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The United States of Reform: The Individual Mandate

Among the more prevalent health care policy themes in the recent times is the shifting of the policymaking power center from the federal government to the states. You've probably seen the headlines evidencing this changing tide; there are [good](#) ones, [bad ones](#), and many downright [ugly](#) ones.

It is exciting and important to see states stepping up where the federal government has stepped down (or, more apt, sought to burn things down). But decentralization inevitably reintroduces more variation—and, therefore, more inequity—in access to health care across the country. It becomes essential to mobilize, as broadly and swiftly as possible, state legislators, and to leverage advances in progressive states to encourage similar reforms elsewhere.

Thus, amid oral arguments in [Texas v. U.S.](#), a case that pits state against state in federal district court over the constitutionality of the Affordable Care Act (ACA) (yes, [here we go again](#)), *Health Care in Motion* is launching a new mini-series: *The United States of Reform*.

These issues will highlight **state-level** legislative and regulatory responses to **federal-level** health care policy changes. We'll identify and explore the types of initiatives that states are rolling out to reinforce, reproduce, or even expand ACA reforms under attack, as well as implications of this evolving environment.

For this first issue, we focus on the **individual mandate**. Read on for an overview of recent federal policy changes to the requirement, implications for states, trends in the design of a state-level mandate and, perhaps most importantly, next steps for advancing legislation in additional states.

Federal Policy Change Overview: The Individual Mandate Loses Its Bite Starting in the 2019 Plan Year

Oh, the individual mandate – requiring individuals to maintain health insurance meeting certain minimum standards or else pay a penalty – now shuffled off its mortal coil. The individual mandate was an important leg of the stool supporting ACA insurance marketplaces. By ensuring the participation of younger and healthier persons with less expensive health care needs, the mandate created a broad and balanced distribution of risk. In turn, the mandate lowered the average cost per person covered and enabled affordable premiums.

Opponents of the ACA targeted this policy from the outset. (Except, of course, at various points prior to the ACA, when the [Heritage Foundation put forward the idea](#) and when [Republican leadership promoted it](#).) With the passage of the Tax Reform Bill, Congress effectively repealed the individual mandate as of the upcoming 2019 plan year. Specifically, the Tax Reform Bill zeros out the resulting penalty, crippling whatever incentive it provided for enrollment in qualifying ACA plans.

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As we have written about [before](#), eliminating the mandate's penalty also revived legal challenges to the constitutionality of the ACA by the 20 plaintiff-states in *Texas v. U.S.* These plaintiffs assert that the Tax Reform Bill's removal of the individual mandate renders the ACA in its entirety unconstitutional. The argument rests on the Supreme Court's [prior decision](#) that the ACA was a permissible exercise of Congress's taxing power; if that basis is removed, the entire statute must fall, according to the Plaintiff-states. The Department of Justice is taking a more limited position, targeting the community rating and guaranteed issue provisions. These provisions prohibit insurers from denying coverage or imposing prohibitive premiums on individuals living with preexisting conditions. About [27% of American adults under age 65 have health conditions](#) that would leave them virtually uninsurable without the ACA's consumer protections.

A dangerous and baseless challenge in the eyes of the [17 attorneys general who have intervened to defend the law](#), the many organizations and associations that filed [amicus briefs](#), and other [legal experts](#), there is nonetheless some risk that the weakening of the mandate will give rise to more sweeping federal policy upheaval. In the near-term, however, *Texas v. U.S.* is likely to just cause more confusion and uncertainty (which could convince further some insurance companies to exit the Marketplaces). The plaintiffs have requested a preliminary injunction to enjoin enforcement of the ACA while the challenge plays out, and it is likely that this first order—in whatever form of it takes—will be appealed to the Fifth Circuit.

Implications for States: Impact on Market Stabilization Certain, Extent Uncertain

The impact of this change remains uncertain. Primarily, concerns relate to the stability of the non-group insurance market. For example, according to a [November 2017 Congressional Budget Office \(CBO\) report](#):

- Repeal of the mandate would result in an estimated decrease of enrollment in the non-group market by approximately 4 million in 2019 and 13 million in 2027.
- Average premiums in the non-group market would increase by an estimated 10% of baseline projections for most years of the decade.
- Elimination of the penalty would have a similar effect to repeal because “with no penalty at all, only a small number of people who enroll in insurance because of the mandate under current law would continue to do so solely because of a willingness to comply with the law.”

However, analyses vary and the CBO itself acknowledged that it is difficult to predict the ways in which affected stakeholders—including states, insurers, employers, and individuals—respond to any such change.

Further complicating the issue is that the elimination of the penalty is not occurring in a vacuum.

Concurrent efforts to undermine the ACA can reasonably be expected to stifle enrollment even more. Consider, for example, [CMS' slashing of the budget for the navigator program](#), which weakens the capacity of community-based organizations to conduct enrollment outreach, education, and support.

On the other hand, there are initiatives underway that seek to counteract the harmful effects of this federal policy change, such as the creation of state-level coverage mandates. (Fortunately, Congress can only have it [one way or another](#) when it comes to the debate over federalism and a mandate. The [Senate rejected an amendment](#), proffered by Senator Ted Cruz, which would have blocked D.C. from making its own laws as a local government.)

