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MARYLAND HEALTH BENEFIT EXCHANGE

February 8, 2018

The Honorable Edward J. Kasemeyer
Chairman
Senate Budget and Taxation Committee
Miller Senate Office Building, 3 West Wing
11 Bladen Street
Annapolis, MD 21401

The Honorable Maggie McIntosh
Chairman
House Appropriations Committee
House Office Building, Room 121
6 Bladen Street
Annapolis, MD 21401

Re: Joint Chairmen's Report – Impact of the Elimination of the Individual Mandate Penalty

Dear Chairman Kasemeyer and Chairman McIntosh:

Pursuant to page 32 of the Joint Chairmen's Report for the 2017 Session, the Maryland Health Benefit Exchange (MHBE) submits this report on the Impact of the Elimination of the Individual Mandate Penalty. Specifically, the JCR requires the MHBE to report on the enactment of any legislation at the federal level that impacts the operation of the MHBE or qualified health plans. Although this recent federal policy modification was implemented without legislation, the MHBE understands that the intent of the JCR requirement is to report on federal policy changes that impact the MHBE and qualified health plans.

If you have any questions regarding this report, please contact John-Pierre Cardenas at 410-412-9671 or at jcardenas@maryland.gov.

Sincerely,

Michele Eberle

Michele Eberle
Executive Director

cc: Robert Neall, Secretary, Maryland Department of Health
Chair, MHBE Board of Trustees

MARYLAND HEALTH BENEFIT EXCHANGE

# Joint Chairmen's Report:
## Impact of the Elimination of the Individual Mandate Penalty

**Maryland Health Benefit Exchange**
**January 25, 2018**

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## I. Introduction

The 2017 Joint Chairmen's *Report on the Fiscal 2018 State Operating Budget (HB 150) and the State Capital Budget (HB 151) and Related Recommendations* requests that the Maryland Health Benefit Exchange (MHBE) provide a report on federal legislation that impacts the operation of the MHBE or qualified health plans (QHPs).[1] Specifically, the MHBE must:

> Submit a report 60 days after the enactment of any legislation at the federal level that impacts the operation of the MHBE or qualified health plans. The report should include the impact of the legislation on qualified health plans, review potential changes that need to be made to plans as a result of those changes, and also establish a timeline for the implementation of any necessary changes.

On December 20, 2017, Congress passed a tax reform bill that included a provision eliminating the penalty for individuals who fail to maintain qualifying health insurance, effectively repealing the individual mandate.[2] The bill was then signed into law on December 22, 2017. In accordance with this requirement, the MHBE submits this report to the Chairmen of the Senate Budget and Taxation Committee and House Appropriations Committee.

## II. Background on the Individual Mandate

The Affordable Care Act (ACA) provides both financial incentives and penalties to encourage health insurance coverage and a healthy risk pool. The individual mandate, one of the main tenants of the ACA, requires all U.S. citizens and legal residents to maintain qualifying health insurance coverage,[3] or face a tax penalty beginning in 2014.[4] The purpose of the individual mandate is to encourage more people, especially younger and healthier individuals, to enroll in insurance coverage. If everyone is required to have insurance, especially healthy people, the risk pools will be broad enough to lower premiums for everyone, even those with expensive medical conditions. Exemptions to the mandate are granted in certain cases, including financial hardship, religious objections, American Indians, individuals without coverage for less than three months, undocumented immigrants, incarcerated individuals, individuals for whom the lowest cost plan exceeds 8 percent of income, and individuals with incomes below the tax filing threshold.[5] Individuals who do not maintain qualifying health insurance coverage and do not qualify for an exemption are subject to a tax penalty that is the greater of either a specified flat fee or a percentage of household income.[6] The penalty began in 2014 and gradually increased through 2016 to the greater of $695 per year for an individual (three times that amount per family) or 2.5

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[1] Chairmen of the Senate Budget and Taxation Committee and House Appropriations Committee (. *Report on the Fiscal 2018 State Operating Budget (HB 150) and the State Capital Budget (HB 151) and Related Recommendations*. Retrieved from http://mgaleg.maryland.gov/pubs/budgetfiscal/2017rs-budget-docs-jcr.pdf.

[2] H.R. 1, 115th Cong. § 11081 (2017) (enacted).

[3] Any insurance plan that meets the ACA requirement for having health coverage qualifies as minimum essential coverage. Examples of plans that qualify include: marketplace plans; job-based plans; Medicare; and Medicaid and CHIP.

[4] 26 USC § 5000A.

[5] 26 USC § 5000A(e). In 2016, the tax filing threshold for a person filing as single who was under the age of 65 was $10,350 and $11,900 for a person who was 65 or older.

