Enforcing Health Insurance Mandates

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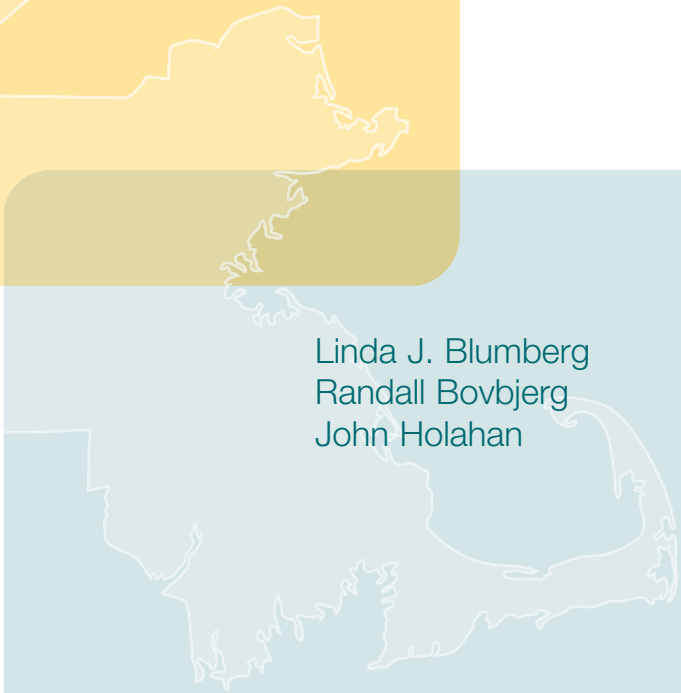

roadmap
TO COVERAGE

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Introduction

The Roadmap to Coverage develops three options to implement universal health insurance coverage in Massachusetts. The first is a mandate requiring individuals to acquire health insurance coverage. The second combines an individual with an employer mandate exempting only firms with fewer than 10 employees (the broad employer mandate). The third combines an individual with an employer mandate that exempts firms with fewer than 500 empoyees (the narrow employer mandate). Since all three rely on mandates, success in reaching the goal of universal coverage will depend on enforcing the coverage requirements. The focus of the implementation strategy presented here is to maximize voluntary acquisition of coverage by making compliance as easy as possible, reserving strict penalties for persistent, flagrant violations.

Since awareness and understanding of the new programs and requirements will be a gradual process, education and compliance assistance should be the central tenet of implementation, particularly in the early years of the program. Penalties should be phased-in over time, with payment plans developed to ease fulfillment of the requirements.

The next section presents the ways in which voluntary compliance with the new reform might best be encouraged and eased under an individual mandate. We follow this by describing mechanisms that would serve to enforce the individual mandate for the small segment of the population that fails to participate on its own. We then delineate back-up enforcement strategies to ensure that, if an employer mandate is added to the individual mandate, employers also meet the terms of the program's requirements.

Easing Voluntary Compliance under an Individual Mandate

Under an individual mandate, each resident of the Commonwealth would be required to hold health insurance coverage that meets the minimum mandate requirements. In the options outlined in the Roadmap, the mandate itself can be satisfied with a relatively high deductible policy. However, the coverage offered in the purchasing pool and subsidized with tax credits has been deliberately designed to be more comprehensive than the mandate requirements for two reasons; (a) to make coverage affordable for the many low-income residents who would have to enroll in pool-based coverage and (b) to avoid the costly and complex procedures required to administer income-related subsidies for out-of-pocket spending. Consistent with current policy, MassHealth coverage would be even more comprehensive than coverage through the pool.

The individual mandate, as noted, can be satisfied through (a) private (including employment-based) coverage outside the purchasing pool (as long as it meets the minimum mandated standards), (b) private plans offered in the pool, or (c) MassHealth. Enrollment in Medicare would also satisfy the terms of the mandate, for those eligible. The enrollment processes for employer-based insurance, through which the majority of the Massachusetts population currently receives coverage, are well established, requiring no outreach efforts on behalf of state government. Nearly three-quarters of the currently uninsured in Massachusetts—the people universal coverage is designed to reach--would qualify for free coverage through expanded MassHealth and/or subsidized coverage in the new purchasing pool (Cook 2005). The focus of outreach and compliance efforts, therefore, should be on easing enrollment in plans offered in the pool and in MassHealth.

Three major steps by the state would help make enrollment in pool coverage and MassHealth as easy as possible. First, allow enrollment through a wide array of locations. Second, make enrollment and re-enrollment seem as much like employer-based insurance as possible. Third, ensure that the enrollment process is as simple as is feasible. We discuss each in turn.

Enrollment Locations

Massachusetts has an outstanding record of successful enrollment of eligible people into its Medicaid (MassHealth) program, with historical participation rates extremely high compared with those of other states (Dubay, Kenney, and Haley 2002). Much can be learned from this experience and applied to reform enrollment in both the expanded MassHealth program and the purchasing pool. MassHealth applications are relatively short (3 pages to fill out). Proof of current income requires two current pay stubs for each worker or last tax return for the self-employed. Proof is required for non-wage sources of income as well. Application forms are available on-line and can be submitted via mail. Information supplied is verified, and a notice of enrollment is usually made within 10 days of applying.

