MEMORANDUM

To: Health Connector Board of Directors
Cc: Louis Gutierrez, Executive Director
From: Marissa Woltmann, Associate Director of Policy and ACA Implementation Specialist
Date: February 7, 2016
Re: Affordability Schedule Recommendations for Calendar Year 2017

BACKGROUND

The Health Connector serves as the primary policymaker with regard to the Commonwealth's requirement that individuals carry health insurance, also called the individual mandate. The Health Connector Board is required to annually devise a schedule that describes the percentage of income an individual could be expected to contribute towards the purchase of health insurance.[1] The primary purpose of this affordability schedule is to determine if an individual is subject to a penalty for forgoing insurance, or if the individual is not subject to a penalty because insurance would be deemed too costly.

In practice, an individual compares the monthly contribution to employer sponsored insurance (ESI), publicly subsidized insurance, or the lowest cost commercial insurance plan available through the Health Connector to the corresponding maximum monthly premium for his or her income. Failing to enroll in affordable coverage may result in a penalty assessment. Conversely, if no affordable plan was available, no penalty for being uninsured will be assessed.

The federal Patient Protection and Affordable Care Act (ACA) also includes a health insurance coverage mandate that first took effect in 2014, and it also defines an affordability standard to identify those subject to the mandate. Under the ACA, a taxpayer is exempt from the mandate if the required contribution for coverage exceeds 8% of household income, indexed annually for inflation.[2] The proposed federal affordability standard for 2017 is 8.16% of income, a small increase to the 2016 standard of 8.13%.[3]

The flat percentage approach used in the federal affordability standard contrasts with the progressive approach taken by the Board with respect to the Massachusetts affordability schedule. Historically, higher-income individuals in Massachusetts were subject to affordability standards in excess of 8%, while lower-income individuals were subject to standards well below 8%. Over the past several years, Health Connector staff worked with the Board, other state

[1] M.G.L. 176Q § 3.

[2] The ACA outlines an indexing methodology that accounts for the rate of growth in premiums divided by the rate of growth in income. Growth is considered for national figures for the preceding calendar year compared to 2013. This new rate is applied to the 8% standard. For 2017, the U.S. Secretary of Health and Human Services considered the rate of premium growth from 2013 to 2015, divided by the rate of income growth from 2013 to 2015, and multiplied by 8%, resulting in a proposed maximum expected contribution to health insurance of 8.16% of income.

[3] The Federal Department of Health and Human Services proposed the contribution percentage of 8.16% in its proposed rule "HHS Notice of Benefit and Payment Parameters for 2017" on December 2, 2015. A final version of the rule is expected later this winter.

agencies, and key stakeholders to determine how to best align the state and the federal individual mandates, including approaches to defining affordability for state residents. The goal of this work was to preserve high levels of enrollment in robust coverage while prioritizing simplicity for residents and state agencies administering the mandate.

Although both state and federal individual mandate policies are in effect, the vast majority of state residents are already covered by insurance and thus do not need to apply either state or federal affordability standards to determine whether they are subject to a penalty under either law. There are a small number of instances in which the state affordability schedule will be required to determine application of the state individual mandate requirement and the potential for a state penalty. Individuals who are uninsured altogether may face state and federal penalties. Also, an individual may have health insurance that meets Minimum Essential Coverage (MEC) requirements, the federal coverage standard, but fails to meet the state's Minimum Creditable Coverage (MCC) requirements.[4] In this scenario, the state affordability schedule would be employed to determine if that individual would be subject to the state mandate and penalty.

For uninsured individuals who may face penalties under both the state and federal mandates, Massachusetts has modified its rules to avoid "stacking" of state and federal penalties. Individuals may subtract the amount paid in federal mandate penalty from the amount of their state penalty beginning with their 2014 state income tax returns. If the federal penalty is less than the state penalty, taxpayers will only pay the difference to the state, capping their liability at the original state amount. If the federal penalty is more than the state penalty, the state penalty will be reduced to $0.

