MLRI MASSACHUSETTS LAW REFORM INSTITUTE
99 CHAUNCY STREET
SUITE 500
BOSTON, MA 02111
617.357.0700 PHONE
617.357.0777 FAX
WWW.MLRI.ORG

Understanding the Affordable Care Act:

Six Ways It Will Affect Low Income People in Massachusetts in 2014

May 1, 2013

The Affordable Care Act (ACA) was enacted in 2010. While some of its provisions have already taken effect, many of its most important provisions for low income people will not take effect until January 2014. In contrast to states still debating whether to participate in the expansion of the Medicaid program, Massachusetts has been committed to implementing the ACA since its enactment. Multiple state agencies formed an ACA Task Force, led by the Executive Office of Health and Human Services (EOHHS), and have been intensively preparing for 2014 for the last three years.

It has always been clear that Massachusetts would expand its Medicaid program and the Commonwealth Connector Authority would function as its Exchange. In 2012, the legislature passed the first authorizing legislation related to the ACA. Among other things, the legislature authorized the state to implement the Basic Health Plan (BHP) option and to supplement federal subsidies for those up to 300 % of poverty. The BHP option enables states to use federal funds to create a subsidized coverage program for individuals not eligible for Medicaid with income up to twice the poverty level. Unfortunately, federal regulators later made clear that guidance to states on the BHP option will not be released in time for implementation in 2014. Without the BHP in 2014, the Task Force instead proposed supplementing federal subsidies for those under 200 % of poverty who would have been eligible for the BHP as well as those up to 300 % of poverty. Funding for the Medicaid expansion and state supplement were included in the Governor's budget proposal for FY 2014, and in the House budget. The Senate has not yet released its budget. A separate ACA implementation bill from the Governor was just filed on May 3, 2013.

This summary is based on legislation and the recommendations of the ACA Task Force to date including proposed amendments to the 1115 demonstration proposal just released on May 1. The bottom line is that in 2014 tens of thousands of low income uninsured individuals will be newly eligible for subsidized coverage, and hundreds of thousands will experience a change for the better in the type of subsidized coverage they receive. But for thousands more, the delay in the Basic Health Plan option puts them at risk of being worse off in 2014 unless the Administration's recommendations for additional state-funded assistance is enacted and carefully implemented. Further ACA related changes will create a new managed care option for 100,000 individuals with disabilities with both Medicare and Medicaid, who will gain access to a new integrated delivery system starting as soon as the summer of 2013. Also, for over a million people, eligibility and enrollment systems will be changing; promising a simple, streamlined system for obtaining and maintaining health coverage. However, as with all complex reforms promising improvements, the devil is in the details.

1. Low income adults with income up to 133% of the poverty level will be eligible for a new kind of Medicaid coverage to be called MassHealth CarePlus.

In 2014, about 325,000 adults under age 65 with income up to 133 % of the federal poverty level (FPL) who are not otherwise eligible for MassHealth Standard or CommonHealth will be eligible to

receive a new kind of Medicaid coverage. This will change coverage for many people now covered under the 1115 demonstration as described below, and make some people newly eligible for subsidized coverage. It will not change coverage for pregnant women, families with children, and individuals with disabilities in MassHealth Standard, children in Family Assistance, or individuals with disabilities in CommonHealth. Nor will coverage change for the elderly.

This new Medicaid coverage eliminates the role for some types of MassHealth under the state's 1115 demonstration waiver that had income limits lower than 133 % FPL such as MassHealth Basic and MassHealth Essential. It will shift some people into MassHealth —those with income under 133% of poverty—who have been enrolled in other programs under the demonstration like Commonwealth Care, the Medical Security Program or the Insurance Partnership. Because the new Medicaid group will not have the restrictive eligibility rules of the expansion programs under the state's 1115 demonstration waiver regarding employment, college attendance or access to other forms of insurance, more people will qualify for subsidized coverage.

Some individuals in the new Medicaid coverage group will receive MassHealth Standard benefits including 19 and 20 year olds, individuals with breast or cervical cancer, individuals eligible for services from the Dept. of Mental Health and certain other exempt groups.[1] A separate provision of the ACA will extend MassHealth Standard to former foster children up to age 26.

