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[*Updated Jan 8, 2017*] The tax bill passed in December 2017 repealed the penalty associated with the Affordable Care Act's individual shared responsibility provision, also known as the individual mandate. The provision required those who could afford health coverage to either maintain coverage, qualify for an exemption, or make a payment with their federal income tax return. The [Congressional Budget Office projects](#) that repealing the mandate penalty will increase insurance premiums by 10 percent on average and result in 13 million more persons being uninsured. A number of states have expressed an interest in examining a state-level individual mandate, which Massachusetts has had in place since before the ACA.

Frequent State Health and Value Strategies partner Jason Levitis, health tax expert and former Counselor and ACA Implementation Lead at the U.S. Department of the Treasury, has developed model legislation for states interested in a state-level individual mandate. The model legislation that follows may be revised, so be sure to check back to the [resource page](#) to ensure you are working from the most current draft. For questions, contact Jason Levitis at jason.levitis@gmail.com.

MODEL LEGISLATION FOR STATE INDIVIDUAL MANDATE
Draft – 1/8/2018

Note to drafters: This document provides model legislative language for three pieces of legislation needed to implement a State individual mandate (also referred to as an individual shared responsibility provision), and one piece that is optional but recommended:

- I. Individual Mandate
- II. Requirement for State Entity to Grant Certain Exemptions
- III. Reporting Requirement for Providers of Minimum Essential Coverage
- IV. Notification to Uninsured of Opportunity to Enroll (Optional but Recommended)

Each piece either cross-references or is closely based on the corresponding Federal provision.

The language in Parts I, III, and IV should be codified in the State Tax Code, while the language in Part II may be codified there or elsewhere in the State code, e.g. the section governing the responsibilities of a State Exchange or State Health Department.

Throughout, italics indicate notes to legislative drafters. Brackets set off notes to drafters or indicate that customization is necessary or desirable because: (1) several options are provided (separated by forward slashes (/)), (2) the language needs to be conformed to State terminology, or (3) the State may want to alter the language for policy or technical reasons.

This language is generally designed for States with existing income taxes that use concepts similar to the Federal income tax (AGI, dependents, etc.). Where feasible, language that would work in other States is also provided (generally by cross-referencing Federal tax concepts).

This language will be periodically updated to reflect additional refinements. Questions and comments may be directed to Jason Levitis at jason.levitis@gmail.com

I. INDIVIDUAL MANDATE

Note to drafters: What follows is legislative language to impose a State individual mandate penalty to replace the Federal individual mandate penalty by means of “conforming” to the Federal individual mandate as of December 15, 2017. The Republican tax bill (the [Tax Cut and Jobs Act of 2017](#)), enacted December 22, 2017, “zeroed out” the individual mandate penalty but left the rest of the Federal law related to the individual mandate unchanged. The language below adopts the Federal penalty and associated rules by reference to the Federal statutory provisions in section 5000A of the Internal Revenue Code, as it was in effect on December 15, 2017. The language also, in subsection (a), includes bracketed language to adopt the ACA mandate’s substantive requirement to maintain health insurance. Finally, the language includes changes to adapt to State law, to ensure that Federal regulations implementing section 5000A are generally adopted, and to address policy and technical issues.

An alternative approach for imposing a State individual mandate is included at the end of this document in Part V. That approach creates a free-standing State individual mandate by generally restating section 5000A in whole, again while making suitable adjustments.

The first approach (conforming to Federal law by cross-reference) is generally preferable, as it is shorter and simpler, makes it clearer that the State is simply restoring the Federal policy, and lends itself more readily to State adoption of Federal regulations and other guidance implementing the Federal individual mandate. Adopting Federal guidance is important to successful implementation, especially given the short implementation timeline States will face. Nonetheless, State-specific factors may dictate the use of the second approach.

