On Subsidies and Mandates: A Regulatory Critique of ACA

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I. INTRODUCTION ........................................................................................................ 781

II. BACKGROUND ON ACA & HEALTH INSURANCE COVERAGE .......................... 782

III. ENCOURAGING HEALTH INSURANCE PURCHASE: ACA’S CARROT AND STICK ... 784

A. The Carrot: Tax Credits for Health Insurance Purchase ......................................... 784

B. The Stick: The Individual Mandate ........................................................................ 786

  1. Policy Rationales .................................................................................................. 787

  2. The Structure of the Individual Mandate and Its Effects ........................................ 788

  3. Analysis of the Financial Penalty as a Tax ............................................................ 793

  4. The Impact of the Mandate on Purchasing Decisions ............................................ 794

  5. Putting the Pieces Together .................................................................................. 796

IV. AN ALTERNATIVE: MASSACHUSETTS’ EXPERIENCE ...................................... 798

A. Subsidies in Massachusetts .................................................................................... 798

B. The Individual Mandate in Massachusetts ............................................................... 799

  1. The Mandate as a Tax ............................................................................................ 801

  2. Mandate as Nudge ................................................................................................ 802

  3. Putting the Pieces Together .................................................................................. 802

V. KEY DIFFERENCES AND CONSIDERATIONS ................................................... 804

VI. CONCLUSION ......................................................................................................... 806

I. INTRODUCTION

This Article examines one of the most controversial elements of the Patient Protection and Affordable Care Act (ACA),¹ the so-called individual mandate, as well as its lesser-discussed but intimately related system of tax credits given to lower-income individuals to subsidize health insurance purchase.² A few caveats are important at the

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2. See ACA §§ 1401, 1501 (describing the refundable tax credit and the requirement to maintain
outset. First, this Article provides an examination of the structure and likely effects of the individual mandate. It puts aside entirely the constitutional and liberty issues raised by the mandate. Second, while the Article offers a critique of the current regulatory structure of both the mandate and the subsidies, I am cognizant of the political realities that affected ACA’s passage and that are likely to affect any subsequent reform efforts. As a result, while this Article suggests regulatory improvements, my main goal is to alert readers to potential shortcomings in ACA’s reform efforts that warrant further monitoring and study following implementation.

The Article begins with a very brief background on ACA, before analyzing ACA’s subsidies and individual mandate in detail. It then offers a comparison to the subsidies and individual mandate provided under the Massachusetts health reform law that passed in 2006, arguing that in many ways Massachusetts’ approach appears to be preferable. Massachusetts’ system of subsidies provides better financial security to low-income individuals and has an individual mandate that provides a clear, equitable incentive to all but the lowest-income individuals to purchase health insurance coverage.

II. BACKGROUND ON ACA & HEALTH INSURANCE COVERAGE

ACA is an immense piece of legislation that has been likened to a “finely crafted watch” given its complicated and interrelated provisions. It has many and varied goals, but primary among these is a desire to greatly increase the number of Americans with health insurance coverage, to provide better access to health insurance for those with poor health history or risks, and to make health insurance coverage more affordable.

In 2009, there were 50 million uninsured individuals under age 65 in the United States. This figure includes all individuals present in the United States, regardless of citizenship or immigration status. Most of the uninsured are part of a family with at least one full-time worker. Not surprisingly, those with lower incomes make up a large percentage of the uninsured. Among the uninsured, 40% have incomes below the federal poverty limit (FPL); 38% have incomes between 100% and 250% FPL, 13% have incomes between 251% and 399% FPL, while only 10% of the uninsured have incomes at or above 400% FPL.

minimum essential coverage).

4. For an overview of the many motivations behind ACA, see Reports on Health Reform, HEALTHREFORM.GOV, http://www.healthreform.gov/reports/index.html (last visited May 16, 2011), which provides many reports, prepared prior to ACA’s passage, explaining the various motivations for health care reform.
6. Id. at 5–6.
7. Id. at 5.
8. Id.
10. KAISER FAM. FOUND., supra note 5, at 5.
Following full implementation of ACA’s major insurance reforms in 2014, health insurance market dynamics are likely to change dramatically from their current state. ACA will require health insurers to offer coverage to every applicant at premiums that vary based only on age, geographic location, family size, and tobacco use, and even then only within certain ranges.\footnote{11} These policies must have guaranteed renewability, and can be rescinded only under limited circumstances.\footnote{12} In the individual and small group markets, ACA will require all new policies to offer “essential health benefits” and all markets will be subject to restrictions on deductibles, out-of-pocket maximums, and other annual and lifetime limits on benefits.\footnote{13} In order to make coverage more affordable, individuals with household income below 400% FPL are eligible for refundable tax credits that subsidize insurance purchase.\footnote{14} To help organize the market for individuals and small groups, each state will have an insurance exchange to simplify, facilitate, and oversee insurance purchase.\footnote{15} And of course, ACA also requires most individuals to purchase health insurance or face a significant monetary penalty.\footnote{16}

The Centers for Medicare & Medicaid Services, a division of Health & Human Services, estimates that by 2019, ACA will expand coverage to nearly 34 million individuals, reducing the number of uninsured individuals by more than half.\footnote{17} Of those gaining coverage, they estimate that 20.4 million will receive publicly-financed coverage such as Medicare and Children’s Health Insurance Program (CHIP).\footnote{18} Another 16 million are expected to obtain insurance through exchange-based private markets.\footnote{19} The remaining uninsured will include illegal immigrants (who are not eligible for public coverage or federal subsidies), those exempt from the mandate because affordable coverage is unavailable to them, and those subject to the mandate, but who choose to pay the penalty in lieu of coverage.\footnote{20}

\footnotesize

12. Id. § 1201 (adding Section 2703 to the PHSA) (codified at 42 U.S.C. § 300gg-2); id. § 1001 (adding Section 2712 to the PHSA) (codified at 42 U.S.C. § 300gg-12).
13. Id. § 1201 (adding Section 2707 to the PHSA) (codified at 42 U.S.C. § 300gg-6) (“A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.”); id. § 1201 (adding Section 2707(b) to the PHSA) (codified at 42 U.S.C. § 300gg-6); ACA § 1001 (adding Section 2711 to the PHSA) (codified at 42 U.S.C. § 300gg-11). Grandfathered health plans are exempt from many of these requirements.
15. Id. § 1311.
16. See infra Part III.B (examining the structure of the individual mandate).
18. Id. at 24, tbl.2.
19. Id. at 7. The increases in public and private insurance are actually greater than the overall reduction in the uninsured because 14 million individuals are expected to lose employer-sponsored coverage by 2019. Id.
III. ENCOURAGING HEALTH INSURANCE PURCHASE: ACA’S CARROT AND STICK

A. The Carrot: Tax Credits for Health Insurance Purchase

Recognizing that the out-of-pocket premium cost of health insurance coverage has a significant impact on an individual’s decision to purchase insurance, 21 and that the impact is particularly strong for low-income individuals, 22 ACA provides advanceable, 23 refundable 24 premium tax credits to help subsidize the purchase of insurance for individuals at or below 400% FPL. 25 In part, these credits allow the individual mandate, discussed below, to have a broader reach than it otherwise might. 26

The credits, which are not fixed in amount, are calculated based on the difference between the maximum percentage of income an individual is required to spend on health insurance coverage and the premium for the second-lowest cost silver plan that the individual is eligible to purchase. 27 The following chart provides the maximum percentage of income that individuals at various income levels are required to contribute to coverage for purposes of calculating the credit.

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22. See, e.g., id. at 28 (finding a strong positive effect of household income on the likelihood of a household to elect coverage under an employer plan).

23. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1412, 124 Stat. 119, 231 (2010). “Advanceable” refers to the ability of tax payers to receive the benefit of the credit prior to filing their income tax return for the year at issue. See id. (describing the advance determination of tax credit eligibility). In general, an individual must wait until she files her tax return for a given year in order to receive the benefit of an available tax credit. The credit was presumably made advanceable in this circumstance in order to alleviate the cash flow problem that would otherwise prevent low income individuals from purchasing coverage. Without an advanceable credit, low income individuals would need to pay the full premium cost on their own and wait many months before receiving the tax credit.

24. Id. § 1401. When a credit is refundable, the taxpayer is able to receive the full economic value of the credit regardless of federal income tax liability. See Lily L. Batchelder et al., Efficiency and Tax Incentives: The Case for Refundable Tax Credits, 59 STAN. L. REV. 23 (2006) (discussing refundable tax credits as a policy tool). For example, if an individual has only $1000 in federal income tax liability and is eligible for a $3000 premium tax credit, the individual would receive a $2000 refund from the IRS. If the credit were non-refundable, the individual’s tax liability would be reduced to zero, but she would not receive any refund, thereby losing the $2000 excess value of the credit. For a discussion of the efficiency of refundable tax credits as a policy tool, see id.


26. See Jonathan Gruber, Covering the Uninsured in the United States, 46 J. ECON. LIT. 571, 602–03 (2008) (discussing how removing the tax exclusion for employer-provided health care could generate sufficient revenue to subsidize health insurance purchase for a wide range of low-income individuals, leading to near universal coverage under a system with an individual mandate).

27. ACA § 1401 (codified at I.R.C. § 36B). The exchanges may offer plans at bronze, silver, gold, and platinum levels. Id. § 1302(d)(1). These levels are based on actuarial value. Id. § 1302(d)(2). A bronze level plan is one designed to provide benefits that are equivalent to 60% of the full actuarial value of the benefits. Id. § 1301(d)(1). The actuarial value of a silver plan is 70%, gold is 80%, and platinum is 90%. Id.
Table 1: Maximum Percentage of Income Required to be Spent on Health Insurance for Purposes of Calculating Premium Tax Credit

<table>
<thead>
<tr>
<th>For household income (expressed as a percentage of FPL) within the following income tier:</th>
<th>The initial premium percentage is:</th>
<th>The final premium percentage is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 133%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>133% up to 150%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>150% up to 200%</td>
<td>4%</td>
<td>6.3%</td>
</tr>
<tr>
<td>200% up to 250%</td>
<td>6.3%</td>
<td>8.05%</td>
</tr>
<tr>
<td>250% up to 300%</td>
<td>8.05%</td>
<td>9.5%</td>
</tr>
<tr>
<td>300% up to 400%</td>
<td>9.5%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

To illustrate, assume that a single individual has household income of $21,780, exactly equal to 200% FPL, and that individual seeks health insurance coverage through her state exchange. Further assume that the premium for the second-lowest-cost silver plan available to the individual is $4780. The individual would then be entitled to a tax credit equal to the difference between $4780 (the silver plan premium) and $1372 (6.3% of household income), which is $3408. It is important to note that while the credit amount is calculated on the basis of the second-lowest-cost silver plan, the individual is not in any way required to purchase that plan; the second-lowest-cost silver plan is used solely to determine the amount of the tax credit. The individual is free to choose any plan offered within the exchange. If the individual chose a bronze level plan with an annual premium of only $4100, she would still receive the $3408 tax credit and would only be required to pay $692 out-of-pocket for such coverage. And if she chose platinum level coverage with a $6150 annual premium she would again receive the $3408 tax credit and be required to pay $2742 out-of-pocket for premiums.

Structuring the premium tax credits in this manner creates an interesting incentive for individuals without known medical needs to purchase the lowest cost plan that is available to them, in order to reduce their out-of-pocket premium payment. This type of regulatory incentive is consistent with economic theory that suggests that a significant cost driver of medical care and health insurance in the United States is “overinsurance.” Overinsurance, which typically takes the form of a generous plan with very low deductibles, copayments, and cost-sharing requirements, is thought to lead to moral hazard, whereby insurance coverage makes an individual more likely to incur a covered loss. For example, in the case of health insurance, moral hazard might cause an overconsumption.

28. ACA § 1401 (codified at I.R.C. § 36B(b)(3)(A)(i)).
29. See id. §§ 1312, 1401 (discussing consumer choice and the refundable tax credit respectively).
30. Id. § 1312.
individual to consent to an expensive diagnostic procedure to which the individual would not consent if she faced the full price of the service. Cost sharing is thought to significantly reduce moral hazard, and low cost plans available on the exchange are likely to have significant cost sharing.

Of course, encouraging low and moderate income individuals to purchase plans with high cost sharing requirements may significantly undercut the financial security offered by health insurance and ACA, at least partly, recognizes this fact. Section 1402 of ACA provides that tax credit-eligible individuals who enroll in silver level coverage are eligible for cost-sharing reductions. First, out-of-pocket maximums are reduced by two-thirds for those with income between 100% and 200% FPL, by one-half for individuals with income between 200.1% and 300% FPL, and by one-third for individuals with income between 300.1% and 400% FPL. Further, the percent of covered expenses that a plan must pay is increased to between 94% and 73%, depending on the individual’s income. Notably, however, the statute does not appear to limit the deductible that can be applied to such individuals, except indirectly.

Pity the tax credit-eligible individual that has to sort through all of these competing incentives. The tax credit encourages individuals to purchase a low-cost plan, in order to minimize their out-of-pocket premium payments. But the reduced cost-sharing requirements apply only if the individual purchases silver-level coverage, requiring an upfront premium payment that may be unaffordable. And this is before the impact of the individual mandate is factored in.

B. The Stick: The Individual Mandate

This subpart details the structure of the individual mandate, and examines it from both a tax and health policy perspective. But first, the policy goals of ACA’s individual mandate are briefly reviewed.


See, e.g., Kathleen N. Lohr et al., Use of Medical Care in the RAND Health Insurance Experiment, 24 MEd. Care S1, S31–38 (1986) (discussing the impact of cost-sharing on utilization of medical services). Unfortunately, cost-sharing has been found to lower use when care is thought to be highly effective to the same extent that it lowers use when the care is thought to be only rarely effective. Id.


35. ACA § 1402(b)(1).
36. Id. § 1402(c)(1).
37. Id. § 1402(c)(2).
38. The only apparent effect on the deductible is the lowering of the out-of-pocket maximum, which would include the deductible. However, even where out-of-pocket maximums are significantly reduced, deductibles could still be quite large. For example, if the out-of-pocket maximum under ACA is $5950 and it is reduced by two-thirds for a low income individual under Section 1402 of ACA, the new limit would be $1964. The deductible faced by a low income individual could therefore remain quite sizeable.
1. Policy Rationales

The individual mandate is important in many ways to the success of health care reform. Recall that under ACA, health insurers are required to offer coverage to all applicants, cannot exclude pre-existing conditions, and are constrained in their ability to vary premiums. These changes make the health insurance market very attractive for high-risk purchasers (those with existing health problems or a negative health history or risk factors). All other things equal, we would expect high-risk individuals to elect to purchase insurance in greater numbers than average or low-risk individuals. Adverse selection in this market would be expected to be even worse than in existing state markets with guaranteed issue and community rating requirements, because under ACA an insurer cannot exclude pre-existing conditions nor can they rescind coverage.39