All others in the new Medicaid group will receive a new kind of coverage to be called MassHealth CarePlus. Like MassHealth Standard, there will be no premium for CarePlus and copayments will be nominal. Under the ACA, CarePlus benefits must be based on one of several benchmark commercial plans or be approved by the Secretary after comparison with a benchmark plan. The Task Force has recommended a scope of benefits at least as generous as Commonwealth Care Plan Type 1 (CCPT 1) plus Medicaid-required non-emergency transportation. This scope of coverage will mean added services not now available in MassHealth Essential and Basic such as home health, short-term rehabilitation facility and skilled nursing home care.

Key decision: *Selecting one or more benefit benchmarks for the new Medicaid group and contracting for the new coverage.* The state has not yet disclosed selection of a benchmark; some choices would enable the state to further expand benefits in CarePlus to include benefits not now available in Medicaid. The Governor's budget for FY 2014 proposed a January 2014 restoration of adult dental in MassHealth, including CarePlus, but the final budget is several months away. The House budget proposed a more limited restoration of only dental fillings. A recent notice on the state procurement website, indicates that as early as May 2013 EOHHS is planning a separate procurement for CarePlus managed care plans but was not clear whether managed care choices would be equivalent to those available in other kinds of MassHealth.

Bottom line: About 80,000 adults not now in subsidized coverage will be newly eligible for MassHealth CarePlus. This includes individuals only receiving Health Safety Net benefits now, individuals eligible for Commonwealth Care but not enrolled, as well as low-income adults not

[1] The Task force recommended MassHealth Standard for 19 and 20 year olds up to 150% of poverty to correspond to the existing income standard for those under 19.

now eligible for Commonwealth Care because they have access to employer-sponsored insurance or student health insurance. In addition, over 240,000 individuals enrolled in existing subsidized coverage will switch to MassHealth CarePlus with more benefits and/or lower copayments than they have now. An added advantage is that the state will receive enhanced federal matching funds to provide coverage to adults in the new benchmark group. The only potential negative would be if the state provides fewer managed care choices than under existing programs.

For more information, see the MLRI paper called, "Understanding the Affordable Care Act: Changes expected in Massachusetts' subsidized health program in 2014."

2. Adults not eligible for Medicaid based on income or having a lawful but not Medicaid-qualified immigration status will have access to new, but very different, forms of affordable coverage.

In 2014, individuals not otherwise eligible for Medicaid, Medicare, affordable employer-sponsored insurance, or other "minimum essential coverage" with income up to 400% FPL will be eligible for **federal premium tax credits** to reduce the premium cost of private insurance meeting certain minimum standards called **Qualified Health Plans (QHPs)** purchased through a health care marketplace called an **Exchange**. Eligible individuals include lawfully present immigrants who do not meet the more restrictive rules for immigrants to qualify for Medicaid. Enrollment will be limited to annual **open enrollment** periods or 60 days after a "triggering event" like the loss of employer coverage.

Individuals with income up to 250% of poverty will also be eligible for **cost-sharing reduction subsidies** to enable them to obtain coverage with lower deductibles, copays or co-insurance. The advance tax credits and cost sharing reduction will be determined at the time of application and paid directly to the health plan in which the individual is enrolled. However, advance tax credits are subject to **reconciliation.** When an individual later files a tax return for the year, the amount of premium tax credits due will be reconciled with the amount advanced. The amount of any excess credit will be subject to repayment up to a capped amount based on income. (There is no reconciliation for cost-sharing subsidies).

The legislature has designated the Health Insurance Connector Authority to operate the state Exchange. The scope of coverage in QHPs in 2014-2015 must be substantially equivalent to the benefits in the largest small group insurance plan in the state, Blue Cross Blue Shield HMO Blue, and pediatric dental care benefits will also be available. The permissible cost-sharing is regulated by the ACA which identifies different tiers of coverage with more cost-sharing in Bronze tier plans than in Silver, Gold or Platinum tier plans. For those under 250% FPL, the cost-sharing reduction subsidies further reduce cost-sharing but only in Silver tier plans.

However, even with federally funded assistance, premiums and cost-sharing will be substantially higher than the existing costs of Commonwealth Care. See, Figure 1 and 2. Therefore, the state is recommending **supplemental state funded assistance** (sometimes called a **"state wrap"**) for those under 300% FPL in order to bring premiums and cost sharing to Commonwealth Care levels while still taking advantage of federal funding of tax credits and cost sharing subsidies. Ideally, individuals

shopping for coverage would see options that look like Commonwealth Care with the different levels and kinds of credits and subsidies functioning behind the scenes.