Providing for mail-in and on-line applications for both post-reform MassHealth and the purchasing pool makes good sense and would increase accessibility to the programs compared with limiting enrollment to in-person locations. However, a wide array of in-person enrollment locations across the state is also important in facilitating coverage. In-person interaction with trained counselors can provide important assistance in sorting through coverage options available in the purchasing pool, for example. And counselors can help those potentially eligible for both MassHealth and subsidized coverage in the purchasing pool to decide which option makes the most sense for them. Having individuals enroll in person is also likely to speed up the review process-- shortening the time between application and either notice of MassHealth eligibility and/or the amount of direct premium owed in the purchasing pool (net of applicable tax credits). Individuals can be enrolled virtually immediately in the purchasing pool plan of their choosing, with final verification of the tax credit amount to which the enrollee is entitled following soon thereafter.

Applicants to MassHealth who are found ineligible can be asked to choose a plan in the purchasing pool. Using the same application for both MassHealth and the pool would ease this process and reduce the number of people who might fall through the crack between the two programs. Those not interested in applying for MassHealth or advanced tax credits could be allowed to enroll in the purchasing pool using a greatly abbreviated form.

Combined enrollment offices for MassHealth and the purchasing pool should be spread across the state with at least as many locations as exist for the DMV and with similar geographic diversity. DMV staff could also be required to remind each contact of the requirement to enroll in insurance coverage and to provide them with information on how to enroll if they are currently uninsured.

A variety of other locations could be empowered to enroll people into the purchasing pools and MassHealth as well. For example, public school staff and/or volunteers could be trained to assist families to fill out enrollment/application forms. Reminders of the requirement to hold insurance coverage could also come through the schools. Public aid offices would continue to do Medicaid enrollment and could also provide assistance in purchasing pool enrollment for those interested. This should help to smooth transitions between MassHealth and the purchasing pool for those losing or gaining eligibility for MassHealth. Enrollment drives could also be held in high pedestrian traffic areas, such as shopping centers and banks, during open enrollment periods.

Private insurance agents would receive commissions on the sale of pool-based insurance products, just as they do for non-pool coverage. Agents could also be required to explain purchasing pool and MassHealth options to their contacts. The state also might want to consider some type of sanction that would be applied against agents caught discouraging low-cost (i.e., more profitable) clients from enrolling in the purchasing pool.

Uninsured individuals who seek services from a provider would be put into contact with the purchasing pool at that provider visit. Providers would be able to electronically contact purchasing pool staff, providing them with relevant information on the patient, such as name, address, social security number, number of people in the health insurance unit, and their ages, but no health-related information. Doing so would qualify the provider to receive payment for that visit. The purchasing pool would enroll the individual in a default plan at that time—defined as a plan that falls at or below the benchmark plan premium. Such individuals would then be sent further information by mail on the plan in which they are enrolled and given 30 days to switch into a different pool based plan if they so choose. They would also be given information on the availability of tax credits and how to apply for them.

Employer Involvement

Nearly 90 percent of the currently uninsured in Massachusetts come from working families. Consequently, employer involvement in enrolling workers in health insurance, even when coverage is not provided by the employer, would greatly increase voluntary compliance with the individual mandate. The state should make

this involvement as simple as possible, however, to minimize the burdens placed upon employers. The more similar enrollment and re-enrollment in MassHealth and the purchasing pool can be made to enrollment in employer-based insurance, the higher will be the rate of employer involvement.

We recognize that many of these functions can be performed without employer involvement (as detailed above in the discussion of enrollment locations). But eliminating all employer involvement would almost certainly be less efficient and less effective, given the daily interactions between employers and employees and the existing processes of employer wage withholding on workers' behalf for tax purposes. The challenge is to weigh the private costs on employers from their involvement in the individual coverage process against the public benefits from their involvement in deciding exactly how employers should be involved and to what extent that involvement should be mandatory versus voluntary.

Potentially valuable roles for employers are several. Employers could be required to remind workers each year, during the open enrollment period for the purchasing pool, of the legal requirement to obtain coverage. They could also be required to provide information (supplied to employers by the state) on pool-based coverage options and MassHealth coverage, whether or not the employer also offers non-pool coverage. Such information would include plan choices, premiums, benefit information, and enrollment forms. Web-based tools could help employers and workers estimate the worker's direct costs of enrolling in each pool-based plan, net of any applicable tax credits and/or employer contributions.

Employers, in addition, could be required to submit enrollment forms to the proper agency (MassHealth/Purchasing Pool) on behalf of workers wishing to enroll, most likely through electronic means. For workers enrolling in the purchasing pool, employers could also be expected to withhold the premium payments from the worker's wages and to remit those payments to the purchasing pool, on the basis of premium amounts supplied to them by the pool. This withholding and remittance process would be consistent with how employers currently withhold and remit income tax payments on behalf of their workers. If these functions are judged too burdensome on employers, they could be performed by intermediaries that provide employers with routine business services (payroll, etc.).

Simplification of Purchasing Pool Decisions

Anyone who has enrolled in insurance knows that the decisions required during the process can seem overwhelming. Keeping such choices straightforward will reduce the time it takes to enroll, reduce participant stress, and thereby increase voluntary participation. Simple enrollment processes are also important to make it feasible for enrollment to take place through the wide variety of venues we have discussed.

Choosing which pool plan to purchase can be kept relatively simple if the benefit packages across pool plans are standardized. Individuals can then make their choices based upon differences in price and in provider networks, without having to confront the much greater complexity of variations in the benefits themselves. Keeping benefit

packages consistent in the pool also has the added benefit of reducing risk selection across pool-based plans.

