



CALIFORNIA
HEALTH
POLICY
STRATEGIES, L.L.C.

Policy Brief

Toward Universal Coverage: State Alternatives to the Federal Individual Mandate July 2018

I. Executive Summary

The Tax Cuts and Jobs Act, signed into law at the end of 2017, included a provision that effectively eliminated the shared responsibility payment for individuals failing to maintain minimum essential coverage. Effective in 2019, the penalty associated with the shared responsibility payment is now reduced to \$0.

Better known as the individual mandate, this shared responsibility payment—established by the Affordable Care Act (ACA)—required nearly all Americans to purchase health insurance or pay a penalty. The elimination of the mandate penalty, without an effective replacement, is predicted to reduce enrollment and distort states' risk pools, because the young and healthy have less incentive to enroll in individual market coverage. This is likely to impact the stability of the individual market and result in premium increases. In this time of uncertainty, states are now exploring options to dull the expected effects of the federal action.

This policy brief offers an analysis of several alternatives that California policy-makers may wish to consider to stabilize the state's individual marketplace. These options include:

- ❖ **A State-Level Individual Mandate:** The success of Massachusetts's state-level individual mandate may offer a model for consideration. New Jersey and the District of Columbia have recently adopted their own mandate and several other states are considering proposals. Although the policy and political challenges are daunting, it is noteworthy that an individual mandate requirement was included in California Assembly Speaker Fabian Núñez's unsuccessful 2008-health reform (ABx1-1). At the time, this legislation and its provisions for the individual mandate needed only a majority vote of the Legislature for passage, rather than the more onerous two-thirds requirement.

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- ❖ **An Auto-Enrollment Process:** An auto-enrollment policy, mirroring Maryland’s health insurance down payment proposal, would reinstitute the mandate’s penalty at a state level and use the accrued funds as a “down payment” to enroll individuals in coverage. Proponents of the auto-enrollment proposal argue that market stabilization and lower premium prices would yield an uptick in insurance enrollment, helping to make these marketplaces into a more attractive option for all consumers. Meanwhile, detractors insist that such a policy would place a tremendous administrative strain upon a state.
 - ❖ **A State Reinsurance Program:** The implementation of a well-funded state reinsurance program can moderate the immediate effects of repeal by insulating an insurance risk pool from exposure to very high cost claims. Maryland and New Jersey are currently awaiting federal approval for the creation of reinsurance programs that would position them along the lines of Alaska, Minnesota, and Oregon; all of which have established successful reinsurance programs. However, this approach requires an ongoing annual appropriation of state funds, a potential downside of the policy’s long-term effectiveness.
 - ❖ **A Continuous Coverage Requirement:** A continuous coverage requirement has served as a substitute of the individual mandate in most efforts to “repeal and replace” the ACA. This is because, similar to the mandate, a continuous coverage requirement intends to limit adverse selection by encouraging individuals to maintain coverage. The issue with this policy is that as long as the ACA is the law of the land there is no need to implement such a requirement. The ACA established a limited open enrollment period that essentially serves the same function as a continuous coverage requirement—a key reason for why most states have not pursued this policy alternative.

Table 1. Status Updates on State Efforts to Replace Individual Mandate

Action	Description	Status	
Connecticut	<i>State-Level Individual Mandate</i>	<ul style="list-style-type: none"> ❖ HB 5039 (Governor’s Bill) – Restores the ACA’s individual mandate at the state level, albeit with lower fees. 	Held in the Office of Legislative Research and the Office of Fiscal Finance
		<ul style="list-style-type: none"> ❖ HB 5379 (State Senator’s Bill) – Levies a tax of 9.66% of annual income or \$10,000 (whichever is higher) for violating the mandate. 	Held in the Joint Committee on Insurance and Real Estate
District of Columbia	<i>District-Level Individual Mandate</i>	<ul style="list-style-type: none"> ❖ B 753 – Restores the individual mandate at the district level. ❖ The maximum penalty is fixed to the average premium of a DC Bronze-level health plan. 	Approved by D.C. Council
Hawaii	<i>State-Level Individual Mandate</i>	<ul style="list-style-type: none"> ❖ SB 2924 – Declares intent to establish a state-level individual mandate but lacks detail. 	Held in House Committee on Finance
Maryland	<i>Auto-Enrollment</i>	<ul style="list-style-type: none"> ❖ SB 1011 (or HB 1167) – Would re-impose the mandate penalty on residents who remain uninsured. ❖ The accrued penalty funds would be used as a “down payment” to enroll those who paid the penalty into coverage. 	Held in the Finance Committee
	<i>Reinsurance</i>	<ul style="list-style-type: none"> ❖ HB 1782 – A \$380 million reinsurance fund, financed by a 2.75% tax on insurance companies. 	Signed by Governor
New Jersey	<i>State-Level Individual Mandate</i>	<ul style="list-style-type: none"> ❖ A 3380 – Restores the ACA’s individual mandate at the state-level and goes into effect January 1, 2019. ❖ The maximum penalty is fixed to the average premium of a NJ Bronze-level health plan. 	Signed by Governor
	<i>Reinsurance</i>	<ul style="list-style-type: none"> ❖ S 1878 – The funds accrued by the state-level mandate would be deposited into a reinsurance program that would cover the healthcare costs of catastrophically ill. 	Signed by Governor
Vermont	<i>State-Level Individual Mandate</i>	<ul style="list-style-type: none"> ❖ H 696 – Leaves specifics for a working group to determine but establishes intent to implement a state-level individual mandate by January 1 2020. 	Signed by Governor
Washington	<i>State-Level Individual Mandate</i>	<ul style="list-style-type: none"> ❖ SB 6084 – Creates a working group to study possible individual mandate enforcement mechanisms. 	Held in Senate Rules Committee

II. Background

A. Rationale for the ACA Individual Mandate

Prior to the ACA's implementation, the individual insurance market was an inaccessible or unattractive option for many Americans who needed health insurance coverage. Insurance exclusions prevented individuals with pre-existing health conditions from applying, and high premium costs limited affordability for those with low incomes. The ACA sought to address this broken insurance market through a "three-legged stool" strategy:¹

