with a State Individual Mandate](#),” *Massachusetts Health Connector*, January 23, 2018: slide 17.

³² [Section 6103](#) of the Internal Revenue Code generally permits the IRS to share tax return information only when specifically authorized. Sections 6103(d) authorizes the sharing of specified data with states to assist with state tax administration, but individual mandate data does not appear to be among the data that may be shared.

³³ Individual market coverage is heavily subsidized by the federal government. CBO has estimated that more than half of individual market enrollees receive the premium tax credit or other federal subsidies, with subsidies averaging \$6,140 per subsidized enrollee in 2019; See Congressional Budget Office, “[Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027](#),” September 2017, showing about 10 million of the 17 million individual market enrollees receiving subsidies in 2019.

CBO has subsequently reported that it has reduced its estimates of the coverage impact of the federal mandate by around one-third.³⁴ The new report does not provide updated estimates of the budgetary effects of mandate repeal, but if the change to the spending estimates were proportional, then CBO's updated estimate of the impact on net federal health care spending would be about \$250 billion.

A state can avert this reduction in federal spending in the state by imposing a state mandate. A state mandate modeled on the federal mandate would generally maintain enrollment at what it would have been with the federal mandate in place, and thereby maintain federal health subsidy spending as well. A state mandate with different rules might affect enrollment and therefore federal spending differently.

E. Collecting State Revenue that Can be Used to Make Coverage More Affordable

Collecting revenue is not the main goal of a mandate, but the revenue it produces for a state may be put to good purpose. While the revenue may be used for anything, states considering mandates may direct it towards programs to make coverage more affordable, thereby helping state residents comply with the mandate. The Massachusetts, New Jersey, and D.C. mandates all take this approach, and other states that have considered mandates have generally contemplated this approach as well.

A state's penalty revenue from a mandate modeled on the federal one can be estimated from available data on the federal mandate. The most recent figures from the Treasury Department before the federal mandate was repealed projected that it would have raised about \$5.7 billion total in tax year 2020.³⁵ IRS figures regarding mandate penalty collections by state in tax year 2016 – the most recent year available – can be used to allocate this amount among the states.³⁶ The results are shown in Table 1.³⁷

³⁴ Congressional Budget Office, "[Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028](#)," May 2018. The report indicates that CBO now believes that the coverage impact of mandate repeal is about "one-third smaller" than it estimated in the November 2017 report.

³⁵ This figure comes from the [current-law revenue estimates](#) prepared by the Treasury Department and released May 23, 2017 to accompany the [President's Fiscal Year \(FY\) 2018 Budget](#). By the time the FY 2019 Budget was released in early 2018, the federal mandate had been repealed, so updated figures were not included. The estimate shows receipts of \$5.681 billion in FY 2021, which generally corresponds to collections for tax year 2020. This is generally consistent with the \$5 billion estimate included with CBO's analysis of federal mandate repeal, found at Congressional Budget Office, "[Repealing the Individual Health Insurance Mandate: An Updated Estimate](#)," November 2017.

³⁶ Internal Revenue Service (IRS), "[SOI Tax Stats – Historic Table 2](#)." *State Data Tax Year 2016*, August 31, 2018.

³⁷ As explained in Section III.A, IRS data about federal mandate penalty collections overstate the likely amount that would be collected from low-income residents under a state mandate due to erroneous payments that occurred. It is unclear to what extent the Treasury projections for 2019 collections assumed that these erroneous payments would continue. By 2016 Treasury officials were aware of the erroneous payments and considering options to reduce them going forward, but it is unclear to what extent they would have reflected those potential improvements in their revenue projections. Accordingly, it is

A state may also need to take other considerations into account in determining the funding a mandate makes available. For example, to the extent a state mandate prevents a drop-off in Medicaid and CHIP enrollment, it will prevent a reduction in state spending in those programs. Conversely, by preventing an increase in the number of state residents without insurance, a mandate is likely to avert an increase in uncompensated care, which many states have programs to subsidize.³⁸ These considerations are discussed in greater detail in Appendix I.

States that realize net budgetary savings from a mandate can use those savings to make insurance coverage more affordable, thereby making it easier for state residents to comply with the mandate. Options include providing additional premium or cost-sharing subsidies, funding a state-based reinsurance program, or performing additional outreach. Depending on how these options are designed, state mandate revenue may be sufficient to pay for most or all of the cost. These options are explored in greater detail in Section IV.D.6.

possible that the estimates in Table 1 overstate the revenue that would be collected by a significant amount, perhaps as much as 25 percent.

³⁸ Matthew Buettgens, Linda J. Blumberg, and John Holahan, "[The Impact on Health Care Providers of Partial ACA Repeal through Reconciliation](#)," *Urban Institute*, January 2017.

Table I. Estimated Revenue from a State Mandate Modelled on the Federal Mandate, Tax Year 2020

State	Estimated Revenue (\$ millions)	State	Estimated Revenue (\$ millions)
Alabama	52.8	Montana	24.2
Alaska	20.8	Nebraska	34.8
Arizona	131.3	Nevada	62.2
Arkansas	48.5	New Hampshire	27.2
California	697.9	New Jersey	174.8
Colorado	112.7	New Mexico	30.9
Connecticut	48.7	New York	315.6
Delaware	12.7	North Carolina	174.2
District of Columbia	5.9	North Dakota	14.0
Florida	442.3	Ohio	145.9
Georgia	181.9	Oklahoma	66.5
Hawaii	11.7	Oregon	70.1
Idaho	37.7	Pennsylvania	170.4
Illinois	190.6	Rhode Island	16.7
Indiana	120.1	South Carolina	79.7
Iowa	39.2	South Dakota	12.9
Kansas	44.3	Tennessee	98.4
Kentucky	59.9	Texas	814.7
Louisiana	79.2	Utah	58.4
Maine	29.6	Vermont	11.5
Maryland	79.8	Virginia	135.9
Massachusetts	81.6	Washington	123.5
Michigan	149.4	West Virginia	27.2
Minnesota	70.8	Wisconsin	82.4
Mississippi	46.4	Wyoming	14.9
Missouri	92.4		
		U.S. Total	5,681.0

Source: Author's calculations based on Treasury Department forecasts in Public Budget Database from FY 2018 Budget, and IRS Statistics of Income (SOI) figures for tax year 2016.

Notes: (1) These estimates do not include other potential effects of an individual mandate on state budgets.

(2) State figures sum to 5,675.1, slightly less than U.S. total, because SOI data attribute some returns to "Other Areas," which generally includes filers residing abroad or in U.S Territories.

III. Additional considerations for states

This section addresses some additional factors that states considering a mandate may wish to take into account, with a focus on concerns that have been raised about enacting a mandate.

A. Impact on Low-Income Individuals

Some observers have raised concerns about the distributional impact of the federal mandate, pointing to IRS data suggesting that the penalty is paid disproportionately by low-income individuals.³⁹

The impact of a mandate – or any policy – on low-income individuals is important to consider. But there are reasons to believe that a state mandate based on the federal mandate strikes an appropriate balance – or could with straightforward adjustments. First, it is important to note that the tax return data in question overstate the impact a state mandate would have on low-income individuals, especially if a state makes straightforward adjustments. Second, the mandate should be considered in light of the ACA’s treatment of low- and moderate-income individuals more broadly, including the broad range of mandate exemptions and generous subsidies available to them. Third, applying the mandate relatively broadly is important for achieving the policy goals of a mandate and the ACA generally.

- **Historical Federal Data Reflect Erroneous Payments that States Can Avoid.** IRS tax return data, released by the IRS Statistics of Income (SOI) division, show substantial numbers of low-income taxpayers making mandate payments. For example, for tax year 2016 (the most recent data available), almost 400,000 mandate penalty payers had incomes under \$15,000, and 1.9 million had incomes between \$15,000 and \$30,000.⁴⁰ Together, these groups accounted for about 35 percent of the dollar value of penalties reported.⁴¹ While concerning on their face, these figures overstate the likely impact of a state mandate on low-income individuals. The reason is that they count erroneous payments that resulted from two temporary implementation weaknesses. The IRS has now taken steps to improve its

³⁹ See, for example, Rachel Greszler, “[Why Eliminating Obamacare’s Individual Mandate Should Be Part of Tax Reform](#),” *Heritage Foundation*, November 27, 2017; The Office of Senator Steve Daines, “[Fact Sheet: Repealing Obamacare’s Individual Mandate](#),” [undated]; and Dan Mangan, “[Senate’s GOP tax reform bill seeks repeal of Obamacare individual mandate](#),” *CNBC*, November 14, 2017.

⁴⁰ Author calculations based on IRS Statistics of Income, “[Individual Income Tax Returns Publication 1304](#),” Table 2.7—Affordable Care Act Items, by Size of Adjusted Gross Income.

⁴¹ *Ibid.*

processes, and states could adopt these improvements and others to avert high rates of erroneous payments.⁴²

The first issue was that the IRS's return processing systems accepted and processed returns reporting mandate payments from taxpayers who were evidently eligible for an exemption. The National Taxpayer Advocate (NTA) reported that for tax year 2014, over 400,000 tax returns – mostly with low-incomes – showed mandate payments despite including other information sufficient to establish an exemption, such as income under the tax filing threshold.⁴³ The NTA recommended that IRS modify its systems to limit these overpayments. The IRS took several actions after the fact to address these overpayments, but systems changes were apparently not made in time for tax years 2015 and 2016, so return data from those years reflect the higher error rates.⁴⁴

The second implementation issue was a lack of clear information about the affordability exemption. The operation of this exemption makes it available to virtually all individuals who are eligible for Medicaid – even though these individuals are generally eligible for free coverage.⁴⁵ In states that chose to expand Medicaid eligibility under the ACA, the income cut-off for Medicaid is generally 138 percent of the federal poverty line, or FPL.⁴⁶ Thus, individuals with incomes in this range are generally exempt from the mandate. This covers a large group outside those eligible for the filing-threshold exemption: for a family of four in 2016, the filing threshold was \$20,700,⁴⁷ while 138 percent of FPL was \$33,463.⁴⁸ IRS forms and instructions

⁴² The author worked closely with the IRS on ACA implementation and shares responsibility for implementation decisions. More generally, Congress charged the IRS with implementing the ACA's several dozen tax provisions but then repeatedly cut IRS funding. Despite these challenges, the IRS generally implemented the ACA's many tax provisions accurately and on time.

