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No Good Deed Goes Unpunished: Enforcing an Individual Health Insurance Mandate

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Pending federal health insurance reform legislation appears set on a course to adopt an individual mandate requiring the purchase of health insurance that would be enforced through the federal income tax system. Similar proposals were considered in the mid-1990's during the 103rd Congress in connection with health care reform legislation.

At that time, it was considered "an unprecedented form of federal action" to transform a voluntary private transaction into a requirement for people to buy any good or service as a condition of lawful residence in the United States. See CBO Memorandum, *The Budgetary Treatment of An Individual Mandate to Buy Health Insurance* (August 1994).

In 2007, Massachusetts began phasing in a mandate that all adult residents have "affordable" health insurance. Beginning in 2008, a financial penalty is assessed for each month that a Massachusetts resident is not covered. In its report entitled *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), the CBO notes that "it is still too soon to evaluate the full effect of the mandate in Massachusetts."

CBO also notes that a recent study did not attempt to isolate the effects of the mandate on the rate of the uninsured from other aspects of the state's health reform initiative including insurance market reforms and new

premium subsidies for lower-income individuals and families.

Enforcing an Individual Mandate

A mandate is only as good and effective as is its enforcement mechanism. There is limited experience or guidance with an individual health insurance mandate that is enforced through the federal individual income tax system. A federal mandate would impact everyone, not just the uninsured.

Much of the administrative burden of compliance would fall upon individuals who already have health insurance and who will be required to prove that they are in compliance with the mandate. It would also be complicated and poses significant challenges because: the income tax compliance system operates retrospectively and not all of the uninsured are participants in the income tax filing system. These challenges are discussed below.

The Insured Must Prove Compliance

Individuals who currently have health insurance may not be fully aware that the individual mandate would require them to prove that they have coverage in compliance with the requirement. Everyone will be required to prove that they are in compliance with a federal health insurance mandate.

The administrative burdens of compliance would not be invisible to those who have done the "good deed" and voluntarily purchased health insurance. This compliance burden may come as a surprise. Taxpayers will experience additional filing burdens and increased complexity of an income tax based enforcement mecha-

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nism for a health insurance mandate which will be borne by individuals who already have health insurance and those “compelled” to have coverage.

Enforcement Model. The Commonwealth of Massachusetts is the only jurisdiction in the United States to require the individual purchase of health insurance and to enforce this mandate through its income tax system. Accordingly, the state’s income tax-based enforcement mechanism is a likely “model” for implementation of the federal health insurance mandate.

In 2007, individuals in Massachusetts faced losing their entire personal income tax exemption for failure to purchase health insurance (or were uncovered for more than 63 days). Beginning in 2008, individuals were subject to a monthly income-based penalty for failure to comply with the mandate.

In order to prove compliance, a new three-page schedule had to be completed and filed with other schedules required to be filed for the state income tax return. In addition, a 10-page booklet with instructions and worksheets accompanies the other income tax instructions and worksheets for the state income tax return. A similar schedule, instructions, and worksheets would likely be required for use in any federal income tax-based enforcement mechanism.

The Massachusetts “Schedule HC” must be completed and enclosed with the individual income tax return. The form requires all tax filers to “declare” their coverage status and to report general information regarding: name; Social Security number; date of birth for the filer and spouse; family size; and federal adjusted gross income.

Next, the schedule requires the filer to indicate whether they and their spouse had health insurance (including Medicare, Veterans Administration health care, Tri-Care, or “other” government health coverage) at any point during the year, or whether they were enrolled in the MassHealth (Medicaid) program or Commonwealth Care program.

If the filer was enrolled in a private health insurance policy, the schedule requires information regarding health insurance coverages of the filer and spouse from the new 1099-HC form required to be filed by the health insurer (name of company, federal identification number of the insurance company, and subscriber name).

The 1099-HC form requires: the name of the insurance company or health benefit plan administrator; the federal identification number of the insurance company or plan administrator; the subscriber’s name, date of birth, and subscriber number, and address. The form requires information regarding whether the subscriber had full-year coverage, or to indicate month-by-month the subscriber’s coverage history for the year.