Section [X1]. Shared Responsibility [Tax/Payment/Fee]. *[Note to drafters: As noted below, it is possible that litigation may be brought claiming that the application of the reporting requirement in Part III to employer sponsors of coverage is preempted by ERISA. The reporting requirement applies to the same entities as the Massachusetts reporting requirement, which has been [in place since coverage year 2007](#). Nonetheless, States may wish to, in consultation with ERISA counsel, takes steps to make ERISA compliance as clear as possible. There is some ERISA case law suggesting greater deference to State provisions related to taxation. Since the reporting is in support of the mandate penalty, there may be benefit in calling the penalty a “tax.” Such benefit must be weighed against the impact of calling it a “tax” on its legislative prospects. Other options include “fee,” which better captures its purpose, and “payment,” which is more generic. Another option is to use a combination of the terms. For example, “fee” could be used throughout, but subsection (b) could make clear that it’s a tax by saying something like “there is hereby imposed a tax (referred to as the [State] ‘shared responsibility fee’) equal to a taxpayer’s Federal shared responsibility payment....”]*

[(a) Requirement to Maintain Minimum Essential Coverage. A taxpayer shall for each month beginning after 2018 ensure that the taxpayer, if an applicable individual, and any dependent of the taxpayer who is an applicable individual, is covered under minimum essential coverage for such month.] **[Note to drafters:** *This subsection is not necessary as a legal matter. Section 5000A imposes both a requirement to maintain coverage and a penalty for non-exempt individuals who fail to maintain coverage. The tax bill repealed only the penalty, so technically the requirement to have coverage is still in effect. And regardless, a coverage requirement is not a legal prerequisite for a tax on those without coverage. Thus States may choose to omit this subsection (a). Omitting it may be helpful to emphasize that the State legislation merely restores the policy under the ACA without imposing additional requirements. On the other hand, States may choose to include it to emphasize the importance of maintaining coverage beyond the financial implications, especially given that the tax bill may be seen as undermining the Federal requirement to do so.]*

(b) Shared responsibility [tax/payment/fee]. Except as provided in subsection (c), there is hereby imposed a [State] shared responsibility [tax/payment/fee] equal to a taxpayer’s Federal shared responsibility payment for the taxable year under section 5000A of the Internal Revenue Code of 1986, as amended, and as in effect on [the 15th day of December 2017]. **[Note to drafters:** *The IRS issued helpful [guidance](#) on Dec. 6, 2017, so it is important for the State’s guidance to be conformed no earlier than that date, as is done below. For simplicity, the statutory language is conformed as of the same date.]*

(c) Exceptions. The rules for determining the [State] shared responsibility [tax/payment/fee] under this section shall reflect the following changes relative to the rules for determining the Federal shared responsibility payment under section 5000A of the Internal Revenue Code of 1986.

(1) [Tax/payment/fee] cap. The amount of the [tax/payment/fee] imposed by this section shall be determined, if applicable, using the [State] average premium for bronze-level plans rather than the national average premium for bronze-level plans.

[(2) Additional coverage qualifying as minimum essential coverage. For purposes of this section, minimum essential shall include, in addition to the types of coverage included under section 5000A of the Internal Revenue Code of 1986, the following: *[placeholder for State-specific coverage that should satisfy the mandate and is not listed in section 5000A(f).]*

(3) Designation of additional coverage as minimum essential coverage. The authority to recognize additional health benefits coverage as “minimum essential coverage” shall lie with the [Chief Executive of the State Exchange/State Secretary of Health], in coordination with the [Commissioner of Revenue], rather than the U.S. Secretary of Health and Human Services, in coordination with the U.S. Secretary of the Treasury.

[(4) Required contribution for affordability exemption. For purposes of the exemption for individuals who cannot afford coverage, the required contribution for an individual eligible for minimum essential coverage under both an eligible employer-sponsored plan and a qualified health plan is the lesser of the amounts that the individual would have to pay for coverage of each type.] **[Note to drafters: This change is optional to correct a technical issue with section 5000A.]**

[(5) Required contribution percentage for affordability exemption. For purposes of the exemption for individuals who cannot afford coverage, the income threshold for coverage to be considered unaffordable shall be equal to *[placeholder for alternative applicable percentage rules]*, rather than 8 percent, indexed.] **[Note to drafters: This optional change would make the threshold for receiving the affordability exemption a higher percentage of income for those with higher incomes, as under the Massachusetts individual mandate.]**

(6) Additional exemption for taxpayers with gross income below State filing threshold. No [tax/payment/fee] shall be imposed under this section with respect to any applicable individual for any month during a calendar year if the taxpayer’s [State gross income] for the taxable year is less than the *[insert reference to State income tax filing threshold]* with respect to the taxpayer.

