

# Massachusetts Health Connector

## The Massachusetts Individual Mandate: Design, Administration, and Results

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## Introduction

In 2006, Massachusetts enacted a comprehensive package of landmark health care reforms designed to expand health coverage. Among these reforms was a requirement that adult state residents enroll in affordable health coverage or face a penalty. The Massachusetts Health Connector and the Department of Revenue (DOR) have worked together since then to implement this “individual mandate.” The individual mandate reflected the guiding principle of shared responsibility that governed the Commonwealth’s first-in-the-nation health reform effort. It ensured that residents bore personal responsibility to purchase coverage, introduced policies and programs designed to help people afford coverage, and made sure that coverage included essential benefits that could help promote health and reduce financial risk.

The individual mandate is composed of three broad sets of policies. First, it includes coverage standards, known as Minimum Creditable Coverage, which an individual’s health coverage must meet in order for them to avoid a penalty. Second, it requires that the Health Connector Board of Directors define affordability standards to avoid penalizing uninsured individuals whose available insurance options are deemed too costly. Third, it defines penalty amounts and exemption standards. This brief outlines how the Massachusetts individual mandate is designed and continues to be administered, as well as data about compliance levels among state residents.

Although the Affordable Care Act (ACA) created an individual mandate nationally, Massachusetts chose to keep its state-level mandate in place because its associated benefit coverage standards, which varied somewhat from the national approach, had proven to be effective in our market. A broad group of stakeholders were convened to consider modifications to help align the two mandates in order to minimize confusion or complexity for Massachusetts residents; the most notable of these changes was the decision to allow residents to deduct any federal penalty paid from a state penalty owed.

This brief seeks to highlight and explain the key components of the Massachusetts individual mandate, its role in furthering the goals of the Commonwealth’s health reform efforts, and data on compliance for recent tax years.

# Coverage Standards

## Certain plans automatically satisfy coverage standards

In order to satisfy the individual mandate requirements, state residents must enroll in a health plan that meets the Minimum Creditable Coverage (MCC) standards. While certain kinds of insurance are identified in state law as meeting MCC requirements (see Figure 1), the Health Connector has also issued regulations further defining MCC.<sup>i</sup>

### Figure 1: Coverage Deemed MCC by Statute

- Medicare
- Medicaid (MassHealth)
- Qualified Health Plans, as certified for sale by the Health Connector
- Military and veterans' coverage
- Federal employee health plans
- Peace Corps, VISTA, AmeriCorps, and National Civilian Community Corps coverage
- Federally qualified high deductible health plans (HDHPs)
- Student health plans
- Tribal or Indian Health Service plans

## Other plans must meet specific criteria related to benefits and cost sharing

For plans not identified as being categorically MCC-compliant in the statute, the Health Connector promulgated regulations to define key benefits that a plan must provide in order to satisfy the individual mandate requirements. These benefits encompass a broad range of services, and they apply to all members covered by the plan. (See Figure 2.) Further, MCC regulations prohibit lifetime and annual benefit limits on core services and set out parameters for out of pocket spending. Compliant plans must cap deductibles at \$2,000 for individual coverage and \$4,000 for family coverage, with separate prescription drug deductibles capped at \$250 for individual coverage and \$500 for family coverage. The maximum out of pocket amount for a compliant plan may not exceed the maximum defined by the U.S. Department of Health and Human Services each year.<sup>ii</sup>

## **Figure 2: Benefits Required in an MCC-Compliant Plan**

- Ambulatory services, including outpatient, day surgery and related anesthesia
- Diagnostic imaging and screening procedures, including x-rays
- Emergency services
- Hospitalization
- Maternity and newborn care, including pre- and post-natal care
- Medical/surgical care, including preventive and primary care
- Mental health and substance abuse services
- Prescription drugs
- Radiation therapy and chemotherapy

### **The Health Connector may exercise some discretion in deeming plans compliant with coverage standards**

If a plan does not precisely meet certain standards outlined in regulation but still provides robust coverage overall, the Health Connector has a process by which a plan sponsor can apply for and receive designation as an MCC-compliant plan. Certain deviations from regulatory requirements will not – as a policy matter – be considered, such as failure to provide a broad range of services, imposition of lifetime limits, or failure to provide services (such as maternity care) to all dependents. The Health Connector generally receives several hundred such applications per year.