In the absence of an individual mandate, individuals would be likely to forgo insurance because (1) they know that they cannot be denied insurance in the event that they develop significant health needs and (2) they know an insurer cannot exclude coverage for pre-existing conditions. Compared with pre-ACA regulation, pursuant to which insurers could not only refuse to cover pre-existing conditions, but also charge premiums based on health risk and even decline to offer coverage at any price,40 the new regulatory system significantly reduces the risk associated with forgoing health insurance. At the same time, high-risk individuals are guaranteed access to coverage at average rates and are therefore quite likely to purchase coverage. To combat this likelihood of adverse selection, the individual mandate seeks to get everyone, particularly healthy individuals, into the risk pool.41 This, in turn, keeps premium prices low and essentially requires low-risk individuals to cross-subsidize high-risk individuals.42

While combating adverse selection is clearly a dominant motivation for the


41. ACA also contains an additional provision that may help to limit the adverse selection that we would otherwise expect to see in a market with guaranteed issue and modified community rating requirements. ACA provides that there will be only a single enrollment period each year within the exchanges, with exceptions made only for specific qualifying changes in status. ACA § 1311(c)(6). ACA also allows insurers who offer policies outside of an exchange to limit enrollment to a single annual enrollment period. Id. § 1201 (adding Section 2702 to the PHSA). Therefore, even though an individual is guaranteed to have the ability to purchase health insurance at more or less average rates, she may have to wait up to twelve months in order to enroll in such coverage. As a result, a healthy individual continues to take on risk if she declines to enroll in coverage. If she develops significant medical needs, she would—absent a qualifying change in status—need to wait until the next open enrollment period to obtain coverage. The open enrollment period would, therefore, be expected to result in a greater number of individuals enrolling in coverage than would otherwise be the case, but there is a lack of empirical evidence on this point.

individual mandate, the mandate may have other policy motivations as well. \textsuperscript{43} It can reduce the perceived problem with “free riders” within the medical system—those that consume medical services but do not pay for their care, shifting their costs onto providers, other consumers, and charitable organizations.\textsuperscript{44} It can also have paternalistic motivations, overriding individuals’ preferences in order to force a decision that society believes is in an individual’s best interest.\textsuperscript{45} And the mandate can also be supported on the grounds that it enhances efficiency in insurance markets.\textsuperscript{46} When insurers are not spending their time and effort trying to combat adverse selection, overhead costs should decrease significantly, resulting in lower health insurance premiums, which in turn further encourages low-risk individuals to purchase coverage.

2. \textbf{The Structure of the Individual Mandate and Its Effects}

ACA’s individual mandate requires nearly all Americans to purchase health insurance, unless such insurance is “unaffordable.”\textsuperscript{47} If an individual has affordable coverage available to her and does not purchase coverage, she faces a penalty equal to the greater of (1) $695 per person in her household, up to a maximum of $2085 and (2) 2.5% of household income.\textsuperscript{48} In no event will the fee exceed the national average cost for a plan that offers bronze-level coverage.\textsuperscript{49} In addition, individuals whose income is below the federal income tax filing threshold are in no circumstances subject to the mandate.\textsuperscript{50}

Health insurance is considered unaffordable if the premium cost exceeds eight percent of the individual’s household income.\textsuperscript{51} In determining affordability, both tax credits and any employer contribution toward coverage are taken into account.\textsuperscript{52} There are two particularly interesting aspects of the unaffordability exception to the mandate. First, the affordability threshold is flat. Regardless of income level, everyone is assumed to be able to spend eight percent of income on health insurance.\textsuperscript{53} There is no acknowledgement that lower income individuals may not be able to spend the same percent of their income on health insurance as higher income individuals.

In addition, the unaffordability exception to the individual mandate has the potential to exempt a significant number of Americans from the mandate’s reach.\textsuperscript{54} In determining

\begin{itemize}
\item \textsuperscript{43} For a broader discussion of mandate goals, see generally Hoffman, \textit{supra} note 42, and Sherry A. Glied et al., \textit{Consider it Done? The Likely Efficacy of Mandates for Health Insurance}, 26 \textit{HEALTH AFF.} 1612, 1613 (2007).
\item \textsuperscript{44} Hoffman, \textit{supra} note 42, at 30.
\item \textsuperscript{45} Id. at 23–26.
\item \textsuperscript{46} See id. at 26–31 (discussing the efficiency of the mandate).
\item \textsuperscript{48} Id. § 1501(b) (codified at I.R.C. § 5000A(c)). The penalty amounts listed are those that go into effect in 2016. Id. In the initial years of the mandate’s applicability—2014 and 2015—lower penalty amounts apply. See id. (providing a penalty amount of $95 for 2014, and $350 for 2015).
\item \textsuperscript{49} Id. “Bronze level coverage” refers to a plan where the actuarial value of the benefits is equal to 60% of the full actuarial value of benefits provided under the plan. ACA § 1302(d)(1).
\item \textsuperscript{50} Id. § 1501(b) (codified at I.R.C. § 5000A(e)(2)).
\item \textsuperscript{51} Id.
\item \textsuperscript{52} Id. § 1501 (codified at I.R.C. § 5000A(e)(1)).
\item \textsuperscript{53} Id.
\item \textsuperscript{54} While this Article suggests structural reasons why there is likely to be a gap, others have used various
affordability, the available tax credits are taken into account, so those individuals and families with income below 250% FPL but above the federal income tax filing threshold will in all circumstances be subject to the mandate, because that is the level at which premiums are kept equal to or less than eight percent of household income. While those with incomes between 250% and 400% FPL are eligible for premium tax credits, they may not actually be subject to the individual mandate, because even with the credits they may be required to contribute more than eight percent of their income toward coverage. The outcome is not, however, certain. It depends in part on the relative premiums of the second-lowest-cost silver plan available to the individual (on which the tax credit is calculated) and the lowest cost bronze coverage available to the individual (which is the cheapest way to satisfy the mandate). For purposes of this Article, I have assumed that tax credits will be based on an individual premium of $4780 for the second-lowest-cost silver plan, while the premiums available to an individual for the lowest-cost bronze-level plan will be $4100. As Table 2 shows, utilizing these assumptions, all single taxpayers who are eligible to receive tax credits would in fact be subject to the mandate. However, those with incomes just above the cut-off for tax credit eligibility would be exempt pursuant to the unaffordability exception. Table 3 illustrates a similar outcome for married families with one child, except that the income range within which the mandate is inapplicable is even larger. It is important to note that these estimates do not take into account individual premium fluctuations. Recall that under ACA, premiums can vary based on age, family size, geographic location, and tobacco use. As a result, the mandate’s applicability at various income levels will in fact vary based on the factors that may be taken into account when determining premiums. For example, it may be the case that an individual earning $50,000 in a low-cost geographic location will be subject to the mandate, while an individual earning $50,000 in a high-cost location will not be. This Article, for the sake of simplicity, uses only average premiums to calculate the mandate’s applicability.

models to predict the size of that group. See, e.g., BUETTGENS & HALL, supra note 20, at 10 (projecting that 16.2% of the uninsured population post-ACA will be those with an affordability exemption from the mandate).

55. While individuals with income between 250% and 400% FPL are eligible for premium tax credits, those credits will cap individuals’ required contribution toward coverage at 8.05% of income for those with income at 250% FPL, rising to 9.5% for those with incomes between 300% and 400% FPL. ACA § 1401 (codified at I.R.C. § 36B(b)(3)(A)(ii)).