(7) Additional exemption for residents of another State. No [tax/payment/fee] shall be imposed by this section with respect to any applicable individual for any month during which the individual is [a bona fide resident of another State].

(8) Hardship exemption determinations. Determinations as to hardship exemptions shall be made by the [Chief Executive of the State Exchange/State Secretary of Health] under section [B] rather than by the U.S. Secretary of Health and Human Services under section 1331(d)(4)(H) of the Patient Protection and Affordable Care Act of 2010, as amended.

(9) Religious conscience exemption determinations. Determinations as to religious conscience exemptions shall be made under section *[insert reference to State Code section on requirement for State*

to grant certain exemptions, as shown below] rather than under section 1331(d)(4)(H) of the Patient Protection and Affordable Care Act of 2010, as amended.

[(10) Health care sharing ministries. **[Note to drafters:** *The following are three options States may consider for addressing health care sharing ministries, which some State officials have identified as raising concerns for their unregulated status. Options 2 and 3 could be combined.*]

[Option 1:] Health care sharing ministries. There shall be no exemption from being an applicable individual for members of a health care sharing ministry.

[Option 2:] Health care sharing ministries. The exemption from being an applicable individual for members of a health care sharing ministry shall apply only to individuals who have been continuously enrolled in a health care sharing ministry since [December 15, 2017] [or since birth].

[Option 3:] Health care sharing ministries. The exemption from being an applicable individual for members of a health care sharing ministry shall apply only to individuals enrolled in a health care sharing ministry that complies with the requirements of the following sections of the Public Health Service Act: [section 2701 (relating to fair health insurance premiums), section 2703 (related to guaranteed renewability), section 2704 (relating to exclusions for pre-existing conditions), section 2705 (prohibiting discrimination based on health status), section 2711 (prohibiting lifetime and annual limits), and section 2712 (prohibiting rescissions)].]

[(11) Additional requirements for association health plans to qualify as minimum essential coverage. Health coverage provided under an association health plan shall qualify as minimum essential coverage only if, in addition to satisfying other requirements for being minimum essential coverage under this section, it [placeholder for additional requirements]. **[Note to drafters:** *This provision is intended to address the [proposed regulations](#) released by the U.S. Department of Labor on January 4, 2017. If finalized as proposed, the regulations would [permit AHPs that do not satisfy the individual- and small-group consumer protections to be marketed to individuals and small groups](#), potentially destabilizing those markets. Possible approaches for imposing additional requirements include:*

- *Such coverage qualifies as minimum essential coverage only to the extent it satisfies AHP rules in place as of [December 15, 2017] (i.e., before the new regulations take effect).*
- *Such coverage qualifies as minimum essential coverage with respect to a member's employees and their dependents only to the extent it satisfies the Federal insurance market regulations that are applicable to the health insurance market through which the member would normally purchase coverage outside of an AHP. (For example, an AHP qualifies as minimum essential coverage for sole proprietors and their dependents only if the AHP coverage satisfies the federal insurance market regulations that apply to plans in the individual health insurance market, since absent an AHP sole proprietors purchase coverage in the individual market.)]*

[(12) Additional requirements for grandfathered plans to qualify as minimum essential coverage. A grandfathered plan, as defined in section 1251(e) of the Affordable Care Act, shall qualify as minimum essential coverage only if it satisfies the requirements that apply to non-grandfathered plans sold in the market in which the grandfathered plan is sold.]

[(13) Additional requirements for employer-sponsored coverage to qualify as minimum essential coverage. *[Placeholder for additional requirements, such as the [Massachusetts requirement](#) to provide all enrollees with “core services” and with “some level of coverage” for all of the essential health benefits (e.g., providing maternity coverage to dependents).]*

[(14) Adjustment for Federal individual shared responsibility payment. If a taxpayer is subject to both the [tax/payment/fee] imposed by this section and the Federal shared responsibility payment under section 5000A of the Internal Revenue Code of 1986 for a taxable year, the amount of the taxpayer’s [State] [tax/payment/fee] is reduced, but not below zero, by the amount of the taxpayer’s Federal shared responsibility payment.]