The “Schedule HC” also requires the filer and spouse to indicate on a month-by-month basis if they were uninsured for any part of the year; whether any religious exemption or a certificate of exemption issued by the Health Insurance Connector applies; and whether the affordability requirements were met by the filer’s employer.

The form also requires filers to indicate whether they were eligible for government-subsidized health insurance and whether they were able to afford private health insurance coverage. Finally, the schedule includes instructions for the filing of an appeal if the filer

was unable to obtain affordable health insurance due to “hardship” or other circumstances.

Numerous Penalty Exemptions Provided

Poverty Level Exemption. Any applicable penalties for noncompliance with the requirement to purchase health insurance *would not apply* to persons whose income was at or below 150 percent of the federal poverty level. In Table 2 of the instructions for 2008, for example, this federal poverty level exemption from the enforcement penalty would apply for a family of one at an income level of \$15,612; and for a family of four at an income level of \$31,812.

Health insurance coverage is “deemed” to be unaffordable for persons in these income categories. Interestingly, of the estimated 154 million federal “income tax units” in the United States, 62 million have adjusted gross incomes of less than \$20,000. Nearly 15 million of the 45 million uninsured have incomes of less than \$20,000.

Using a similar “poverty level” exemption might significantly dilute the effect of this enforcement mechanism and would leave its efficacy to the incentive eligibility for a subsidy that is provided to purchase health insurance.

Hardship Exemption. Taxpayers may also appeal the imposition of an income-based penalty by claiming that a “hardship” prevented them from purchasing health insurance. A special Schedule HC-A must be filed with the state income tax return to request an appeal on the basis of a “hardship.”

The determination of whether to allow a “hardship” appeal is made in accord with procedures established by the Health Insurance Connector Authority and not the Massachusetts Department of Revenue. The Connector Authority is empowered to determine the appeal, and the Department of Revenue would not assess a penalty amount until a final determination is conveyed to the Department by the Connector Authority if the appeal is denied.

Pending federal health reform legislation would also incorporate a “hardship” exemption into the health insurance mandate structure.

In Massachusetts, to establish a “hardship” the instruction for Schedule HC provides that the taxpayer: (1) must have been homeless, more than 30 days in arrears in rent or mortgage payments, or received an eviction or foreclosure notice; (2) received a “shut off” notice, were shut off, or were refused the delivery of essential utilities (gas, electric, oil, water, or telephone); (3) had non-cosmetic medical and/or dental out-of-pocket expenses (exclusive of premium payments, and not covered by a third party) totaling more than 7.5 percent of adjusted gross income; (4) had incurred significant, unexpected increase in essential expenses (due to domestic violence, death, extended illness, aged parent, fire, flood, other natural or human-caused event); (5) experienced financial circumstances that would deprive them of food, shelter, clothing or other necessities; (6) had a family size such that affordability is inequitable; or (7) experienced other circumstances that made the taxpayer unable to purchase insurance.

Lapse in Coverage. No penalty is assessed if there is only a lapse in coverage of 63 days or less. This is borrowed from the federal “creditable coverage” rules

wherein a period of “creditable coverage” is not counted when there is a lapse of more than 63-days during which an individual is not covered under any “creditable coverage.”

Deemed Affordability. Table 3 of the Schedule HC instructions includes various ranges of Federal adjusted gross income levels with corresponding monthly premiums to annually determine whether employer-offered health insurance is “affordable.”

This will depend upon the filing status (individual, married filing jointly, married filing jointly with dependents, etc.) and income of the taxpayer. For example, for an individual with a federal adjusted gross income between \$42,501 and \$52,500, the “affordable” monthly premium is \$330.

The filer must then compare this amount to the lowest cost of coverage offered by an employer and if that amount for the offered coverage is less than the amount from Table 3, then the filer is “deemed” to be able to afford employer-sponsored coverage.

For purposes of a federal “affordability” measure, it would seem that the amount designated as the measure of employer-provided coverage affordability would have to differ by geographic region. This would greatly complicate the burden on the IRS and in the tax instruction forms for federal taxpayers.

