Key Considerations Related to the State Individual Mandate and Proposed Amendments to Minimum Creditable Coverage Regulations (VOTE)

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Board of Directors Meeting
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Outline

1. Executive Summary
2. State and Federal Individual Mandate Background
3. Key Questions
   - Should we maintain a state individual mandate?
   - What should state penalties be?
   - What should the state affordability schedule be?
   - What should state coverage standards be?
4. Outstanding Issues
5. Timeline and Next Steps

Executive Summary

- Both federal and state reform require individuals who can afford health insurance to obtain it, but the particular rules associated with each mandate differ
  - This means decisions need to be made about how to fashion a workable approach for the Commonwealth
- While this is an important issue, it will not have a major practical impact on the people and businesses of Massachusetts in terms of forcing major changes in behavior or requirements relative to today
  - Virtually all of Massachusetts' residents have comprehensive health insurance, meaning they would not face penalties under state or federal law moving forward
  - Under our Minimum Creditable Coverage (MCC) rules, businesses of all sizes are accustomed to providing coverage to MA employees that meets certain standards
- The proposed approach to address this issue does not require a legislative change, but rather relies on the regulatory authority of the Health Connector Board to refine the state individual mandate

Executive Summary (cont'd)

- The recommendation included here is to maintain a state individual mandate in addition to the federal mandate
- This will preserve core elements of the Massachusetts model that have proved successful in ensuring high value coverage for residents, regardless of the market in which they receive coverage
  - Absent a state mandate, large employers could, for example, see an opportunity to eliminate the prescription drug coverage they have been providing to their employees under Massachusetts' reform
  - This would create serious problems for consumers and present inequities for small employers, who will be required under federal law to provide prescription drug coverage (among other specified benefits)

Executive Summary (cont'd)

- The recommendation here includes refinements to address longstanding concerns of both consumers and employers with our state rules
  - **Affordability**: we propose to maintain a progressive schedule which will now protect consumers from paying more than 8% of their income on health insurance (the current state affordability schedule requires some consumers to pay more)
  - **Coverage Standards**: we propose to refine existing state coverage standards (*i.e.*, MCC regulations); these refinements provide employers modest additional flexibility to provide lower-priced products to their employees by matching federal rules related to permissible deductibles and out-of-pocket maximums
- Under the approach we are proposing, no one will pay aggregated federal and state penalties
- The rationale for addressing this now is to provide advance guidance to the market and to residents with respect to how the mandate will work in Massachusetts in 2014

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State and Federal Individual Mandate Background

- **Chapter 58 of the Acts of 2006** established an individual mandate, which requires adults in Massachusetts to purchase health insurance if it is affordable to them. The mandate has three primary components:
  - Tax Penalties
  - Affordability Standards
  - Minimum Creditable Coverage

- The Health Connector is responsible for setting the affordability and coverage standards and managing the appeals process. DOR enforces the mandate via tax filings, using Schedule HC and the 1099HC form

- **The Affordable Care Act (ACA)** also includes an individual mandate for adults and children, effective in 2014, but includes different standards around affordability and coverage, and will be enforced by the IRS, which will use a different penalty structure

State and Federal Individual Mandates: Penalty Structure

State Penalty Overview

- Penalties prorated by month
- Penalty must not exceed 50% of the minimum monthly premium for a plan that satisfies MCC for which the uninsured adult would have qualified through the Health Connector
  - half the lowest Commonwealth Care premium for individuals at or below 300% FPL
  - half the lowest YAP premium for individuals above 300% FPL aged 18-26, or
  - half the lowest premium for individuals above 300% FPL aged 27 and over
- Penalty is paid to the state and deposited in Commonwealth Care Trust Fund, which helps fund Commonwealth Care coverage
- Permissible gap in coverage of 90 days