⁴³ Taxpayer Advocate Service, "[2015 Annual Report to Congress – Volume One](#)," pg. 170. See also Taxpayer Advocate Service, "[Fiscal Year 2016 Objectives Report to Congress – Volume One](#)," pg. 41, indicating that most were eligible for the filing threshold exemption.

⁴⁴ Taxpayer Advocate Service, "[Fiscal Year 2017 Objectives Report to Congress – Volume One](#)," pg. 140.

⁴⁵ The affordability exemption applies to individuals whose cost to purchase coverage exceeds a percent of income (8 percent in 2014, then indexed). But Medicaid coverage, which is generally free, is ignored for this purpose. Medicaid-eligible individuals are not eligible for the premium tax credit, and the unsubsidized premium for a bronze plan is generally well above the affordability threshold for a low-income individual. As a result, unless they are eligible for highly subsidized employer coverage, they generally treated as having no affordable coverage options.

⁴⁶ Due to the Supreme Court decision in *NFIB*, states can choose whether to expand Medicaid eligibility up to 138 percent of FPL or to leave it at a lower level. In states that opted not to expand Medicaid eligibility, there is an exemption, created through guidance, for those who would be Medicaid-eligible had the state opted to expand Medicaid. *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

⁴⁷ IRS, "[Tax Guide for Individuals 2016](#)."

⁴⁸ Author calculation based on HHS, "[Computations for the 2016 Annual Update of the HHS Poverty Guidelines for the 48 Contiguous States and the District of Columbia](#)," April 25, 2016.

for tax years 2014 through 2016 did not clearly explain this rule.⁴⁹ There are no public estimates of the resulting erroneous payments, but Treasury Department officials who examined the issue thought it was likely a substantial number of taxpayers.⁵⁰

The IRS took a variety of measures to address these issues after the fact, including clarifying the instructions, sending taxpayers letters encouraging them to file amended returns, and sending refunds unprompted to taxpayers whose payments were clearly erroneous.⁵¹ But these measures are not reflected in the available SOI data, which are based on returns as initially filed.⁵² As a result, the historical IRS figures include at least hundreds of thousands – and perhaps over one million – payments by low-income individuals that should never have been paid (and that in some cases were refunded).

Fortunately, states can take straightforward actions to prevent similar erroneous payments. Measures include checking for apparent overpayment during return processing, ensuring that forms and instructions accurately capture and emphasize the exemptions available, and using administrative authority to create a simpler exemption rule for those who are Medicaid-eligible. These measures are discussed in detail in Section IV.D.4.⁵³

- **The ACA’s Broader Policy Context for Low- and Moderate-Income Individuals.** The ACA implemented an integrated network of policies aimed at ensuring that coverage was affordable for low- and moderate-income individuals and that individuals were only required to obtain coverage when those measures were successful. It provides generous subsidies to help them afford coverage, including generally-costless Medicaid coverage for those with incomes up to 138 percent of FPL and Marketplace subsidies up to 400 percent of FPL.⁵⁴ It

⁴⁹ See IRS [Form 8965 and its instructions](#), for tax years 2014, 2015, and 2016. All of these versions include two errors. First, the “Marketplace Coverage Affordability Worksheet,” which taxpayers use to determine whether Marketplace coverage counts as affordable, erroneously suggests that Medicaid-eligible individuals can get the premium tax credit (PTC), which is the lynchpin of exemption eligibility for this group. Second, the form and instructions include no indication that an individual who is Medicaid-eligible should consider the affordability exemption at all. The instructions for tax year 2017 addressed this issue, clarifying the affordability exemption calculation and flagging this as a “common mistake.”

⁵⁰ Author conversations with fellow Treasury Department officials, 2016.

⁵¹ Taxpayer Advocate Service, “[2016 Annual Report to Congress – Volume One](#),” pg. 268.

⁵² Specifically, the SOI tables in question include a footnote stating “This table is based on tax returns as initially processed by IRS and does not reflect amended returns or errors that were corrected after initial processing.”

⁵³ In addition to these measures states can take, a separate change in federal law in the recent tax bill will help to limit erroneous payments by low-income individuals under a state mandate. The tax bill increased the filing thresholds, effective in 2018. For example, the threshold for a family of four will increase from \$20,700 in 2017 to \$24,000 in 2018. As a result, individuals in this range can claim the filing threshold exemption, which is simpler to understand than the affordability exemption.

⁵⁴ Marketplace subsidies include premium support (through the premium tax credit) for those with incomes up to 400 percent of FPL and cost-sharing support (through cost-sharing reductions) up to 250 percent of FPL. For example, in 2019 a family of 3 with income of \$40,000 is eligible for coverage with an 87 percent actuarial value (meaning the enrollees’ cost-sharing on average amounts to 13 percent of the health care costs they incur) by paying a monthly premium of about \$200.

provides a broad range of mandate exemptions for those with the lowest incomes, those who cannot afford coverage, those in certain protected classes, and those facing other challenges in maintaining coverage.⁵⁵ These subsidies and exemptions are coordinated to ensure there is an exemption for individuals who fall into gaps in the subsidy structure.⁵⁶

Taken together, this structure ensures that the lowest-income individuals are offered free coverage and are exempt from the penalty, while moderate-income individuals are offered relatively generous subsidies and owe a penalty only if they choose to turn down affordable coverage without good cause. Given this structure, many of the remaining uninsured have highly affordable coverage options: a Kaiser Family Foundation analysis found that over half of uninsured individuals who are eligible for Marketplace coverage could purchase coverage for less than the federal mandate penalty.⁵⁷

- **Applying the Mandate Broadly Is Important for Achieving its Goals.** While (1) the historical IRS data reflect erroneous payments by low- and moderate-income individuals, and (2) the ACA’s broader structure aids and protects these individuals, some of them – especially those with moderate incomes – actually owed a penalty. That is by design. Low- and moderate-income individuals account for a large and disproportionate share of the uninsured.⁵⁸ This exposes them to catastrophic health and financial risks, weakens the risk pool, and generates uncompensated care costs that must ultimately be borne by providers, governments, or others in the health care system. The ACA’s wider structure helps to mitigate the concerns about a mandate’s costs for these individuals. But broadly exempting them would substantially weaken the mandate’s ability to address these problems, and this must be weighed against the financial savings for the individuals involved.

⁵⁵ In addition to the filing threshold and affordability exemptions, the federal mandate also includes exemptions for those ineligible for Medicaid because they reside in a non-expansion state, undocumented immigrants and non-resident aliens, many Native Americans, those with a religious objection to social insurance, those facing a variety of specific “hardship” situations such as the loss of a job or the death of a family member, and those facing miscellaneous hardship situations that make it difficult to maintain coverage. For a complete list of available exemptions, see [irs.gov](https://www.irs.gov), “[2017 Instructions for Form 8965](#).” For details about hardship exemptions, see [healthcare.gov](https://www.healthcare.gov), “[Hardship exemptions, forms & how to apply](#).”

⁵⁶ For example, there are exemptions for (1) for individuals ineligible for Medicaid because their state has not expanded Medicaid eligibility, (2) individuals who are incarcerated or undocumented (and thus ineligible for subsidies), and (3) individuals affected by the so-called “family glitch,” which denies the premium tax credit (PTC) to certain families who are eligible for employer-sponsored that may cost substantially more than the PTC’s affordability threshold.

⁵⁷ Matthew Rae et al., “[How Many of the Uninsured can Purchase a Marketplace Plan for Less Than Their Shared Responsibility Penalty?](#),” *Kaiser Family Foundation*, November 2017.

⁵⁸ For example, about 50 percent of the uninsured have incomes under 200 percent of FPL, and 80 percent have incomes under 400 percent of FPL. See Figure 4 in “[Key Facts about the Uninsured Population](#).”

B. Implementation Costs for States and Stakeholders

As with any statutory requirement, implementing a state mandate creates operational costs and challenges for the state and compliance costs for taxpayers. These costs and challenges may be minimized through policy choices, making implementation manageable for most states.

To minimize implementation costs, both the federal mandate and Massachusetts' mandate are implemented through the existing individual income tax systems. This approach allows the state to rely on an established administrative apparatus for public communications, return processing, and payment collection. A single line can be added to the state income tax return, where taxpayers check a box indicating that they had coverage or report a payment. The payment is included with the income tax payment or reduces the refund. A simple one-page form is used to claim certain exemptions.⁵⁹ (States without income taxes cannot rely on this approach. Appendix III discusses options for these states.⁶⁰)

Beyond incorporating a state mandate into the state income tax system, this paper describes an approach that further limits implementation costs by closely tracking the federal mandate. As explained further in Section IV.A, this allows states to adapt federal guidance, forms, instructions, and educational materials rather than starting from scratch. And it creates a relatively seamless transition for taxpayers.

Adopting this approach makes implementing a mandate relatively straightforward for states, and nearly effortless for taxpayers. But the state would need to adapt forms and other materials, modify its form processing systems, develop procedures to grant exemptions, and administer the rules on an ongoing basis. The precise cost will depend on a state's current administrative apparatus and implementation decisions.

C. Philosophical Concerns

Ideological considerations are generally beyond the scope of this paper, but it may be helpful to review them at a high level given their prominence in debates about coverage mandates.

The federal mandate has long been one of the most controversial provisions of the ACA. A major source of this controversy is philosophical opposition to the government requiring the purchase of health insurance, or indeed any product. Opponents have argued that a mandate conflicts with the bedrock

⁵⁹ See IRS, "[Form 8965](#)." A state exemption form could likely be even simpler: Form 8965 includes three separate sections for claiming exemptions whereas a state could likely combine those three sections into one to create an even simpler form.