56. Id. § 1501.

57. These numbers are based on estimates prepared for Consumers Union by Towers Perrin. CONSUMERS UNION, WHAT WILL AN “ACTUARIAL VALUE” STANDARD MEAN FOR CONSUMERS 4 (2011), available at http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/01/consumers_union-health_policy_brief-2011_01-what_will_an_actuarial_value_standard_mean_for_consumers.pdf. While there are other estimates available, the Consumers Union estimate was the only one identified that provided both a bronze and silver-level estimate based on the requirements of ACA. For example, the Congressional Budget Office (CBO) has provided estimates of average premiums under ACA in the individual and small group markets, and estimates for bronze-level coverage, but has not made estimates regarding silver-level premiums available. See An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, attachment to a letter from Cong. Budget Office to the Honorable Evan Bayh (Nov. 30, 2009); Letter from Cong. Budget Office to the Honorable Olivia Snow (Jan. 11, 2010).
Table 2: Estimated Mandate Applicability for a Single Taxpayer, Assuming Bronze Level Premium of $4100 and Second-Lowest-Cost Silver Premium of $4780

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Subject to Mandate?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below $9350\textsuperscript{a}</td>
<td>No</td>
</tr>
<tr>
<td>$9350–$43,560\textsuperscript{b}</td>
<td>Yes</td>
</tr>
<tr>
<td>$43,561–$51,249\textsuperscript{c}</td>
<td>No</td>
</tr>
<tr>
<td>$51,250 and above\textsuperscript{d}</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Table 3: Estimated Mandate Applicability for Married Taxpayers with One Child, Assuming Bronze Level Premium of $11,193 and Second-Lowest-Cost Silver Premium of $13,049

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Subject to Mandate?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below $18,700(^a)</td>
<td>No</td>
</tr>
<tr>
<td>$18,701–$74,120(^b)</td>
<td>Yes</td>
</tr>
<tr>
<td>$74,121–$139,912(^c)</td>
<td>No</td>
</tr>
<tr>
<td>$139,913 and above(^d)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

\(^a\) This group is exempt from the mandate because their income is below the tax filing threshold. The 2010 federal income tax filing threshold has been used for this purpose. See I.R.C. § 6012(a)(1)(A) (2006).

\(^b\) This group is subject to the mandate because, once the tax credits are taken into account, their required contribution to coverage is less than eight percent of their household income.

\(^c\) This group is not subject to the mandate because premiums exceed eight percent of household income. This assumes that the individuals are not eligible for employer-provided coverage to which the employer contributes.

\(^d\) This group is subject to the mandate because premiums are less than eight percent of household income, regardless of any available employer contribution.

While there is uncertainty regarding premium rates within exchanges, the above tables show that there is likely to be a significant number of taxpayers exempt from the individual mandate. This group is a middle income group; they are not poor enough to qualify for a subsidy, but not well-off enough to be penalized for failing to purchase coverage. This group has no incentive—other than the benefits offered by health insurance—to purchase coverage.

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58. The Consumers Union estimates for bronze and silver coverage did not include estimates for family premiums. See CONSUMERS UNION, supra note 57, at 4 (providing premium estimates only for single coverage). As a result, I used the same $4100 and $4780 premium levels, but multiplied them by the amount by which family coverage premiums currently exceed individual coverage premiums in employer plans, based on the results of the Kaiser Family Foundation’s 2010 annual survey of employer plans. KAIser Fam. FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2010 ANNUAL SURVEY 34 (2011), available at http://ehbs.kff.org/pdf/2010/8085.pdf. Average individual premiums are $5049 in employer plans, and $13,770 for family coverage (2.73 times greater than the individual premium). Id. As a result, I multiplied the Consumers Union estimates for bronze and silver level coverage by 2.73 to produce estimates of family coverage premiums.
In practice, the gap may not in fact be as large as it appears, because many who are in the income range that is not subject to the mandate are likely to be eligible for employer-provided coverage. The income levels for both individuals and families that fall into the gap are high enough to suggest that there is at least one full-time worker in the family, and the majority of full-time workers are covered by employer-provided health insurance. Further, most employers contribute to coverage and contribute generously. Because employer contributions are taken into account in determining affordability, such contributions may cause an employee’s cost to fall below the eight percent threshold, subjecting the individual to the mandate. This, of course, assumes the status quo with respect to employer-provided coverage. It assumes most employers will continue to offer coverage and heavily subsidize that coverage. If employers do not continue to offer coverage under ACA, many middle-income individuals may end up being unaffected by the individual mandate.

Regardless of the exact size of the group that falls within the affordability gap, it is nonetheless problematic for two primary reasons. First, to the extent that there are uninsured individuals within the “gap” range, those are individuals who remain unlikely to purchase insurance if they have low expected health costs. Second, exempting a middle income group from the mandate, while subjecting others to its reach, is potentially damaging for norm development. Perceptions of a law’s fairness may affect an individual’s decision to comply with the law or not. Therefore, carving out a group from the law’s applicability, without any clear justification, may negatively affect compliance with the mandate. In addition, it may prevent the development of a strong social norm in favor of health insurance purchase. And if a sufficient number of individuals are either exempt from the mandate, or chose not to purchase coverage despite the mandate, adverse selection may begin to negatively affect health insurance premiums and coverage rates.

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59. See id. at 29 (finding that 69% of firms offered health benefits to employees in 2010).

60. See id. at 48 (finding that 59% of employees are covered by employer-provided health plans).

61. On average in 2009, workers paid only 17% of the cost of single coverage and 27% of the cost for family coverage. Id. at 68. The majority of workers are employed by firms that contribute at least half of the premium cost. KAISER FAM. FOUND., supra note 58, at 81.

62. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501(b), 124 Stat. 119, 244 (2010) (codified at I.R.C. § 5000A(e)(1)) (defining “individuals who cannot afford coverage” as any individual whose required contribution to coverage exceeds eight percent of the individual’s household income).


64. This result is to be expected because a healthy individual’s endogenous desire for health insurance should be lower than average. Some models have predicted lower rates of insurance for healthy individuals post-ACA. See, e.g., KAISER FAM. FOUND., A PROFILE OF HEALTH INSURANCE EXCHANGE ENROLLEES 8 (2011) (estimating that those who chose to enroll in exchange-based coverage will have worse mental and physical health, on average, than non-enrollees).

65. See, e.g., Eric A. Posner, Law & Social Norms: The Case of Tax Compliance, 86 Va. L. REV. 1781, 1806 (2000) (analyzing the effect of the law and social norms on tax compliance, and stating that “[t]he propensity to pay taxes is positively related to perceptions of fairness about tax enforcement procedures, tax rates, and/or fiscal policy”).

66. See id. (recognizing that tax compliance “tips in the direction of most people complying or few people complying”).
3. Analysis of the Financial Penalty as a Tax

For individuals to whom the mandate applies, there is a choice presented; they can either purchase health insurance coverage or pay a financial penalty. This section examines the impact of the individual mandate on those who chose to pay the financial penalty in lieu of purchasing health insurance coverage, examining the mandate’s tax function.

Our federal income tax system uses progressive marginal rates. The current structure of the individual mandate penalty, however, is neither purely progressive, flat, nor regressive, but a rather interesting combination. Individuals at the lower end of the income spectrum will pay the largest percentage of income if they fail to purchase coverage. Because ACA’s penalty is the greater of $695 and 2.5% of household income, anyone earning below $27,800 (the income level at which $695 is equal to 2.5% of income) pays a penalty that exceeds 2.5% of income. There is an unsubsidized middle income group that will pay no penalty at all, because coverage is deemed unaffordable pursuant to the eight percentage affordability threshold. Beginning at the income level at which premiums are equal to eight percent of income, the penalty rate stays constant as a percentage of income, until 2.5% of a taxpayer’s income is equivalent to the average national premium for a bronze-level plan, at which point the penalty is capped and starts to decline as a percentage of income. Figure 1 graphically illustrates the impact of the individual mandate penalty as a percentage of income.