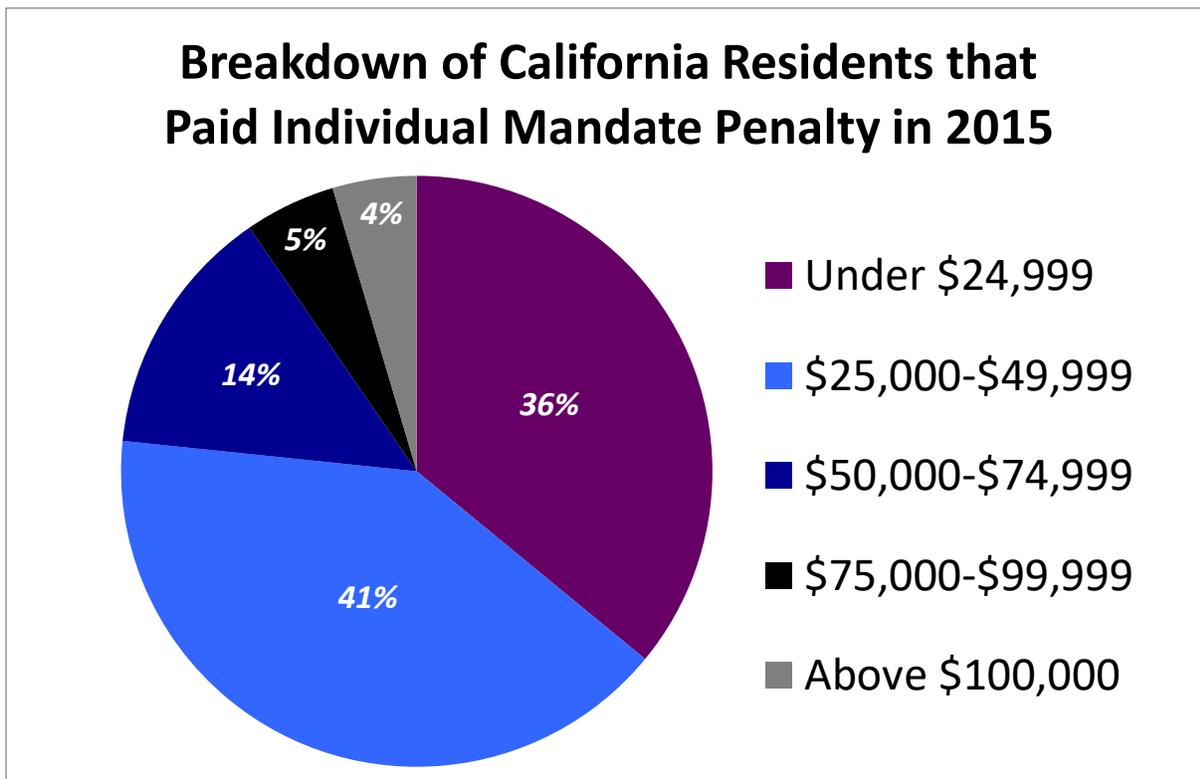
1. **Individual Mandate.** The individual mandate forms the basis of the first leg of the stool, serving as a crucial incentive to ensure the young and healthy enroll in coverage.² According to research from the *New England Journal of Medicine* (NEJM), mandating health coverage brought a larger amount of healthy individuals, compared to unhealthy individuals, into the risk pool.³ Without a mandate, the individual insurance market would be exposed to adverse selection, because sicker and more costly individuals would have the strongest incentive to purchase insurance.
2. **Subsidies for Low-Income Individuals.** Advanced Premium Tax Credits (APTCs) form the second leg of the stool, granting subsidies to low-income individuals with incomes up to 400% of the Federal Poverty Level (FPL). Access to sliding scale subsidies offers a powerful tool to increasing affordability of coverage. These first two legs—the mandate and subsidies—are designed to bring as many consumers into the market as possible, in effect creating a large-enough balanced risk pool that would result in affordable costs for everyone involved.
3. **Guaranteed Issue.** Requiring insurers to offer coverage regardless of an individual's pre-existing health condition is the third leg of the stool. This requirement now prohibits health insurers from employing exclusionary underwriting practices. As a result, individuals cannot be denied coverage or charged higher premium prices based upon pre-existing conditions or their health status.

¹ Jonathan Gruber, "Health Care Reform Is a 'Three-Legged Stool,'" *Center for American Progress* (blog), August 5, 2010, <https://www.americanprogress.org/issues/healthcare/reports/2010/08/05/8226/health-care-reform-is-a-three-legged-stool/>.

² Jonathan Oberlander, "Under Siege — The Individual Mandate for Health Insurance and Its Alternatives," *New England Journal of Medicine* 364, no. 12 (March 24, 2011): 1085–87, <https://doi.org/10.1056/NEJMp1101240>.

³ Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "The Importance of the Individual Mandate — Evidence from Massachusetts," *New England Journal of Medicine* 364, no. 4 (January 27, 2011): 293–95, <https://doi.org/10.1056/NEJMp1013067>.

The individual mandate was one of the most politically challenging components of the ACA during the law’s deliberation in Congress and it has continued to be a lightning rod. Polling in 2016 conducted by the Kaiser Family Foundation (KFF) found that two-thirds of the public viewed the mandate unfavorably.⁴ Those who opted to pay the penalty were particularly aggrieved. In California, 777,940 paid the penalty in 2015 for a total of \$377 million. According to IRS data, of the individuals who paid the penalty in 2015, 41% were families with annual incomes less than \$25,000, and 77% had annual incomes less than \$50,000.⁵



B. Potential Impact of Eliminating the Mandate Penalty

Eliminating the mandate penalty is likely to lead to both increases in the number of uninsured and in health insurance premiums. The latest estimates provided by the Congressional Budget Office (CBO) found that premiums on the individual market are projected to increase by an average of 15% in 2019 and then by 7% each year

⁴ Elise Sugarman, Ashley Kirzinger, and Mollyann Brodie, “Kaiser Health Tracking Poll: November 2016,” *The Henry J. Kaiser Family Foundation* (blog), December 1, 2016, <https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-november-2016/>.

⁵ Internal Revenue Service, “SOI Tax Stats Historic Table 2 | Internal Revenue Service,” IRS, 2017, <https://www.irs.gov/statistics/soi-tax-stats-historic-table-2>.

thereafter.⁶ A significant portion of the hike in premiums—approximately 10%—will be due to the elimination of the mandate’s penalty. These higher premiums go hand in hand with the forecasted loss of coverage caused by the elimination of the mandate penalty. According to the CBO, there will be three million more uninsured individuals in 2019, increasing to a total of 8.6 million more uninsured by 2027.⁷

Previous CBO estimates were higher. Late last year, the CBO estimated that the zeroing out of the mandate’ penalty would save the federal government \$338 billion over the next decade. These savings were predicated on the assumption that fewer low-income individuals would apply for coverage, allowing the federal government to avoid the cost of federal subsidies. During the push for tax reform, these sizeable savings—a third of a trillion dollars—attracted the attention of Congressional Republicans and may have contributed to their decision to include the mandate penalty elimination provision in the Tax Cuts and Jobs Act.

The penalty elimination is also likely to have significant impact on the California individual market. An analysis conducted by John Hsu and Vicki Fung at Harvard Medical School projected that the mandate penalty’s erasure could result in more than 378,000 Californians choosing to go uninsured in 2019; about 250,000 of which currently obtain their coverage through Covered California.⁸ Given this expected change in the state’s risk pool, the Harvard study estimates a 5%-9% premium increase in California’s individual market. This estimate is echoed by an independent analysis by the California Simulation of Insurance Markets (CalSIM), jointly developed by the UCLA Center for Health Policy Research and the UC Berkeley Labor Center. CalSIM’s model forecasts that eliminating the mandate penalty will bring a net decrease of 300,000 in 2019 enrollment on the California marketplace and an 8-10% rise in individual market premiums.⁹

⁶ Congressional Budget Office, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028,” Congressional Budget Office, May 23, 2018, <https://www.cbo.gov/publication/53826>.

⁷ Ibid.

⁸ John Hsu et al., “Eliminating The Individual Mandate Penalty In California: Harmful But Non-Fatal Changes In Enrollment And Premiums” (Health Affairs, March 1, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180223.551552/full/>.