Provider networks for each pool-based plan would be available on paper and on the internet. The internet version would be searchable, facilitating an individual's check on which plan networks include his/her current providers. In addition, web-based calculators would use information on the number of family members, their ages, and their incomes to compute eligibility both for MassHealth and for tax credits for the purchasing pool plans. Information on employer contributions could also be fed in, if applicable, on the basis of which the system would then list the direct premium payments required. These calculators could also be made available as programs usable on PCs or PDAs. The final tax credit to which an individual or family is entitled would depend on information from year-end income tax returns (as discussed in the following section). However, accurate input information on current income and family composition would enable these calculators to yield good estimates of premiums owed for each pool plan of interest. Given enforcement through the income tax system, it is in each individual's interest to provide as accurate information on current income as possible.

Enforcing an Individual Mandate

This section describes the mechanisms through which the individual mandate can be enforced for those unwilling to comply voluntarily, along with related policy design issues. We begin with the issues involved in defining the population subject to the individual mandate – one cannot enforce a mandate without understanding precisely to whom it applies. We follow this, in turn, with specifics on how the tax system would be used as the primary enforcement tool of that mandate, how providers and insurers would enhance and support its enforcement, and options for use of the funds (back-payments and penalties) that would result from enforcement activities.

Population Subject to the Individual Mandate

Deciding on the definition of the population to be subject to the mandate involves a tradeoff between how much uncompensated care will remain outside the universal coverage system, on the one hand, and how complex the enforcement process and costly the tax subsidies will be, on the other. The more narrowly defined the categories of individuals covered , the greater will be the costs of residual uncompensated care. The more broadly the categories covered, the more complex will be the enforcement necessary, and the higher will be the cost of the health insurance tax subsidies within the universal coverage system.

It seems obvious that full-time residents would be required to have coverage under an individual mandate. We recommend following the definition of full-time residency found in Massachusetts tax law: "An individual is a full-year resident if:

- his or her legal residence (domicile) is in Massachusetts for the entire taxable year; or

- his or her legal residence (domicile) is not in Massachusetts for the entire taxable year but who:
    1. maintains a permanent place of abode in Massachusetts; and
    2. spends in the aggregate more than 183 days of the taxable year in Massachusetts, including days spent partially in and partially out of Massachusetts."

The tax law defines a non-resident as someone who does not meet the definition cited above.

A more difficult issue is whether the mandate should apply to part-year residents, defined in the Massachusetts tax law as one who:

- "moves to Massachusetts during the taxable year and becomes a resident; or
- terminates his or her status as a Massachusetts resident during the taxable year and establishes a residence outside the state."

Part-year residents may owe Massachusetts state taxes, and, depending upon circumstances, fill out a different tax form than full-year residents.

The major reason for the definitional difficulty is that there are several kinds of part-year residents, each raising different issues. A new resident—that is, someone who moves to the State of Massachusetts—could be made subject to the mandate following a limited grace period of, say, 30-days. Those moving out of the state and establishing a residence elsewhere during the course of the year could be required to comply with the mandate during the time that they were residing in the state.

Part-year residents who live in Massachusetts for less than 183 days and elsewhere for the rest of the year (such as those who have two homes, one of which is in another state) raise more complex issues. The argument for making these individuals subject to the mandate is that they may return to Massachusetts when they need healthcare services; without subjecting them to the mandate, their care could result in uncompensated care costs. The argument against their inclusion is that if they live in the state for a very small part of the year, enforcing enrollment may be more costly than it is worth and may lead to additional costs in coverage subsidies (see further discussion under tax credit eligibility below). It is also true that exempting such persons provides an incentive for them to change behavior so that they spend at most 182 days in the state, simply to avoid the requirement of health insurance. This seems unlikely to be a strong enough incentive in practice to be a major concern, however.

Temporary workers are yet another type of part-time resident. One example is a lawyer or consultant who works in the state for short periods and is required to file Massachusetts taxes. Another example is a seasonal worker, such as those who work in resort areas during the summer season. These individuals are also required to file Massachusetts state taxes. The connection of both these types of temporary worker to the tax system makes enforcement feasible, but is it worth the cost? They could be required to obtain coverage if they are in the state for more than 30 days.

Alternatively, since their primary residence is elsewhere and they are in the state for less than 183 days, they could be excluded. How this issue should be resolved is, again, a benefit-cost issue for the state, which needs to be carefully weighed.

A group that is pretty clearly not worth the state's effort to make subject to the mandate is the commuting population. These people may commute from New Hampshire or Rhode Island, for example, to work in Massachusetts, although they live and have primary residence elsewhere. They file Massachusetts tax forms, which could be the basis of enforcing the mandate, and they could potentially be cared for in Massachusetts hospitals, since they spend time working in Massachusetts. It is true that exempting them from the mandate provides an incentive to live just outside the state boundaries and commute into Massachusetts for their health care. But this is extremely unlikely to be a major problem, because most people in this position are earning sufficient income that they are very likely to be insured anyway. For those low-income persons who commute, the differential costs of commuting for work may be just as high as the cost of health insurance, particularly in the case of subsidized coverage. The legal issues involved in enforcing a mandate on non-residents are likely to be substantial, leading us to conclude that this population should be exempt.

