MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

MA Association of Health Plans Analysis Comparing Key ACA and AHCA Provisions with Current State Law

Commercial			
Issue	**ACA**	**House AHCA**	**Current State Provisions & Potential MA Impact**
Cost Sharing Subsidies	• Provides CSRs to individuals up to 250% FPL who purchase a silver-tier product on Exchange.	• Repeals CSRs at end of 2019. No federal appropriation for CSR payments for 2017 or 2017. • CSR lawsuit pending in federal court.	• Elimination of CSRs would make coverage for low-income individuals more expensive and affect approximately 150,000 current ConnectorCare enrollees. • An estimated $63M at risk for remainder of CY17 (May onward), $125M for CY 18.
Premium Tax Credits	• Provides income-based tax credits to individuals up to 400% FPL who purchase coverage through an Exchange.	• Repeals income-based tax credits at end of 2019 and replaces with age-based tax credits in 2020: ○ $2000-$4000 annually for incomes up to $75,000, household cap of $14,000, limited to citizens w/o access to ESI or government programs. • Instructs the Senate to provide enhanced tax credits ($75-85 billion) to individuals aged 50-64.	• In 2016, 258,000 state residents benefitted from a total of $360 million APTCs, at an average monthly credit of $190 per member per month. • Repeal of premium tax credits would make coverage for low- and moderate-income individuals more expensive.
Pre-existing Conditions	• Requires insurers to cover individuals regardless of pre-existing medical conditions and prohibits utilizing health status to establish premium rates.	• Allows state to apply for a waiver to end community rating in the individual market and vary premiums based on an individual's health status or claims history for those individuals who do not maintain continuous coverage. • Adds $8 billion in funding over 5 years to fund state high-risk pools.	• Massachusetts statute maintains pre-existing conditions protections (guaranteed issue) which prohibit individuals with pre-existing conditions from being denied coverage or from charging a higher premium based on medical expenses.

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Essential Health Benefits	• Requires insurers to cover ten categories of comprehensive benefits; Prohibition on annual and lifetime limits.	• States may apply for waiver of EHB rules for the individual and small group markets beginning with the 2020 plan year. HHS Secretary has 60 days to deny, or deemed approved.	• Massachusetts state law prohibits annual or lifetime limits. • Massachusetts statutes requires specific coverage for more than 45 mandated benefits. • Minimum creditable coverage regulations established by the Connector require coverage of a certain level of benefits for individuals to comply with the individual mandate.
Individual Mandate	• Requires individuals who can afford it to obtain health insurance.	• Eliminates individual mandate by reducing penalties to zero beginning in 2016. • Establishes continuous coverage requirement - Carriers to impose a 30% premium penalty on individuals with a coverage gap of more than 63 days in a 12-month look-back pried.	• Massachusetts statute maintains individual mandate and associated penalties.
Premium Rating	• States may utilize an age rating band of 3:1. • Prohibits plans from using rating factors beyond age, geographic region, and family size.	• Allows state flexibility to expand age rating band to 5:1. • Allows states to apply for a waiver to end community rating in the individual market and vary premiums based on an individual's health status or claims history for those individuals who do not maintain continuous coverage.	• Massachusetts statutes specify allowable rating factors, including an age rating band of 2:1 (c. 176J, section 3). • Massachusetts is presently required to phase-out existing state rating factors including industry participation rate, group size. • Unclear whether MA could continue to utilize MA-specific factors.