(15) Administration and procedure. The [tax/payment/fee] imposed by this section shall be assessed and collected in the same manner as *[insert State tax code reference]*.

(d) Regulations.

(1) Incorporation of Federal rules. **[Note to drafters:** *This provision is intended to ensure that State regulations and other guidance are in place that generally reflect the Federal regulations and other guidance that implement section 5000A, while also being adapted to conform with State law. The Federal regulations and guidance are substantive and extensive, so it is advisable for States to adopt them as a starting point, making modifications for differences in State law and any policy preferences. For reference, the key Federal regulations are at 26 CFR 1.5000A-1 through -5; 45 CFR 155.600 and 155.605; and 45 CFR 156.600 through 156.606.*]

(A) In general. Except as provided in subparagraph (B), any Federal regulations implementing section 5000A of the Internal Revenue Code of 1986, as amended, as such section and regulations are in effect on [the 15th day of December 2017], shall apply as though incorporated into [the State Code of Regulations]. Federal guidance interpreting these Federal regulations shall similarly apply.

(B) Exceptions.

(i) The Federal regulations and guidance described in subparagraph (A) shall apply with modifications necessary to reflect differences between this section and section 5000A of the Internal Revenue Code of 1986, as amended, and to reflect other differences between the [State tax code] and the Internal Revenue Code of 1986, as amended.

(ii) Any changes made under paragraph (2) supersede the regulations and guidance described in subparagraph (A), as modified by clause (i).

(2) Authority.

(A) In general. Except as provided in paragraph (1) and subparagraph (B), the [Commissioner of Revenue] shall prescribe rules implementing this section.

(B) Exceptions. The [Chief Executive of the State Exchange/State Secretary of Health] shall prescribe rules governing:

(i) The designation of additional coverage as minimum essential coverage; and

(ii) Eligibility for the exemptions for religious conscience and hardships.

(e) Effective date. The amendments made by this section shall apply beginning on the [1st day October 2018], except that the [tax/payment/fee] imposed by subsection (a) shall apply to taxable years beginning after December 31, 2018.

II. REQUIREMENT FOR STATE ENTITY TO GRANT CERTAIN EXEMPTIONS

(Note to drafters: This section has been adapted from ACA sections 1411(a)(4) and 1311(d)(4)(H).)

Section [X2]. Granting of exemptions.

(a) Establishment of program. The [Chief Executive of the Exchange/Secretary of Health] shall establish a program for determining whether to grant a certification that an individual is entitled to an exemption from either the individual responsibility requirement or the [tax/payment/fee] imposed by *[insert reference to State Code section imposing individual mandate]* by reason of religious conscience or hardship.

(b) Eligibility determinations. The [Chief Executive of the Exchange/Secretary of Health] shall make determinations as to whether to grant a certification described in subsection (a). The [Chief Executive of the Exchange/Secretary of Health] shall notify the individual and the [Commissioner of Revenue] of any such determinations in such a time and manner as the [Chief Executive of the Exchange/Secretary of Health], in consultation with the [Commissioner of Revenue], shall prescribe.

III. REPORTING REQUIREMENT FOR PROVIDERS OF MINIMUM ESSENTIAL COVERAGE

(Note to drafters: This section has been adapted from section 6055 of the Internal Revenue Code of 1986, as added by ACA section 1502(a). It also incorporates elements of Massachusetts General Laws Chapter 62C, Section 8B, and simplifications to reduce any burden on reporting entities.)

Section [X3]. Reporting of health insurance coverage *[Note to drafters: The reporting requirement in this section applies to the same entities as the Massachusetts reporting requirement. Nonetheless, it is possible that, once this requirement is implemented, litigation could be brought claiming that the application of the reporting requirement to employer sponsors of health coverage is preempted by ERISA. While Massachusetts' requirement has been [in place since coverage year 2007](#), States may wish to, in consultation with ERISA counsel, take steps to make ERISA compliance as clear as possible. The language below includes several features designed to do this.]*

(a) FINDINGS.—The [State Legislature] makes the following findings:

(1) The reporting requirement provided for in this section is necessary for the successful implementation of the [tax/payment/fee] imposed by *[insert reference to State Tax Code section providing for the individual mandate]*. In particular, this requirement provides the only widespread source of third-party reporting to help taxpayers and the [Commissioner of Revenue] verify whether an applicable individual maintains minimum essential coverage. There is compelling [evidence](#) that third-party reporting is crucial for ensuring compliance with tax provisions.