⁹ UCLA and UC Berkeley CalSIM team, “CalSIM Memo to CCA: Individual Market Effects of Eliminating the Individual Mandate Penalty” (UCLA Center for Health Policy Research and UC Berkeley Labor Center, May 9, 2018), http://board.coveredca.com/meetings/2018/05-17/CalSIM%20Memo%20to%20CC_IndivMktMandate_09may2018_sent.pdf.

Table 2. Estimated Impact in California of the Removal of the Mandate Penalty

	<i>Estimated Increase in Uninsured</i>	<i>Premium Impact in 2019 (Individual Market)</i>
Harvard Study	❖ 378,000 in 2019	+5% to 9%
CalSIM Model	❖ 300,000 in 2019	+ 8% to 10%
<i>Expected Premium Impact in \$\$\$</i>		
Center for American Progress (CAP)	↑ ↑ 2019 Premiums to increase by \$983	

When discussing the impact of the mandate’s penalty elimination, it is important to note the different experiences of those with subsidies and those without. Subsidized marketplace enrollees are insulated from premium increases in the individual market because of how ACA subsidies are calculated. For subsidy eligible individuals (generally, those with an income under 400% of the federal poverty level), the amount of subsidy that an individual or family obtains is tied to the second lowest cost silver plan in that rating region. When premiums go up, the cost of a silver plan also goes up, as do the federal subsidies that are available to the consumer. For unsubsidized enrollees, their reality is quite different—they must pay for premium hikes themselves. The end of the mandate will be severe for these vulnerable consumers, a majority of whom are not high-income individuals¹⁰ and are already struggling with the existing premiums offered.¹¹

The Center for American Progress (CAP), a progressive research and advocacy organization, calculated estimates on the expected premium increases due to the penalty’s repeal for each state. In California, CAP projects 2019 premiums will increase by \$983, climbing from \$5,521 to \$6,504.¹² This means that non-subsidized Californians, which account for 15% of the state’s individual market, will face a near \$1,000 rise in their premiums.

¹⁰ The 2016 Nation Health Interview Survey determined that the estimated median household income for unsubsidized consumers was roughly \$75,000.

¹¹ John Bertko, “The Roller Coaster Continues — The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies,” *Covered California*, January 18, 2018.

¹² Thomas Huelskoetter, “State-by-State Estimated Premium Increases Due to Individual Mandate Repeal and Short-Term Plan Rule,” *Center for American Progress* (blog), May 18, 2018, <https://www.americanprogress.org/issues/healthcare/news/2018/05/18/450943/state-state-estimated-premium-increases-due-individual-mandate-repeal-short-term-plan-rule/>.

As California policy-makers and stakeholders evaluate the potential implications of the federal decision to eliminate the individual mandate penalty, several policy alternatives should be considered. This policy brief will focus on four **options**:

- **State-level individual mandate,**
- **Auto-enrollment process,**
- **State reinsurance program, and**
- **Continuous coverage requirement.**

III. Options for Addressing the Problem

A. A State-level Individual Mandate

In addition to California, other states are concerned with the impending loss of the individual mandate penalty and are weighing the merits of state-level individual mandates. These states look to Massachusetts, which has had the longest experience with a state health insurance individual mandate.

Massachusetts's individual mandate was enacted as part of the state's landmark 2006 health reform and has remained law even after the ACA's passage in 2010. According to tax filing data for the last decade from the Massachusetts Department of Revenue (DOR)—the agency that enforces the mandate—between 93%-95% of adults have reported full-year coverage.¹³ Massachusetts's state-level mandate penalty will persist through 2019 and beyond, unlike the federal mandate penalty.

As the first state to implement an individual mandate, Massachusetts had to resolve many technical issues that had previously stymied other states. For example, by having the mandate require individuals maintain coverage that adheres to specific coverage standards, the state sidestepped ERISA (the Employment Retirement Income Security Act of 1974), the federal law that prohibits states from regulating self-funded plans or requiring employers to offer health insurance. By placing the onus on the individual to enroll in a plan that meets the state's coverage standards or be penalized, Massachusetts managed to indirectly regulate these large-group plans.

To minimize confusion in the state, Massachusetts modified their own mandate to better align with the federal mandate, essentially syncing up the state's coverage standards with the ACA's essential health benefits (EHBs). Massachusetts also modified its state

¹³ Marissa Woltmann and Audrey Gasteier, "The Massachusetts Individual Mandate: Design, Administration, and Results" (Massachusetts Health Connector, November 2017), <https://www.mahealthconnector.org/wp-content/uploads/Individual-Mandate-Report-Nov2017.pdf>.

penalty to permit residents to deduct any penalty paid to the federal government from a state penalty owed.¹⁴ As a result, there would be no “double penalty” incurred for residents violating the state mandate.

The Massachusetts individual mandate is comprised of three sets of policies:

1. *Minimum Creditable Coverage (MCC).* The state mandate requires residents to be enrolled in a health plan that meets the Minimum Creditable Coverage (MCC) standards; these standards specify the package of benefits and cost sharing that consumers must maintain—or pay a penalty.¹⁵ The key difference between Massachusetts’s MCC standards and the ACA’s Minimum Essential Coverage (MEC) standards lies in their regulation of private insurance. While large-group, employer-sponsored insurance typically satisfies ACA’s MEC without a requirement that they include EHBs that is not the case under Massachusetts’s coverage standards. If an individual’s health coverage does not satisfy MCC standards, a penalty will be charged, even if they are enrolled in a large group plan. As mentioned previously, the responsibility of maintaining MCC compliant coverage in the state of Massachusetts is borne by the individual, not by insurance companies or by employers. For residents without access to an MCC-compliant plan, the Massachusetts Health Connector provides compliant plans.
2. *Affordability Standards.* The Massachusetts law directs the Health Connector Board of Directors to annually define affordability standards that determine the cost at which health insurance would be deemed too costly for a household. This has meant that Massachusetts’s affordability standards are different than the Federal standards.¹⁶ For example, Massachusetts’ schedule of affordability has always been on a sliding scale, with people under 150% FPL exempt from any penalty, and then sliding up to 8% of income at 300% FPL or above. Thus, Massachusetts’s mandate seeks to be fair and avoid financial punishment for residents lacking affordable coverage options. In effect, the state provides a more progressive approach than the ACA.¹⁷
3. *Penalties and Exemption Criteria.* Penalties are pegged to half the lowest cost Health Connector plan available to the household and are assessed when residents file their state income tax return.¹⁸ If found to owe a penalty, residents

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Subsidies for Massachusetts’s residents who do not qualify for Medicaid have always been much higher than APTCs. Thus, coverage is more affordable in the state for lower income individuals (up to 300% FPL) and the coverage is better as it has a much higher actuarial value than the federal plans.

¹⁷ Woltmann and Gasteier, “The Massachusetts Individual Mandate: Design, Administration, and Results.”

¹⁸ Ibid.

can appeal based on a financial hardship claim. Exemptions are allowed if the resident has an income below 150% FPL, a gap in coverage that does not extend past 63 days (three calendar months), or holds a sincerely held religious belief. The Massachusetts Health Connector handles this exemption process, while the state's Department of Revenue is responsible for administering the mandate's financial requirement such as verification of coverage, notification, and collection of penalties.¹⁹

According to the *New England Journal of Medicine*, the state's mandate helped cultivate a more balanced risk pool.²⁰ The implementation of a state mandate coincided with a significant increase in the number of healthy enrollees who signed up for coverage. Prior to the mandate's rollout, new enrollees in the Massachusetts marketplace were 35.5% likely to be chronically ill; this percentage dropped to 23.9% once the mandate came into the effect. In addition, the average age of new enrollees decreased by 4 years, reflecting the enrollment of younger individuals.²¹

The Massachusetts experience with a state-managed mandate has informed other states seeking alternatives to the elimination of federal mandate penalties.