⁶⁰ Forty-one states and D.C. currently levy broad-based income taxes. Urban Institute, "[Individual Income Taxes](#)".

American value of self-determination.⁶¹ To the extent that these values are reflected in the Constitution, they provide the basis for the legal challenge in the *NFIB v. Sebelius*,⁶² the landmark litigation challenging the mandate. In that case, the Supreme Court upheld the mandate penalty as an exercise of the Constitutional taxing power but rejected Congressional authority to require the purchase of insurance through its regulatory powers.

There are several responses to these concerns. One is to note that remaining uninsured is not a purely personal decision: it has consequences for others like higher premiums and more uncompensated care.⁶³ In this respect, a health coverage mandate is not unlike decades-old state requirements to purchase auto insurance.⁶⁴ Another response is to focus on the Supreme Court holding that the mandate is supportable as a tax, and to note that the mandate is economically equivalent to other tax provisions that incentivize the purchase of certain goods. Others note that Massachusetts' mandate has been in place for 10 years without any apparent impairment to liberty.

These arguments are unlikely to sway hardcore partisans on either side. But there is reason to believe that such divisions may not be dispositive, at least at the state level. The Massachusetts mandate has not been the subject of major repeal efforts, and health reform there is generally non-controversial (and was enacted on a bipartisan basis and signed by a Republican governor).⁶⁵ In Vermont, the mandate bill passed this year with broad bipartisan support and was signed by the Republican governor.⁶⁶ And the D.C. legislation was passed unanimously and responds to the unanimous recommendation of an advisory group representing a broad range of interests, including the D.C. Chamber of Commerce.⁶⁷ In short, philosophical opposition to the mandate is far from universal. A state should consider the values and priorities of its own residents as it decides how to proceed.

⁶¹ For example, see Hans Von Spakovsky, "[Individual Mandate Goes Against Basic Freedom and Liberty](#)," *U.S. News*, March 25, 2012; and Robert Moffit, "[Obamacare and the Individual Mandate: Violating Personal Liberty and Federalism](#)," *Heritage Foundation*, January 18, 2011.

⁶² *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

⁶³ See Linda Blumberg et al, "[How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs?](#)" *Urban Institute*, July 20, 2018.

⁶⁴ Jennifer Wriggins, "[Is the Health Insurance Individual Mandate 'Unprecedented?': The Case of Auto Insurance Mandates](#)," April 6, 2012.

⁶⁵ For example, a 2010 survey found that 66 percent of non-elderly adults in Massachusetts support its health reform law: Blue Cross Blue Shield of Massachusetts Foundation, "[Health Reform in Massachusetts – Expanding Access to Health Insurance Coverage – Assessing the Results](#)," March 2014: slide 29.

⁶⁶ Vermont General Assembly, "[H.696 bill status](#)."

⁶⁷ See "[Recommendations of the Reconvened ACA Advisory Working Group to the District of Columbia Health Benefit Exchange Authority](#)," April 6, 2018, pg. 19-20.

IV. Designing a state individual shared responsibility provision

A mandate generally consists of a requirement that non-exempt individuals maintain qualifying health coverage or pay a penalty. The key design elements are:

- The definition of qualifying coverage;
- The amount of the penalty;
- The exemptions available; and
- The administrative apparatus, such as procedures for granting exemptions and a requirement for third-party reporting of coverage to verify compliance.

There are numerous options for each of these elements. The federal mandate and the Massachusetts mandate offer similar but slightly different approaches to each.

This paper recommends taking the federal mandate as a baseline for a state mandate. Doing so maximizes continuity for stakeholders given the short timeline for standing up a state IRSP. It also simplifies legislative drafting and the timely promulgation of guidance. And it readily accommodates specific policy changes, including adopting specific aspects of the Massachusetts mandate.

The rest of Section IV walks through this general approach and specific design considerations. Section IV.A explores reasons for taking the federal mandate as a starting point. Section IV.B describes the statutory components of mandate legislation following this approach. Section IV.C describes technical changes that are necessary to adapt the federal mandate for use at the state level. And Section IV.D explores policy options to change the federal framework without unduly complicating implementation.

Recommended Approach to Creating a State Mandate

- Use federal law as baseline
- Enact state mandate through conformity with federal mandate as of a fixed date (pre-repeal)
- Incorporate federal regulations and other legal guidance as starting point
- Make technical adjustments for state context
- Make policy adjustments as desired to reflect state preferences

A. Why State Mandates Should Generally Be Based on the Federal Mandate

For a state developing mandate legislation, the natural starting points are the two models enacted to date: the federal mandate and the Massachusetts mandate. These versions are quite similar in broad strokes. Both have definitions of qualifying coverage that include most conventional public and private health coverage. Both impose penalties that increase based on ability to pay and are capped based on

the cost of coverage. Both provide exemptions for short coverage gaps and individuals with low incomes, unaffordable coverage, and other hardships. Both require providers of health coverage to report coverage to the revenue authority, with a copy of the statement to the covered individual. And both are administered through the existing income tax system but rely on the health insurance Marketplace to grant certain exemptions on a prospective basis. (These similarities are not surprising, given that the Massachusetts health reform law was the primary model for the ACA.)

But there are differences at the margins. The Massachusetts mandate imposes substantive requirements on employer coverage to qualify, while the federal mandate categorically recognizes most employer coverage and relies on insurance regulations for substantive standards. The threshold for the affordability exemption under the federal mandate is 8 percent (indexed) of income,⁶⁸ while in Massachusetts the threshold percentage varies based on income. The penalty amounts follow somewhat different schedules, with the Massachusetts penalty generally smaller at very low and very high incomes and larger in the middle. The reporting requirements apply to somewhat different entities and require somewhat different information. The two use somewhat different administrative processes and different terminology – for example, qualifying coverage is called “minimum essential coverage” by the ACA and “minimum creditable coverage” by Massachusetts. Some marginal rules differ as well: Massachusetts counts an individual as covered for a month if they had coverage for at least 15 days; under the ACA it is one day.⁶⁹

This paper recommends adopting the federal mandate as a baseline for a state mandate and incorporating Massachusetts rules only as specifically needed. The New Jersey and D.C. mandates both reflect this approach. This recommendation is not based on any judgement as to the merits of two existing mandates. Both have generally functioned well, and some features of Massachusetts’ policy have important advantages, as discussed below. Rather, the preference is based on several practical considerations related to the federal mandate having already been in effect nationwide:

- 1. Eases and Expedites Stakeholder Adjustment.** Adopting a state mandate similar to the federal mandate provides continuity for stakeholders, who have spent several years learning about and adjusting to the ACA rules and have little or no familiarity with Massachusetts’ rules or others. These stakeholders include:

⁶⁸ The 8 percent figure is indexed to reflect the observed growth in the share of income consumed by health insurance premiums. Specifically, it is indexed to reflect “the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.” [26 U.S. Code § 5000A\(e\)\(1\)\(D\)](#). For 2019, the figure will be 8.3 percent.

⁶⁹ As explained in greater detail below, the Massachusetts mandate also contains a coordination provision that reduces the amount of the Massachusetts penalty by the amount of any federal penalty, thereby preventing individuals from being penalized twice.

- Insurers, who have spent substantial resources developing systems to track and report coverage and who would need substantial lead time to modify these systems and plan offerings and materials;
- Employers, who must choose coverage to offer to their employees and are familiar with the current ACA-compliant offerings;
- Tax preparers, who must explain the mandate rules and build software reflecting them; and
- Taxpayers, who must ultimately comply with the rules.

Adjusting to a new set of rules would impose substantial additional cost on all these stakeholders. And it would take time. With enforcement of the federal mandate ending at the end of this year, there are reasons to make a state mandate effective as quickly as possible.⁷⁰

2. Simplifies Legislative Drafting. Using the federal mandate as a baseline allows states to enact a mandate through “conformity” with federal law, a common state legislative drafting technique in which state law is defined by reference to federal law.⁷¹ Many state Tax Codes rely on conformity to simplify legislative drafting, state implementation, and taxpayer compliance. For example, 27 states define adjusted gross income (AGI) for state tax purposes by reference to federal AGI.⁷² Many states do the same thing with tax credits, for example providing an earned income tax credit (EITC) that is defined as a certain percentage of the federal EITC.⁷³

Enacting a state mandate by conforming to the federal mandate greatly simplifies and shortens the required legislative language.⁷⁴ It also emphasizes the continuity between the state mandate and the federal one.

Conformity is generally described as either “rolling,” meaning that the state Code incorporates the current federal rules on an ongoing basis, or “static,” meaning that the state adopts the federal rules

⁷⁰ A good example is Massachusetts requiring 15 days of coverage in a month to satisfy the mandate versus one day under the federal mandate. This difference has relatively little given policy valence given that most coverage is monthly and the existence of the exemption for short coverage gaps. But adopting the Massachusetts rule would impose substantial cost on insurers, who have implemented tracking and reporting systems based on the one-day rule and would need to open new contracts with vendors to change to the 15-day rule.

⁷¹ Mike Porter et al., “[State conformity to federal provisions: exploring the variances](#),” *Deloitte*, reprinted from *State Tax Notes*, July 10, 2017.

⁷² Nicole Kaeding & Kyle Pomerleau, “[Federal Tax Reform: The Impact on States](#),” *Tax Foundation*, March 2017. For an example of state law taking this approach, see [Ohio Revised Code section 5747.01](#), “Income tax definitions.”

⁷³ IRS, “[States and Local Governments with Earned Income Tax Credit](#).” For an example of state law taking this approach, see [Maine Revised Statutes section 5219-S](#), “Earned Income Credit.”