### **The responsibility to carry coverage that meets MCC standards is borne by the individual, not by employers or other plan sponsors**

It is important to note that, while a state resident must enroll in coverage that complies with Massachusetts' coverage standards, no employer or other plan sponsor is required to offer plans that meet MCC standards. There is no penalty for an employer who offers coverage that does not meet MCC. However, carriers conducting business in Massachusetts are, of course, aware of the MCC standards and offer compliant coverage. Further, most Massachusetts employers want to meet their employees' needs and, as such, offer compliant coverage. Residents without access to an MCC-compliant plan through employment or other means can rely on the Health Connector to provide MCC-compliant plans. Nearly all Massachusetts residents have MCC-compliant coverage year-round, suggesting this market arrangement has succeeded in delivering high-quality, comprehensive benefits to the Massachusetts population. (See Figure 3.)

## Massachusetts residents overwhelmingly comply with the state’s individual mandate

Individuals report on their health coverage status as a part of their state tax filing process with the Massachusetts Department of Revenue. The vast majority of Massachusetts adults filing taxes report that they are in compliance with the state’s individual mandate. While this data differs in nature from survey-based estimates of insurance coverage, it corroborates the findings of state and federal insurance coverage estimates that suggest widespread and near-universal coverage in the Commonwealth. Specifically, the Department of Revenue tax filing data indicates that for the last decade, between 93 and 95 percent of adults report full year coverage in an MCC-compliant plan. In the most recent year for which tax data is available (2015), only 3 percent of adult residents reported having no MCC-compliant coverage. (See Figure 3.)

**Figure 3. Health Insurance Status Reported to DOR, 2007 – 2015**

Year	Full Year Coverage	Part Year Coverage	No Coverage
2007	95%	*	5%
2008	95%	2%	4%
2009	92%	4%	4%
2010	92%	4%	4%
2011	92%	4%	4%
2012	92%	4%	4%
2013	92%	4%	4%
2014	94%	3%	3%
2015	93%	3%	3%

*\*In 2007, taxpayers were only required to report coverage as of December 31, 2007, so no distinction for full year or part year coverage was captured*

*Percentages may not add to 100% due to rounding*

## Affordability Standards

### **The law does not penalize individuals who fail to purchase coverage considered by the Health Connector to be unaffordable**

The Health Connector’s Board of Directors is charged with developing an “affordability schedule” each year that determines the cost at which health insurance would be considered prohibitively expensive for an individual to purchase. If a resident were only able to access coverage for a premium higher than the affordable amount, the state will not assess a penalty if that person reports being uninsured.

The portion of uninsured residents who are exempt from the mandate penalty because no affordable plans were available to them has stayed relatively steady over time, with two exceptions. (See Figure 4.) Because the individual mandate required coverage on December 31, 2007, a larger number individuals was uninsured. In 2014, implementation of the Affordable Care Act offered new coverage opportunities, notably the expansion of Medicaid coverage for low income, childless adults. The portion of those uninsured exempt on affordability grounds rose because exemptions for other reasons declined as residents gained coverage.