(2) The tax [tax/payment/fee] imposed by *[insert reference to State individual mandate]*, and therefore the reporting requirement in this section, is necessary to protect the compelling State interest of protecting the health and welfare of its residents. The Congressional Budget Office estimates that, in the absence of an individual mandate, health insurance premiums would increase by 10 percent, and about 13 million people nationwide would lose coverage. There is substantial evidence that uninsurance causes health problems and unnecessary deaths.

(3) The tax [tax/payment/fee] imposed by *[insert reference to State individual mandate]*, and therefore the reporting requirement in this section, is necessary to protect the compelling State interest of fostering economic stability and growth in the State.

(4) The tax [tax/payment/fee] imposed by *[insert reference to State individual mandate]*, and therefore the reporting requirement in this section, is necessary to protect the compelling State interest of ensuring a stable and well-functioning health insurance market. There is compelling evidence that, without an effective [tax/payment/fee] in place for those who go without coverage, there would be substantial instability in health insurance markets, including higher prices and the possibility of areas without any insurance available. Ensuring the health of insurance markets is a responsibility reserved for States under the McCarran-Ferguson Act and other Federal law.

(6) The reporting requirement in this section has been narrowly tailored to support compliance with the [tax/payment/fee] imposed by *[insert reference to State individual mandate]*, while imposing only an incidental burden on reporting entities. In particular, the information that must be reported is a subset of the information that must already be reported under a similar Federal reporting requirement under section 6055 of the Internal Revenue Code of 1986. In addition, this section provides that its reporting requirement may be satisfied by providing the same information that is currently reported under such Federal requirement.

(b) In general. For purposes of administering the [tax/payment/fee] on individuals who fail to maintain minimum essential coverage under *[insert reference to State Code section imposing individual mandate]*, every applicable entity that provides minimum essential coverage to an individual during a calendar year shall, at such time as the [Commissioner of Revenue] may prescribe, make a return described in subsection (c).

(c) Form and manner of return.

(1) In general. Except as provided in paragraph (2), a return is described in this subsection if such return—

(A) Is in such form as the [Commissioner of Revenue] may prescribe, and

(B) contains—

(i) the name, address and [TIN] of the primary insured and the name and [TIN] of each other individual obtaining coverage under the policy,

(ii) the dates during which such individual was covered under minimum essential coverage during the calendar year, and

(iii) such other information as the [Commissioner of Revenue] may require.

(2) Notwithstanding the requirements of paragraph (1), a return shall not fail to be a return described in this section if it includes the information contained in a return described in section 6055 of the Internal Revenue Code of 1986, as that section is in effect and interpreted on the [15th day of December 2017].

[Note to drafters: This paragraph minimizes any burden on reporting entities by ensuring that this reporting requirement can be satisfied by submitting the same information that has long been submitted under the ACA's coverage reporting requirement.]

(d) Statements to be furnished to individuals with respect to whom information is reported.

(1) In general. Every applicable entity required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

(B) the information required to be shown on the return with respect to such individual.

(2) Time for furnishing statements. The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (b) was required to be made.

(e) Reporting responsibility.

(1) Coverage provided by governmental units. In the case of coverage provided by an applicable entity that is any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall be responsible for the returns and statements required by this section.

(2) Delegation. An applicable entity may contract with third-party service providers, including insurance carriers, to provide the returns and statements required by this section.

(f) Definitions.

(1) Applicable entity. **[Note to drafters: this definition is included here to leave out Medicare and other Federal programs that a State likely cannot compel to provide reporting. States will need to use other information to verify coverage through Federal programs (e.g., information about residents' age or employer). This is consistent with the approach taken by the Massachusetts coverage reporting requirement.]** For purposes of this section, the term "applicable entity" has the following meaning with respect to the minimum essential coverage:

(A) An employer or other sponsor of an employment-based health plan with respect to employment-based minimum essential coverage.