- **New Jersey:** On May 30, 2018, New Jersey became the first state since the ACA's passage to adopt a state-level individual mandate through the enactment of A3380, which was signed into law by Governor Phil Murphy.²² This bill reinstates the ACA's individual mandate at the state level, requiring most New Jersey residents to have health insurance or pay a tax penalty. The penalty is either 2.5% of annual income or \$695 per adult and \$347.50 per child, whichever is greater.

Motivated by Congress's decision to eliminate the individual mandate, Democratic lawmakers in New Jersey drafted A3380 to protect their individual market from adverse risk selection and premium spikes. The mandate is scheduled to go into effect on January 1, 2019. Based on IRS data from 2015, the state expects to collect between \$90-\$100 million in penalties.²³

¹⁹ Massachusetts is the only state in which the IRS is currently not involved in administering the state's mandate.

²⁰ Chandra, Gruber, and McKnight, "The Importance of the Individual Mandate — Evidence from Massachusetts."

²¹ Ibid.

²² Katie Jennings, "New Jersey Will Become Second State to Enact Individual Health Insurance Mandate," Politico PRO, May 30, 2018, <https://politi.co/2H88Sgu>.

²³ Ibid.

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- **District of Columbia:** In the District of Columbia, the Executive Board of the District of Columbia Health Benefit Exchange Authority (DCHBX) created a working group to develop recommendations on policy options that will improve affordability, strengthen ACA protections, and ensure the stabilization of DC’s individual market. In the spring of 2018, the DC working group recommended an individual mandate nearly indistinguishable from the federal mandate. The working group based their recommendation on research provided by actuaries from the Oliver Wyman consulting firm. The firm estimated that the District’s marketplace would incur a 15.1% (~2,500-individual) reduction in ACA enrollment and a 10-15% rise in premium rates, due to the repeal of the individual mandate.²⁴ These outcomes would damage the District’s recent progress under the ACA, where the uninsured rate fell from 7.2% to 4% within the past decade.²⁵

The D.C. Council heeded the working group’s advice; on Jun 26, 2018, the council approved a district-level individual mandate that will take effect on January 1, 2019.²⁶ In the bill’s legislative text, the specific penalty amount associated with the mandate is not explicitly stated. Interestingly, the bill instead references the federal IRS Code as of December 15, 2017 as the basis for the district’s mandate penalty.²⁷ (December 15, 2017 is four days before Congress zeroed out the federal individual mandate penalty.) Altogether, this means that DC will reinstitute the mandate’s penalty of either 2.5% of annual income or \$695 per adult and \$347.50 per child, depending upon which amount is greater.

- **Connecticut:** Connecticut lawmakers have sought to mitigate the potential harm of the mandate’s penalty elimination to their individual market. Governor Dannel Malloy sponsored HB 5039, which proposed to reconstitute the structure of the federal mandate at the state level, albeit with lower fees, imposing a \$500 penalty or 2% of an individual’s adjusted gross income for not possessing ACA-compliant coverage.

²⁴ Leighton Ku and Jodi Kwarcianny, “Recommendations of the Reconvened ACA Advisory Working Group to the District of Columbia Health Benefit Exchange Authority,” April 6, 2018, <https://hbx.dc.gov/page/affordable-care-act-aca-working-group-2018-meeting-materials>.

²⁵ Ibid.

²⁶ Charles Gaba, “District of Columbia Becomes Fourth* State** to Reinstate ACA Individual Mandate!” Text, ACA Signups, June 27, 2018, <http://acasignups.net/18/06/27/district-columbia-becomes-fourth-state-reinstate-aca-individual-mandate>.

²⁷ Ibid.

A more stringent alternative proposal (HB 5379) was introduced by the State's Senate president Martin Looney. Senator Looney's proposal imposes a tax penalty of 9.66% of annual income or \$10,000, depending upon which amount is higher. The Senate bill does offer a choice: The individual in violation of the coverage mandate would have the opportunity to either pay the penalty or place 9.66% of their monthly income into a health savings account (HSA) managed by the state. The HSA would be fully operational as residents could withdraw money to pay for healthcare expenses.

The genesis for State Senator Looney's proposal (HB 5379) was a research paper by Fiona Scott Morton, a health economics professor at Yale. The recommendation from Professor Morton uses the ACA's definition of affordability²⁸ to establish the minimum tax penalty. According to the paper, around 60,000 state residents paid the federal mandate each year, because the mandate in its current form is not high enough.²⁹ Morton estimated that the implementation of HB 5379 would decrease annual premiums by at least \$300 and had the potential to boost enrollment by up to 60,000.³⁰ Morton's research found that if the state opts against a policy to encourage participation in the marketplace, a third of the healthiest enrollees would leave the market.³¹ This exodus would likely produce an \$1,000-plus increase in annual premiums for non-subsidized individuals who remain in the state marketplace. Unfortunately, these legislative efforts to establish an individual mandate in Connecticut have been unsuccessful so far. Both pieces of legislation—HB 5039 & HB 5379—have been held in committee; the Insurance and Real Estate Committee adjourned earlier this spring without passing either of the policy proposals.

- **Vermont:** On May 28, 2018, Vermont took a significant step toward enacting its own individual mandate when Republican Governor Phil Scott signed H.696 into law. The bill proposes to establish an individual mandate that will go into effect on January 1, 2020.³²

²⁸ Health care is deemed affordable when all the payments total 9.66% of income.

²⁹ Scott Morton, "The Connecticut Individual Healthcare Responsibility Fee | Institution for Social and Policy Studies," Yale Institution for Social and Policy Studies, February 5, 2018, <https://isps.yale.edu/research/publications/isps18-04>.

³⁰ Ibid.

³¹ Morton, "The Connecticut Individual Healthcare Responsibility Fee | Institution for Social and Policy Studies."

³² In 2019 there will be no penalty for going without health insurance in the state of Vermont.

The legislation originally duplicated the federal mandate, using the specifics outlined in the ACA. However, the updated version of the bill that was passed is quite different. The legislation is largely silent on how Vermont’s individual mandate would be structured, declining to even define how much the penalty itself will be. Instead, the new law leaves the details to a working group that will publish a report with recommendations by November 1, 2018.³³ These recommendations will not automatically become law. The Legislature will still need to draft legislation, deliberate, and secure approval of both houses of government to become law. Therefore, there is no guarantee that Vermont will establish a state-level individual mandate by 2020.

- **Washington:** As a state with no income tax, Washington has additional challenges in establishing a state-level mandate. Specifically, with no easy revenue collection process, like a state income tax, there is no straightforward implementation and enforcement mechanism available. This led to six Democratic state senators co-sponsoring SB 6084, legislation that would require the state’s Insurance Commissioner to establish a task force to study possible individual mandate enforcement mechanisms. The bill is currently in the state’s Senate Rules Committee.
- **Hawaii:** Two Hawaiian State Senators—Rosalyn Baker and Karl Rhoads—proposed legislation (SB 2924) that would establish a state-level individual mandate for Hawaii. However, the legislation lacks clarity on (1) what is considered minimum coverage and (2) the administration of penalties associated with the mandate. The bill did gain passage in the Senate, but was shelved in the Hawaiian House Finance Committee.