**Figure 4. Residents Exempt Due to Lack of Affordable Plans, by Full Year or Part Year Uninsurance, 2007 – 2014**

Year	Full Year Uninsured	% Full Year Uninsured Exempt Due to No Affordable Plan	Part Year Uninsured	% Part Year Uninsured Exempt Due to No Affordable Plan
2007	204,000	37%	*	*
2008	150,000	15%	71,000	0%
2009	170,000	13%	150,000	12%
2010	170,000	16%	150,000	11%
2011	180,000	16%	160,000	14%
2012	180,000	16%	160,000	16%
2013	190,000	22%	160,000	14%
2014	170,000	28%	130,000	9%

*\*In 2007, taxpayers were only required to report coverage as of December 31, 2007, so no distinction for full year or part year coverage was captured*

### **Defining what is “affordable” is complex**

There are several methods for determining how much a household would be able to pay for health insurance. Two of the most prominent are by looking at what the market charges and by determining the income available after other essential expenses. After reviewing a number of options calculated by different methodologies during the formative chapter of the state’s health reform implementation, the Board ultimately set affordability standards for higher income individuals based on a blend of premiums for employer-sponsored and non-group coverage, set standards based on Medicaid eligibility for the lowest income individuals, and then progressively bridged the gap between for others under 300% of the Federal Poverty Level. The result could generally be described as deferring to market norms for spending on premiums. Also of note, the Board of Directors chose to deem subsidized Health Connector premiums as, de facto, affordable. This meant that individuals eligible for the pre-ACA Commonwealth Care and current ConnectorCare programs could not forgo coverage without penalty.<sup>iii</sup>

The affordability schedule has maintained its progressive approach over time, based on the reasoning that households with higher incomes can afford to spend more on coverage, and those with lower incomes are less able to devote substantial portions of their household budgets to coverage. The current affordability schedule defines a percentage of income to be spent on health coverage that is deemed affordable at different multiples of the federal poverty level for families of one, two, and three or more. These amounts are then used to establish baseline enrollee premiums for ConnectorCare coverage.

As with MCC, the affordability schedule is narrowly applied as a tool by which individuals can determine if they are exempt from owing a penalty for not enrolling in coverage. It does not compel employers or carriers to offer plans that are considered affordable according to the schedule.

Unlike the federal mandate, the Massachusetts mandate does not rely on a particular indexing methodology for automatic updates. The Board of Directors explored such an approach, but timely and complete state-level data were not available to do so. For the last several years, the Board has adopted an approach whereby the percentage of income deemed affordable is applied to the next year's federal poverty standards, allowing for modest growth in the actual dollar amount considered affordable.

### **While out of pocket cost sharing is a growing burden for many people with insurance, it is not addressed by the affordability schedule**

In advance of setting the 2016 affordability schedule, the Health Connector considered ways to incorporate enrollee cost sharing into the schedule, in recognition of the growing burden of out of pocket costs for the insured, despite the deductible and out of pocket spending limits embedded in the individual mandate's Minimum Creditable Coverage standards. However, the Health Connector ultimately was not able to identify a methodology that did not result in problematic policy trade-offs or operational impracticalities. Although many struggle with out of pocket costs, the purpose of the affordability schedule is to help residents determine whether a forgone health plan was too expensive to purchase. Two individuals offered the same plan at the same premium might have had very different out of pocket costs depending on the services they needed. A sound approach for accurately assessing one's out of pocket burden in the decision to go without coverage was not immediately evident, though the Health Connector continues to be open to exploration of appropriately nuanced methodologies. The Health Connector also recognizes that continued focus on overall cost containment and value promotion remain critical to ensuring that out of pocket cost growth does not present untenable burdens for the Massachusetts population or to the overall stability of the Commonwealth's continued commitment to universal coverage.



## **Penalties and Exemptions**

### **State residents determine if they owe a penalty when they file their state income tax return**

When Massachusetts residents file their state income tax returns, they are required to provide information about their compliance with the mandate on the “Schedule HC,” a form that captures information about health coverage and access to affordable coverage options and is a required component of the tax return. The Schedule HC asks covered individuals for the name of their carrier and subscriber identification number. If they did not have full year coverage, the Schedule HC asks about any months they did have coverage, and then helps them to assess whether they are subject to a penalty. Taxpayers complete worksheets to determine if they had access to an affordable plan through a job, through the state’s ConnectorCare program, or through unsubsidized non-group coverage available through the Health Connector. If the individual could have enrolled in affordable coverage through any one of these channels, they will be assessed a penalty. Those who determine that they are subject to a penalty can indicate whether they wish to appeal based on a financial hardship. If so, they will receive a follow-up mailing with appeal forms after they file. Per statute, DOR will not assess any penalty until the appeal process is complete.