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Advancing a State-Level Coverage Mandate: State Models Incorporate Core Features of ACA Mandate

In the face of these threats, some states have stepped forward with reforms of their own. While [Massachusetts](#) has had an individual mandate on the books since 2006, [New Jersey](#), [Vermont](#), and the [District of Columbia](#) enacted state-/local-level mandates this year. Whereas the New Jersey and D.C. rules apply to the 2019 plan year, Vermont's mandate will take effect in 2020.

State models thus far share several common features with the structure of the federal mandate: (i) the imposition of a penalty, (ii) the inclusion of minimum coverage standards, and (iii) the establishment of exemptions from the mandate, for affordability and hardship. Each of these features serves a unique purpose and is commonly viewed as a central feature of a mandate. That said, we are seeing some variation in the details, such as in the thresholds for maximum penalties and income-based exemptions.

PENALTY FOR NON-COMPLIANCE

The Massachusetts, New Jersey, and D.C. mandates each include a financial penalty. In Massachusetts, a penalty schedule is published annually, subject to limits set forth in law. The New Jersey and D.C. penalties are modeled on federal rules; both jurisdictions have established the penalty amount as the greater of a percentage of household income or a per-person charge, subject to maximums and adjusted for inflation.

Enforcement—the objective underlying a penalty—was at the center of debate among Vermont legislators. The Vermont House voted to enact a mandate that would have taken effect in 2019 but which did not impose a penalty for non-compliance. The Senate rejected this plan, urging that a penalty is necessary to a mandate's effectiveness. The version ultimately signed into law calls for enforcement of the mandate by means of a financial penalty or “other mechanism,” the details of which are to be determined during the 2019 legislative session.

Innovations in Penalty Design

States are experimenting with program designs that would reinvest penalty revenue in insurance reform and market stability. For example:

- The D.C. mandate specifically provides that money collected via the penalty will be reinvested into insurance activities, such as those “that increase the availability of health insurance options or increase the affordability of insurance premiums in the individual health insurance market.”
- A [Maryland](#) proposal for a mandate would have allowed people to apply penalty-related money owed to the purchase of coverage for the following year.
- In New Jersey, penalty revenue will finance a state-operated reinsurance program.

MINIMUM COVERAGE STANDARDS

Minimum coverage standards seek to increase the likelihood that people have the coverage that they need and avert a “race to the bottom” among competing insurers seeking to save money. Facilitating a smooth transition from a federal mandate to a jurisdictional one, the Vermont, New Jersey, and D.C. mandates generally incorporate the standards for essential coverage currently set forth in [federal law](#).

D.C. deviates from the federal definition of minimum essential coverage in two respects: (i) acknowledging coverage provided under its Immigrant Children's Program as qualifying coverage; and (ii) accepting health coverage provided by certain employer-based arrangements. As to the latter, the D.C. mandate specifically (and strategically) links acceptable coverage to federal rules in place prior to the Trump Administration's proliferation of new rules for association health plans (AHPs) and short-term limited duration plans (STLDs). In other words, junk insurance, even if allowable under federal law, won't cut it for purposes of compliance with D.C.'s mandate.

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New Jersey's mandate similarly limits AHPs and STLDs, but does so via reference to additional standards set forth in state law instead of reliance on federal provisions.

EXEMPTIONS

In addition to penalties and minimum coverage standards, exemptions—the identification of people to whom the mandate does not apply—is another common, core feature of mandate design. For example, exemptions for people who cannot afford insurance work in tandem with federal premium assistance that makes the purchase of coverage in an ACA-regulated Marketplace more affordable (i.e., the Advance Premium Tax Credit).

A mandate's exemptions therefrom is also where we might expect to see the most variation from state to state, as they are designed to meet local needs. A state might recognize different types or thresholds of vulnerability. In D.C., for example, the mandate newly exempts people enrolled in the Healthcare Alliance Program—a locally-funded program that provides medical assistance to D.C. residents who are not eligible for Medicaid. Massachusetts' mandate, unlike the ACA's mandate, exempts children.

But My State Does Not Have a Mandate: Next Steps to Take Now

With only a couple of exceptions, 2018 state legislative sessions have ended. Because of this, it is a good time for advocates to be organizing around one or more proposals to be considered in 2019. A few ideas to focus organizing efforts on:

- Penalties, minimum coverage standards, and affordability/hardship exemptions each serve a unique purpose and are central features of a mandate.
- Remember that this federal policy change is not occurring in a vacuum. Mandates can be designed to promote market stability in a way that slaps back at other deleterious initiatives, as is the case with the D.C. and New Jersey exclusions of certain AHPs and STLDs from qualifying coverage.
- Take stock of enrollment and other trends in states that will have a mandate in effect for 2019—Massachusetts, D.C., and New Jersey—as analyses could support similar legislation in other states.

The ACA sought to create a more uniform health care system but the weakening of some reforms and the dismantling of others allows more variation to make its way back in. With the sweet taste of expanded access and critical consumer protections still fresh in these states, we are at a unique moment to demand that state legislators step up and preserve the advances. We're at a unique moment to advocate for states to unite in reform. So, who'll be next to join in with an individual mandate?

Questions? Looking for additional guidance on advocacy strategy and options? Contact us at chlpi@law.harvard.edu.

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