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Examining only the impact of the financial penalty associated with a failure to purchase health insurance, the distribution is nonsensical. Those with the lowest income level pay the greatest percentage of income, while those with moderate income levels pay nothing. At higher income levels the penalty is a flat 2.5% rate before declining at the highest income levels. Not surprisingly, this type of distribution does not fit within any known theories of the distribution of income tax burden. If it is to survive rational analysis, it must be because of its impact on purchasing decisions. As a result, Part III.B.4 below discusses how the penalty structure does or does not encourage the purchase of health insurance at different income levels.

4. The Impact of the Mandate on Purchasing Decisions

The individual mandate was not structured primarily to raise revenue, but rather to change the cost-benefit analysis associated with the purchase of health insurance. That is, the idea was to create a financial incentive for healthy individuals for whom the benefit of insurance is perceived to be less than its cost to purchase coverage. By imposing a penalty for failing to purchase coverage, the mandate shifts the cost-benefit analysis a purchaser would normally make. Instead of comparing the full cost of insurance against its benefits, a purchaser should instead compare the benefit of coverage to the excess of the full premium over the mandate penalty (hereinafter referred to as the “delta”). In other words, they should compare the benefit of insurance not to its full cost, but only to the cost that exceeds the mandate penalty, since they must forgo the amount of the mandate penalty whether they purchase coverage or not. Therefore, the extent to which the mandate encourages individuals to purchase insurance will depend in large part on the size of the delta. The smaller the delta, the more likely it should be that an individual will chose to purchase coverage. What is interesting about ACA’s mandate is that the delta varies based on income level (and not just with respect to the actual dollar amount of the delta, but also the relative size of the penalty to the total premium), as illustrated in Figure 2 below.

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70. Of course, while our federal income tax system is progressive, overall tax burdens may not be, since the federal income tax is but one facet of overall tax burden. The effect of the federal payroll tax, as well as state and local taxes, would also need to be taken into account.

What we can see from this illustration is that even those who are eligible for premium tax credits still face a significant difference between the penalty amount and the total cost of health insurance. And for those that fall within the mandate’s “unaffordability” gap, there is no extra incentive created to help encourage insurance purchase. As income levels rise, however, the penalty associated with failing to purchase health insurance becomes compelling, equaling the premiums of a bronze-level plan.  

For example, an individual earning $52,000 would face a penalty of $1300 (2.5% of income), while an individual with household income of $164,000 or greater would face a penalty equal to the average bronze-level premium of $4100. Those making $164,000 or more would obviously purchase the insurance because the premium and the penalty are equal. The choice for the individual earning $52,000 is less obvious. If the insurance provides $2800 of perceived value, the individual should purchase it. Valuing health insurance is of course difficult because the individual is unaware, ex ante, what her medical expenses will be and whether the insurance policy purchased would pay for the particular expenses incurred. However, if the individual is in good health, she might rationally prefer to pay the $1300 penalty and self-insure any unexpected expenses.

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72. ACA § 1501(b) (codified at I.R.C. § 5000A(c)). Assuming a national average bronze level premium of $4100, single individuals with household income at or above $164,000 would face a penalty equal to the bronze level premium.

73. This assumes, of course, that coverage is in fact available to the individual at premiums of $4100 or less.

74. This may be particularly true given that the lowest cost plan available to the individual is likely to be one that has high cost-sharing requirements, which would lower the plan’s value to the individual.
This is particularly true since ACA requires insurers to offer coverage to all applicants at essentially community-level rates. This means that if the healthy individual forgoes coverage and unexpectedly becomes sick, she can enroll in coverage during the next open enrollment period and face no penalty for having chosen not to insure in the previous year. Of course, it is a risky choice, as unexpected medical expenses can easily bankrupt an individual if the expenses must be incurred before she can purchase insurance. But if the risk is perceived as sufficiently small, and the cost sufficiently great, we may see significant numbers of individuals pay the monetary fee instead of purchase coverage.

Loss aversion may, however, lessen this phenomenon. Individuals may feel better paying a larger amount that provides them with a benefit (coverage) than a smaller amount that represents a pure loss (paying the mandate penalty to the government). In addition, to the extent an individual is eligible for a tax subsidy, loss aversion may be even stronger. The individual may be likely to purchase coverage in order to avoid “losing” the payment she would otherwise receive from the government. And finally, one large unknown in this area is the extent to which the “penalty” aspect of the individual mandate is psychologically significant to compel purchase. Norms can powerfully influence behavior.

The individual mandate may create such a norm and may result in a greater number of individuals purchasing insurance than we might otherwise expect from a straight cost-benefit analysis.

5. Putting the Pieces Together

Given the differing penalty levels and differing deltas between mandate penalties and total premium cost, how might the mandate actually impact insurance purchasing decisions? Table 4 presents the two factors that are most likely to impact purchasing decisions—the size of the delta, as well as the size of the penalty, expressed both as dollar amounts and as percentages of income. These two factors are likely to have differing, but overlapping effects on purchasing decisions. The smaller the delta between the mandate penalty and the total premium cost is, the more likely an individual should be to purchase coverage. For example, if an individual faces a mandate penalty of $1000, but the cost to purchase health insurance is only $1200, the individual faces a delta of $200. It is the amount of the delta that an individual should compare to the benefit of health insurance, so in the example just given the individual should purchase coverage if it is worth $200 to her. The second factor, the size of the penalty, is also likely to affect purchasing decisions due to loss aversion. Because individuals weigh potential losses

75. ACA § 1201 (adding Section 2701 to the PHSA).
77. Where a tax subsidy is available, an individual would likely be hesitant to walk away from that benefit. Doing so might be perceived by the individual to be a loss, and that perceived loss would be factored into the individual’s decision making process, making it more likely, all other things being equal, that the individual will elect to purchase coverage.
78. See, e.g., Cass R. Sunstein, Social Norms and Social Roles, 96 COLUM. L. REV. 903 (1996) (describing the impact social norms have on behavior).
79. See generally Posner, supra note 65 (discussing the relationship between norms, cost-benefit analysis, and compliance with the law).
more heavily than gains of the same size, it would seem likely that the higher the penalty amount, the more likely an individual is to purchase coverage in order to avoid the loss associated with paying the penalty. Of course, this would only hold true if the individual viewed health insurance coverage as a gain. If they view the premium payment as a loss, the penalty amount would not drive insurance purchase. The two factors are interrelated because, as the penalty level rises, the delta is reduced.

Table 4: Purchase Incentives for Single Taxpayers Based on Income Level (assuming a $4780 premium for second-lowest-cost silver plan and a $4100 premium for lowest-cost bronze plan)

<table>
<thead>
<tr>
<th>Income</th>
<th>Difference between penalty amount and total premium cost</th>
<th>Penalty amount</th>
<th>% of income</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000</td>
<td>$463 $1.8%</td>
<td>$695 $2.8%</td>
<td></td>
</tr>
<tr>
<td>$50,000</td>
<td>$4100 $8.2%</td>
<td>$0 N/A</td>
<td></td>
</tr>
<tr>
<td>$52,000</td>
<td>$2800 $5.4%</td>
<td>$1300 $2.5%</td>
<td></td>
</tr>
<tr>
<td>$100,000</td>
<td>$1600 $1.6%</td>
<td>$2500 $2.5%</td>
<td></td>
</tr>
<tr>
<td>$150,000</td>
<td>$350 $0.2%</td>
<td>$3750 $2.5%</td>
<td></td>
</tr>
<tr>
<td>$200,000</td>
<td>$0 N/A</td>
<td>$4100 $2.1%</td>
<td></td>
</tr>
</tbody>
</table>

Examining how incentives differ at various income levels provides an interesting perspective on ACA’s mandate. At the low income levels, purchasers have a moderately strong incentive to purchase coverage. They face a high penalty, and a moderate delta. Those at $50,000 have no extra incentive to purchase coverage, because they are exempt from the mandate. At incomes above $50,000, the incentives start out fairly weak but become progressively stronger as income level rises. At the highest income levels, the incentive is compelling where the penalty equals the full cost of health insurance coverage.