(B) The [State Medicaid office] with respect to Medicaid or CHIP coverage.

(C) Carriers licensed or otherwise authorized to offer health coverage with respect coverage they provide that is not described in subparagraphs (A) or (B).

(2) Minimum essential coverage. For purposes of this section, the term "minimum essential coverage" has the meaning given such term by *[insert reference to State Code section imposing individual mandate]*.

IV. NOTIFICATION TO UNINSURED OF OPPORTUNITY TO ENROLL (Optional but Recommended)

(Note to drafters: This section has been adapted from ACA section 1502(c).)

Section [X4]. Notification of non-enrollment – Not earlier than [November 1 nor later than November 30] of each year, the [Commissioner of Revenue], in consultation with the [Chief Executive of the Exchange/Secretary of Health], shall send a notification to each taxpayer who files an [individual income tax return] indicating that the taxpayer or one of the taxpayer’s dependents is not enrolled in minimum essential coverage (as defined for purposes of [insert citation for State Code section imposing individual mandate]). Such notification shall contain information on the services available through the Exchange.

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V. ALTERNATIVE LANGUAGE FOR INDIVIDUAL MANDATE

(Note to drafters: The following is a second option for legislative language to impose a State individual mandate, in addition to the language provided above. This option generally restates section 5000A in whole, while making adjustments to conform with State law, provide appropriate regulations, and address policy and technical issues. As noted above, the option provided above (in Part I) is probably a better choice for most States, but this one is provided as an alternative.

This version is adapted from section 5000A of the Internal Revenue Code, as added by ACA section 1501(b).)

Section [X1]. Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage

A taxpayer shall for each month beginning after 2018 ensure that the taxpayer, if an applicable individual, and any dependent of the taxpayer who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared responsibility [tax/payment/fee]

(1) In general. If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subparagraph (3)(A) and subsection (e), there is hereby imposed on the taxpayer a [tax/payment/fee] with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return. Any [tax/payment/fee] imposed by this section with respect to any month shall be included with a taxpayer's return under *[insert reference to State income tax]* for the taxable year which includes such month.

(3) Payment of [tax/payment/fee]. If an individual with respect to whom a [tax/payment/fee] is imposed by this section for any month—

(A) is a dependent (as defined in *[insert reference under State Tax Code/section 152 of the Internal Revenue Code of 1986, as amended]*) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such [tax/payment/fee], or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such [tax/payment/fee].

(c) Amount of [tax/payment/fee]

(1) In general. [Except as provided in paragraph (5),] the amount of the [tax/payment/fee] imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly [tax/payment/fee] amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the State average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly [tax/payment/fee] amounts. For purposes of paragraph (1)(A), the monthly [tax/payment/fee] amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount. An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) [300] percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income. An amount equal to [2.5 percent] of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) of the Internal Revenue Code of 1986 with respect to the taxpayer for the taxable year

(3) Applicable dollar amount. For purposes of paragraph (1)—

(A) In general. Except as provided in subparagraph (B) and (C), the applicable dollar amount is [\$695].

(B) Special rule for individuals under age 18

If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(C) Indexing of amount. In the case of any calendar year beginning after 2019, the applicable dollar amount shall be equal to [\$695], increased by an amount equal to—

(i) [\$695], multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2015" for "calendar year 1992" in subparagraph (B) thereof.

If the amount as increased under this subparagraph (C) is not a multiple of \$50, such increase shall be rounded down to the next multiple of \$50.

(4) Terms relating to income and families. For purposes of this section—

(A) Family size. The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income. The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under subparagraph (A), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income. The term "modified adjusted gross income" means adjusted gross income as defined in [section 62 of the Internal Revenue Code of 1986/*insert reference to State AGI definition*], increased by—

(i) any amount excluded from gross income under section 911 of the Internal Revenue Code of 1986, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

(5) Adjustment for payment of federal shared responsibility payment. If a taxpayer is subject to both the [tax/payment/fee] imposed by this section and the Federal shared responsibility payment imposed by section 5000A of the Internal Revenue Code of 1986 for a taxable year, the amount of the taxpayer's [State] [tax/payment/fee] is reduced, but not below zero, by the amount of the taxpayer's federal shared responsibility payment.]