A second, but equally important, aspect of the affordability schedule is that it aligns with the subsidized ConnectorCare premiums for individuals with income at or below 300% of the Federal Poverty Level (FPL). In 2015, the Board approved affordability schedules for calendar years 2015 and 2016 in an effort to re-sequence policy decisions such that the affordability schedule precedes the Seal of Approval process for a given calendar year.[5] The 2017 affordability schedule will inform the Health Connector's Seal of Approval plan certification process, which is set to launch later this winter. Although the affordability schedule does not create any requirement that the market offer plans that fall within the affordable ranges set by the Board, the Health Connector's policy has been to set its own subsidized premiums in accordance with what the Board has determined affordable. During the Seal of Approval

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[4] There is broad overlap in the types of coverage that meet both state MCC and federal MEC standards. The main difference is that all employer-sponsored and individual market coverage is deemed MEC *per se*, while state rules look for specific benefits, such as prescription coverage, and limitations on enrollee cost sharing in determining whether a plan obtained through an employer or carrier is MCC compliant. Neither MCC nor MEC requires that employers or carriers include those benefits, but an individual who chooses to enroll in a non-compliant plan may face a penalty under the individual mandate.

[5] The timing of the affordability schedule was historically constrained by the publication date of relevant Federal Poverty Level standards. Under the ACA, program rules for subsidized Health Connector benefits rely on FPL standards published in the prior calendar year, eliminating this constraint going forward.

process, carriers will submit plan proposals informed by the anticipated base enrollee premiums, and Health Connector staff will use the base premiums in analyzing the fiscal and operational administration of the ConnectorCare program.

We have included below a proposal for the 2017 affordability schedule. Should the Board vote in favor of issuing this proposal, the Health Connector will open a public comment period during which we invite feedback from the public on the recommended approaches to affordability standards. Health Connector staff will review comments submitted during this period and bring a final recommendation before the Board in March for the Directors to vote on.

PROPOSED APPROACH FOR 2017 STATE AFFORDABILITY SCHEDULE

The proposed schedule for 2017 upholds the transition to a percentage-based approach adopted by the Health Connector Board in 2015, while updating the schedule to reflect the adjusted FPL standards for 2016, which will be used to determine eligibility for Health Connector subsidies during the 2017 benefit year.[6]

For households up to 300% FPL, updates to the federal poverty standards translate to minor increases in the dollar amounts considered affordable. This change will, if approved, also increase base enrollee premiums for ConnectorCare members in Plan Types 3A and 3B. The base premium for Plan Type 3A would increase from $82 to $83, and the base premium for Plan Type 3B would increase from $123 to $124.

For households between 300% and 400% FPL, updates to the federal poverty standards translate to minor increases in the dollar amounts considered affordable, similar to the impact on those in the lower income brackets.

For households above 400% FPL, we propose a slight increase from 8.13% to 8.16% of income, consistent with the application of the federal standard applied to this income cohort. The federal mandate considers all individuals able to afford coverage that costs 8.16% of income or less in 2017.[7]

The stability offered by the proposed approach for the 2017 affordability schedule, which again maintains the percentage-based approach adopted for 2016, will also provide an opportunity to more thoroughly discuss other policy initiatives related to affordability. During 2015, Health Connector staff considered modifications to the affordability schedule based on feedback

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[6] In 2013, Health Connector staff proposed to the Board a three-year approach to transitioning the Massachusetts affordability schedule closer to the ACA, shifting from a progressive fixed-dollar standard to a percentage of income standard capped at the federal 8% contribution. To this end, the 2013 and 2014 affordability schedules gradually adjusted the maximum allowable premium contributions in the schedule to 10% and 8%, respectively, where previous schedules had defined coverage as affordable in excess of those amounts for higher income brackets. Beginning with calendar year 2015 (CY2015), the Board shifted to an entirely percentage-based schedule. The schedule for 2016 then introduced the first increases to subsidized Health Connector premiums since 2012.

[7] Subject to finalization by the U.S. Department of Health and Human Services

received last winter from the Board and from stakeholders. These modifications included indexing methodologies and the incorporation of individuals' out of pocket cost sharing obligations into the determination of affordability. However, exploration of these topics led to Health Connector staff concluding that such changes would be complex to administer and have limited impact on consumers because the federal mandate would remain unchanged. While no structural changes to the schedule are proposed for 2017, staff will continue to investigate ways to improve the schedule in future years, in conjunction with the Board, state and federal partners, and other stakeholders. In addition to improving the affordability schedule itself, Health Connector staff will also continue addressing the availability of affordable plans in the market, and determining the impact of federal policy changes on state policy.