At first glance, it appears troubling to have incentives differ so significantly based on income. However, if we unpack the nudge at various income levels, we see that there are likely multiple policy goals working at once. First, there is the overwhelming nudge given to the highest income taxpayers (those for whom the mandate penalty equals the lowest cost premium) and the strong nudge given to those with high incomes (those for whom the penalty amount is a significant percentage of the total premium cost). This is almost certainly motivated by a desire to require the relatively healthy and wealthy to subsidize care for the relatively sick and poor. It is a redistribution of wealth, forcing high income individuals to be financiers of others’ medical care.80 It makes sense that such

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80. Hoffman, supra note 42, at 20–21. As a practical matter, there may be little gained by this system, because very few individuals with high incomes appear to lack health insurance. See, e.g., Hanns Kuttner & Matthew S. Rutledge, Higher Income Uninsured: Common or Rare?, 26 HEALTH AFF. 1745, 1750 Exhibit 4 (2007) (finding that high income individuals, defined as those earning more than $50,000, make up approximately 5% of the uninsured population). The reason that it is difficult to get data based on income level
efforts would be aimed only at the wealthy, as few would likely support a system that required the healthy poor to subsidize the wealthy sick. 81

Next, the system creates strong, but not necessarily overwhelming incentives for those on the lower end of the income distribution. The policy motivation for the high penalty for lower income individuals is likely the perceived free rider problem, given that those with low incomes are both statistically more likely to be in poor health and be unable to pay for care. 82 Additionally, paternalistic concerns likely support this nudge. After all, if lower income individuals are more likely to be in poor health, it should be in the individual’s best interest to have health insurance that allows her to access needed medical care. 83

Finally, we have the group that faces no incentive to purchase coverage because of the affordability gap. This gap is troubling for a number of reasons, but in the end it is a reflection that health insurance is simply unaffordable for some, and we should not punish those who fall into this group. Implicitly, of course, it is also an acknowledgment that we are unwilling or unable to subsidize insurance purchase for this group. 84

IV. AN ALTERNATIVE: MASSACHUSETTS’ EXPERIENCE

There are many apparent similarities between ACA and the health reform law passed by Massachusetts in 2006. Both reform efforts included subsidies to make health insurance more affordable for low and moderate income individuals, as well as an individual mandate that imposes a financial penalty on those that fail to purchase coverage. The particulars of both the subsidies and the individual mandate in Massachusetts are, however, noticeably different from those in ACA, and reflect a different approach to these aspects of health care reform.

A. Subsidies in Massachusetts

Massachusetts subsidies health insurance coverage for individuals with income at or below 300% FPL, not through tax credits, but through directly subsidized health plans. 85 For those not otherwise eligible for Medicaid, subsidized coverage is provided through the Commonwealth Care program, which gives eligible individuals a choice of managed care organizations from which to receive coverage. 86 For those earning 100%
FPL or below, there are no premiums and very low co-payments for services. For those earning between 100% and 300% FPL, premiums are determined based on a sliding scale determined by the Connector Board. For 2010, premiums for this group ranged from $10 to $12 per month for those with incomes between 100% and 150% FPL, $39 to $60 per month for those with incomes between 150.1% and 200% FPL, $77 to $110 per month for those between 200.1% and 250% FPL, and $116 to $151 per month for those between 250.1% and 300% FPL. None of the plans have a deductible, but those with incomes between 200% and 300% FPL are given a choice between lower premiums and higher copays, or lower copays and higher premiums.

Assuming that an individual earns $25,000 annually (equal to 230% FPL), she could obtain coverage in Massachusetts for $924 (the lowest $77 monthly premium over 12 months), equivalent to 3.7% of her income. The plan would not have a deductible, but she would have a limited choice of carrier. Assuming the premium estimates previously used, under ACA the same individual would have to pay $1158 to obtain the least expensive coverage. The individual would have a much greater choice of carrier and plan type, but may very well only be able to pick a plan with a high deductible, restricted network, or both, at that price.

B. The Individual Mandate in Massachusetts

The individual mandate that Massachusetts enacted as part of its 2006 health care reform has a noticeably different structure than the mandate under ACA. In Massachusetts, as in ACA, the mandate applies only if the individual has affordable

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87. MASS. GEN. LAWS ch. 118H, § 6.
88. Id. §§ 2, 3, 6.
91. There are currently five insurers offering Commonwealth Care plans in Massachusetts, although not all plans are available in all regions. Commonwealth Care Health Plans – effective 7/1/10, MASS. HEALTH CONNECTOR, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Connector%2520Programs/Benefits%2520and%2520Plan%2520Information/PlansByRegion.pdf (last visited May 26, 2011).
92. An individual earning 230% FPL is eligible under ACA for a tax credit equal to the difference between silver level coverage and 7.35% of income. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401, 124 Stat. 119, 213 (2010). Assuming that the relevant silver level coverage costs $4780, the amount of the tax credit would be $4780−$1838 (7.35% of income), or $2942. Assuming she used her tax credit to purchase the lowest-cost bronze plan with premiums of $4100, she would face an out-of-pocket premium cost of $4100−$2942, or $1158.
93. An individual who is eligible for subsidized coverage under ACA can use the available tax credit to purchase any coverage available on the exchange located in the state where the individual resides. Id. § 1401(a). The least expensive plan on an exchange would likely be a bronze-level plan, which provides 60% actuarial value. An actuarial value of 60% is likely to involve significant patient cost-sharing. See CONSUMERS UNION, supra note 34, at 4 (detailing the cost-sharing likely to be required in bronze-level coverage).
coverage available to them. However, unlike ACA, Massachusetts implements affordability standards progressively—those with higher incomes are expected to be able to spend a greater percentage of income on coverage. In Massachusetts, those residents with incomes below 150% FPL are automatically exempt from any mandate penalty. For taxpayers above that income threshold, affordability is determined each year by the Connector. For 2010, single individuals with income greater than or equal to $54,601 (roughly 500% FPL) are deemed to have affordable coverage available to them. An individual earning $25,000 is deemed to be able to afford $77 per month, or $924 per year—an amount equal to 3.7% of the taxpayer’s income—significantly less than the federal affordability threshold. A taxpayer who earns $50,000 per year is deemed to be able to afford $354 per month, or $4248 per year. This amount is equal to 8.5% of income and therefore exceeds the federal affordability threshold. For those to whom affordable coverage is available, the penalty for failing to purchase coverage is equal to one-half of the cost of the lowest-cost health plan available to the taxpayer. Table 5 details the affordability threshold in Massachusetts for various income levels, and also provides information on whether affordable coverage was actually available in the market for such purchasers in 2010.