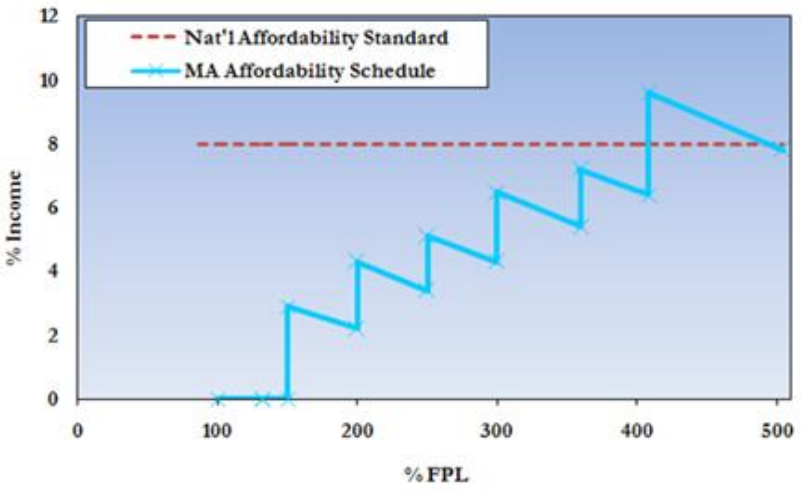
Federal Penalty Overview

- Penalties prorated by month
- Phased-in approach to penalties:*
  - **2014**: Penalty per person is the higher of $95 per year or 1.0% of income over the tax filing threshold, whichever is higher
  - **2015**: Penalty per person is $325 per year or 2.0% of income over the tax filing threshold, whichever is higher
  - **2016**: Penalty per person is $695 per year or 2.5% of income over the tax filing threshold in 2016, whichever is higher
- Penalty is paid to the U.S. Treasury
- Permissible coverage gap of 3 consecutive months per tax year (and if there is more than 1 such gap, the exemption applies only to the first gap)

*Penalty capped at the national average annual premium for a bronze plan and total family penalty amount is capped at 3x the per person penalty amount

State and Individual Mandates: Affordability Standards

- **State Affordability Standard:** The current state affordability standards define specific dollar amounts for each FPL bucket that are considered to be affordable premiums for an individual or a family
  - The affordability schedule is not set by statute, but rather is left to the discretion of the Health Connector Board of Directors



At about 500%FPL, the Massachusetts Affordability Schedule defines coverage as "affordable."

- **Federal Affordability Standard:** The federal affordability standard defines affordability according to a percentage of income approach; a contribution of 8% of household income or less is considered affordable for an individual or a family
  - The affordability standard is defined in statute

State and Federal Individual Mandates: Coverage Standards

- **State Coverage Standards:** Minimum Creditable Coverage (MCC) is the minimum level of benefits for satisfying the Massachusetts individual mandate
  - MCC has a number of different components, including designating certain types of coverage, per statute, as per se compliant (*e.g.*, Commonwealth Care, Medicare, VA Insurance, Student Health Plans, Young Adult Plans, etc.)
  - For other forms of coverage, the Health Connector adopts regulations specifying services that are required to be covered (*e.g.*, Rx), imposing some limits on out-of-pocket costs (*e.g.*, deductibles), and prohibiting certain forms of limitations on benefits (*e.g.,* annual limitations)
  - MCC standards specify the standards an individual's insurance coverage must meet in order to satisfy the mandate requirement. MCC does not directly impose any benefit standards on carriers or employers
- **Federal Coverage Standards:** Minimum Essential Coverage (MEC) is the minimum standard of coverage to comply with the ACA's individual mandate
  - MEC includes a few broad categories of coverage which, per ACA statute, are automatically compliant (*e.g.*, employer plan) for the purpose of satisfying the individual mandate
  - MEC does not directly impose any benefit standards on carriers or employers, ***but (unlike with chapter 58 in Massachusetts) there are several new insurance market reforms in the ACA that do directly regulate health plans. Many of these, however, are only applicable to the fully-insured small/non-group market***

State and Federal Individual Mandates: Coverage Standards (cont'd)

Select ACA Insurance Market Reforms: Market Applicability and Effective Date							
Provision		Market Segment					Effective Date
		Non - Grandfathered plans					
		MA merged market					
		Non Group	Small Group (fully-insured)	Large Group (fully-insured)	Self Insured	Grandfathered (fully-insured)	
Essential Health Benefits (EHBs):	Plans are required to cover EHBs. This is based on the "benchmark" selected by each state and includes at least the 10 benefit categories that are listed in §1302 of the ACA.	√	√	No	No	No	Jan 1, 2014
Cost sharing limitations:	Limitations on annual deductibles of $2,000 (individuals) / $4,000 (families).	√	√	No	No	No	Jan 1, 2014
	Limitations on Maximum Out-of-Pocket (MOOP) spending indexed to Internal Revenue Code limits for High Deductible Health Plans (e.g., $6,250 ind/$12,500 fam in 2013).	√	√	No	No	No	Jan 1, 2014
Coverage limitations:	Lifetime limits are prohibited.	√	√	√	√	√	Sept 23, 2010
	Annual limits are restricted.	√	√	√	√	√ [1]	Sept 23, 2010
	Annual limits are prohibited.	√	√	√	√	√ [1]	Jan 1, 2014
Benefits Coverage:	Coverage for preventive care without cost sharing.	√	√	√	√	No	Sept 23, 2010 [2]