A final group to consider is tourists who come to the state for varying lengths of time. The direct cost of enforcing a mandate on them would be prohibitively high (in addition to the potentially major cost in lost tourism) compared with any benefits to the state.

Eligibility for Tax Credits

Some concern has been expressed, whether legitimate or not, that uninsured individuals with high cost illnesses would move to Massachusetts to take advantage of the publicly subsidized health insurance coverage in a post-reform world. This concern relates directly to the discussion above concerning whether part-year residents should be subject to the mandate. The overriding policy issue is whether all populations covered by the mandate must also be eligible for tax credits, or whether a waiting period could be imposed.

Suppose a new state resident has family income of 250% of the federal poverty line and has cancer. If she enrolls in purchasing pool-based coverage within the 30-day grace period after moving into the state, should she also be eligible for tax credits that would subsidize her premiums? One solution would be regulations requiring six to twelve months of residency prior to enrollment in the purchasing pool and/or eligibility for tax credits. This would address concerns with adverse selection into the state purchasing pool, but would also subject the new resident to a mandate she may not be able to afford.

Those holding full-year coverage in the purchasing pool should clearly be eligible for tax credits, regardless of part-year residency. Those moving into the state for part of the year and only holding purchasing pool-based coverage for that time period raise more complicated issues of balancing broad fulfillment of the mandate, individual affordability, and protection against adverse selection.

Enforcing the Mandate

Once the precise population covered by the mandate is defined, attention can be turned to mechanisms of enforcement for the minority of the population expected not to comply voluntarily. The obvious primary means of enforcement of the individual mandate would be through the tax system. A secondary enforcement tool, as noted earlier, would be through providers. Each is discussed in turn.

Enforcement through the Tax System

We identify five different types of people and indicate how enforcement would take place through the tax system in each case.

1. **High Income Individuals and Families.** These individuals are tax filers who would not receive health insurance tax credits under the universal coverage options developed in the Roadmap. A plausible enforcement system for this group would be for state tax returns to require insurer and policy number information for the filer(s) and any dependents claimed on the return. This could be done by attaching to the tax return a 1098-type Form--similar to those provided by mortgage lenders; for the purpose of verifying health insurance coverage, such forms would be provided by health insurers. Self-insuring firms could also be required to provide 1098 Forms to their enrollees. The Department of Revenue could provide information on policy numbers to the state agency administering the health reform, enabling that agency to perform random audits to ensure that the policies in question meet the standards of the mandate. Alternatively, the enabling legislation could prohibit the sale of health insurance policies that do not meet at least the minimum mandate standards. The 1098 Form would indicate the family members covered by the policy and include the months of the year during which each person was covered. Individuals who did not have a policy, or did not have coverage for some part of the year, would be liable for premium payments for the period in which they lacked coverage, plus a penalty – say 25% of back premiums. The collection of the back premiums and the penalty could be done as part of the tax filing process, as is currently done with payment of income taxes due.

2. **Moderate Income Individuals and Families Who Are Tax-Filers and also Recipients of Tax Credits (or Covered by Medicaid).** Moderate income tax filers would also be required to indicate their insurers and their policy numbers on their state tax returns. Again, this could be accomplished by attaching a 1098 Form. Since this group is eligible to receive tax credits toward the purchase of pool-based coverage, information on any credits advanced during the year must be included as well. The Department of Revenue could supply a form indicating the value of the tax credits provided – much like states today provide forms with information on overpayment of state taxes in the previous year. The state tax form could be modified to contain information necessary to calculate the final value of credits that should have been received. Such a form would allow individuals to compare reported credits with allowed credits and calculate whether this adds or subtracts from the individual's or family's tax liability.

Since some people in this group would be eligible for and enrolled in MassHealth, it might be necessary for MassHealth to submit 1098 Forms to enrollees as well. Alternatively, individuals could be asked to indicate on their tax form whether they or their dependents were enrolled in Medicaid during the past year, and for how many months. This could then be checked for accuracy against state enrollment records on a random basis.

Individuals falling into this group could also be subject to back premium payments and penalties for lack of compliance with the mandate. Any back premiums owed should be limited by the tax credits for which they would have been eligible, however. Those eligible for MassHealth for the entire period of noncompliance would have no back payment liability. For others, payment plans could be developed to facilitate payments owed, with the focus of this effort on plan enrollment and future compliance.

3. **Low and Moderate Income Individuals or Families Who Are Eligible for and Obtain Tax Credits but Do Not Owe Taxes and Would Not Be Tax Filers under Current Law**. Under the new system, individuals would be required to file a tax form if they obtain a tax credit, even if they do not owe other taxes. This is consistent with federal law regarding advance payments under the Earned Income Tax Credit. This group should be quite small, however, since the income levels below which individuals are not required to file taxes are $8,000 for a single individual, $12,700 for head of a household, and $14,200 for married couples filing jointly. Below these income levels, parents and childless adults are eligible for MassHealth. Above these income levels, people must file tax returns anyway, so they would apply for tax credits via that route--providing the same information on their returns as for those with taxes due, so that allowed tax credits could be reconciled with actual credits received. In some of these cases, filers will be owed more credit than had been advanced. In such cases, payment to the individual or family would be made through the same mechanisms as tax refunds.