(d) Applicable individual. For purposes of this section—

(1) In general. The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) Religious exemptions

(A) Religious conscience exemption. Such term shall not include any individual for any month if such individual has in effect an exemption under [*Insert reference to the requirement for a State entity to grant certain exemptions, as provided below*], which certifies that such individual is—

(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1) of the Internal Revenue Code of 1986, and

(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

[(B) Health care sharing ministry **[Note to drafters: The following language includes two options States may consider for addressing health care sharing ministries, which some State officials have identified as raising concerns for their unregulated status. These options may be combined. In addition, the exemption for health sharing ministries may be omitted.]**

(i) In general. Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month [and has continually been a member of a health care sharing ministry since [the 15th day of December 2017][or since birth]].

(ii) Health care sharing ministry. The term "health care sharing ministry" means an organization—

(I) which is described in section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Code,

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

[(VI) which [complies with the requirements of the following sections of the Public Health Service Act: [section 2701 (relating to fair health insurance premiums), section 2703 (related to guaranteed renewability), section 2704 (relating to exclusions for pre-existing conditions), section 2705 (prohibiting discrimination based on health status), section 2711 (prohibiting lifetime and annual limits), and section 2712 (prohibiting rescissions)]]

(3) Individuals not lawfully present. Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals. Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions. No [tax/payment/fee] shall be imposed under subsection (a) for a month with respect to—

(1) Individuals who cannot afford coverage

(A) In general. Any applicable individual if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds [8.3] percent of such individual's household income for the taxable year. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from [gross income] for any portion of the required contribution made through a salary reduction arrangement.

[Note to drafters: *The 8.3 percent figure is the value that would be in place under federal law, as announced in the [CMS proposed Notice of Benefit and Payments Parameters for 2019](#). Instead of the 8.3 percent figure in the preceding text, a State may wish to make the threshold for receiving the affordability exemption a higher percentage of income for those with higher incomes, as under the Massachusetts individual mandate.]*

(B) Required contribution. For purposes of this paragraph, the term "required contribution" means [the lesser of]—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible employer-sponsored plan, the portion of the annual premium which would be paid

by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible [only] to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan (or if no bronze plan is available, silver plan) available in the individual market through the Exchange in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B of the Internal Revenue Code on 1986 for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) Special rules for individuals related to employees

For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to the portion of the premium required to be paid by the employee for family coverage.

(D) Indexing. In the case of plan years beginning in any calendar year after 2019, subparagraph (A) shall be applied by substituting for “8.3 percent” the percentage the U.S. Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2018 over the rate of income growth for such period.

(2) Taxpayers with household income below Federal filing threshold. Any applicable individual if the taxpayer’s household income for the taxable year containing the month is less than the amount of gross income specified in section 6012(a)(1) of the Internal Revenue Code of 1986 with respect to the taxpayer.

(3) Taxpayers with gross income below State filing threshold. Any applicable individual if the taxpayer’s [State gross income] for the taxable year containing the month is less than the [*insert reference to State income tax filing threshold*] with respect to the taxpayer.

(4) Members of Indian tribes. Any applicable individual who is a member of an Indian tribe (as defined in section 45A(c)(6) of the Internal Revenue Code of 1986) during the month.

(5) Short coverage gaps

(A) In general. Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) Special rules. For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The [Commissioner of Revenue] shall prescribe rules for the collection of the [tax/payment/fee] imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) Hardships. Any applicable individual who is determined by the [Chief Executive of the Exchange/Secretary of Health] under *[Insert reference to the requirement for a State entity to grant certain exemptions, as provided below]* to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage. For purposes of this section—

(1) In general. The term “minimum essential coverage” means any of the following:

(A) Government sponsored programs. Coverage under—

(i) the Medicare program under part A or C of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(v) a health care program under chapter 17 or 18 of title 38, United States Code

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995.

(B) Employer-sponsored plan. Coverage under an eligible employer-sponsored plan.

(C) Plans in the individual market. Coverage under a health plan offered in the individual market, as defined in section 1304 of the Patient Protection and Affordable Care Act of 2010.