⁷⁴ While it is easiest to incorporate the federal mandate by cross-reference (conformity), the other necessary statutory elements are simpler to restate in full, since they are shorter and reflect more changes from the Federal laws.

as of a certain date.⁷⁵ To avoid incorporating the repeal of the federal mandate, a state mandate should conform to the federal mandate as of a date before the enactment of the tax bill. For example, the New Jersey and D.C. legislation both adopt December 15, 2017 as the date of conformity, as this date falls between the publication of the most recent normal-course agency guidance on the federal mandate⁷⁶ and the passage of the tax bill.

- 3. Facilitates the Adoption of Regulations and other Guidance.** Adapting the federal mandate allows states to rely on federal regulations and other guidance rather than starting from scratch. This is important given the extensive and detailed guidance implementing section 5000A and the brief time states may have to implement a mandate.⁷⁷ Stakeholders need guidance with adequate lead time to adjust to any new rules. The IRS and HHS spent several years promulgating individual mandate guidance. It covers a wide range of topics and provides some non-obvious substantive interpretations.⁷⁸ Developing guidance from scratch risks providing rules that are suboptimal, late, or both.
- 4. Emphasizes Status Quo and Avoids Winners and Losers.** A state mandate based on the federal one may be easier to defend, as it merely restores the status quo and makes the ACA whole again. By contrast, imposing new rules is more likely to invite debate over design issues. Similarly, adopting federal rules minimizes creating winners and losers, which are likely if, for example, the penalty formula changes or certain coverage no longer satisfies the mandate.

Adopting the federal mandate as a baseline does not preclude making specific policy changes to incorporate Massachusetts rules – or other changes – on a case-by-case basis. For example, as discussed above, there may be good reason to exclude certain substandard plans from satisfying a state mandate, even if they satisfy the federal mandate. There are long-standing and straightforward methods for incorporating such modifications into state law enacted using conformity.⁷⁹

⁷⁵ Nicole Kaeding & Kyle Pomerleau, “[Federal Tax Reform: The Impact on States](#),” Tax Foundation, March 2017.

⁷⁶ IRS Notice 2017-74, “[Section 5000A Guidance for Individuals with No Available Marketplace Bronze-Level Plan](#),” December 6, 2017.

⁷⁷ For a list of regulations and guidance issued under the federal individual mandate, see IRS, “[Affordable Care Act Tax Provisions for Individuals](#),” under the heading “Individual Shared Responsibility Provision.”

⁷⁸ For example, the guidance covers what constitutes minimum essential coverage; the details of the penalty calculation, including for partial-year coverage; the definition of “affordable” for purposes of the affordability exemption, including how it is determined for dependents of employees offered employer-sponsored coverage; the conditions that qualify for a hardship exemption; eligibility and administrative rules for other exemptions; rules for indexing the various parameters; rules for calculating the national average bronze plan that caps the penalty; and substantive and procedural rules for designating additional minimum essential coverage.

⁷⁹ The common approach is to cross-reference the relevant federal provisions(s) and then add a list of specific changes. For example, see the treatment “adjusted gross income” in [Ohio Revised Code section 5747.01](#), “Income tax definitions.”

For all these reasons, most states will be best served by taking federal law as the starting point for a state mandate. A state that takes a different path should be prepared for a longer and more difficult implementation process for the state and stakeholders, and the possibility of stronger stakeholder resistance.

B. Components of State Mandate Legislation

Taking the approach called for in this paper generally requires state legislation with four components, each based on different sections of the ACA. The elements may break down differently based on a state's drafting conventions.

1. **Individual Shared Responsibility Requirement and Penalty.** This is the core of mandate legislation, imposing a requirement for individuals to maintain coverage and a penalty equal to the federal penalty as defined in section 5000A of the Internal Revenue Code. Incorporating the federal penalty pulls in the federal rules for qualifying coverage, exemptions, and penalty amounts.
2. **Program to Provide Certain Exemptions.** This section sets up a state program to grant the few exemptions that are not claimed on the tax return, generally because they need to be available outside the tax filing season. The language can draw from portions of sections 1311 and 1411 of the ACA, which provide for the program under which CMS, through the federally facilitated Marketplace, currently grants certain exemptions.
3. **Coverage Reporting.** This section requires insurance companies and other providers of qualifying health coverage to provide information reporting on the fact of coverage to the state revenue agency and to enrollees. Such reporting is currently required (to the IRS and enrollees) under section 6055 of the Internal Revenue Code. Section 6055 remains in effect and is used for purposes other than the mandate, so its reporting is likely to continue. A state can craft its reporting requirement to minimize any burden on reporting entities by (a) permitting them to submit the same information to the state revenue agency as they currently submit to the IRS under section 6055, and (b) allowing them to send nothing additional to enrollees who already receive forms under section 6055. This section should include some important modifications for state context, as explained in Appendix II below.
4. **Outreach to the Uninsured.** This section provides for outreach about coverage options to individuals who pay the penalty or claim an exemption. As explained above in Section II.C, enacting a mandate provides the state with valuable information for doing targeted outreach

to the uninsured. This outreach provision is based on a similar requirement in ACA section 1502(c).⁸⁰

Adapting the federal statutory provisions for state context requires some technical changes, as explained in Section IV.C. Policy changes may also be incorporated, as discussed in Section IV.D.

C. Technical Adjustments to Adapt the Legislation for State Context

While the federal rules for the mandate and related provisions will generally work for states, some technical adjustments should be made to reflect state-specific factors and differences between federal and state authority. These adjustments are generally included in New Jersey's and D.C.'s mandate legislation.

Examples of these technical adjustments include:

- The federal mandate provides an exemption for individuals with gross incomes below the income tax filing threshold. This serves the dual goals of ensuring that individuals with very low incomes are not penalized and avoiding a new tax filing requirement for individuals not otherwise required to file. A state can ensure that its mandate supports these same goals by creating a similar exemption tied to the state income tax filing requirement.
- The federal mandate penalty is capped at the national average bronze premium, as calculated annually by the IRS.⁸¹ With the federal mandate penalty repealed, the IRS will likely stop performing that calculation, and states may not have the necessary nationwide premium data. State mandate penalty legislation can address this issue by capping the penalty at the state average bronze premium. Tailoring the cap to specific conditions in the state in this way also seems consistent with the purpose of the cap.
- Both the ACA and Massachusetts require health insurers and other providers of qualifying coverage to report on the fact of coverage to the revenue agency, with a copy to covered individuals. But a state cannot require Medicare and other federal programs to do reporting. Also, state requirements related to employer benefits like health coverage may be subject to legal challenge based on ERISA preemption, especially if the requirements refer to ERISA concepts. To address this, a state reporting requirement should be carefully drafted, including following Massachusetts in exempting federal programs and assigning reporting responsibility for employer-sponsored insurance to the employer rather than the ERISA plan.

A complete list of suggested technical adjustments is included in Appendix II.

⁸⁰ Model state legislative language reflecting this approach is available at <http://shvs.org/resource/model-legislation-for-state-individual-mandate/>.

⁸¹ See, for example, IRS, [Rev. Proc. 2018-43](#), August 17, 2018.

D. Policy Changes for States to Consider

While there are advantages, discussed above, to modeling a state mandate closely on the federal rules, there may be good reason to make discrete policy changes. This section discusses some changes that states may want to consider, including several based on Massachusetts rules. The changes discussed here can generally be made without significantly complicating state implementation or stakeholder compliance. The New Jersey and D.C. mandates each incorporate several of these options.

1. Discouraging Substandard Coverage

As discussed in Section II.B, substandard health coverage poses risks both to the individuals it covers and to insurance markets broadly. Enacting a state mandate that does not recognize this coverage can limit its impact by effectively increasing its price relative to ACA-compliant coverage. The mandates in Massachusetts, New Jersey, and D.C. all go further than the federal mandate in this regard.

Not recognizing substandard coverage requires delineating substandard coverage from coverage that does satisfy the mandate. There are three common approaches to drawing these lines:

- **Categorical Exclusions.** Mandate legislation may explicitly exclude certain whole categories of coverage from satisfying the mandate. The federal mandate takes this approach with short-term plans⁸² and with another type of limited coverage called excepted benefits,⁸³ and the New Jersey and D.C. mandates adopt these rules by cross-referencing federal definitions. This approach may be attractive when a state concludes that a category of coverage is seldom if ever adequate.⁸⁴
- **Substantive Standards.** Mandate legislation may impose substantive requirements that certain coverage must meet to satisfy the mandate. The Massachusetts mandate has long done this with employer plans and grandfathered plans. It requires most private coverage to provide consumer protections, including substantially providing a broad set of benefits similar to the ACA's essential health benefits.⁸⁵ The New Jersey mandate adopted a similar approach towards AHPs by incorporating the state's current substantive requirements for AHPs into its

⁸² In particular, section 5000A's list of qualifying coverage includes "plans in the individual market," which under section 2791(b)(5) of the Public Health Service Act excludes "short-term limited duration insurance."

⁸³ See [26 U.S. Code § 5000A\(f\)\(3\)](#).

⁸⁴ Each of the mandate laws discussed here come with an administrative safety valve for categorical exclusions, allowing the executive branch to designate additional coverage as satisfying the mandate on a case-by-case basis. This provision has been rarely if ever used for short-term plans and excepted benefits.

⁸⁵ Massachusetts Health Connector, "[MCC Certification Application for Plan Years Beginning on or after 1/1/2017.](#)"

requirements for AHPs to satisfy the mandate.⁸⁶ This approach may be attractive when a state concludes that a category of coverage may be inadequate when it fails to meet certain additional standards. Besides AHPs, this may be an attractive option for employer plans, grandfathered plans, and health care sharing ministries.⁸⁷

- **Excluding New Plans.** A state may recognize coverage of certain types only if it was offered in the state or complied with rules in effect as of a certain date. The D.C. mandate takes this approach with AHPs, counting them as qualifying coverage only if they previously offered coverage in D.C. or comply with the federal rules in place before the new AHP regulations were finalized.⁸⁸ This approach may be attractive when a state concludes that a category of coverage has historically been relatively harmless but could pose risks if it were to gain market share, especially under new, looser rules.