94. MASS. GEN. LAWS ch. 111M, § 2.
97. MASS. GEN. LAWS ch. 111M, § 2. The “Connector” is an independent state agency with significant regulatory authority over the individual and small group health insurance market in Massachusetts. See id. It was established pursuant to the 2006 Massachusetts health reform legislation. See id. (explaining the “Connector”).
98. Id.
99. Id.
100. MASS. GEN. LAWS ch. 111M, § 2.
101. Id.; 830 MASS. CODE REGS. 111M.2.1(5) (2008). The penalty was phased in. Id. In the first year of the individual mandate’s effectiveness, the penalty for non-coverage was a loss of the taxpayer’s personal exemption, resulting in an effective penalty of $219 per year. See id. (showing the value of the penalty calculated using the exemption amount for a single taxpayer in 2007, $4125, and Massachusetts’ flat income tax rate of 5.3%).
Table 5: Mandate Applicability for Single Taxpayers in Massachusetts in 2010 by Income Level

<table>
<thead>
<tr>
<th>Income</th>
<th>Affordability Threshold</th>
<th>Is coverage available that is considered affordable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000</td>
<td>3.7% of income</td>
<td>Yes (subsidized)</td>
</tr>
<tr>
<td>$50,000</td>
<td>8.5% of income</td>
<td>Yes</td>
</tr>
<tr>
<td>$100,000</td>
<td>Automatically met</td>
<td>Yes</td>
</tr>
</tbody>
</table>

1. The Mandate as a Tax

As described above, the penalty for failing to purchase coverage in Massachusetts is determined not by the individual’s income level, but rather by reference to the lowest cost premium available to the individual.\footnote{102}{Id.} Because the actual penalty amount is determined by reference to the lowest premium the particular taxpayer at issue would have faced, the actual dollar amounts vary by income level, as illustrated in the table below, because those with incomes equal to or less than 300% FPL are eligible for subsidized coverage. Essentially, once 300% FPL is reached (the cut-off for subsidized coverage in Massachusetts), the penalty for non-purchase becomes regressive, because it is a flat dollar amount for all those with incomes above 300% FPL.\footnote{103}{The penalty is a flat dollar amount because it is always equal to one-half of the lowest cost premium available to the individual. Individuals who are the same age and reside in the same geographic area would therefore face the same penalty, regardless of the amount by which their income exceeds 300% FPL. Because the dollar amount is fixed, the penalty declines as a percentage of income as income rises, and is therefore regressive in nature.} Overall, like the penalties for noncompliance under ACA, the penalties for noncompliance in Massachusetts are both progressive and regressive. A key difference, however, is that in Massachusetts, those with the lowest income levels do not face the highest penalties for failing to purchase coverage.
Table 6: Penalty Amounts in Massachusetts for Failing to Satisfy the Individual Mandate for Single Taxpayers in 2010

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Penalty amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000</td>
<td>$456 (1.8% of income)</td>
</tr>
<tr>
<td>$50,000</td>
<td>$1116 (2.2% of income)</td>
</tr>
<tr>
<td>$100,000</td>
<td>$1116 (1.1% of income)</td>
</tr>
</tbody>
</table>

2. Mandate as Nudge

Unlike ACA, Massachusetts’ penalty amount is fixed as a percentage of the total premium cost. The penalty is always equal to one-half the premium of the lowest cost plan available to the individual, and therefore the delta is fixed. As a result, in Massachusetts, individuals at nearly all income levels face the same basic incentive regarding insurance purchase. And notably, in Massachusetts those at the highest income levels face a reasonable decision to purchase insurance or not, unlike under ACA’s mandate, which essentially forces the purchase of insurance by high-income individuals.

3. Putting the Pieces Together

Table 7 illustrates the various impacts of the Massachusetts mandate on taxpayers of different income levels, assuming the purchaser is 35 years old, residing in Suffolk County. As before, the smaller the difference between the penalty and the total premium cost, the more likely the individual should be to purchase coverage. It should also be true that the higher the penalty amount the more likely the individual should be to purchase coverage, given the desire to avoid the financial loss associated with the penalty. What we therefore see in Massachusetts is a more even distribution of incentives. While not equal for all taxpayers, everyone to whom the mandate applies faces the same basic decision: do they want to give half the premium cost to the government and get nothing in return, or do they want to pay twice that amount and get health insurance in return. Those on the higher end of the income spectrum may be less motivated by the mandate penalty to purchase insurance, since the penalty itself may be less than 1% of their income, but they are likely to have other compelling reasons to purchase insurance, such as the desire to protect their assets from large medical bills.

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104. This figure assumes the taxpayer is age 27 or older. For those between the ages of 18 and 26, a lower penalty amount of $792 applies. Mass. Dep’t of Revenue, TIR 09-25: Individual Mandate Penalties for Tax Year 2010 (2011).
Table 7: Purchase Incentives for 35 Year Old Single Taxpayer Residing in Suffolk County Based on 2010 Premium Levels

<table>
<thead>
<tr>
<th>Income</th>
<th>Difference between penalty amount and total premium cost</th>
<th>Penalty amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>% of income</td>
</tr>
<tr>
<td>$25,000</td>
<td>$462</td>
<td>1.8%</td>
</tr>
<tr>
<td>$50,000</td>
<td>$1362</td>
<td>2.7%</td>
</tr>
<tr>
<td>$100,000</td>
<td>$1362</td>
<td>1.4%</td>
</tr>
<tr>
<td>$150,000</td>
<td>$1362</td>
<td>0.9%</td>
</tr>
<tr>
<td>$200,000</td>
<td>$1362</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

The data that are available suggest that Massachusetts’ reform has indeed been successful at reducing the number of uninsured residents.\(^\text{106}\) In 2008, the most recent year for which data are available, there were very few taxpayers in Massachusetts subject to the mandate who chose to pay the penalty in lieu of purchasing coverage. Out of 4.8 million tax filers in that year, only 26,000 individuals (less than 1%) were assessed a penalty under the individual mandate.\(^\text{107}\) This provides cautious support for the notion that Massachusetts’ nudge is effective, although we do not know precisely why. For example, it may be that the nudge changes the cost benefit analysis sufficiently to result in a vast majority of individuals deciding to purchase coverage, or it may be that the mandate has created a powerful new social norm. Other factors such as loss aversion may also be at play.

Interestingly, despite the fact that high-income individuals have the least incentive to purchase coverage under the mandate, data show that very few individuals in Massachusetts with household income in excess of 500% FPL are uninsured. As of 2009, less than one percent of individuals in that income cohort lacked health insurance.\(^\text{108}\)

\(^{106}\) As of 2009, less than 3% of residents lacked health insurance, compared to 8.7% of residents in 2006, the year reform was passed. MASS. DIV. OF HEALTH CARE FIN. & POLICY, HEALTH INSURANCE COVERAGE IN MASSACHUSETTS: RESULTS FROM THE 2008 AND 2009 MASSACHUSETTS HEALTH INSURANCE SURVEYS 3 (2009), available at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/his_coverage_2008-2009_oct-2009.ppt.


While rates of uninsurance appear to have fallen within all income levels, the greatest decreases have been in the highest income levels. This result is perhaps not surprising for the simple reason that those at lower income levels face greater competing demands with respect to basic goods and services, and because those at the lowest end of the income spectrum are not subject to the mandate at all.