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Dependent Coverage	• Coverage for dependents until age 26.	• Coverage for dependents until age 26.	• Massachusetts statutes also require coverage for dependents until age 26 (c. 175, section 108).
ACA Taxes	Established taxes, including: • HIT tax on insurers • Cadillac tax • medical device tax • OTC meds	Repeals taxes at end of 2017, including: • HIT tax on insurers • medical device tax • OTC meds. • Postpones implementation of the Cadillac tax to 2026.	• Elimination of over $600B in taxes to the federal government over 10 years.
HSAs	• In 2017, individuals can put $3400 ($6750 family) into a tax-free HSA.	• Expand HSAs- reduces penalties for non-eligible expenses and raises the basic limit on HSA contributions to equal the maximum on the sum of the annual deductible and out-of-pocket expenses under a HDHP. • Allows OTC medications as qualified medical expenses.	• Chapter 176G, Section 16A permits an HMO to include a maximum deductible consistent with the maximum contribution allowed for a federally-established HSA. • A HDHP meets MCC if the carrier facilitates access to a HSA administrator or the plan sponsor maintains a HRA.
Self-Insured Coverage	• Rating factors do not apply to self-insured business. • EHBs do not apply to self-insured business, except where a category is covered, lifetime and annual limits are prohibited. MOOP applies. • Coverage of preventative services without cost-sharing is required.	• Community rating waivers only apply to the individual market. • If a state waives EHB coverage, lifetime and annual limits do not apply to those benefits and the benefits are not included in the MOOP. • Coverage of preventative services without cost-sharing is required.	• Self-insured plans can continue to develop rates as they've done. • MCC standards would remain in place and MA residents would still be required to meet MCC to comply with the individual mandate.

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Employer Mandate	• Requires employers with 50 or more full-time equivalent employees to provide health insurance.	• Repeals employer mandate.	• No employer mandate in current state statute, but the Governor's FY18 budget included an employer assessment of $2,000 per FTE for those employers with 11 or more FTEs working 35 hours per week; employer must cover 60% of the premium cost for 80% of FTEs • The House FY18 budget includes the assessment, but requires the Administration to hold a public hearing to solicit public comment and file a small business impact statement. The House proposal also includes a sunset to the assessment in 2020 and would allow the Commissioner of Revenue to create an employer hardship waiver.
Federal Grants to States	• ACA allows for CSRs.	• Establishes a Patient and State Stability Fund to grant $100 billion over ten years (2018-2026); state match phase-in beginning in 2020. • May be used for financial assistance to high-risk individuals, incentives for entities to enter into arrangements with state to stabilize premiums, reductions in the cost of providing insurance for high-utilizers, promotion of participation in the market, promotion of access to preventive services, dental services, MH and SUD services, payments to providers, or cost-sharing assistance.	

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Medicaid			
Issue	**ACA**	**House AHCA**	**Current State Provisions & Potential MA Impact**
Enhanced Federal Medical Assistance Percentage (FMAP)	• Allows states to expand Medicaid up to 133% FPL and provides enhanced FMAP	• Eliminates mandatory requirement for states to expand Medicaid up to 133% FPL and sunsets optional expansion effective Dec 31, 2017. • States will receive enhanced matching rate under current law for individuals who remain eligible and continuously enrolled in the program	• Loss of enhanced FMAP for expansion population that drops on/off Medicaid.
Medicaid Funding	• Current 1115 Waiver secures $52.5 billion of expenditures over 5 years and generates $29.2 billion of federal revenue for the state over that time frame, including $8B to support: ○ $1.8B DSRIP for ACO redesign ○ $4.8B for uncompensated care by safety net providers ○ $1.3B for subsidies for consumers on the Connector	• Transitions federal Medicaid funding to a per-capita allotment payment system by 2020 with FY2016 as the base year for setting targeted spending for each enrollee category in FY2019 and subsequent years. • • Each state's targeted spending amount would increase by the percentage increase in the medical are component of the consumer price index for all urban consumers from September, 2019 to September of the next fiscal year. • Beginning FY2020, any state with spending higher than their specified target aggregate amount would receive 25% reductions to their Medicaid funding the following year. • States also have the option of a block grant.	• By FY22, an additional $425MM-$475MM per year of reduced federal revenue in potential elimination of 1115 payments not captured under the per capita targets, including matching funds for a state run ConnectorCare wrap subsidy. • Loss of $1B in federal revenue in 2020 • $1.3B less in 2021 • $1.5B less in 2022