2. Rationalizing Interaction with Federal Mandate Penalty

When the ACA passed, Massachusetts had to contend with the possibility of taxpayers being subject to two mandate penalties. To avoid double penalties, the state adopted rules providing that the state penalty would be reduced by the amount of any federal penalty paid.⁸⁹ This approach (as opposed to repealing its mandate) allowed Massachusetts' state-specific rules to continue to have effect. For example, individuals with employer coverage that satisfies the federal mandate but not the additional requirements of the Massachusetts mandate have continued to owe the Massachusetts penalty, effectively discouraging such coverage.

With the federal mandate penalty repealed, the Massachusetts offset rule will soon have no effect. Nonetheless, an offset provision may be worth including. It is not inconceivable that a federal mandate will be reinstated if experience shows insurance markets faring better in states with mandates. And the provision seems harmless: it has no effect without the federal penalty in place, and a generally desirable effect with the federal penalty in place. Both the New Jersey and D.C. mandates include such a rule.

⁸⁶ New Jersey State Legislature, "[New Jersey Health Insurance Market Preservation Act](#)". Bill No. A3380 section 4a. This approach was designed as a safeguard in case federal AHP regulations are held to preempt states' substantive regulation of AHPs. In that case, New Jersey's substantive AHP requirements might no longer apply, but an AHP violating them would not satisfy the mandate.

⁸⁷ Under the federal mandate, health care sharing ministries do not satisfy the mandate, but individuals with these products are exempt from the mandate, which generally has the same effect. Working within this framework, state mandate legislation could attach any substantive standards to eligibility for this exemption. For example, legislation could provide that an individual in a health care sharing ministry is exempt from the mandate only if the ministry accepts all applicants, covers any pre-existing conditions, and charges the same price regardless of an applicant's health status.

⁸⁸ Muriel Bowser, "[Fiscal Year 2019 Budget Support Act of 2018](#)," Chapter 50: Health Insurance Individual Responsibility Requirement, March 22, 2018.

⁸⁹ Mass.gov, "[Learn about the Assessment of Penalties](#)," accessed, under the heading "Massachusetts Interaction with Federal Health Care Shared Responsibility Payment."

Another option would be to provide that the state mandate is zeroed out if the federal mandate comes back. This would have the advantage of simplicity, but it would negate any state-specific features a state included in its mandate, such as limiting the impact of substandard coverage.

Finally, omitting any rule defining the relationship with a federal penalty is not a huge risk, as a state could change its law to avoid double payment once the federal mandate was restored.

3. Rationalizing the Operation of the Affordability Exemption

The ACA and Massachusetts mandates both provide an exemption for individuals who lack an affordable option to purchase coverage. Both define “affordable” by comparing the individual’s required contribution – generally the individual’s cost of coverage – to a fraction of the individual’s income. But the federal mandate defines “required contribution” in a way that leads it to grant exemptions in certain instances where an exemption is likely not appropriate, so states may wish to conform this specific rule to Massachusetts’ approach.

Conceptually, the required contribution is the lowest price for which an individual could purchase qualifying coverage. That is how Massachusetts defines it. The ACA generally follows that approach for individuals not eligible for employer-sponsored coverage: the required contribution is the amount the individual would have to pay towards the lowest-cost bronze plan on the Marketplace, net of any available premium tax credit (PTC). But for individuals eligible for employer-sponsored coverage, the ACA defines the required contribution as the lowest amount they would have to pay for employer-sponsored coverage – even if Marketplace coverage would be cheaper.

This creates some undesirable outcomes. Consider an individual eligible for unaffordable employer coverage as well as highly subsidized Marketplace coverage. Under the federal rule, her required contribution is based on the unaffordable employer offer. As a result, the individual qualifies for the affordability exemption even though she is in fact eligible for highly affordable Marketplace coverage. This is problematic in its own right, but it also creates some potentially troubling inequities. Consider a similar individual but without the unaffordable employer offer. His required contribution is based on the highly subsidized Marketplace coverage, so no exemption is available. In other words, the two individuals can purchase Marketplace coverage for the same (highly affordable) amount, yet one is exempt from the mandate because she also has a second, unaffordable option.

This issue can be readily addressed by tweaking the definition of required contribution to follow Massachusetts’ rule: the required contribution is the lesser of the amounts the individual would need to pay for Marketplace coverage or employer coverage. This addresses the horizontal inequity described above, fits more intuitively with the term “required contribution,” and avoids needlessly exempting individuals with highly affordable coverage options.

4. Avoiding Erroneous Payments by Low-Income Individuals

Section III.A above considered the impact of a state mandate on low-income individuals, noting that (1) widely-discussed IRS data overstate the likely impact a state mandate would have on low-income individuals, so long as the state takes straightforward measures to avoid erroneous payments; (2) the ACA provides a coordinated array of mandate exemptions and generous subsidies for low-income individuals; and (3) applying the mandate broadly is important for achieving its policy goals. This section discusses the straightforward measures for avoiding erroneous payments by low-income individuals. State legislation based on the federal mandate likely provides administrative authority for a state to adopt any or all of these options, without any additional specific authority. But a state could also write these measures into its mandate legislation to provide greater assurance, as D.C. has done.⁹⁰

- **Implement Return Processing Filters to Catch Erroneous Payments.** Most tax returns are filed electronically,⁹¹ permitting the IRS and state revenue agencies to check for errors that are apparent on the face of the return. These errors include computational mistakes, transcription errors, and leaving required fields blank. As the National Taxpayer Advocate noted, many of the erroneous payments of the federal mandate penalty came from low-income individuals, most with income below the filing threshold. A state could greatly reduce these errors by incorporating real-time checks into its return processing system.
- **Provide Instructions and Other Materials that Accurately Reflect, and Emphasize, the Affordability Exemption.** As explained above, the operation of the affordability exemption makes it available to most Medicaid-eligible individuals, but this operation is complex and unintuitive. IRS forms and instructions for tax years 2014 through 2016 did not clearly explain this rule. The instructions for tax year 2017 took steps to address this issue, clarifying the affordability exemption calculation and adding reminders that Medicaid-eligible individuals should see if they qualify.⁹² States should incorporate these improvements and could further clarify this language and add additional reminders and online resources.

⁹⁰ It should be noted that a state might reasonably prefer not to exempt Medicaid-eligible individuals from the mandate. Applying the mandate to them would likely increase Medicaid take-up, while also increasing the share of mandate penalties paid by poor taxpayers. Even for a state with this policy preference, the current approach is flawed, as it imposes the mandate penalty selectively on those poor taxpayers who misunderstand the rules

⁹¹ For example, in 2018, 92 percent of returns have been efiled: efile.com, "[U.S. Taxpayers efiled More Than 126 Million Returns in 2018](#)," as of May 2018. While data on state e-filing is less readily available, the virtually every state with an income tax permits it, so the rate is probably comparable; see TaxAct, "[E-filing States Stand Alone vs. Piggyback](#)," 2015.

⁹² In particular, the tax year 2017 instructions (1) changed the "Marketplace Coverage Affordability Worksheet," which taxpayers use to determine whether Marketplace coverage counts as affordable, to reflect that Medicaid-eligible individuals cannot get the PTC; and (2) added a "Tip" flagging this rule; and (3) flagging this issue in a section listing "common mistakes." See IRS, "[Form 8965 instructions – tax year 2017](#)."

- **Create a Clearer Exemption for Medicaid-Eligible Individuals.** Clarifying and emphasizing the affordability exemption rules can increase the likelihood that Medicaid-eligible people will claim it. But the rule is inherently complex and unintuitive, so some level of error is likely to continue.⁹³ A state could provide stronger assurances that such individuals would not pay a penalty by providing a simpler exemption for Medicaid-eligible individuals. For example, a state could provide an expanded low-income exemption for anyone with income under 138 percent of FPL. The D.C. legislation follows an approach like this, tying an exemption to D.C.’s income threshold for Medicaid eligibility. A state basing its mandate on federal rules could also create this exemption administratively using the authority to designate new categories of hardship exemptions.

A state could also consider changes that exempt larger numbers of relatively low-income individuals. For example, a state could adopt an affordability exemption similar to the one in Massachusetts, which ties the threshold to a percent of income.⁹⁴ For the reasons discussed above, this would materially weaken the mandate, rather than just avoiding overpayments, and thus reduce its impact on coverage and premiums. It would also be a relatively more complicated change to make, as it would replace the uniform 8 percent (indexed) exemption threshold with a sliding scale. States considering such changes must weigh these concerns against their goals in broadening the exemption.

5. Increasing the Penalty

After early-year enrollment figures in the individual market came in lower than forecast, some observers suggested that the penalty was too small to create a sufficient enrollment incentive.⁹⁵ In keeping with this concern, some state mandate proposals have called for more aggressive penalties.⁹⁶

There is little evidence for the claim that the federal mandate is too small to be effective. The federal mandate penalty phased in over time and was felt by taxpayers only after the fact, so observations from the first few years likely understate its impact.⁹⁷ The best evidence from recent research is that the

⁹³ As explained above, intuitively the “required contribution” for an individual who can enroll in Medicaid at no cost is zero. But in fact it is generally the full (unsubsidized) premium for a Marketplace bronze plan.

⁹⁴ mass.gov, “[2017 Massachusetts Schedule HC Health Care](#),” Table 3: Affordability, January 16, 2018.

⁹⁵ For example, see Rachel Roubein, “[Should ObamaCare’s individual mandate penalties, subsidies increase?](#)” *The Hill*, October 18, 2016. See also Avik Roy, “[Obamacare’s Dark Secret: The Individual Mandate is Too Weak](#),” *Forbes*, July 11, 2012.