### **Massachusetts allows for exemptions in recognition of the complexities of each household’s circumstances**

State law allows for a gap of 63 days as individuals transition between spans of insurance coverage. The Health Connector has interpreted this as three calendar months for purposes of mandate administration. Anyone with a gap in coverage of three or fewer months is not subject to a penalty.

Individuals with income up to 150% FPL are not subject to a penalty, representing roughly half of uninsured individuals in any given year. Individuals are provided a worksheet with their Schedule HC to determine if their income is below 150% FPL. If it is, they are directed to not complete the rest of the form and to proceed with their return.

Exemptions are available for individuals who claim a sincerely held religious belief as the reason for remaining uninsured. If this were the reason for failing to obtain coverage, they would indicate this on their Schedule HC. Massachusetts statute instructs DOR to work with state agencies that oversee uncompensated medical care claims to confirm that individuals claiming a religious exemption are not accessing medical services at taxpayer expense.

Additionally, the Health Connector has issued regulations outlining the types of financial hardships that may be grounds for an exemption from the individual mandate penalty.<sup>iv</sup> (See Figure 5.) Appeal forms are reviewed by the Health Connector and may be adjudicated by an independent hearing officer engaged by the Health Connector if additional information is required. On average, the Health Connector has reviewed 2,400 hardship appeals each year since 2007. However, an average of 4,671

individuals each year have indicated a wish to appeal but then never returned the appeal paperwork to complete the process. They are assessed a penalty as a result.

### **Figure 5: Financial Hardships**

The Health Connector considers whether the appellant

- Was homeless, was more than 30 days in arrears in rent or mortgage payments, or received an eviction or foreclosure notice
- Received a shut-off notice, or was shut off, or was refused the delivery of essential utilities (gas, electric, oil, water, or telephone)
- Incurred a significant, unexpected increase in essential expenses resulting directly from:
  - Domestic violence
  - The death of a spouse, family member, or partner with primary responsibility for child care where that individual had shared household expenses
  - The sudden responsibility for providing full care for an aging parent or other family member, including a major, extended illness of a child that required a working parent to hire a full-time caretaker
  - A fire, flood, natural disaster, or other unexpected natural or human-caused event causing substantial household or personal damage for the individual
- Experienced financial circumstances such that purchasing compliant coverage would have caused a serious deprivation of food, shelter, clothing, or other necessities
- Had any other grounds the appellant claims demonstrate that he or she could not pay for coverage

### **Penalties are one-half of the lowest cost Health Connector premium available**

Since 2008, penalties for non-compliance with the state's individual mandate have been set at half of the lowest cost Health Connector plan available to the individual, pursuant to the formula set by statute. (Because the individual mandate went into effect on December 31, 2007, the penalty for not having coverage in 2007 was not half of a Health Connector premium; instead, the penalty for 2007 was the loss of the individual's personal income tax exemption, roughly \$219.) The Health Connector and DOR publish penalty amounts each year that reflect half of the lowest subsidized enrollee premiums for individuals under 300% FPL. For individuals above 300% FPL, penalty amounts reflect unsubsidized non-group premiums, though they also take into consideration the availability of lower cost plans for young adults. Before the ACA, these were called "young adult plans" and were for individuals up to age 26; since 2014, catastrophic plans have been available for individuals up to age 30. (See Figure

6.) Overall, the individual mandate penalizes roughly 50,000 taxpayers per year and generates around \$18M per year in revenue for the trust fund used to subsidize Health Connector programs.