4. **Low-Income Individuals Who Would Not Be Tax Filers even under the New System.** Two groups fall into this category. The first group encompasses those who are on MassHealth and not required to file an income tax return. The fact that they would not file is not an issue because there would be no need for any reconciliation. The second group is made up of low-income people who do not obtain coverage through the purchasing pool or MassHealth and do not file an income tax return. This second group is likely to slip through the system and remain uninsured unless they access the health care system. In that case, providers could be required to assist in their becoming enrolled in the purchasing pool or in MassHealth, and the Department of Revenue could attempt to collect past premiums (processes described further below under provider responsibilities). Past premiums for this group are likely to be low, however, since most would probably be eligible for MassHealth.

5. **Moderate and High-Income People Who Owe Taxes but Do Not File.** These people are straightforward tax cheats and would be difficult to capture as long as

they avoid the healthcare system. If they do use the healthcare system, then the procedures described under provider and insurer responsibilities would be used to sign them up and to collect past premiums—unless they pay cash. Since it would be very difficult to prohibit providers from accepting cash from patients, there seems little enforcement potential for the cash-paying group. It is probably very small, however, and in any case, not paying taxes is itself illegal and has its own set of penalties. Not obtaining health insurance coverage simply adds to the illegality of their behavior.

Insurer Responsibilities

As mentioned earlier, to help enforce the mandate, insurers and firms that self-insure could be required to send out a 1098 Form indicating the names of individuals in the tax-filing unit who had coverage and for what parts of the year. While having insurers provide this information seems the most efficient approach, information could also be provided through other routes. One option would be to require employers to send out an annual W-2 Form with information on the individual's health insurance policy number and the family members covered. Under this option, insurers could be released from providing Form 1098s to those enrolled in plans through their employers. Another option would be to have the purchasing pool send out a form to each household indicating coverage in a pool plan for each family member. This approach would free insurers from providing Form 1098s on individuals with coverage through a pool. Both alternatives would relieve insurers of some administrative burden but only at the cost of transferring that burden to employers and the purchasing pool. It seems more straightforward and more thorough to require insurers, including firms that self-insure, to provide 1098 Forms to their covered families, who can then use this as proof of insurance for tax return purposes.

Provider Responsibilities

As we mentioned in the section on easing voluntary compliance, uninsured individuals would be able to initiate the enrollment process at the point of a provider contact. Providers would have the capacity to link electronically to state enrollment offices or to the purchasing pool, and would provide basic information to the pool on the individual and their family members. By giving this information, providers would be assured of payment by the plan for the care they provide during that encounter. The primary purpose of this process would be to initiate contact between the purchasing pool and the uninsured individual, leading to plan enrollment.

Again, the main focus of enforcement in the early years of the mandate would be to educate and enroll those who have not done so on their own. But the provider contact with the purchasing pool could also serve as a notice to the state of noncompliance by an individual, with the purchasing pool passing information on the uninsured person to the state Department of Revenue. The Department could then track this information and send out notices of back payments and any penalties due . These notices would ideally be accompanied by offers to develop reasonable payment plans to mitigate any financial burden caused by such payment requirements.

Possible Uses of Funds from Back Payment of Premiums and Penalties

Given that at least some funds in back payments of premiums and penalties would be collected due to noncompliance with the individual mandate, thought must be given to how those funds would be used. A number of options exist: the funds could be used as general revenue, earmarked specifically to help fund the costs of the new health care programs, contributed (at least the back payment part) to the health insurance plan in which the previously noncompliant individual/family enrolls, or used for some combination of these.

The first two options (general revenue and program costs) are self-explanatory. The logic behind transferring back payments over to the insurance plans may not be. The idea here is that, although individuals should be enrolled in a health insurance plan for the entire year, some may not enroll in coverage until they have a serious medical need requiring contact with a provider. As discussed earlier, the individual would then be enrolled in an insurance plan at that point (most likely through the purchasing pool). The individual mandate precludes waiting periods or pre-existing condition exclusion periods for coverage in the purchasing pool. However, if the plan does not receive premium payments until a serious medical need arises, it can be financially disadvantaged by after-the-fact enrollments of people who have just gotten sick.

Providing the plan with the back payments required of the late enrollees would, in most cases, place the plan on the same financial footing as if the noncompliers had actually enrolled and begun premium payments at the beginning of the year. For late enrollees who would have received a tax credit during the unenrolled part of the plan year, however, the situation is more complicated. This is because the liability for back payments would not include the forgone tax credit payments that would have been paid to the plan by the Department of Revenue. In such cases, the insurance plan would only be made truly "whole" if the state also paid those forgone tax credits to the plan.

It is also possible that some part-year noncompliers might choose to enroll in a non-pool plan mid-year, although that might prove difficult due to open enrollment periods, pre-existing condition exclusion periods, and waiting periods that may apply outside the pool. The state would need to decide whether any back payments need be made in such cases, or whether they should just be made to pool plans. In the case of late enrollment in MassHealth, there would be neither back premiums to be paid nor tax credits forgone.

A combination of two or three of the above approaches might be the most desirable course to take. For example, penalties could be directed to defray the cost of the income-related tax credits, while back payments of premiums could be directed to the plans in which late enrollees join. Noncompliers not discovered until they are identified through their tax returns, however, may have no plan in which they had been enrolled for any part of the preceding year. The back payments in such cases could be used to defray general program costs or for general revenue.