In California, no legislative proposals have been introduced to establish an individual mandate. However, there has been ongoing discussion and some stakeholder support for the concept. For example, Care4All California, a coalition of over 50 advocacy organizations,³⁴ announced support for a package of proposals intended to protect California’s health care system.³⁵ These policy proposals included introducing an

³³ Louise Norris, “Vermont Health Insurance Marketplace: History and News of the State’s Exchange: Obamacare Enrollment,” [healthinsurance.org](https://www.healthinsurance.org/vermont-state-health-insurance-exchange/), May 30, 2018, <https://www.healthinsurance.org/vermont-state-health-insurance-exchange/>.

³⁴ This coalition includes the California Pan-Ethnic Health Network, Health Access, Western Center on Law & Poverty and the Latino Coalition for a Healthy California.

³⁵ Yasmin Peled, “Over 50 Organizations Launch New Care4All California Campaign,” *Health Access* (blog), March 16, 2018, <http://health-access.org/over-50-organizations-form-new-care4all-california-campaign/>.

individual mandate, prohibiting the sale of short-term limited-duration health insurance, increasing ACA subsidies, and expanding Medi-Cal to cover all income-eligible adults regardless of their immigration status.³⁶ The California Association of Health Plans (CAHP) likewise announced support for a state-level individual mandate, citing concerns about coverage setbacks and potential destabilization of the California marketplace.³⁷

As California policy makers consider options for constructing a state-level individual mandate, it may be useful to examine the design of the mandate incorporated into former California Assembly Speaker Fabian Núñez's 2008 health reform (ABx1-1).

During the 2007-2008 legislative session, Assembly Speaker Núñez pursued wholesale health reform through ABx1-1. The measure included funding for subsidies, guaranteed issue, and an individual mandate.³⁸ Although the legislation did not pass, it earned the support of former Governor Arnold Schwarzenegger and a broad coalition of stakeholders.

If ABx1-1 had passed, the legislation would have established a mandate requiring all residents to obtain a minimal level of coverage. The bill assigned the responsibility of establishing what constitutes minimal coverage to the Managed Risk Medical Insurance Board (MRMIB).³⁹

As California policy makers consider possible variants of an individual mandate, there has been speculation that a state mandate would require a two-thirds vote of the Legislature to pass.⁴⁰ However, it is noteworthy that ABx1-1, at the time of its deliberation, avoided categorization as a new tax and could pass with a majority vote of both houses of the Legislature. This was because ABx1-1 did not include a tax penalty. Instead, under ABx1-1, MRMIB would automatically enroll uninsured individuals in the cheapest plan that satisfied minimal coverage standards.⁴¹ This approach differed from Massachusetts's enforcement mechanism, which did levy a tax penalty upon non-

³⁶ Care 4 All California, "Legislative Priorities – Care 4 All California," Care 4 All California, *Legislative Priorities* (blog), March 15, 2018, <http://care4allca.org/legislative-priorities/>.

³⁷ Mary Ellen Grant, "CAHP Supports Enacting a State-Based Individual Mandate" (California Association of Health Plans, March 5, 2018), <http://www.calhealthplans.org/pdfs/CAHPReleaseIndividualMandate-03-05-18.pdf>.

³⁸ Rick Curtis and Ed Neuschler, "Affording Shared Responsibility For Universal Coverage: Insights From California," *Health Affairs* 28, no. 3 (May 1, 2009): w417–30, <https://doi.org/10.1377/hlthaff.28.3.w417>.

³⁹ Shelia Kuehl, "Senate Health Committee Analysis of Assembly Bill x 1-1" (Senate Health Committee, January 25, 2008), http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=200720081AB1#.

⁴⁰ California's State Constitution requires a supermajority vote requirement on all tax increase measures.

⁴¹ Kuehl, "Senate Health Committee Analysis of Assembly Bill x 1-1."

exempt, uninsured individuals.⁴²

Assembly Speaker Núñez and the legislation’s sponsors envisioned the auto-enrollment system as a means of producing greater compliance and ensuring that the healthiest individuals joined the market. This would produce a more balanced risk pool and lower premium prices for everyone in the individual market.⁴³

To recoup costs, the bill directed MRMIB to develop a plan for how CA could recover the costs from those who failed to pay their monthly premiums.⁴⁴ In addition, the legislation authorizes a partnership between MRMIB and the Franchise Tax Board (FTB) to use all existing authority and procedures to recoup funds. According to the Senate Health Committee Analysis of ABx1-1, recovery practices could include granting authority to FTB to “...assess interest and monetary penalties, offset taxpayer refunds, garnish wages, file judgments, and impose tax liens”.⁴⁵

The analysis by the California Senate Health Committee found issues with the possible enforcement of ABx1-1’s mandate. For example, determining individuals’ incompliance, correctly enrolling them into adequate coverage, and recovering funds could be difficult.⁴⁶ At the time, proponents of ABx1-1 suggested that a possible practice to identify the uninsured could involve intervention at various points of access, such as hospitals or county health departments.⁴⁷

⁴² Katherine Howitt and Michael Miller, “California’s Near Miss: Understanding the Policies and Politics of the Proposed ABx1-1 Legislation,” *Community Catalyst*, July 2008.

⁴³ Ibid.

⁴⁴ Kuehl, “Senate Health Committee Analysis of Assembly Bill x 1-1.”

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ Ibid.

