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The House Bill to Repeal and Replace the ACA and What it May Mean for MassHealth and ConnectorCare

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After years of inveighing against ObamaCare, last week the House Republicans released the "American Health Care Act" and seem intent on pushing it through the House with no hearings and little opportunity for debate. This week we should learn the Congressional Budget Office "score" of just how many are expected to lose coverage and whether the many tax cuts for corporations and the wealthy will be offset by the provisions for defunding Medicaid for the poor. From a preliminary review, it is clear the bill will not be good for Massachusetts. Summarized below are some of the most worrisome features affecting MassHealth and ConnectorCare. Citations are to sections in the Energy and Commerce bill (E & C) primarily concerning Medicaid and the Ways and Means bill (W & M) primarily concerning, the individual market and premium tax credits.

Medicaid and CHIP

Reducing & fundamentally changing federal reimbursement for state Medicaid spending:

E & C § 121. In 2020 federal reimbursement for most Medicaid spending will be capped through a Per Capita Allotment that is likely to cost Massachusetts billions in lost federal revenue over time. This is a fundamental change in the basic structure of Medicaid which since its enactment has promised the states federal matching funds for all eligible spending.

Massachusetts will lose more federal revenue over time as capped allotments based on 2016 spending adjusted for medical inflation will not keep pace with higher needs of an aging population or other changes that increase utilization or costs of services. In addition, it appears that the allotment will not include certain 1115 Demonstration funding in the base spending that determines available federal reimbursement. In Massachusetts, this will likely mean no added federal matching funds for the recently approved Delivery System Reform Incentive Program to transform payment and delivery of care in MassHealth, for supplemental state spending to keep ConnectorCare affordable, and for other purposes.

E & C § 112. Massachusetts' enhanced matching rate for the Medicaid expansion adults will be frozen at the 2017 rate of 86% instead of growing to 90% as provided for in the ACA. In 2020, state spending on newly enrolled adults under the Medicaid expansion and those adults enrolled in Dec 2019 who experience a break in coverage of 30 days or more will no longer qualify for an enhanced match. In MassHealth, this means a drop from 86% to 50% federal matching funds. To help along breaks in coverage for the grandfathered group of Dec. 2019 enrollees, States will be required to redetermine eligibility for the expansion adults every 6 months. Historically, 30% of MassHealth beneficiaries lose eligibility at redetermination but most supply missing documents and requalify within a few months.

Adding procedural barriers for establishing and maintaining Medicaid eligibility:

E & C § 114(c). The bill changes current law to no longer allow US citizens and eligible immigrants a reasonable opportunity in which to prove their citizenship or status. This delays Medicaid enrollment until documents are requested, submitted and processed by the state Medicaid agency.

E & C § 116. As discussed above, the bill requires redetermination every 6 months for Medicaid expansion adults instead of the current annual review requirement starting Oct. 1, 2017.

Rolling back minimum Medicaid eligibility for children:

E & C § 111. The bill reduces the minimum required Medicaid income eligibility levels for children age 6-19 from 133% to 100% of the poverty level. Prior to the ACA, MassHealth already covered children with income over the poverty level, but 22 other states did not.

Making Medicaid less accessible to the elderly poor:

E & C § 114(b). The bill repeals 3 month retroactive eligibility that now enables the elderly to cover medical debts incurred in the months prior to completion of a Medicaid application. The bill limits enrollment to the 1st of the month in which someone is found eligible which would even roll back the 10 day retroactive eligibility which is all that MassHealth covers for the non-elderly poor under the terms of its 1115 waiver.

E & C §114(d). The bill repeals the current state option to use a higher home equity limit in determining eligibility for Medicaid long term care effective 6 months after enactment. This will disqualify seniors needing long term care because of the value of their homes and take away flexibility that MassHealth now uses to set limits that reflect Massachusetts' high real estate prices.

E & C § 111. The bill repeals the 6-percentage bonus in federal matching rate for programs designed to keep people out of nursing homes.[1]

Restricting access to reproductive services for poor women:

E & C §103. The bill designates organizations like Planned Parenthood "prohibited entities" and freezes their federal funding from Medicaid, CHIP and other sources.