**Figure 6. Monthly Penalties for Non-Compliance with the Massachusetts Individual Mandate, 2007 – 2017**

Year	150.1 – 200% FPL	200.1 – 250% FPL	250.1 – 300% FPL	>300% FPL, Young Adults	>300% FPL, Older Adults
2008	\$17.50	\$35	\$52.50	\$56	\$76
2009	\$17	\$35	\$52	\$52	\$89
2010	\$19	\$38	\$58	\$66	\$93
2011	\$19	\$38	\$58	\$72	\$101
2012	\$19	\$38	\$58	\$83	\$105
2013	\$20	\$39	\$59	\$84	\$106
2014	\$20	\$39	\$59	\$58	\$92
2015	\$20	\$39	\$59	\$60	\$91
2016	\$21	\$41	\$61	\$71	\$97
2017	\$21	\$41	\$62	\$74	\$96

## Conclusions

**The individual mandate in the Massachusetts market has effectively supported a nation-leading health coverage expansion effort**

Over the last ten years, the Massachusetts health care market has undergone monumental changes, designed to expand coverage to as many of the state’s residents as possible. The state’s pioneering health reform law, passed in 2006, was guided by the principle of shared responsibility, which included an expectation that residents would, when they could afford to, be responsible for obtaining comprehensive health coverage. This tool has been at the center of the state’s success in expanding coverage and in keeping our health insurance market stable, providing an important incentive to all adult residents to obtain coverage, regardless of health status or health needs. A health insurance market that has broad participation from residents across the range of health needs, ages, and expected utilization is the critical foundation upon which our state’s coverage rate has been built. At present, an estimated 97.5% of state residents have insurance—the highest rate in the nation—and the state remains well positioned to use state-based policy tools, like its individual mandate, to continue to ensure broad coverage, meaningful health care access, and a continued commitment to the health and wellbeing of its residents.<sup>v</sup>

# Appendix

## Relevant Law

### [Massachusetts General Laws, Chapter 111M](#)

- Defines Minimum Creditable Coverage
- Outlines requirements for administration and enforcement of mandate through tax law

### [Massachusetts General Laws, Chapter 176Q](#)

- Outlines powers and duties of the Health Connector Board of Directors with regard to mandate related policy development

## Relevant Regulations

### [956 CMR 5.00](#)

- Health Connector regulation, “Minimum Creditable Coverage”

### [956 CMR 6.00](#)

- Health Connector regulation, “Determining Affordability for the Individual Mandate”

### [830 CMR 111M.2.1](#)

- Department of Revenue regulation, “Health Insurance Individual Mandate”

## Other Reference Documents

### [“Schedule HC” tax form](#) and [associated instructions](#)

### [Health Connector Administrative Bulletin 03-10](#)

- Interprets statute’s allowable gap in coverage of 63 days as three calendar months

### [Massachusetts Residents without Health Insurance Coverage: Understanding Those at Risk of Long-Term Uninsurance](#)

### [The Remaining Uninsured in Massachusetts: Experiences of Individuals Living Without Health Insurance Coverage](#)

## Reports on Individual Mandate Data

### [Tax Year 2007](#)

### [Tax Year 2008](#)

### [Tax Year 2009](#)

### [Tax Year 2010](#)

### [Tax Year 2011](#)

### [Tax Year 2012](#)

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## Endnotes

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<sup>i</sup> 956 CMR 5.00

<sup>ii</sup> The U.S. Department of Health and Human Services updates out of pocket maximums in annual guidance related to regulations at 45 C.F.R. 156.130.

<sup>iii</sup> In practice, because the penalty for not enrolling in a plan without a premium would be \$0, individuals who could access a Commonwealth Care or ConnectorCare plan with no premium are effectively exempted from the individual mandate. This has been true since the inception of the mandate.

<sup>iv</sup> 956 CMR 6.00, Defining Affordability for the Individual Mandate, available at

<https://www.mahealthconnector.org/wp-content/uploads/rules-and-regulations/956CMR6.00.pdf>

<sup>v</sup> U.S. Census Bureau. (2017.) Health Insurance Coverage in the United States: 2016. Available at <https://census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf>.