V. KEY DIFFERENCES AND CONSIDERATIONS

The comparative choices made by Massachusetts and the federal government in their respective health reform laws present an interesting contrast with respect to approaches to subsidies and mandates. The differences with respect to subsidies are particularly stark. In Massachusetts, a smaller group is subsidized, but arguably at a higher level. While those in Massachusetts do not currently have a significant choice of plan type, they get the financial security associated with coverage that has no deductible, and limited co-pays. In contrast, ACA’s approach is much more market-oriented. A larger group is subsidized, and they are able to take their subsidy and use it to purchase any type of coverage available on the individual market. In an ideal world, this type of choice would be, well, ideal. But it is somewhat troubling to think that a low income individual could, whether because of financial necessity or imperfect decisionmaking, purchase a plan that carries with it a deductible and cost-sharing requirements that would result in financial distress or bankruptcy for the individual in the event of significant medical expenses. Massachusetts, it seems, focuses on the financial security aspect of health insurance for low income individuals much more than ACA does.

We also see different choices with respect to the mandate. First, the two governments have taken different approaches to the concept of affordability. Massachusetts takes the position that those with lower incomes are able to spend a lower percentage of their income on health insurance than can their higher earning counterparts. ACA, however, assumes everyone can afford a flat eight percent of household income. On its face, a flat rate has some appeal because it makes the same relative imposition on an individual’s consumption choices. However, it ignores the fact that lower income taxpayers have to spend a greater percentage of their income on basic subsistence than higher-income taxpayers. For this reason, progressivity in a mandate’s affordability

109. See Cheryl R. Clark et al., Lack of Access Due to Costs Remains a Problem for Some in Massachusetts Despite the State’s Health Reforms, 30 HEALTH AFF. 247, 250 (2011) (finding reductions in the rate of uninsurance for low-income residents from 20.7% to 9.7%, 8.3% to 3.8% for middle-income residents, and 2.6% to .5% for high-income residents from 2002–06 compared to 2008).

110. For a discussion of affordability standards, see Linda J. Blumberg et al., Setting a Standard of Affordability for Health Insurance Coverage, 26 HEALTH AFF. w463 (2007).

111. See MASS. HEALTH CONNECTOR, supra note 96.


113. For an overview of the financial security aspect of health insurance, as well as other competing functions, see Allison K. Hoffman, Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act, 159 PENN. L. REV. (forthcoming 2011).

114. The flat threshold is a bit misleading because of the subsidies provided to individuals with incomes at or below 250% FPL, which essentially provide that such individuals will have to pay less than eight percent of their income on health insurance. But the mandate affordability threshold remains important because subsidies, of course, can be amended without affecting the mandate or its applicability.
threshold is appealing.

The second fundamental distinction between the two mandates concerns the relative nudges given to taxpayers to encourage insurance purchase. Massachusetts has taken the position that all taxpayers should face the same basic nudge: either pay half of the premium amount to the government, or pay the full premium and get coverage. It is elegant in its simplicity. Because ACA’s penalty is determined by reference to an individual’s income, and not to the premium amount, nudges differ significantly by income level. One striking aspect of the structure is that high income individuals are either compelled or very strongly incented to purchase insurance, reflecting a redistributive motivation that is not reflected in Massachusetts’ mandate. Deciding which approach is preferable depends on one’s goal for the mandate. If the goal is to eliminate free riders, those who are least likely to purchase insurance should face the biggest nudge. If the goal is simply to get as many healthy individuals into the insurance pool, arguably everyone who is subject to the mandate should face the same, strong nudge. And if the goal is redistribution from the healthy and wealthy to the sick, then the nudge should be strongest at high income levels.

Finally, there is the impact that the penalty will have on non-purchasers. Under both Massachusetts’ and ACA’s mandates, the penalties are somewhat regressive. ACA, however, imposes the highest penalty on the lowest income individuals. Because ACA’s penalty is the greater of $695 and 2.5% of household income, anyone earning below $27,800 (the income level at which $695 is equal to 2.5% of income) pays a penalty that exceeds 2.5% of income. That those with the lowest income are least likely to be able to afford insurance, and therefore the most likely to pay the penalty, is troubling. This concern is compounded by the fact that the structure of the subsidy makes it likely that individuals who are financially stressed are incented to buy coverage that may not provide adequate financial security in the event of a loss.

Take, for example, an individual who earns $25,000. Under ACA, that individual would face a penalty of $695 if she fails to purchase coverage. The minimum out-of-pocket premium cost for coverage is $1158. One possibility is that the individual does not, after meeting her basic need for food, clothing, and shelter, have $1158 to spend. She must then pay the $695 penalty and is essentially subject to a regressive tax—clearly not a good policy outcome. Another alternative is that she can scrape together $1158 to spend on health insurance, but she cannot afford appreciably more than that amount. She must

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116. See ACA § 1501(b) (codified at I.R.C. §5000A(c)) (defining ACA’s individual mandate penalty).

117. It is of course difficult to find the ideal penalty size. While compliance may rise as penalties increase, if they are either too high or too low, studies suggest that compliance will suffer. Glied et al., supra note 43, at 1618.

118. See supra Parts III.B.3 and IV.B.1 (discussing the ACA and Massachusetts mandates, respectively).

119. ACA § 1501(b).

120. See id. (the greater of $695 and 2.5% of income for an individual earning $25,000 is $695).

121. A taxpayer with income of $25,000 is at 230% FPL. At that level, the tax credit is equal to the difference between silver level coverage and 7.35% of income. Id. § 1401. Assuming that the relevant silver level coverage costs $4780, the amount of the tax credit would be $4780–$1838, or $2942. If she used that tax credit to purchase the lowest-cost bronze level plan at $4100 per year, her out-of-pocket premium cost would be $4100–$2942, or $1158.
then buy bronze level coverage, which would likely have a sizeable deductible and cost-sharing requirements. Assuming she has no savings and she incurs medical expenses, financial distress would result even though she carries insurance. This should make bronze level coverage unattractive, but it may be the only option if she wants to avoid paying the mandate penalty. Interestingly, it may be that the rational choice for this individual is to forgo coverage and pay the $695 fee. With that choice, she has $463 more income and may not be any worse off than under coverage with high cost-sharing requirements. Only if she has enough money to afford the premium for a plan that provides reasonable cost sharing requirements will she be provided with financial protection in the event of significant medical expenses. And under the assumptions previously used, this would mean an out-of-pocket cost of at least $1838, equal to 7.35% of the individual’s household income.

In the end, Massachusetts’ models, subsidy, and mandate appear in many ways preferable to ACA’s. Massachusetts provides better financial security to low income individuals and the nudge provided by its individual mandate is both easier to understand and more equitable.

VI. CONCLUSION

Prior to the passage of ACA there was broad consensus that some form of health care reform was necessary. ACA includes wide-ranging reforms in the insurance market, many of which appear to depend on the individual mandate for their success. Even if one supports the general idea of a mandate, this Article suggests that there are reasons to be dissatisfied with the current structure of the mandate in achieving its goals. It also suggests that there are reasons to be dissatisfied with the structure of the subsidies under ACA. While the particulars of the subsidies and mandates are unlikely to be fundamentally changed prior to implementation, the issues raised in this Article suggest the need to study the effects of both mandates and subsidies in order to monitor and better understand the effects they have on purchasing decisions and financial security.

122. In addition, by purchasing bronze level coverage, and not silver coverage, she would be forgoing the cost sharing reductions that would otherwise be available to her. See id. § 1402(b)(1) (providing for a reduction in cost-sharing only where an individual purchases silver-level coverage).

123. She would be no worse off, provided that she can still access medical services to the same extent whether insured under bronze level coverage or not and provided further that she has no assets that she desires to protect from bankruptcy.

124. These dollar amounts are based on the assumed premium of $4780 for silver level coverage, which is the coverage that must be purchased to qualify for cost-sharing reductions. ACA § 1402(b)(1).

125. For an overview of various views of health care reform, see volume 29, issue 6 of HEALTH AFFAIRS, published in June 2010.