Decreasing state flexibility and innovation:

All of the above

[1] In FY 2017 MassHealth reported to the legislature that it had retained a consultant regarding opportunities for enhanced FMAP under this provision of the ACA.

A**uthorizing states to restrict services:**

E & C § 112(c). The bill repeals the requirement that Medicaid coverage for expansion adults cover certain Essential Health Benefits giving states "flexibility" to cover fewer services.

Private insurance in the individual market

Making ConnectorCare less affordable for older and poorer adults:

W & M § 02. In 2018 and 2019 the bill changes the ACA's schedule for determining what percentage of income eligible taxpayers contribute to insurance before qualifying for a premium tax credit. The Bill's schedule charges a lower percentage of income for younger adults and a higher percentage for older adults than the current ACA schedule. Because health plans are allowed to charge higher rates based on age, older adults have higher premiums. The higher percentage of income will reduce the amount the federal premium tax credit pays for older adults and increase the amount of added state subsidies required to keep ConnectorCare affordable for older adults.

E & C § 131. The bill repeals cost sharing reduction subsidies after 2019. These are the subsidies that now help Massachusetts to make ConnectorCare affordable for people with income no higher than three times the poverty level. In ConnectorCare, cost sharing subsidies paid directly to the health plans make it possible for plans to have no deductibles or coinsurance, and for ConnectorCare copayment schedules to start low and go up by income. Currently, Massachusetts combines the federal cost sharing subsidy with added state subsidies which are eligible for a 50% match under the 1115 demonstration. The Republican bill repeals the federal cost sharing subsidy and, under the 2020 provision for capped Medicaid payments, will no longer provide any added federal reimbursement towards the added state premium assistance and cost sharing subsidy for ConnectorCare.

W & M § 15. After 2019, the bill changes the premium tax credit to a flat amount that varies by age not by income, except that it begins to phase out for individuals with income over $75,000 per year. Under the ACA, subsidies end at 4 times the poverty level, about $47,500 per year. The flat rate contributes up to $2000 toward annual premium costs for individual younger than 30 and $4000 for individuals over age 59. Under the flat rate, younger people qualify for higher tax credits than under the ACA and tax credits are extended to higher income people. However, older lower income enrollees qualify for a smaller federal tax credit than under the ACA. This will be true in Massachusetts too, but to a lesser extent because of the unique features of ConnectorCare and the relatively low cost of the Connector's benchmark plans used to determine the amount of the tax credit under the ACA.

Making insurance less affordable for legal immigrants:

W & M §15. The bill changes current law to no longer allow lawfully present non-citizens to be eligible for premium tax credits after 2019 unless they are "Qualified" as defined in a 1996 federal law. This will exclude many categories of legal immigrants including asylum applicants

with work authorization, U-visa holders, people granted Temporary Protected Status (TPS), & people granted withholding of removal under the Convention Against Torture among others.

Adding penalties for gaps in coverage:

E & C § 133. Beginning with special enrollment in 2018, the bill provides that after enrollment in the individual or small group market, there will be 12-month lookback period, and a 30% surcharge will be added to the cost of insurance if a person fails to certify that he or she did not experience a gap in coverage of more than 63 days. There is no minimum income threshold for this surcharge and no hardship exemptions as there are for the ACA's current individual mandate tax penalties which the surcharge replaces. Also unlike the ACA, the penalty is not pro-rated for the months a person was uninsured.

Increasing tax burdens for families under 4 times the poverty level:

W& M §01. The bill eliminates the income-based caps on repayment of excess premium tax credits starting with tax year 2018. Currently, premium tax credits can be paid in advance directly to the health plan to reduce monthly premium costs for the consumer. The actual amount of tax credit someone is due is not calculated until the next year when he or she files taxes. Currently, for taxpayers with income less than 4 times the poverty level, there is an income-based cap on the amount that the taxpayer is responsible to repay if there was a mistake in the amount of his or her advance tax credit.

For questions or comments about this summary, please contact Vicky Pulos, vpulos@mlri.org