Table 3. Various Individual Mandates

	ACA's Individual Mandate (Prior to Tax Bill)	Massachusetts's Individual Mandate	New Jersey's Individual Mandate	AB x 1-1 (Nunez) Individual Mandate Provision
Coverage Requirements	<ul style="list-style-type: none"> To avoid the federal penalty, non-exempt residents must maintain minimum essential coverage (MEC). Qualified Health Plans offered through small employers and on the marketplaces must include Essential Health Benefits (EHB). Public insurance coverage, Employer and large-group health plans satisfy MEC. 	<ul style="list-style-type: none"> To avoid the state penalty, all adults must enroll in minimum creditable coverage (MCC). Public insurance coverage, student health coverage, and young adult plans automatically satisfy MCC requirement. 	<ul style="list-style-type: none"> To avoid the state penalty, non-exempt residents must satisfy the ACA's minimum essential coverage (MEC). 	<ul style="list-style-type: none"> To avoid violation of the mandate, all residents must enroll in and maintain minimum creditable coverage (MCC) established by MRMIB. MCC must include doctor, hospital and preventative services.
Affordability Standards	<ul style="list-style-type: none"> Exemptions, on the basis of affordability, are granted if the premium for the cheapest health plan is greater than 8% of the household's income. 	<ul style="list-style-type: none"> Exemptions, on the basis of affordability, adjust with income, requiring smaller shares of income be devoted to health insurance by individuals with smaller incomes. In comparison to the ACA affordability standard, Massachusetts's affordability schedule maintains a more progressive approach. 	<ul style="list-style-type: none"> Exemptions, on the basis of affordability, are to be determined by the Commissioner of Banking and Insurance, in consultation with the State Treasurer. 	<ul style="list-style-type: none"> Exemptions, on the basis of affordability, are granted for those below 250% FPL when the premium exceeds 5% of their income.
Exemptions	<ul style="list-style-type: none"> Exempted Groups: <ul style="list-style-type: none"> -Residents with incomes beneath the income-tax-filling threshold -Individuals with religious objections -Undocumented immigrants -Native Americans -Incarcerated individuals -Those with a single gap of coverage less than three consecutive months 	<ul style="list-style-type: none"> Exempted Groups: <ul style="list-style-type: none"> -Children -Individuals with religious objections -Those with a gap of coverage less than 63 days/three months -Individuals with incomes up to 150% FPL -Those who have successfully appealed on the basis of financial hardship 	<ul style="list-style-type: none"> Exempted Groups: <ul style="list-style-type: none"> -Income threshold for coverage exemptions will be determined by the State Treasurer -Determinations as to religious conscience or hardship exemptions shall also be made by the State Treasurer 	<ul style="list-style-type: none"> Exempted Groups: <ul style="list-style-type: none"> -Residents of the state for less than six months -Undocumented immigrants -Childless adults without an affordable health option -Those with demonstrated financial barriers or other hardships that prevent obtaining of insurance
The Level of Penalties	<ul style="list-style-type: none"> For this most recent year, the Federal Penalty is calculated in two ways: <ul style="list-style-type: none"> o Per person: \$695 per adult / \$347.50 per child -Max: \$2,085 Percentage of household income: 2.5% of household income. -Max: <i>The annual premium for the nationwide average Bronze plan.</i> *Whichever amount is greater is the designated tax penalty. 	<ul style="list-style-type: none"> For individuals above 300% FPL, the state penalty is set at half the lowest-priced Health Connector plan available to the household/individual. For individuals below 300% FPL, the state penalty is set at half of the lowest subsidized premium. Unlike Nunez's bill, violators of the mandate would be subject to a tax penalty. 	<ul style="list-style-type: none"> Restores the ACA's individual mandate penalty. <ul style="list-style-type: none"> o Per person: \$695 per adult / \$347.50 per child -Max: \$2,085 o Percentage of household income: 2.5% of household income. -Max: <i>The New Jersey average annual premium for Bronze-level plans.</i> *Whichever amount is greater is the designated tax penalty. 	<ul style="list-style-type: none"> In comparison to Massachusetts and the ACA, AB x1 possesses a different enforcement mechanism. Under Nunez's bill, MRMIB automatically enrolls uninsured individuals in the cheapest plan that satisfies minimum standards. MRMIB also would develop a plan for how CA could collect money from those who failed to pay the premiums associated with their plan.

B. An Auto-Enrollment Process

Automatic enrollment is another option to shield against potential destabilization from the loss of the federal mandate penalty. An auto-enrollment process fixated upon the uninsured population can increase enrollment, bringing many new young and healthy individuals into the marketplace. This uptick in enrollment would have the potential to decrease average risk levels and lower premium prices, transforming our marketplace into a more stable and attractive option for all.

This past year, Maryland’s legislature considered the implementation of an automatic enrollment process. Two Maryland legislators—Senator Brian Feldman and Delegate Joseline Peña-Melnyk—proposed legislation (SB 1011 or HB 1167) that would re-impose the mandate penalty on residents who remain uninsured. The accrued penalty funds would then be used as a “down payment” to enroll those who paid the penalty into coverage on the state’s marketplace.⁴⁸ The plan is intended to prevent coverage loss while moving forward with an innovative approach directed at the state’s uninsured population.^{49 50}

Key elements of the Maryland proposal include:

Adequate Notice

- Beginning in 2020, after filing state tax returns, uninsured residents will receive a notification that the fee they paid, as a result of their coverage status, will be used as a down payment to help them purchase health insurance. The fee paid is the greater of 2.5% of the sum of the individual’s federal gross income or \$695 per adult and \$347.50 per child.⁵¹
- If the resident’s tax returns indicate Medicaid eligibility, they will automatically be enrolled.

Price Check

- With the consent of the consumer, the state marketplace will determine if the individual is offered coverage at zero additional cost. This means the health plan

⁴⁸ Josh Hicks, “With Obama’s Federal Mandate Disappearing, Md. Democrats Push ‘down Payment’ Plan,” *Washington Post*, January 9, 2018, sec. Maryland Politics, https://www.washingtonpost.com/local/md-politics/md-democrats-push-insurance-down-payment-plan-to-replace-federal-mandate/2018/01/09/bc0afb0-f4f4-11e7-beb6-c8d48830c54d_story.html.

⁴⁹ Stan Dorn, “Transforming the Federal Individual Mandate into State Health Insurance Down Payments,” *Families USA*, January 11, 2018, <http://familiesusa.org/blog/2018/01/transforming-federal-individual-mandate-state-health-insurance-down-payments>.

⁵⁰ Proponents of the measure initially considered implementing a state-level mandate like Massachusetts. However, the “down payment” approach was seen as engendering less political opposition.

⁵¹ Finance and Budget and Taxation Committee, “Fiscal and Policy Note by the Maryland General Assembly on Senate Bill 1011--Protect Maryland Health Care Act of 2018,” February 20, 2018, http://mgaleg.maryland.gov/2018RS/fnotes/bil_0001/sb1011.pdf.

does not cost more than the “down payment fee” plus any ACA subsidy for which the individual qualifies. If such a plan is found, the consumer will be enrolled automatically.

- This step alone could insure numerous residents. In Maryland, an analysis by Families USA determined that more than 60,000 residents qualify for insurance that costs less than the combined amount of their ACA subsidy and the down payment fee.⁵²

Escrow Accounts

- If the state marketplace is unable to find a zero-cost plan, the individual’s fee is placed in an “escrow” account, which can be used in the subsequent open enrollment period to purchase health insurance.

Hands-On Involvement

- The state marketplace notifies the consumer at the start of the subsequent enrollment period of the fee held in the escrow account. If no plan is chosen by the end of the enrollment period and a zero-cost plan is still unavailable, the unused fee will be put into a health insurance stabilization fund established by the state.

To avoid imposing a financial burden on low-income families, the proposal has built-in protections. For example, no one would be required to pay a monthly premium, unless they selected a plan that entails premium payments.⁵³ In addition, automatic enrollment is only available if the cost of the plan comes at zero additional cost to the individual. A health policy expert and architect of the ACA, Jonathan Gruber, called Maryland’s proposal a “very promising way to combine the best of standard health economics (the mandate) with the best of behavioral economics (the auto-enrollment).”⁵⁴

Maryland’s proposal could serve as a substitute for the individual mandate’s enforcement mechanism. Gruber agrees that this policy can be exported to California because the state is similar to Maryland, in that it runs its own marketplace and has a state income tax.⁵⁵ Moreover, Maryland’s proposal could work well for lower-income Californians that qualify for subsidies.

⁵² Dorn, “Transforming the Federal Individual Mandate into State Health Insurance Down Payments.”

⁵³ Sarah Kliff, “Maryland’s Plan to Save Obamacare from Individual Mandate Repeal,” Vox, January 10, 2018, <https://www.vox.com/policy-and-politics/2018/1/10/16875352/voxcare-maryland-obamacare-plan>.