Much of the information included in this table was adapted from the April 2012 Congressional Research Service Report, "Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)" which is available online at: www.fas.org/sgp/crs/misc/R42069.pdf

[1] Among grandfathered plans, this market reform applies to the fully-insured and self-insured large group plans, but does not apply to non-group grandfathered plans.

[2] Some preventive services were required to be covered with no cost-sharing beginning on September 23, 2010. Additional preventive services that must be covered with no cost-sharing went into effect at a later date, such as coverage for contraceptive services which went into effect August 1, 2012.

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Key Question: Should We Maintain A State Individual Mandate?

- There are compelling reasons for keeping a state individual mandate
  - Retention of the state individual mandate serves as a mechanism to preserve Minimum Creditable Coverage standards
    - Provides protection for consumers in any market they receive coverage
    - Mitigates inequities for large and small employers
  - Retention of state penalties is necessary particularly in the early years of ACA implementation to preserve our coverage gains
    - Federal individual mandate penalties are very low during their initial phase-in
    - State should develop a way to ensure residents are not subject to "penalty stacking" (*i.e.*, having to pay aggregated state *and* federal penalties, if applicable)

Key Question: Should We Maintain A State Individual Mandate? (cont'd)

- Retention of the individual mandate does create some policy and operational issues that must be addressed. However, DOR and Health Connector staff (through the Individual Mandate Workgroup) have begun to develop proposals for addressing these issues, and the size of the potentially impacted population is small
  - DHCFP Health Insurance Survey (HIS) data reveal **over 98% of MA residents have health insurance**
  - DOR Tax-Filing data reveal **over 92% of tax-filers have insurance for the full year** (among those required to file a Schedule HC)
  - Among the insured, the vast majority have MCC-compliant coverage
    - Health Connector appeals data suggest very few cases of insured residents with non MCC-compliant coverage

Key Question: Should We Maintain A State Individual Mandate? (cont'd)

- DHCFP Household Insurance Survey data and DOR Tax-Filing data indicate the remaining uninsured are largely low income (*i.e.*, income <150% FPL)
  - Maintenance of the state mandate does not have a major impact on this population as penalties have been and will continue to be nominal (*i.e.*, historically $0)
- Access to subsidized coverage will be expanded under the ACA, particularly to the population that may currently be unable to afford ESI but is ineligible for Commonwealth Care due to the offer of ESI
  - Medicaid expansion to 133% FPL
  - APTCs available through the Exchange to 400% FPL (and those with access to ESI may be eligible if ESI is not "affordable")

Key Question: What Should State Penalties Be?

- Health Connector and DOR staff recommend a "credit" approach to penalties, relying on the current penalty methodology employed by the state
  - This approach prevents penalty stacking
- In practice, this would work as follows:
  - **Scenario #1:** Both a federal and a state penalty
    - Federal penalty> state penalty: adjusted state = $0
    - Federal penalty < state penalty: adjusted state = (state penalty) – (federal penalty)
  - **Scenario #2:** Only a state penalty
    - Pay full state penalty to the state
  - **Scenario #3:** Only a federal penalty
    - Pay full federal penalty to the IRS

Key Question: What Should the State Affordability Schedule Be?