⁹⁶ See Fiona M. Scott Morton, “[The Connecticut Individual Healthcare Responsibility Fee](#),” *Yale Institute for Social and Policy Studies*. February 5, 2018, calling for a fee that is generally 9.66 percent of income.

⁹⁷ Specifically, the federal mandate penalty reached its full value (generally \$695 per uninsured adult plus half that per uninsured child, or 2.5 percent of household income over the filing threshold, whichever is greater) only in 2016. Given that most 2016 tax returns were filed in early 2017, the open enrollment period in late 2017 was the first one when people were likely to be aware of the full size of the penalty. Results from the 2017 open enrollment period suggest [surprisingly strong](#)

federal mandate had a substantial impact on coverage.⁹⁸ And the federal mandate is generally approximately the same size as the Massachusetts mandate,⁹⁹ which evidence suggests has been quite effective.¹⁰⁰

The fact that the current penalty is large enough to motivate changes in behavior does not, of course, establish that it is optimally sized. A larger penalty would probably increase coverage more, so states wishing to surpass the coverage levels achieved under the ACA could evaluate options for doing so. These benefits must be weighed against the disadvantages, including higher costs to individuals, reduced continuity with the federal mandate, and potentially greater political resistance. In the near term, it seems likely that these disadvantages will deter most states interested in implementing their own individual mandates from imposing penalties higher than those in place under the federal mandate. In the longer term, the appropriate size of a mandate penalty is a question that would benefit from additional research.

6. Using Mandate Penalty Revenue to Make Coverage More Affordable

States that realize net budgetary savings from a mandate and wish to use those savings to make insurance coverage more affordable have several options. These options would generally increase enrollment in the individual insurance market, especially among healthier consumers, thereby reducing premiums. Several of these options could be funded in great part or entirely by the revenue from a mandate.

- **Reinsurance.** Mandate revenue can cover most or all of the cost of a state reinsurance program. Seven states have applied for and received federal approval to establish these programs as part of section 1332 State Innovation Waivers, which provide federal funding to

[performance](#) given the various factors depressing take-up. See, e.g., Katie Keith, “[Marketplace Enrollment Remained Stable, Increased in State-Based Marketplaces. NASHP Reports](#),” *Health Affairs Blog*, February 8, 2018. While it is impossible to tease out the effect of various factors in play, experience with the fully-phased-in mandate penalty could be a reason for the strong results.

⁹⁸ Matthew Fiedler, “[How Did the ACA’s Individual Mandate Affect Insurance Coverage?](#)” *The Brookings Institution*, May 2018. As Fiedler explains, evaluating the mandate’s impact is complicated because the mandate took effect in 2014, at the same time as the Medicaid expansion, Marketplaces and related subsidies, and several insurance market regulations. In an effort to isolate the mandate’s effect, Fiedler focuses on the impact on individuals with incomes over 400 percent of the poverty line, who were less affected by these contemporaneous changes.

⁹⁹ Linda J. Blumberg and Lisa Clemans-Cope, “[Reconciling the Massachusetts and Federal Individual Mandates for Health Insurance: A Comparison of Policy Options](#),” *Urban Institute*, December 2012.

¹⁰⁰ Amitabh Chandra et al., “[The Importance of the Individual Mandate — Evidence from Massachusetts](#),” *New England Journal of Medicine*, January 27, 2011.

help pay for reinsurance programs.¹⁰¹ New Jersey enacted its waiver authorization as part of a legislative package that also included its individual mandate, with mandate revenue dedicated to pay the state's share of the reinsurance program.¹⁰² The actuarial firm Oliver Wyman has calculated that New Jersey's share of the cost of the reinsurance program in 2020 will be \$105 million.¹⁰³ This is substantially less than the state's \$175 million in potential revenue from a mandate in 2020, as shown in Table 1. Wyman also estimates that the federal government would pitch in \$218 million in 2020 – a substantial advantage of this approach.

- **Affordability Wrap.** States with state-based marketplaces could use mandate revenue to support programs that “wrap around” federal affordability subsidies, thereby making premiums or cost-sharing more affordable for low- and moderate-income individuals. Massachusetts and Vermont have long-standing wraps for individuals eligible for federal Marketplace subsidies, with Massachusetts' program funded in part by its mandate.¹⁰⁴ Minnesota had such a program in 2017 for Marketplace enrollees ineligible for federal subsidies.¹⁰⁵

State mandate revenue may be sufficient to cover much or all of the cost of such a wrap, depending on its specific design. For example, for state fiscal year 2018, Vermont's premium assistance wrap cost was forecast to cost \$6.6 million, and its cost-sharing wrap cost was forecast to cost \$2.6 million¹⁰⁶ – together this comes to less than the \$11.3 million a state individual mandate in Vermont could raise in 2020, per Table 1. More broadly, RAND researchers writing for the Commonwealth Fund analyzed two representative options for expanding the PTC that are analogous to state wraps – increasing the PTC for those currently

¹⁰¹ See Heather Howard, “[More States Looking to Section 1332 Waivers](#),” State Health and Value Strategies, updated August 16, 2018. For more information on 1332 reinsurance waivers, see Joel Ario and Jessica Nysenbaum, Manatt Health, “[State Reinsurance Programs: Design, Funding, and 1332 Waiver Considerations for States](#),” *State Health and Value Strategies*, March 2018.

¹⁰² Katie Jennings, “[New Jersey will become second state to enact individual health insurance mandate](#),” *Politico*, Updated May 31, 2018. The waiver application has since been approved. See Seema Verma, [Letter to Marlene Caride](#), August 16, 2018. In addition, the [recommendations](#) issued by the Executive Board of the D.C. Health Benefits Exchange (DCHBX) called for using mandate revenue to support a reinsurance program without a 1332 waiver, though the legislation did not ultimately include such a program.

¹⁰³ State of New Jersey, “[New Jersey 1332 Waiver Application](#),” July 2, 2018.

¹⁰⁴ Massachusetts Health Connector, “[ConnectorCare Health Plans](#),” and Lawrence Miller and Steven Costantino, “[Cost Sharing Program](#),” Presentation to Vermont Health Reform Oversight Committee, September 15, 2015. The DCHBX [recommendations](#) also called for a wrap of this sort, though it was not included in the legislation.

¹⁰⁵ See mn.gov, “[Health Insurance Subsidy Program](#).” Minnesota's program was allowed to expire after 2017, when its reinsurance program took effect.

¹⁰⁶ See Vermont Department of Health Access, [Medicaid Program Enrollment and Expenditures Report for Q3 SFY 2018](#), June 1, 2018.

receiving it and expanding it to those above 400 percent of FPL. RAND found the two options would cost \$5.9 billion and \$4.9 billion respectively in 2020¹⁰⁷ – each comparable to the Treasury Department’s forecast of \$5.7 billion in nationwide mandate revenue for that year. By contrast, Massachusetts’ generous ConnectorCare program costs over \$300 million per year¹⁰⁸ – far more than the \$82 million that would be expected from a mandate there modelled on the federal one. And Minnesota’s 2017 program cost \$137 million, far more than the \$71 million a state mandate might raise there.¹⁰⁹

- **Outreach.** States could spend the funds on outreach and education programs to help more people get covered. Deep cuts in federal outreach funding have created a potential need for states to do more.¹¹⁰ Research by Covered California suggests that this can be effective in driving enrollment and lowering premiums.¹¹¹ The D.C. mandate generally takes this approach, though mandate revenue may also be used for other purposes supporting the availability or affordability of health coverage.¹¹² Revenue from a state mandate is likely more than enough to pay for a generous outreach campaign. For example, nationwide federal spending on Marketplace outreach and navigators in 2016 (before recent deep cuts) totaled about \$163 million – a fraction of the \$5.6 billion of potential revenue from state mandates.¹¹³ Even a highly aggressive outreach program like California’s would easily be covered – it cost \$111 million for 2018, compared to potential mandate revenue there of around \$600 million.¹¹⁴
- **Individual Down Payments or Accounts.** Several states have explored options to use a taxpayer’s payment for going uninsured towards the future health care expenses of that specific taxpayer, thereby reframing the “penalty” as a “down payment.” There are at least two versions of this concept.

The first version is allowing individuals’ payments to be used towards their future premiums. This approach is found in legislation that was introduced in Maryland, based on a proposal

¹⁰⁷ Christine Eibner and Jodi Liu, “[Options to Expand Health Insurance Enrollment in the Individual Market](#),” Commonwealth Fund, October 19, 2017.

¹⁰⁸ Author communications with Massachusetts Health Connector Staff, September 4, 2018.

¹⁰⁹ Minnesota Office of the Legislative Auditor, “[Premium Subsidy Program](#),” May 7, 2018

¹¹⁰ Tim Jost, “[CMS Cuts ACA Advertising By 90 Percent Amid Other Cuts To Enrollment Outreach](#),” *Health Affairs Blog*, August 31, 2017.

¹¹¹ Peter Lee et al., “[Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets](#),” *Covered California*, September 2017.

¹¹² See section 47-5008(c) in Muriel Bowser, “[Fiscal Year 2019 Budget Support Act of 2018](#),” Chapter 50: Health Insurance Individual Responsibility Requirement, March 22, 2018.

¹¹³ Timothy Jost, “[CMS Cuts ACA Advertising by 90 Percent Amid Other Cuts to Enrollment Outreach](#),” *Health Affairs Blog*, August 31, 2017.

¹¹⁴ *Ibid.*

developed by Families USA.¹¹⁵ This approach could incentivize coverage by reducing the price of coverage for consumers who have been required to make a payment in the past, and by appealing to individual’s aversion to “losing” the payments they have made. On the other hand, this approach effectively decreases the cost to consumers of going uninsured in the first place. Taking these opposing dynamics together, the net coverage impact (relatively to a plain mandate) is unclear.

The second version is directing penalty payment towards individual accounts to pay for health care services. This approach is found in legislation released in Connecticut based on a proposal from faculty at the Yale School of Management.¹¹⁶ This approach would likely do less to increase enrollment in traditional health coverage than a conventional individual mandate, as it would weaken the initial incentive to enroll (by reducing the loss from staying uninsured) without later reducing the cost of coverage.