⁵⁴ Ibid.

⁵⁵ Ibid.

The difficulty lies in finding a zero-cost plan for those receiving low or no subsidies. Developing a zero-cost product would entail setting a very high deductible to achieve a premium of zero. Furthermore, an automatic enrollment policy would face a variety of administrative challenges. For example, a state would have to gather precise, present-day data to verify who is uninsured, who to enroll automatically, and the amount of the subsidy for which these individuals are eligible. At the moment, there is little direct evidence on how an auto-enrollment policy would work in reality.⁵⁶

Maryland's Health Insurance Down Payment Proposal has been shelved until 2019. Health care advocates who are a part of the Maryland Health Care for All! coalition⁵⁷ are seeking to position this policy atop the legislative agenda during the 2018 Gubernatorial election. This endeavor has included a campaign to obtain a signed "Candidate Statement of Support" for the policy from the state's major parties' gubernatorial candidates by May 18, 2018.⁵⁸ It concluded with the Maryland Citizens' Health Initiative publicly announcing on May 23, 2018 that the seven major Democratic candidates have endorsed the Health Insurance Down Payment Plan.⁵⁹

C. A State Reinsurance Program

A reinsurance program is a type of reimbursement system that provides monetary compensation to insurance companies that cover higher-cost marketplace enrollees. A reinsurance program establishes a certain threshold—referred to as an attachment point—and once an enrollee's medical expenses surpass the threshold, the insurer is eligible for reimbursement.⁶⁰ By insulating the risk pool from extraordinary individual costs, reinsurance helps insurers better predict their financial exposure and helps stabilize the marketplace.

⁵⁶ Erin Duffy, Michael Dworsky, and Christopher Whaley, "Can a Continuous Coverage Requirement Produce a Healthy Insurance Market?," *TheHill*, January 4, 2017, <http://thehill.com/blogs/congress-blog/healthcare/312590-can-a-continuous-coverage-requirement-produce-a-healthy>.

⁵⁷ This coalition includes the American Lung Association, Communications Workers of America (CWA), Community Catalyst, Maryland Nurses Association, Maryland State and DC AFL-CIO, and the Maryland Association of Resources for Families and Youth.

⁵⁸ Stan Dorn, "Health Insurance Down Payment Plan Should Be the next Top Priority in Md.," *baltimoresun.com*, May 10, 2018, <http://www.baltimoresun.com/news/opinion/oped/bs-ed-op-0511-health-payment-20180509-story.html>.

⁵⁹ Erin Cox, "Democrats Running for Maryland Governor Pledging to Support a State Individual Mandate for Health Care - Baltimore Sun," May 23, 2018, <http://www.baltimoresun.com/news/maryland/politics/bs-md-individual-mandate-20180522-story.html>.

⁶⁰ Ashley Semanskee et al., "Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors," *The Henry J. Kaiser Family Foundation* (blog), August 17, 2016, <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/>.

During the initial years of the ACA's implementation, from 2014-2016, a temporary nationwide reinsurance program was established. The focus of this interim policy was to stabilize premiums on the individual market and ease insurers' concerns about participating in the reformed individual markets that now mandated guaranteed issuance.

In today's context, the implementation of a well-funded state reinsurance program can mitigate the immediate effects of the mandate's cancelation. An analysis by the head actuary for Covered California, John Bertko, determined that funding state-based reinsurance programs could lower premiums by 12%, with a range of between 9 and 16%, depending upon the state.⁶¹

Primarily due to the policy's ability to lower premiums, the creation of a reinsurance program has been on the agenda of numerous states:

- **Maryland:** Although Maryland has been unsuccessful in creating a direct replacement of the federal individual mandate, the state has taken significant steps to stabilize and preserve their individual market. On April 5, 2018, Maryland Governor Larry Hogan signed into law a bipartisan bill that creates a \$380 million reinsurance fund, financed by a 2.75% tax on insurance companies. The focus of the reinsurance bill is the 125,000 state residents currently enrolled in unsubsidized coverage, as they would be the ones directly impacted by an increase in premium rates.

The \$380 million dollar figure attached to the bill should negate 21% of the impending 2019 premium hikes in the state's marketplace, approximately \$132 per month in rate increases.⁶² Before it can be implemented, the reinsurance program first requires approval by the Federal Government. Without approval, Maryland will be unable to continue. This would be an alarming outcome, because insurers selling ACA-compliant plans in Maryland are once again requesting significant rate increases. The state has two primary insurers. The first is CareFirst BlueCross BlueShield, which accounts for more than 50% of the state's individual market in 2018. They are seeking to increase their HMO rates

⁶¹ Bertko, "The Roller Coaster Continues."

⁶² Charles Gaba, "Maryland: Gov. Signs Bipartisan Reinsurance Bill, Should Cancel out 21% Worth of Rate Hikes next Year," Text, ACA Signups, April 9, 2018, <http://acasignups.net/18/04/09/maryland-gov-signs-bipartisan-reinsurance-bill-should-cancel-out-21-worth-rate-hikes-next>.

by 18.5%. Kaiser Permanente—the state’s other primary marketplace insurer—wants a 37.4% increase in its HMO plans and a 90% increase in its PPO plans.⁶³

- **New Jersey:** A second bill (S1878) closely followed New Jersey’s passage of a state-level individual mandate. S1878 creates a state reinsurance program, called the Health Insurance Premium Security Fund. The funds accrued by the state-level mandate would be deposited straight into this account, which would then be used to cover health care expenses of catastrophically ill individuals so that insurers do not have to raise premium rates.

New Jersey’s success on the policy front is timely. According to a report published by Covered California, premiums in New Jersey were expected to increase by 32% this upcoming year and by 90% over the next three years.⁶⁴ The only remaining issue is that the federal government must approve the state reinsurance program.

The concern regarding reinsurance is that it may not be an effective long-term replacement for the individual mandate. For instance, it would be costly. According to the aforementioned Covered California analysis, an effective, federally-financed reinsurance program would require a gross federal funding of \$12 billion, but the net budget cost would be \$5 billion after taking into account reduced federal expenditures for advanced premium tax credits (due to reinsurance lowering premiums).⁶⁵ Moreover, continued appropriation for at least two years is essential if the policy is to be successful in providing stability and certainty to health insurers while lowering premiums in the marketplace; another significant weakness of this policy is that there are no guarantees of continued appropriation. Furthermore, coverage losses would remain. Analyses completed by Avalere Health, a DC-based healthcare consulting firm, found a national reinsurance program would boost enrollment by less than one million.⁶⁶ This slight boost

⁶³ Charles Gaba, “Maryland: Preliminary 2019 ACA Rate Hike Request: 29.5% (~19-24% w/out Sabotage),” Text, ACA Signups, May 7, 2018, <http://acasignups.net/18/05/08/maryland-preliminary-2019-aca-rate-hike-request-295-19-24-wout-sabotage>.

⁶⁴ John Bertko, “Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Action, With Wide Variation Among States,” *Covered California*, March 8, 2018, 11.