Enforcement of an Employer Mandate

In two of the three Roadmap options, the individual mandate is combined with an employer mandate. Under these options, employers exceeding a specified size (9 workers for the broad mandate, 499 workers for the narrow mandate) would be required either to pay a payroll tax or to spend at least the equivalent on health insurance for workers and their dependents. Enforcing any such requirements calls for (a) careful specification of the employers' responsibilities (both tax payments due and offsetting insurance contributions) and (b) creation of administrative structures and processes to track both.

Establishing Employers Responsibilities

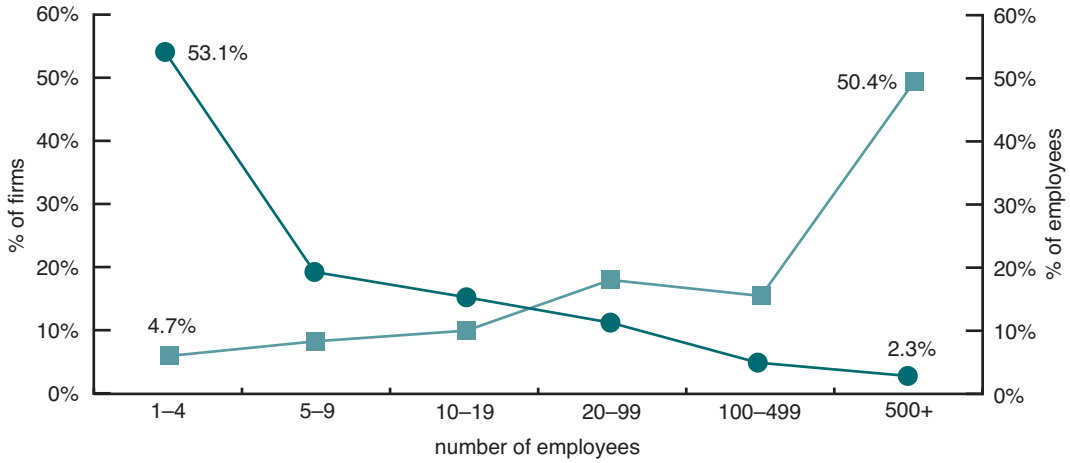
Limiting the new payroll tax and its enforcement to larger employers

The narrower the employer mandate, the easier the enforcement task and the smaller the effort needed for administration and enforcement. First, the number of firms subject to oversight rises rapidly as firm size declines. Second, administration of oversight is relatively easier and cheaper for larger firms. Administrative costs of communication and interaction are inevitably higher when dealing with smaller firms. Smaller firms are also less likely to have specialized personnel in charge of taxes and benefits, and more likely to open, close, and change their name or management during a year. New duties impose fixed administrative costs of compliance that by definition fall disproportionately on smaller firms.

Third, the new tax would constitute a substantial new burden for firms not already providing coverage, a group disproportionately composed of smaller firms. This new burden would make noncompliance more likely among smaller firms and hence more costly for state administrators to monitor effectively. Workers Compensation enforcement has to focus mainly on small firms, for example, and its requirements are less costly than those under the new payroll tax envisioned here. Fourth, because the payroll of smaller firms is considerably lower than that for larger employers, the higher administrative and compliance effort needed for small firms would bring in proportionately less revenue to the state than that needed for larger firms.

Fortunately, most employees work for large firms. Although only 2% of Massachusetts firms would be covered under the narrow mandate, for example, such a mandate would cover about half of all Massachusetts employees (Figure 1, 2001 data). Just over 50% of all Massachusetts firms would be exempt from the broad mandate, yet this would exclude under one-twentieth of the employees in the state.

Figure 1



US Census Bureau, Statistics of U.S. Businesses: 2001

Exempting firms by size does lead to potential distortions, however, because imposing a tax based on business size creates a "cliff" below which the obligation suddenly ceases to apply. Some fraction of larger firms could therefore reorganize themselves into smaller entities in order to avoid the requirements. Rules could be written to avoid such behavior by allowing enforcement to consider whether a set of small firms interrelate so intimately that they constitute a single functional firm. Such monitoring and enforcement would be relatively costly, however, and cost-benefit tradeoffs would need to be weighed as the new system is implemented to judge whether such monitoring is worth the effort. The larger the minimum firm size to which the mandate applies, the fewer the number of firms that may find it worthwhile to split apart. Yet the larger the firm size threshold, the easier it is for the largest firms to break into smaller firms. It should also be noted that the vast majority of large employers already offer health insurance to their workers, so restricting a mandate to large employers would in fact require little change in employer behavior.

Defining "employee" and other terms

Careful definition of all terms is essential, both to encourage compliance and to enable enforcers to penalize noncompliance. Key terms include "doing business in Massachusetts," "covered employee," and "health coverage contribution." Consistency with existing definitions is highly desirable because following established practices would ease the burden on employers and state administrators alike. The existing practice followed should be tax practice wherever feasible, to facilitate enforcement and also emphasize that the insurance-expansion tax is, in fact, a tax and not an employee-benefits requirement as necessitated under ERISA.

The employer mandate approach delineated in the Roadmap proposes that only full-time workers constitute "covered employees." This restriction would reduce the incidence of the new tax because employers are currently more likely to provide coverage to full-time workers than they are to part-time workers. Many details and boundary issues would need to be addressed to make this definition enforceable. For example, how many hours per week constitute full-time (e.g., the Roadmap defines full-time as 30 or more hours per week)? Can that amount be averaged over a typical

month to take into account those whose hours fluctuate? Will seasonal workers that work full-time hours be considered part-time or full-time for purposes of the mandate? The more exclusions, the lower is the burden on the employer, but the more difficult is the monitoring of compliance and the more likely is employer distortion of hiring decisions to avoid the mandate.