- The federal individual mandate will require individuals to spend up to 8% of their income on health insurance, if it is available to them, to satisfy the federal mandate requirement
- Therefore, as we look to 2014, there are, as a practical matter, a narrow set of circumstances in which the state affordability standard has meaningful consequences
  - An individual is uninsured but does not pay a federal penalty because (s)he is exempted from the federal mandate on affordability grounds *(Note: this is unlikely as it is unlikely that the state would adopt an affordability standard that is more stringent than the federal standard)*
  - An individual is uninsured and pays a federal penalty, but that penalty is *less than* the applicable state penalty *(Note: Based on initial analysis, this is largely an issue for a subset of low-income people and theoretically some higher income people)*
  - An individual is insured with non MCC-compliant coverage and because (s)he has coverage that constitutes MEC (s)he is not penalized under the federal mandate but *is potentially* penalized under the state mandate

In these scenarios, the state affordability standard determines if affordable insurance is available and if the individual is subject to the state mandate and a penalty

Key Question: What Should the State Affordability Schedule Be? (cont'd)

- Health Connector staff recommends a progressively increasing standard capped at 8% of income
  - Maintains the progressive approach of the current state schedule, to protect lower-income residents from state penalties in the absence of truly affordable MCC-compliant coverage
  - Provides a cap on what constitutes affordable coverage as opposed to the current standard which defines insurance as "affordable" (regardless of the premium contribution) above approximately median income
- DOR could ultimately move to a percentage-of-income based approach so long as it is clear as to what line(s) in the tax form (*i.e.*, what income standard) should be used to calculate the affordability standard

Key Question: What Should the State Affordability Schedule Be? (cont'd)

- It is difficult to move to a progressive percentage of income-based state affordability standard (capped at 8%) for calendar year/tax year 2014
  - DOR will need to leverage federal forms, processes and data (*i.e.*, household income) to adopt this approach; these are not yet available/complete
- Consequently, for calendar year/tax year 2013 and 2014, we propose maintaining a progressive state affordability schedule that, like today, indicates affordable premium amounts for specified income buckets, ultimately capped at an 8% ceiling to approximate the federal ceiling
  - Health Connector Board would, as it does today, determine those amounts based on broad stakeholder input
- For calendar year/tax year 2015, we propose maintaining a progressive state affordability schedule, based on expected *percentage of income* dedicated to health insurance at various income levels, capped at 8% of income
  - The delay until 2015 is a prudent approach intended to allow MA to learn from the federal implementation process and approach

Key Question: What Should Coverage Standards Be?

- Health Connector staff recommends modest adjustments to the MCC regulations
  - Retention of MCC ensures maintenance of high quality coverage in Massachusetts and consumer protections regardless of market in which coverage is acquired
  - With additional market experience and enactment of the ACA, seeking a balance between protecting consumers and providing adequate choice of coverage
- The recommended amendments to the MCC regulations fall into four main categories
  - Maximum Out of Pockets (MOOPs)
  - Deductibles
  - Catastrophic Health Plans
  - Other "Clean Up"

Key Question: What Should Coverage Standards Be? (cont'd)

- The ACA imposes MOOP limits on the non and small group (fully insured) markets
  - MOOP limits are tied to Internal Revenue Code limits in effect in 2014 for HDHPs
    - These amounts have not yet been released, but for reference the 2013 limits were $6,250 (ind) and $12,500 (fam)
  - These limits are then indexed by average national premium growth on an annual basis
- The ACA and the Notice of Proposed Rule Making (NPRM) on Essential Health Benefits, Actuarial Value and Accreditation suggest a more expansive definition of what cost-sharing must count toward the MOOP
  - According to the NPRM, all cost-sharing for Essential Health Benefits must accumulate toward the MOOP

Key Question: What Should Coverage Standards Be? (cont'd)

- Health Connector staff recommends modifying the existing Maximum Out-of-Pocket (MOOP) limitations of $5,000 (ind) and $10,000 (fam) in MCC regulations*
  - This would mean the base amounts for allowable MOOPs would increase in 2014 (to an amount in effect under the IRC)
  - In years after 2014, the MOOPs would also increase, using the federal indexing approach
- Health Connector staff recommends modifying the existing language in the MCC regulations describing what must count toward the MOOP
  - MCC regulations currently indicate that only deductibles, co-insurance and co-payments over $100 for *medical* expenses must count toward the MOOP
  - There is express language in the regulations indicating cost-sharing for prescription drugs need not count towards the MOOP
  - The new approach would require all cost-sharing for Essential Health Benefits to count toward the MOOP

*Under current MCC regulations, federally qualified High Deductible Health Plans (HDHPs) that meet certain provisions of the MCC regulation (*e.g.*, provide a broad range of medical benefits) may include MOOPs greater than the $5,000 (ind) and $10,000 (fam) and be considered MCC-compliant.