⁶⁵ John Bertko, “State-Based Invisible High Risk Pools or Reinsurance: Structural Elements to Maximize the Stabilizing Impact on Individual Markets for 2019 and Beyond,” *Covered California*, December 20, 2017, [http://hbex.coveredca.com/data-research/library/State-Based_Invisible_High_Risk_Pools_or_Reinsurance-12-17-20%20\(002\)_final.pdf](http://hbex.coveredca.com/data-research/library/State-Based_Invisible_High_Risk_Pools_or_Reinsurance-12-17-20%20(002)_final.pdf).

⁶⁶ Aviva Aron-Dine, “Funding for State Reinsurance Programs Can’t Replace Individual Mandate,” Center on Budget and Policy Priorities, December 21, 2017, <https://www.cbpp.org/blog/funding-for-state-reinsurance-programs-cant-replace-individual-mandate>.

would fail to counterbalance CBO's 2019 projections of three million more becoming uninsured after the mandate's repeal.

D. A Continuous Coverage Requirement

In addition to the individual mandate penalties, the ACA established a limited open enrollment period as a mechanism for avoiding adverse selection. Individual market consumers can only purchase coverage during this period with the exception of specific triggering events, which enable purchase through a "special enrollment" process. Examples of these special enrollment events include loss of employment, divorce, loss of coverage due to aging off of parents' coverage, etc. Under special enrollment procedures, consumers have a sixty-day window to purchase new coverage or they must wait until the next open enrollment period. This process discourages consumers who may otherwise wait to buy coverage until they need costly medical care.

A continuous coverage requirement is starkly similar to this open enrollment period established by the ACA. For example, it usually includes a lockout period, barring an individual from being able to purchase health insurance after three months of going without coverage, which also furthers the goal of limiting adverse selection in the individual market. That is why prior efforts by Congress to repeal the ACA and its individual mandate generally included these requirements as part of a "repeal and replace" strategy. The American Health Care Act (AHCA), passed by the House of Representatives in the summer of 2017, is a prime example.

The AHCA proposed a continuous coverage requirement that would go into effect after an individual's lapse in coverage extended past 63 days. If an individual sought to obtain coverage after that lapse, the health insurer would impose a 30% monthly premium surcharge for a full year.⁶⁷ For instance, a 50-year-old individual that went more than 63 days without coverage would face a surcharge of \$2,161 over the next year.

Although the continuous coverage approach was intended to mitigate the risks of adverse selection, additional policy concerns were also raised. According to an analysis by the Commonwealth Fund, a liberal think tank, if the AHCA requirement had been operational in 2016, 30 million working-age Americans would have paid a

⁶⁷ The Commonwealth Fund, "Essential Facts About Health Reform Alternatives: Continuous Coverage Requirement - The Commonwealth Fund," The Commonwealth Fund, April 19, 2017, <http://www.commonwealthfund.org/publications/explainers/2017/apr/continuous-coverage-requirement>.

premium surcharge had they tried to enroll in coverage on the individual market.⁶⁸ Additionally, the substitution of one of the requirements in place of the ACA's established infrastructure (open enrollment and the individual mandate) could result in increasing the number of uninsured. The Center on Budget and Policies Priorities (CBPP), a progressive think tank, suggests that if individuals are out of the market for extended periods of time, it is highly likely that they will continue without coverage.⁶⁹ This is because there is little incentive for healthy uninsured individuals to gain coverage, unless they become sick and need healthcare services.

There are other continuous coverage alternatives that impose various disincentives to consumers for allowing their coverage to lapse. In his 2008 legislation, former California Speaker Nunez's ABx1-1 included a continuous coverage requirement that allowed plans and insurers to impose a pre-existing condition exclusion period of up to one year on coverage they offer to any individual who failed to maintain coverage for more than 62 days.⁷⁰ Additionally, upon enrolling in coverage, these individuals could only select the health plan with the lowest coverage capability.

Notably, no state has deliberated the implementation of a continuous coverage requirement. This is largely because the ACA's open enrollment period renders this policy approach redundant for any state. Therefore, as long as the ACA is the law of the land there is no need to pursue such a policy.

IV. Conclusion

The individual mandate penalty will drop to \$0 in 2019 and, without an effective replacement, the stability of state marketplaces is at risk. Former HHS Secretary Tom Price summed up the situation best: "There are many, and I am one of them, who believes that that [the mandate penalty's removal] will harm the pool in the exchange market because you'll likely have individuals who are younger and healthier not participating in that market. And, consequently, that drives up the cost for other folks in that market."⁷¹

⁶⁸ Sarah Collins and Munira Gunja, "Millions of Americans Could Face a Premium Surcharge Under the ACA Repeal Bill - The Commonwealth Fund," The Common Wealth Fund, March 9, 2017, <http://www.commonwealthfund.org/publications/blog/2017/mar/premium-surcharge-under-aca-repeal-bill>.

⁶⁹ Paul Van de Water, "Automatic Enrollment in Health Insurance Would Be Complex and Difficult to Administer," Center on Budget and Policy Priorities, June 15, 2017, <https://www.cbpp.org/research/health/automatic-enrollment-in-health-insurance-would-be-complex-and-difficult-to>.

⁷⁰ Kuehl, "Senate Health Committee Analysis of Assembly Bill x 1-1."

⁷¹ Angelica LaVito, "Tom Price Now Says Repealing ACA Individual Mandate Will Raise Costs," May 1, 2018, <https://www.cnbc.com/2018/05/01/tom-price-changes-mind-says-repealing-individual-mandate-will-raise-costs.html>.

The expected uptick in cost, noted by Price, hints at a pressing concern facing state marketplaces. According to recent reports from the Centers for Medicare and Medicaid Services (CMS), the individual market is struggling to serve as a viable option for unsubsidized middle-class consumers.⁷² Average monthly enrollment in the marketplaces shrank by 10% between 2016 and 2017 and premiums spiked by 21%. A significant portion of this drop-in enrollment occurred in the unsubsidized population, with a 20% reduction observed (compared to a 3% reduction in the subsidized population).⁷³

The loss of the mandate penalty will only exacerbate this trend as already states are anticipating significant rate increases--14.9% in DC, 30.2% in Maryland, 24% in New York, and 19.08% in Washington.⁷⁴ This is driving states to find solutions.

Our policy brief outlined four potential options: a state-level individual mandate, an auto-enrollment process, a reinsurance program, and a continuous coverage requirement. These four options are potential tools that states may wish to consider. Each alternative has policy trade-offs and political challenges, which must be balanced by the risks that state marketplaces will be facing in 2019.

⁷²CMS, “Centers for Medicare and Medicaid Services Releases Reports on the Performance of the Exchanges and Individual Health Insurance Market,” July 2, 2018, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-07-02.html>.

⁷³Charles Gaba, “CMS Effectuation Report, Part 4: Four Years of TOTAL ACA Enrollment in One Chart!,” Text, ACA Signups, July 5, 2018, <http://acasignups.net/18/07/06/cms-effectuation-report-part-4-four-years-total-aca-enrollment-one-chart>.

⁷⁴ Rabah Kamal et al., “Tracking 2019 Premium Changes on ACA Exchanges,” *The Henry J. Kaiser Family Foundation* (blog), June 6, 2018, <https://www.kff.org/private-insurance/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/>.

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About California Health Policy Strategies (CalHPS), L.L.C.

- CalHPS is a mission-driven health policy consulting group based in Sacramento. For more information, visit www.calhps.com

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