Table 4 of the instructions includes premium information by each county of the state, by age, and family status (individual, married with no dependents, or family) to annually determine if the taxpayer was able to afford private health insurance. This will depend upon the filing status (individual, married with no dependents, or family), and a person’s age.

For example, an individual between the ages of 18-26 would be able to afford private health insurance of: \$120 per month in Berkshire, Franklin, and Hampshire Counties; or \$140 per month in Bristol, Essex, Hampden, Middlesex, Norfolk, Suffolk, and Worcester Counties; or \$130 per month in Barnstable, Dukes, Nantucket, and Plymouth Counties.

Again, for purposes of a federal “affordability” measure, it would seem that the amount designated as the measure of coverage affordability would have to differ by geographic region. This would greatly complicate the tax instruction forms for federal taxpayers.

Table 5 of the instructions includes annual income standards by family size to determine the income-based penalty that is assessed for noncompliance with the health insurance mandate. For example, a family of four, with annual income above \$63,612, would be placed in Column “D” for purposes of determining penalties.

Table 6 of the instructions includes the schedule of penalties. As an example, for 2008, the penalty for a filer in the Column “D” classification would be subject to a penalty of \$76 per each month of being uninsured. If the taxpayer was uninsured for 12 months, the penalty assessed would be \$912.

Some pending federal health care reform proposals would impose a surtax equal to 2 percent of the taxpayer’s adjusted gross income as a penalty amount.

Tax Filing Retrospective, Not Contemporaneous

In addition, the federal income tax mechanism is not contemporaneous but is retrospective and would permit

a person to go months without insurance. By the time a person has gone months without insurance, or has incurred uninsured medical bills, the prospect of recovering back premiums and charges, let alone penalties, is likely to be remote.

In Massachusetts, for example, monthly compliance is determined by matching tax returns with the 1099-HC information returns required to be filed with the Commonwealth’s Department of Revenue on an annual basis by health insurance companies to confirm that a taxpayer was covered by health insurance for each month of the previous year.

Contemporaneous enforcement is likely to be more effective than retrospective enforcement. For example, relying upon a year-end tax filing poses income tax collection problems where liabilities may be large compared to the taxpayer’s income and savings. Penalties for failure to purchase health insurance would likely be based upon last year’s income using the current federal income tax filing system. See, Steuerle, Eugene. *Implementing Employer and Individual Mandates*, Health Affairs (Spring 1994). See also, Steuerle, Eugene, and Van de Water, Paul N., *Administering Health Insurance Mandates* (National Academy of Social Insurance) (January 2009).

Retroactive enforcement is less effective as a deterrent because tax authorities would not detect noncompliance with the mandate until months after the failure to obtain coverage and penalties are assessed months or even a year after the violation has occurred.

Each April, if a tax filer has to find the money to pay a tax penalty for being without health insurance coverage the previous year, there is little or no incentive or funds to start buying health insurance at that time. See, Connecticut Health Policy Project Issue Paper, *An Individual Health Insurance Mandate: Could It Work for Connecticut?* (December 2008).

Few federal income tax returns are routinely identified for an audit—currently about 1%—and it may take far longer to identify those who may have provided incorrect information on their filed returns regarding the required levels of health insurance coverage. After the IRS would identify a person with inadequate or no coverage, the agency could not impose health insurance coverage on noncompliant filers but would assess penalties. See, Hevener, Mary B. H., and Kerby III, Charles K., *Administrative Issues: Challenges of the Current System in Using Taxes to Reform Health Insurance: Pitfalls and Promises* (Brookings, 2008).

The processing of tax returns would typically take a year or more before the IRS could identify and take steps to impose “penalties” on noncompliant taxpayers. Unfortunately, in the context of health care reform, the IRS cannot correct failures by retroactively providing health insurance coverage or compelling noncompliant taxpayers to obtain health insurance coverage in order to reduce the number of “uninsured” Americans.