Another point for clarification is the circumstances under which a worker may constitute an independent contractor (not subject to wage withholding by the firm for tax purposes), an issue that has often vexed enforcement in other areas. Recent state legislation evidently clarified the definition, which should be helpful. Other clarifications may also be needed to address unusual circumstances (e.g., a multi-state firm's employee from out of state who is briefly detailed to work in Massachusetts, a case that relates to the previous discussion of part-year residence). Existing tax statutes and administrative practice likely can provide useful guidance here.

Also needed is a definition of "health coverage," for purposes of allowing a firm's premiums (or self-insurance retentions in lieu of premiums) to be deducted from the new payroll tax obligation. Federal and state tax laws already define health insurance for purposes of allowing contributions to be deducted from employers' earnings and excluded from employee income. Similar definitions and supporting rules should be used here.

A broad exclusion of part-time and seasonal employees from tax will complicate the work of the oversight agency because other tax regimes (e.g., Social Security and unemployment insurance) use more encompassing definitions of covered workers. Giving workers whose employers have paid the tax an extra discount on purchasing-pool coverage (as the Roadmap suggests) would require reporting and tracking each employee's tax and premium status separately. Such additional effort is one price of holding down employers' new tax burdens and letting part of any employers' tax obligation benefit their own employees in buying coverage through the pool.

Multiple tax payments from multiple jobs during a tax year

Policy makers need to decide whether to enforce the annual payroll tax obligation per employer or per individual. This is because, when employees work for two or more employers during a year, combined tax contributions may exceed the ceiling that would apply if they worked only for a single employer. Fairness and consistency with Social Security practice suggest that policy makers consider limiting annual contributions per worker for all firms combined. That practice would require end-of-year reconciliation across employer accounts, perhaps done only when triggered by a request from an employee or employer. Administration and enforcement would be easier if the per-worker ceiling applied to each employer and "overages" just went to defray costs of the coverage expansion. But this approach would tend to penalize workers with multiple jobs, since employers will hold down growth in wages to compensate for the new tax. To the extent that workers do, in effect, pay indirectly for the new payroll tax in this way, workers with multiple jobs whose total wages sum to more than the wage threshold to which the tax is applied would end up "paying" more in taxes than if they earned the same amount through a single employer.

Designating agencies responsible for collecting taxes, monitoring, and enforcement

It would be highly desirable to use an existing agency with proven capabilities to administer the new tax and also to conduct enforcement as an adjunct to tax collection. A wholly new entity could theoretically implement insurance expansion in all its aspects, but administrative feasibility strongly suggests that any new, nonspecialist office serve mainly as a broad policy maker and coordinator. The relative merits and drawbacks of each possible site for the administration of the new tax should be compared early in reform's design stage.

A promising candidate would be the state's Division of Unemployment Assistance. Collecting the new payroll taxes that would be necessary closely resembles the role already played by the Division of Unemployment Assistance in collecting unemployment insurance contributions from employers. Unemployment insurance contributions are imposed as a percentage payroll tax to an annual ceiling, much like the levy proposed here. The Division also has in place systems to conduct audits and impose penalties and interest. The Division even collects employer contributions for the state's small Medical Security Plan, evidently begun as part of the state's effort to achieve universal coverage in the 1980s. All these are reasons to make it responsible for this aspect of administration and enforcement under a universal coverage system.

A possible alternative would be the Department of Revenue, which collects other taxes on individuals and businesses. The Department of Revenue would likely enforce the individual mandate and transfer tax credits to the purchasing pool that would be made available to low-income individuals buying coverage through the pool. An argument for making that Department responsible for business collections and enforcement as well is to centralize enforcement operations and to have payroll taxes paid to the same entity that would then transfer them (along with other funds) to the purchasing pool.

Most large employers will meet their obligations by making premium contributions in lieu of taxes. One way to monitor such contributions is to require periodic reporting by health insurers and third party administrators to the responsible enforcement agency. Creating and monitoring such a new obligation to report would likely fall to the state Division of Insurance. The Division of Insurance enforcement would also routinely apply to many other aspects of insurance that are only indirectly related to reform. For example, some employers may be defrauded by vendors selling "insurance" that was alleged to satisfy the obligation to pay the expansion-tax but in fact fails IRS or other applicable requirements. The Division of Insurance might or might not need to create new enforcement rules for such activities under the somewhat different post-reform circumstances.

Workers Compensation insurers and self-insurers currently report on their coverage through a private Rating Bureau approved by the Division of Insurance. The Bureau verifies Workers Compensation coverage, among its other functions. It also oversees the provision of Certificates of Insurance by which employers can verify compliance. Such a bureau created with public agreement could be used to oversee compliance

with the new payroll tax payments as well. Using a private bureau might even facilitate good two-way communications with health insurers and self-insurers and could be fully consistent with publicly administered sanctions for noncompliance.