Implementing either of these approaches presents tricky design questions and would add to the operational build for the state. The Maryland approach would require changes to enrollment procedures and therefore is probably feasible only for states with State-Based Marketplaces not using the federal enrollment platform.¹¹⁷ That said, recasting the mandate penalty as a benefit to consumers may be attractive politically.

Conclusion

The repeal of the federal mandate, combined with a series of adverse federal administrative actions, threatens to weaken the ACA in important ways – increasing premiums and cutting into coverage gains.

States and their residents will be adversely affected by many of these actions, but they are not powerless. They have tools at their disposal to take control of their insurance markets and protect their residents. A state mandate is an important tool on that list. It is a straightforward way to protect the health insurance market by merely restoring rules in effect under the ACA, while also offering other benefits like limiting the impact of substandard plans, facilitating coverage outreach, and raising revenue that can be used to support affordability. States would do well to consider it.

¹¹⁵ Stan Dorn, “[The ‘Protect Maryland Health Care Act’ Will Use Health Insurance Down Payments to Prevent Insurance Costs from Skyrocketing](#),” *Families USA*, January 30, 2018.

¹¹⁶ Fiona M. Scott Morton, “[The Connecticut Individual Healthcare Responsibility Fee](#),” *Yale Institution for Social and Policy Studies*, February 5, 2018.

¹¹⁷ For lists of states with state-based marketplaces and state-based marketplaces using the federal platform, see CMS.gov, the Center for Consumer Information & Insurance Oversight, “[State-based Exchanges](#),” updated September 15, 2017.

APPENDIX I: Additional Budgetary Consideration for Enacting a Mandate

As discussed above, a state mandate raises revenues through penalty collections. But creating a state mandate could also affect the state budget through other channels. This section considers CBO's estimates of the federal budgetary impacts of mandate repeal and how those may translate to states.

As discussed above, CBO's November 2017 analysis of mandate repeal provided detailed estimates of the impact on coverage and the federal budget. CBO's May 2018 baseline indicated that it had revised its methodology and now believes that its November 2017 coverage impact estimates were too large by about one-third. But the May 2018 report did not provide a detailed breakdown of its revised coverage impact estimates, and it did not provide any indication of how its revised coverage estimates would translate to revised budgetary estimates. Accordingly, the discussion below refers to the November 2017 figures in order to illustrate the broad magnitude of various federal budgetary effects, which is helpful in understanding the likely patterns of effects on state budgets. The impacts based on CBO's updated estimates of the mandate's effects would likely be somewhat smaller.

CBO's November 2017 report projected that repealing the ACA's mandate would create substantial net federal budget savings because the forgone penalty revenue is more than offset by lower spending on federal health care subsidies. In other words, the federal mandate increased deficits. For states, the fiscal calculus appears far more favorable. The reason is that, while a state mandate would collect about the same amount of revenue from the state's residents as the federal mandate, the resulting increase in the state's net health care spending is likely to be far lower than the impact on federal spending.

It is important to note that the impact of each of these factors will vary from state to state, depending on the state's tax system, uncompensated care programs, Medicaid and CHIP matching rates, other health care subsidies, insurance market conditions in the state, and other factors. In addition, the extent to which these factors would be taken into account for budgeting purposes depends on state budgeting rules and conventions.

For all these reasons, the figures below should be approached with caution. States considering a mandate should rely on state-specific analysis that reflects its specific rules and conditions.

- **Individual Market Subsidies.** CBO projected that the largest federal budget impact from mandate repeal, \$185 billion over the budget window, would come from lower subsidies for individual market coverage (largely the premium tax credit). State analogs to these subsidies are extremely rare.¹¹⁸ Thus there is generally no analogous cost to the state.

¹¹⁸ As noted above, Massachusetts and Vermont provide individual market subsidies that wrap around the federal subsidies.

- **Medicaid.** CBO projected that eliminating the mandate would reduce net federal spending on Medicaid by \$179 billion over the budget window. On average, states pay for about 37 percent of the cost of Medicaid coverage.¹¹⁹ But there is reason to believe that figure may be even lower for Medicaid enrollment induced by a mandate. The reason is that, as discussed in detail above, higher-income Medicaid-eligible individuals are more likely than those with lower incomes (below the income tax filing threshold) to be subject to the mandate, or to believe that they are. Medicaid-eligible individuals with higher incomes are generally eligible under the ACA Medicaid expansion and for these individuals the federal government generally pays a large share of the cost: 93 percent in 2019 and 90 percent in 2020 and thereafter.¹²⁰ As a result, to whatever extent a state mandate increases Medicaid coverage, it is likely to come at disproportionately small cost to the state.
- **Tax Exclusion for Employer-Sponsored Coverage.** CBO did not break out this figure, but included it as the main portion of a \$62 billion figure labeled “Other Effects on Revenues and Outlays.” The value of the tax exclusion is generally proportional to the marginal tax rate on wages. The average state marginal tax rate on wages was about one-fifth of the average federal rate, according to the most recently available data.¹²¹ Accordingly, the impact on state revenues is likely to be much smaller than the federal impact, with the specific impact heavily dependent on the state’s income tax system.
- **Uncompensated care costs.** CBO estimated that repealing the mandate would increase Medicare spending by \$43 billion over the budget window, largely due to “Disproportionate Share Hospital” payments. Many states have programs that similarly reimburse for uncompensated care and therefore can expect savings in uncompensated care programs from a mandate. Before the tax bill passed, the Urban Institute estimated that states were on track to spend \$14.1 billion on uncompensated care in 2019 – or about \$488 per uninsured person.¹²² Adding millions of people to the ranks of the uninsured would greatly increase the need for this state aid and could lead to automatic increases in state spending, depending on how a state’s uncompensated care programs are structured.¹²³

¹¹⁹ Kaiser Family Foundation, “[Federal and State Share of Medicaid Spending, FY 2016.](#)”

¹²⁰ Robin Rudowitz, “[Understanding How States Access the ACA Enhanced Medicaid Match Rates.](#)” *Kaiser Family Foundation*, September 19, 2014.

¹²¹ The most recently available data come from NBER calculations based on [state](#) and [federal](#) tax law in effect in 2016, run off samples drawn from 2008. See National Bureau of Economics Research, “[Marginal Tax Rates by Income Type.](#)” 2018.

¹²² Matthew Buettgens, Linda J. Blumberg, and John Holahan, “[The Impact on Health Care Providers of Partial ACA Repeal through Reconciliation.](#)” *Urban Institute*, January 2017.

¹²³ The Urban Institute’s July 2018 analysis estimated how much a mandate would reduce uncompensated care in each state in 2019, totaling \$11.4 billion. However, these figures represent the total cost of uncompensated care, not the cost to the state budget. Linda Blumberg et al, “[How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs?](#)” *Urban Institute*, July 20, 2018.

APPENDIX II: Technical Adjustments to Federal Mandate Rules for State Context

This appendix lists changes to federal mandate provision that a state should consider including in state mandate legislation to adapt the rules to a state’s legal framework and context. The first section describes general adjustments. The second describes adjustments specifically applicable to the coverage reporting requirement. The New Jersey and D.C. mandate laws generally include all of these adjustments.

General Adjustments for State Context:

- **Cap the penalty based on state-average premiums rather than national-average premiums.** Section 5000A caps the mandate penalty at the national average bronze plan premium. IRS has published guidance with this amount for tax years 2014 through 2018; for 2017 it is \$283 per month per individual.¹²⁴ With the federal mandate penalty zeroed out for 2019, the IRS is likely to stop producing this figure, so states will need to calculate a cap themselves. Doing so based on premiums in the state ensures both that the state has the requisite information and that the cap is well-tailored to conditions in the state.
- **Exempt residents of other states.** The Massachusetts mandate does not apply for months when a taxpayer is not a Massachusetts resident.¹²⁵ This is similar to the ACA exemption for residents of U.S. territories and other countries.
- **Exempt individuals with incomes below the state income tax filing threshold.** The federal mandate provides an exemption for individuals who are not required to file a federal income tax return because their gross incomes are below the income tax filing threshold.¹²⁶ This serves the dual goals of exempting individuals with very low incomes¹²⁷ and avoiding the imposition of a tax filing requirement on individuals not otherwise required to file. To achieve these same goals, state mandate legislation can include a similar exemption tied to the state income tax filing requirement.¹²⁸

¹²⁴ IRS, [Rev. Proc. 2018-43](#), August 17, 2018.

¹²⁵ mass.gov, “[Health care reform for individuals](#).”

¹²⁶ IRS, “[Individual Shared Responsibility Provision – Exemptions: Claiming or Reporting](#),” last modified February 16, 2018.

¹²⁷ Massachusetts Technical Information Release, “[TIR 17-1: Individual Mandate Penalties for Tax Year 2017](#),” February 3, 2017.

¹²⁸ The federal mandate provides two similar exemptions based on the filing threshold: a statutory exemption for those with household income below the filing threshold, and an exemption created by regulations for those with gross income below the filing threshold. The latter was created because the income tax filing requirement is tied to gross income. The state exemption should generally be designed to track the state filing rule.

- **Adopt federal guidance as starting point.** As explained above in Section IV.A, states can take federal guidance implementing the mandate as a starting point to avoid the need for a lengthy and resource-intensive guidance exercise. Adopting federal guidance as a starting point can be readily accomplished by incorporating federal regulations and other guidance into the state Code of Regulations or a similar record, much as the state Code can incorporate federal law. Federal guidance under sections 5000A and 6055 should generally be included, although adapted to any differences in state law. To ensure that states still control their own destiny, the state legislation should specify that any changes to this guidance made by state officials supersede the federal rules. As with section 5000A itself, federal guidance would apply as in effect on December 15, 2017.¹²⁹
- **Adapt legislation to state conventions.** The federal mandate includes numerous references to federal agencies, officials, Code sections, etc. Such references and terminology need to be adapted to reflect state institutions and conventions.