Many Uninsured Are Non-Filers

Although a principle goal of health insurance reform is to extend health insurance coverage to the 47 million Americans who are uninsured, a significant number of the uninsured have incomes at or below the federal poverty level and would not be tax filers under current law.

As a result, they would not be subject to this income tax-based enforcement mechanism. This was identified

as an issue in studies leading up to the recent Massachusetts reforms. See Blumberg, Linda J; Bovbjerg, Randall; and Holahan, John. *Roadmap to Coverage: Enforcing Health Insurance Mandates* (Blue Cross Blue Shield of Massachusetts Foundation) (October 7, 2005).

For example, for 2009, the federal poverty guidelines establish an amount of \$10,830 for a family of one at 100 percent of poverty; \$14,570 for a family of two; \$18,310 for a family of three; and \$22,050 for a family of four. See, Annual Update of the HHS Poverty Guidelines (Jan. 23, 2009). In 2007, one-third of the uninsured were in families with annual incomes of less than \$20,000, and 35% of individuals in families with incomes of less than \$10,000 were uninsured. See EBRI, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey* (September 2008).

The Joint Committee on Taxation has estimated that 136.3 million individual income tax returns were filed in 2008. However, nearly 29 million tax units, headed by nondependents, did not have any reason under current law to file income tax returns. This is because their incomes were not above the filing thresholds, nor did they file to receive refunds of overwithheld income taxes or refundable tax credits. See Joint Committee on Taxation, *Overview of Past Tax Legislation Providing Fiscal Stimulus and Issues in Designing and Delivering a Cash Rebate to Individuals* (JCX-4-08R) (Feb. 13, 2008).

It is possible, therefore, that many of these individuals would be some of the “uninsured” who would be compelled to purchase health insurance and who would likely be eligible for a subsidy to make the purchase “affordable.”

If they have no other reason to file income tax returns, then the “enforcement” mechanism is not effective for this segment of the uninsured. However, the IRS does boast of an overall voluntary compliance rate of about 84 percent. See U.S. Department of the Treasury, *Update on Reducing the Federal Tax Gap and Improving Voluntary Compliance* (July 8, 2009).

Notes on Auto Liability Comparison

The most commonly discussed example of an insurance purchasing mandate is the requirement for drivers to purchase liability insurance. Interestingly, compulsory auto insurance was first introduced in Massachusetts in 1927 for bodily injury and property damage protection.

Some 47 states and the District of Columbia have enacted auto liability coverage mandates. However, studies show that states with compulsory auto insurance have no lower rates of uninsurance than states without the requirement. See California Research Bureau, *Individual Mandate: A Background Report* (April 2009).

One study in 2006 by the Insurance Research Council noted that, nationwide, some 15 percent of motorists did not have auto liability insurance coverage. The highest rates of uninsured drivers were found in Mississippi (26 percent), Alabama (25 percent), California (25 percent), New Mexico (24 percent), and Arizona (22 percent).

States have been required to engage in more extensive data matching and information technology-based efforts to enforce the auto liability insurance mandate. However, automobile insurance data bases have been costly, controversial, and error-prone. See Steuerle, Eugene; and Van de Water, Paul N., *Administering Health Insurance Mandates* (National Academy of Social Insurance) (January 2009).

The point here with the auto liability insurance mandate is that despite the mandate, there remain significant instances of uninsured motorists. In many states, the primary enforcement mechanism must be supplemented by other methods that make the implementation of the mandate more costly.

Conclusion

An individual health insurance mandate that is enforced through the individual income tax system would be complicated and its efficacy questionable. This is because the income tax compliance system operates retrospectively and not all of the uninsured are participants in the income tax filing system.

Individuals who have health insurance may be surprised at the level of administrative burden required for individuals who already have health insurance to prove that they are in compliance with the mandate.

There will be increased costs and burdens placed on the IRS to process and verify the additional “health insurance information returns” and to match that information between individuals, employers, and insurers for compliance purposes.

Most surely, there will also be an increased and more intrusive role for the IRS in the daily lives of both insured and uninsured Americans.