PROPOSED CY2017 AFFORDABILITY SCHEDULE

INDIVIDUALS					
Income Bracket			Monthly Affordability Standard	Dollar Amount	
% of FPL	Bottom	Top		Bottom	Top
0 - 100%	$0	$11,880	0%		
100.1 - 150%	$11,881	$17,820	0%		
150.1 - 200%	$17,821	$23,760	2.90%	$ 43	$ 57
200.1 - 250%	$23,761	$29,700	4.20%	$ 83	$ 104
250.1 - 300%	$29,701	$35,640	5.00%	$ 124	$ 149
300.1 - 350%	$35,641	$41,580	7.40%	$ 220	$ 256
350.1 - 400%	$41,581	$47,520	7.60%	$ 263	$ 301
Above 400%	$47,521		8.16%	$ 323	

COUPLES					
Income Bracket			Monthly Affordability Standard	Dollar Amount	
% of FPL	Bottom	Top		Bottom	Top
0 - 100%	$0	$16,020	0%		
100.1 - 150%	$16,021	$24,030	0%		
150.1 - 200%	$24,031	$32,040	4.30%	$ 86	$ 115
200.1 - 250%	$32,041	$40,050	6.20%	$ 166	$ 207
250.1 - 300%	$40,051	$48,060	7.40%	$ 247	$ 296
300.1 - 350%	$48,061	$56,070	7.40%	$ 296	$ 346
350.1 - 400%	$56,071	$64,080	7.60%	$ 355	$ 406
Above 400%	$64,081		8.16%	$ 436	

FAMILIES					
Income Bracket			Monthly Affordability Standard	Dollar Amount	
% of FPL	Bottom	Top		Bottom	Top
0 - 100%	$0	$20,160	0%		
100.1 - 150%	$20,161	$30,240	0%		
150.1 - 200%	$30,241	$40,320	3.45%	$ 87	$ 116
200.1 - 250%	$40,321	$50,400	4.90%	$ 165	$ 206
250.1 - 300%	$50,401	$60,480	5.90%	$ 248	$ 297
300.1 - 350%	$60,481	$70,560	7.40%	$ 373	$ 435
350.1 - 400%	$70,561	$80,640	7.60%	$ 447	$ 511
Above 400%	$80,641		8.16%	$ 548	

APPENDIX

Enclosed in this appendix are the CY 2016 Affordability Schedule tables for reference.

INDIVIDUALS					
Income Bracket			Monthly Affordability Standard	Dollar Amount	
% of FPL	Bottom	Top		Bottom	Top
0 - 100%	$0	$11,770	0%		
100.1 - 150%	$11,771	$17,655	0%		
150.1 - 200%	$17,656	$23,540	2.90%	$ 43	$ 57
200.1 - 250%	$23,541	$29,425	4.20%	$ 82	$ 103
250.1 - 300%	$29,426	$35,310	5.00%	$ 123	$ 147
300.1 - 350%	$35,311	$41,195	7.40%	$ 218	$ 254
350.1 - 400%	$41,196	$47,080	7.60%	$ 261	$ 298
Above 400%	$47,081		8.13%	$ 319	

COUPLES					
Income Bracket			Monthly Affordability Standard	Dollar Amount	
% of FPL	Bottom	Top		Bottom	Top
0 - 100%	$0	$15,930	0%		
100.1 - 150%	$15,931	$23,895	0%		
150.1 - 200%	$23,896	$31,860	4.30%	$ 86	$ 114
200.1 - 250%	$31,861	$39,825	6.20%	$ 165	$ 206
250.1 - 300%	$39,826	$47,790	7.40%	$ 246	$ 295
300.1 - 350%	$47,791	$55,755	7.40%	$ 295	$ 344
350.1 - 400%	$55,756	$63,720	7.60%	$ 353	$ 404
Above 400%	$63,721		8.13%	$ 432	

FAMILIES					
Income Bracket			Monthly Affordability Standard	Dollar Amount	
% of FPL	Bottom	Top		Bottom	Top
0 - 100%	$0	$20,090	0%		
100.1 - 150%	$20,091	$30,135	0%		
150.1 - 200%	$30,136	$40,180	3.45%	$ 87	$ 116
200.1 - 250%	$40,181	$50,225	4.90%	$ 164	$ 205
250.1 - 300%	$50,226	$60,270	5.90%	$ 247	$ 296
300.1 - 350%	$60,271	$70,315	7.40%	$ 372	$ 434
350.1 - 400%	$70,316	$80,360	7.60%	$ 445	$ 509
Above 400%	$80,361		8.13%	$ 544	