Key Question: What Should Coverage Standards Be? (cont'd)

- The ACA imposes deductible limits of $2,000 (ind) and $4,000 (fam) on the non- and small-group (fully insured) markets
  - These limits are inclusive of the medical deductible and any prescription drug (Rx) deductible (if applicable)
  - These limits are then indexed by average national premium growth on an annual basis
- Health Connector staff recommends adopting the federal approach
  - MCC regulations currently allow medical deductibles of no more than $2,000 (ind) and $4,000 (fam) as well as Rx deductibles of no more than $250 (ind) and $500 (fam)
    - Staff propose modifications to the current regulations such that the current Rx and medical deductible limits are indexed to average national premium growth, but that the combined total of these may not exceed the $2,000 (ind) and $4,000 (fam) limits
    - With the proposed amendment, an individual plan with a combined deductible of $2,250 would no longer meet MCC requirements
  - This approach maintains medical and Rx deductible limits, but provides flexibility in response to evolving market preferences for higher deductible plans

Key Question: What Should Coverage Standards Be? (cont'd)

- The ACA introduces a plan called a Catastrophic Health Plan available exclusively through the Exchange to a restricted population of eligible non-group purchasers
  - Must be 30 years or under, or
  - Must not have affordable insurance available
- The plan design for a Catastrophic Health Plan is statutorily described as:
  - Including coverage for essential health benefits
  - Providing no coverage for benefits until the enrollee has incurred cost-sharing expenses equal to the MOOPs in place per the IRC for High Deductible Health Plans, with the exception of coverage for three primary care visits

Key Question: What Should Coverage Standards Be? (cont'd)

- The Health Connector staff recommends that these "Catastrophic Health Plans" replace Young Adult Plans (YAPs) as a type of insurance coverage that is deemed to meet state MCC regulations
  - Health Connector needs to phase out YAPs to comply with new metallic tiers
  - Uncertain as to if the plan design required of the Catastrophic Health Plan would align with the types of High Deductible Health Plans (HDHPs) that otherwise meet MCC regulations
    - Expressly including this in the regulations ensures those who opt to purchase this type of plan meet the state mandate requirement

Key Question: What Should Coverage Standards Be? (cont'd)

- Since the MCC requirements were phased in over time, there are several components of the regulations which are no longer applicable
- Staff recommends deleting these sections of the regulations; these include, for example:
  - 956 CMR 5.03(1): "For the period beginning on July 1, 2007 and ending on December 31, 2008, the following shall be deemed to provide minimum creditable coverage…"
  - 956 CMR 5.03(2)a(1): "Effective January 1, 2009, "a broad range of medical benefits" shall include, at a minimum, coverage for…"
  - 956 CMR 5.03(2)k(1): "For calendar year 2009 only, a health benefit plan is a high deductible health plan ("HDHP") that complies with federal statutory and regulatory requirements for HDHPs under 26 U.S.C. § 223 (*i.e.*, HSA-compatible)..."

Key Question: What Should Coverage Standards Be? (cont'd)

- Health Connector staff recommend retaining language in the MCC regulations providing the Health Connector discretion to determine a plan MCC-compliant, even if it does not meet every element of the regulations (*i.e.*, the MCC Certification Process)
- This provides flexibility for those plans that meet the spirit of the regulations but may not be directly impacted by ACA insurance reforms or other state regulatory provisions

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Outstanding Issues

- In addition to resolving how the state should move forward with respect to meshing the major components of the mandate with the federal approach, there are several other open issues that also must be considered as part of the enforcement process
- Among others, these include:
  - Children: the federal mandate and penalty applies to adults and dependents (children), while the state mandate and penalty applies to adults ages 18 and older
  - Exemptions: the categories for allowable exemptions differ
    - Federal allows one 3-month gap; state allows multiple 3-month gaps
    - Federal allows religious objection "as per Medicare definition"; state has an attestation that is void if medical services are used
- **We recommend maintenance of our current approach on these issues for the purposes of enforcing the state individual mandate**

Outstanding Issues (cont'd)

- Among others, these include (cont'd):
  - Filing status: may differ in federal and state returns (*e.g.*, same sex couples)
  - Actual federal penalty paid: the state (DOR) will not be able to verify that a penalty is actually paid, but rather, at most, only if/for what federal penalty an individual is liable
  - Details regarding the federal appeals process
  - Details regarding the role of the Exchange in providing federal exemptions

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