(D) Grandfathered health plan. Coverage under a grandfathered health plan, as defined in section 1251(e) of the Patient Protection and Affordable Care Act of 2010 [if such plan satisfies the requirements for non-grandfathered plans sold in the market (either small group, large group or individual) in which the grandfathered plan is sold.

[(E) Placeholder for additional State-specific coverage that should satisfy the mandate.]

(F) Other coverage. Such other health benefits coverage as the [Chief Executive of the Exchange/Secretary of Health], in coordination with the [Commissioner of Revenue], recognizes for purposes of this subsection.

(2) Eligible employer-sponsored plan. The term “eligible employer-sponsored plan” means, with respect to any employee, a group health plan offered by an employer to the employee. Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

[Note to drafters: A State may choose here to impose additional requirements for employer-sponsored coverage to qualify as minimum essential coverage. For example, [Massachusetts requires](#) such coverage to provide all enrollees with “core services” and with “some level of coverage” for all of the essential health benefits (e.g., providing maternity coverage to dependents).]

(3) Excepted benefits not treated as minimum essential coverage. The term “minimum essential coverage” shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

[Note to drafters: A State may choose here to impose additional requirements for association health plans to qualify as minimum essential coverage. States might consider this to address the proposed regulations released by the [Department of Labor](#) on January 4, 2017. If finalized as proposed, the regulations would [permit AHPs that do not satisfy the individual- and small-group consumer protections to be marketed to individuals and small groups](#), potentially destabilizing those markets. Possible approaches for imposing additional requirements include:

- *Such coverage qualifies as minimum essential coverage only to the extent it satisfies AHP rules in place as of [December 15, 2017] (i.e., before the new regulations take effect).*
- *Such coverage qualifies as minimum essential coverage with respect to a member’s employees and their dependents only to the extent it satisfies the Federal insurance market regulations that are applicable to the health insurance market through which the member would normally purchase coverage outside of an AHP. (For example, an AHP qualifies as minimum essential coverage for sole proprietors and their dependents only if the AHP coverage satisfies the federal insurance market regulations that apply to plans in the individual health insurance market, since absent an AHP sole proprietors purchase coverage in the individual market.)]*

(4) Individuals residing outside the State. Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) of the Internal Revenue Code of 1986 which is applicable to the individual,

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a) of the Internal Revenue Code of 1986) for such month, or

(C) if such individual is a [bona fide resident of another State] for such month.

(g) Administration and procedure

(1) In general. [The [tax/payment/fee] imposed by this section shall be paid upon notice and demand by the [Commissioner of Revenue], and [except as provided in paragraph (2),] shall be assessed and collected in the same manner as [Insert State tax code reference].]

[(2) Special rules. Notwithstanding any other provision of law—

(A) Waiver of criminal penalties. In the case of any failure by a taxpayer to timely pay any [tax/payment/fee] imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies. The [Commissioner of Revenue] shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the [tax/payment/fee] imposed by this section, or

(ii) levy on any such property with respect to such failure.]

(h) Regulations

(1) Authority

(A) In general. Except as provided in subparagraph (B), the [Commissioner of Revenue] shall prescribe rules implementing this section.

(B) Exceptions. The [Chief Executive of the Exchange/Secretary of Health] shall prescribe rules governing:

(i) the designation of additional coverage as minimum essential coverage; and (ii) eligibility for the exemptions for religious conscience and hardships.

(2) Adoption of Federal rules.

(A) In general. Not later than [December 31, 2018], the [Commissioner of Revenue], or the [Chief Executive of the Exchange/Secretary of Health] as provided in subparagraph (1)(B), shall promulgate final regulations and other guidance consistent with the Federal regulations and other guidance implementing section 5000A of the Internal Revenue Code of 1986, as amended, as such regulations and guidance are in effect on [the 15th day of December 2017].

(B) Exceptions.

(i) The Federal regulations and guidance described in subparagraph (A) shall include modifications necessary to reflect differences between this section and section 5000A of the Internal Revenue Code of 1986, as amended, and to reflect other differences between the [State tax code] and the Internal Revenue Code of 1986, as amended.

(ii) The [Commissioner of Revenue] and [Chief Executive of the Exchange/Secretary of Health] may make other modifications to the regulations and guidance consistent with this section and other applicable law.