Compliance monitoring mechanisms

Effective enforcement calls for the enforcer not only to promote initial compliance and but also to learn of noncompliance when it occurs. One initial enforcement process would be to ask employers to register with the responsible administrator. Unemployment compensation requires such registration already, which establishes an account with a tracking number. The account can then be routinely checked for payment of UI taxes as they come due, normally each quarter. A line or two could be added to this form to allow self-certification of insurance coverage in lieu of owing tax. Tracking that tax payments occur is relatively easy, and forms used for tax payments can also be modified to allow payment of insurance premiums in lieu of tax. Establishing that payments are correct calls for a strategy for monitoring full compliance, as does verifying that certified premium payments were actually made.

A new reform system might obtain such verification from health insurers and the third-party administrators who assist self-insurers with claims payment and other insurance functions (licensed insurers may play this role). Reports could be submitted via a private bureau, as noted above. In time, cross-checking tax accounts with insurance payments could be made routine. Initially and perhaps also for the long term, conducting both targeted and random audits could be a reasonable strategy. The ability to target audits would benefit from experience with prior tax compliance problems and would grow easier over time with accumulation of experience under the new obligations.

In addition to agency-initiated monitoring and audits, information about possible employer noncompliance may also come from medical providers who serve uninsured workers (as for individuals, see above), whistle blowers, competitors, and sister agencies that detect problems in other tax or regulatory areas. Workers Compensation, for example, has begun a toll-free hotline to encourage such reporting.

Encouraging and assuring employers compliance

The main thrust of enforcement, as we have stressed repeatedly, is voluntary compliance. The key enforcement task, therefore, is to make it easy to do the right thing—for employers just as for individuals. The first response in most cases of suspected employer noncompliance should be to re-educate the firm involved and to encourage voluntary compliance. Another option would be to allow employers that fall behind in tax payments to agree to extended payment plans that pay down past obligations as an increment on top of paying current obligations as they come due.

Taxes that remain unpaid should be routinely recouped by simple administrative notice, adding late-payment interest and a small monetary penalty. The most straightforward enforcement response is to compute back taxes due from the date premium payments ceased or the policy was canceled. Those taxes would then be subject to the same routine collection efforts. Beyond administrative collections, authorities may

sometimes need to make levies against a firm's financial assets or obtain liens against their real property, just as for other taxes.

Stronger sanctions and processes for imposing them

A transition period will enable individuals and firms to become accustomed to the new requirements. Beyond this educational period, if enforcers find cases of persistent or willful non-payment of premiums or taxes, stronger sanctions may need to come into play. The enforcement agency would presumably want to have authority to apply a graduated set of sanctions. The principle of proportionality suggests differentiating among noncompliant behaviors, from minor to major and one time to long term. As for other matters related to tax obligations, it would seem desirable to adopt the sanction practices of the responsible taxing authority that administers the new regime. For unemployment compensation, these include enforced collections, backstopped by civil and criminal penalties. For the long term, adverse publicity, debarment from state and local contracts, and loss of other privileges might also be considered.

Each level of sanction for each agency comes with an administrative and judicial process for application and appeal. An advantage for enforcers using tax processes is that the fact finding and adjudicative processes in this area tend to be streamlined relative to other forms of regulatory enforcement. Here again, it seems likely that existing processes at the Division of Unemployment Assistance or the Department of Revenue are fully adequate to make reasonable determinations, with fairness to firms to be heard. Recourse to an independent arbiter is also important, especially for strong sanctions, at least some of which should probably be applied only by court order. For employers' tax obligations met by insurance purchase, policy makers need to consider during the implementation phase what documentation is appropriate to support tax authorities' verifying insurance premiums paid in lieu of taxes, because this would be a new function for them.

Other cross-cutting issues

Ensuring good support for outreach, compliance, and enforcement

To be effective, efforts to promote insurance enrollment and discourage dis-enrollment need to be well planned, actively pursued, and well funded and staffed. This is true both for the carrots that promote or facilitate compliance and for the sticks that deter noncompliance. MassHealth's enrollment experience offers ample demonstration that strong promotional efforts can succeed. The state's 1990s expansions achieved very high participation rates, for example, which lagged in 2004 when outreach efforts were scaled back. Most recently, state administrators have rolled out a new "virtual gateway" for automated enrollment and made other improvements in their effort to enroll the estimated 100,000 residents who are eligible but remain unenrolled. The lesson of this history--that strong efforts are strongly rewarded with higher participation rates—holds for enforcement efforts against noncompliance as well. Processes and sanctions must be legally adequate to create a credible deterrent before the fact, but they must be actively implemented in practice as well.

Conclusions

Assuring universality of coverage in practice is the function of enforcement, the first level of which should be voluntary compliance. The key role for the responsible state agencies is to educate the public and make it easy to comply.

The second level of enforcement operates through state taxing authorities. They would monitor whether insurance has in fact been obtained and collect any unpaid premiums retroactively, along with interest and modest penalties. The responsible agencies, rules, and processes would need to vary depending on whether they address individuals or businesses. Enforcement for the new requirements should follow already established practices wherever practicable, to ease compliance and facilitate imposition of any sanctions ultimately needed.

Once new obligations are well understood and mechanisms to ease compliance are functioning well, a third level of enforcement--more powerful sanctions--may well be appropriate. A range of sanctions could address various durations of and reasons for non-compliance, just as for existing tax and other regulatory obligations.

As we have shown, enforcement of an individual mandate or an individual mandate combined with an employer mandate would require a number of important policy choices and introduce new administrative responsibilities on state government, individuals, providers, employers and insurers. The good news is that most of these new responsibilities could be made roughly consistent with existing roles and practices, easing the burden of implementation on any particular party.

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