[6] 26 USC § 5000A(c)(2).

percent of household income.[7] After 2016, the penalty of $695 will increase annually by the cost of living adjustment.[8] Some stakeholders have expressed concern that a lack of enforcement and/or elimination of the individual mandate will create further adverse selection in the individual health insurance market, raising concerns about sustainability.

Massachusetts is the only state that has created an individual mandate, which pre-dated the ACA. In 2006, Massachusetts passed an extensive health reform law, which included a requirement that most adults maintain coverage as long as it is affordable or pay a penalty. Under the current law, all residents who file a tax return must complete a state schedule HC, in addition to all federal forms, indicating whether they had creditable coverage for each month of the taxable year or pay a penalty.[9] Massachusetts residents who do not have creditable coverage or qualify for an exemption must pay a tax penalty (DOR, 2017). The penalty is assessed for each month in which the individual did not have creditable coverage and varies based on the individual's age, income, and family size.[10] Massachusetts has modified its rules to allow individuals to subtract the amount paid in the federal penalty from the amount of their state penalty beginning with their 2014 state income tax returns.[11] The Massachusetts Department of Revenue (DOR) is responsible for enforcing the state tax penalty. Taxpayers are required to include a schedule HC, a state tax form, indicating their health insurance status with their annual state tax returns (Doonan & Tull, 2010). The most recent tax data available regarding the Massachusetts mandate are from 2012; 99 percent of taxpayers required to file a Schedule HC form did so in 2012 (Massachusetts Health Connector and DOR, 2015). Almost all of the taxpayers who completed a Schedule HC form reported being insured for 2012. Approximately 4 percent of tax filers reported being uninsured for part of 2012, and 1 percent of tax filers were assessed a penalty.

## III. Impact in Maryland

The tax reform bill, H.R. 1, passed by Congress reduced the individual mandate penalty to $0 effective December 31, 2018. [12] The Congressional Budget Office (CBO) estimated that effectively repealing the individual mandate would increase the number of uninsured nationally by 4 million in 2019 and 13 million in 2027. The CBO projected that average premiums in the individual market would increase by roughly 10 percent each year of the next decade relative to the CBO's baseline projections (CBO, 2017). These changes would occur because healthier individuals are more likely to drop insurance coverage if there is no penalty, which would increase premiums and cause more people not to purchase insurance. Also, without the mandate more people will choose not to enroll in employer-sponsored plans; the CBO expects that 2 to 3 million fewer individuals will have employer sponsored insurance by 2027. In total, CBO estimated that eliminating the individual mandate would increase the number of uninsured by over 50 percent by 2026 (CBO, 2016).

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[7] 26 USC § 5000A(c).
[8] *Id.*
[9] M.G.L. 111M § 2.
[10] 830 CMR 111M.2.1(5).
[11] 830 CMR 111M.2.1(5)(g).
[12] H.R. 1, 115th Cong. § 11081 (2017) (enacted).

Since the enactment of the ACA, the uninsured rate in Maryland has decreased significantly, decreased from 10.2 percent in 2013 to 6.1 percent in 2016 (Bureau of the Census).

The elimination of the individual mandate penalty may likely cause the uninsured rate to rise in Maryland. Although it is difficult to estimate the effects on the number of uninsured specifically in Maryland, the CBO estimated about a 50 percent increase in the numbers of uninsured nationwide (CBO, 2016). Without the individual mandate some people, especially healthier individuals, may choose to forgo insurance coverage, which will in turn increase premiums. Furthermore, uncertainty regarding the future of the ACA could also destabilize the individual insurance markets and cause insurers to raise premiums. Only two carriers in Maryland are currently offering plans in the individual market, CareFirst and Kaiser Permanente. In 13 counties, CareFirst is the only available insurer. With only two insurers, competition in the individual market has decreased, and consumers will have fewer choices when premiums increase.

A small percentage of Maryland tax payers have paid the penalty for failing to have insurance coverage. According to data from the Internal Revenue Service (IRS), 94,130 tax returns filed by Maryland residents in 2015 included an individual responsibility payment, which is roughly three percent of the 2,963,630 tax returns filed by Maryland residents (IRS). In total, Maryland residents paid approximately $44 million in individual responsibility payments.

## IV. Conclusion

In summary, the recently passed tax reform bill eliminates the financial penalty for the individual mandate. Without enforcement of the mandate, the uninsured rate in Maryland may likely increase, and premiums for health plans offered through Maryland Health Connection will likely increase. This would amount to a significant setback for the mission of the MHBE. In 2018, for example, Maryland enjoyed significant increases of health coverage in key demographics, including the African American (12%), Hispanic (10%), and under-34 year old (30%) populations. Of course, regardless of the circumstances, MHBE will continue to strive to help Maryland residents obtain affordable insurance and receive all subsidies to which they are entitled.

## References


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