Adjustments to Federal Reporting Requirement to Reflect State Legal Authority

Both the ACA and Massachusetts require health insurers and other providers of qualifying coverage to report on the fact of coverage to help verify compliance with the mandate. The reporting goes to the revenue agency with a copy to covered individuals. The two requirements differ somewhat in what is reported and who is required to report. This paper recommends a hybrid of the two versions, with Massachusetts' rules for who must report in recognition of state legal authority and the federal rules on what is reported to ease the transition.

- **Who must report.** The ACA reporting requirement, in section 6055 of the Internal Revenue Code, requires reporting from all providers of minimum essential coverage. This includes health insurers; sponsors of self-insured group health plans; federal and state agencies that administer health programs like Medicare, Medicaid, Veterans Affairs (VA) coverage, and Tricare; and any entity that provides coverage designated minimum essential coverage by HHS.

The Massachusetts reporting requirement, by contrast, applies to only certain types of coverage and places the reporting responsibility on different entities.¹³⁰ These changes are apparently in recognition of limits on states' legal authority, and thus should be considered by other states as well.

First, the Massachusetts requirement does not apply to Medicare, VA coverage, Tricare, or other purely federal programs. This is likely because states cannot generally impose

¹²⁹ Depending on administrative law in the state, conforming with section 5000A "as in effect on" December 15, 2017, may be sufficient to incorporate federal guidance without separately discussing the incorporation of guidance.

¹³⁰ malegislature.gov, "[General Law - Part I, Title IX, Chapter 62C, Section 8B.](#)"

requirements on federal agencies. For individuals with these types of coverage, other information like the individual's age or employer can be used to help verify coverage.

Second, Massachusetts places the primary reporting responsibility on any "employer or other sponsor of an employment-sponsored health plan." Only if coverage is not under a "Massachusetts-based employment-sponsored health plan" is Medicaid or the health insurer required to report. Massachusetts law also specifies that reporting entities may "contract with service providers" to provide the reporting (and, indeed, many employers rely on insurers to submit the reporting).¹³¹ These provisions appear designed to help the reporting requirement survive legal challenge under ERISA, which preempts certain state regulation of group health plans. While an analysis of ERISA preemption law is beyond the scope of this paper, two things that may help state laws survive ERISA challenge are (1) avoiding references to ERISA group health plans or other ERISA concepts, and (2) minimizing the burden from the state law. Structuring the reporting responsibility like the Massachusetts rules achieves both of these ends.

- **What must be reported.** Both the federal and Massachusetts reporting requirements are relatively simple. For each enrollment group (generally, a family), they require a list of covered individuals and the months of the year covered, along with identifying information about the coverage provider. The federal requirement also requires that insurers providing coverage under a group health plan identify the employer. The biggest difference between the two requirements is that the federal structure uses taxpayer identification numbers (generally, social security numbers) to identify covered individuals, while Massachusetts uses dates of birth and subscriber numbers.¹³² (Section 6055 also requires the reporting of some additional information, such as the amount of advanced tax credit payments made through the Marketplace, but federal regulations eliminated those requirements as unnecessary.¹³³)

To maximize continuity and minimize the burden on reporting entities, states can follow the federal approach, while simplifying it further and providing an additional safe harbor. The simplification relates to fully insured employer-sponsored coverage: while section 6055 requires information about both the insurance company and the employer, state legislation can follow Massachusetts in permitting that one or the other be provided. The safe harbor would permit the reporting responsibilities to be satisfied by providing the same information that is currently reported under the federal requirement. Taken together these features will maximize continuity for reporting entities and minimize compliance costs, further supporting state authority in light of ERISA.

¹³¹ Massachusetts Department of Revenue, "[Health Care: Frequently Asked Questions for Employers](#)," General Question #2.

¹³² See [IRS Form 1095-B](#) and [Massachusetts Form MA 1099-HC](#).

¹³³ Federal Register, "[Information Reporting of Minimum Essential Coverage](#)," 79 FR 13220, March 10 2014.

- **Who the reporting goes to.** Both the federal reporting requirement and Massachusetts' require that the reporting goes to the revenue agency (IRS or Massachusetts Department of Revenue), with a copy to the enrollee. As result, many Massachusetts residents currently receive two statements documenting that they had coverage. This seems like an unnecessary duplication of effort, especially in the context of a state mandate closely matching the federal one. Accordingly, to minimize the burden on report entities, state legislation can provide that a coverage provider need not send a statement under the state law to enrollees who already get them under federal law.
- **Findings of fact.** To further support the case for ERISA compliance, a state may also include findings of fact in its legislation. Such findings may note, for example, that the reporting requirement is designed to minimize burden and is necessary for the successful enforcement of the mandate, which protects several compelling state interests, including a stable insurance market, a prospering economy, and the health and welfare of state residents. They may also emphasize that the mandate and reporting requirement are both tax provisions, given that there are some indications of greater deference under ERISA to state tax rules.

APPENDIX III. Considerations for States without Income Taxes

As discussed in the body of this paper, implementing a state mandate is generally straightforward because it can be operationalized through a state income tax system, as both the Massachusetts and federal mandates were operationalized through existing income tax systems. This approach allows the state to use its existing infrastructure of forms and instructions, payment mechanisms, return processing systems, and enforcement procedures; and it allows individuals to complete their filing responsibilities as part of an existing interaction with the state.

Without this infrastructure, implementing a state mandate is a heavier lift for both the state and its residents.

Yet states without income taxes do have options, especially if they are motivated to think outside the box. The following three seem the most promising:

1. Requiring Residents to Submit an Individual Mandate Form

A state without an income tax could require residents to submit a paper or electronic form capturing the mandate content that is currently included on federal income tax forms. Residents owing a mandate penalty would include a payment.

Implementing a state mandate with this structure comes with a significant cost to both the state and its residents. The state would face the one-time cost of developing an administrative apparatus to administer the mandate and the ongoing cost of doing so. State residents would need to take a whole new action each year. The burden on individuals could be mitigated by allowing residents to submit their information through a simple online form, or by incorporating the form into tax preparation software. But alternatives would be needed for individuals without ready access to or comfort with computers, which would mean substantial numbers of paper letters going back and forth, which is costly.

2. Piggybacking on an Existing State Procedures

Even states without income taxes have other ways that they interact regularly with residents. One or more of these existing programs might provide a platform for a mandate without developing an entirely new infrastructure or requiring residents to have additional annual interactions with the state. For example, states may have state-based property taxes or may impose excise taxes on utilities or cell phones. While not as straightforward as an income tax, a state willing to think creatively could develop ways to incorporate a mandate into these programs. These approaches might not reach a state's entire population, but they might reach enough people to achieve the benefits of a mandate.

3. Using Administrative Data to Make Initial Determinations

To avoid imposing a new responsibility on state residents to submit a form, a state could instead put the onus on the state to determine who might owe a mandate payment and initiate contact. The process would begin with the state collecting a list of those with health coverage and comparing it to a list of state residents. The state would then reach out to individuals who appeared to be state residents without coverage, and asking them to respond. The mailing could include a simple form the individual could return to claim an exemption, indicating that they actually had coverage, or make a payment. The state could also delay collecting payments for a year or two, until it developed a more reliable list of who in the state has long-term coverage (like Tricare or disability-based Medicare).

A key challenge to this approach is addressing gaps in the coverage list. As explained above in Section IV.C, states do not have authority to require reporting of federal programs like Medicare and Veteran Administration coverage. This creates a risk of false positives – states sending letters to individuals who actually have full-year coverage. States have several tools to address this concern. First, a state would probably refrain from sending letters to anyone over 65, given that they likely have Medicare. Second, the state may have a record of who is a veteran through state veterans’ programs. Third, a state’s database would likely improve over time. For example, if the state sent a notice the first year and the recipient responds that they have VA coverage or disability-based Medicare coverage, the state could then refrain from sending them letters in future years. The same approach could be used with individuals who qualify for exemptions that generally are ongoing, such as the ones for members of Indians tribes and for individuals with religious conscience objections. Over time, a state would have a better sense of whom to correspond with. Following this approach, a state might choose to initially refrain from collecting any penalty or to rely exclusively on self-assessment until there is greater comfort that the system is working.

Another challenge to this approach is acquiring reliable data for the two lists. For the list of those with coverage, states can rely on an information-reporting requirement like the one described in this paper. For the list of state residents, states have several options.

- **Existing reporting about employees and self-employed individuals.** Employers must generally provide states with employee payroll information for purposes of payroll taxes and unemployment insurance;¹³⁴ states may also require self-employed individuals to register as businesses or to pay a specific tax. Combining these lists could produce a fairly comprehensive list of everyone working in the state. Given that most retirees receive Medicare and most other non-workers are exempt from the mandate, this list may be good enough to work with.

¹³⁴ Social Security Administration, “State Directory of New Hires,” Section 453A of the Social Security Act.

- **IRS data sharing.** States can receive federal tax return information from the IRS to assist with state tax administration through information sharing agreements.¹³⁵ States without income taxes may not have such agreements, but they are entitled to them as long as they meet IRS data security standards. With such an agreement, a state could receive a list of state residents who filed a federal income tax.
- **List from other sources.** States may have fairly comprehensive lists of state residents from other contexts. For example, a substantial majority of American adults have a driver's license.¹³⁶ The rate likely varies considerably among states and is likely even higher excluding the elderly (who almost universally have Medicare) and poor (who are exempt from a mandate anyway).

¹³⁵ IRS, "[IRS Information Sharing Programs](#)." This sharing is authorized by section 6103(d) of the Internal Revenue Code.

¹³⁶ Michael Sivak and Brandon Shoettle, "[Recent Decreases in the Proportion of Persons with a Driver's License Across All Age Groups](#)," *University of Michigan Transportation Research Institute*, January 2016.

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