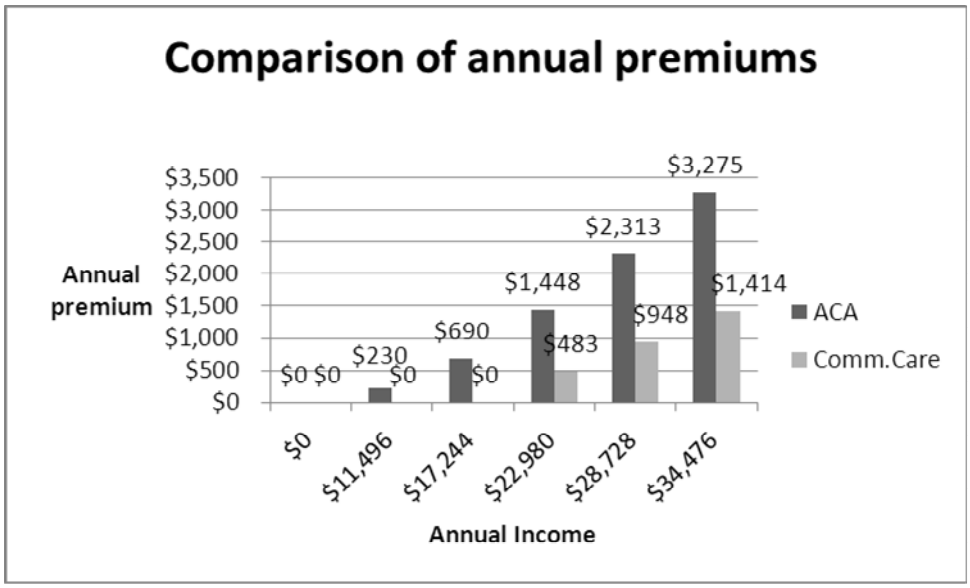
The rules regarding premium nonpayment are also harsher than in Commonwealth Care. The ACA provides for a 3-month grace period before termination for nonpayment of premiums, but QHPs may terminate coverage retroactively to the end of the first month for which a premium was not paid unless all premiums due are paid before the 3-month grace period ends. There is no provision for payment plans beyond the grace period or for hardship waivers as there is in Commonwealth Care.

Key decisions: *Which existing subsidized programs for adults with income over 133% of poverty should be retained and which reconfigured to take advantage of premium tax credits*; *how will the state wrap be funded and operated, which wrap plans will be available through the Connector, and how will the transition to new coverage be managed*. The Task Force is recommending that Massachusetts retain MassHealth coverage for certain small groups of individuals with special health care needs including: MassHealth Standard for pregnant women up to 200% FPL and individuals with breast or cervical cancer up to 250% FPL, CommonHealth for individuals with disabilities, and Family Assistance for individuals who are HIV positive with income up to 200% FPL. It is proposing to eliminate Commonwealth Care, the Medical Security Program, and the Insurance Partnership. However, the state will take advantage of options under the ACA to continue providing benefits that will be comparable to Commonwealth Care at reduced state cost. The legislature has already authorized the state to move ahead with state-funded supplemental assistance, and some federal matching funds may be available for the wrap. The House included wrap funding in its FY 2014 budget bill; Senate action will come in May. The Connector will be soliciting plans to offer benefits through its "seal of approval" process for 2014. Further legislation and state appropriations will also be needed to implement the state wrap in 2013. The state is also planning a premium assistance pilot program to replace the Insurance Partnership for some employees of small employers with access to employer-sponsored insurance that is affordable enough to disqualify them from eligibility for tax credits but not affordable under state standards. The Task Force also recommends retaining state-funded MassHealth programs for certain "aliens with special status" who are ineligible for Medicaid or the Exchange. Finally, the state must decide whether to provide additional premium assistance in hardship situations, and how to manage the transition from existing coverage to QHPs with tax credits and subsidies. Many of these changes will require amending state laws and regulations and the 1115 demonstration waiver in 2013.

Bottom line: With state-funded assistance (the state wrap), about 120,000 individuals now eligible for Commonwealth Care and the Medical Security Program should be able to retain coverage as affordable as what they have now at reduced state cost. Without the wrap, these individuals would be worse off under the ACA. See Figure 1 and 2. In addition, almost 30,000 individuals in the Health Safety Net will be newly eligible for subsidized coverage. However, in 2014, individuals formerly eligible for Commonwealth Care and the Medical Security Program will face new challenges such as only being able to enroll during limited periods, being subject to repay advance premium tax credits if the income on their tax return turns out to be more than they expected, and facing less flexible policies if they fall behind on premiums. Also, so far, there are no plans to replace the feature of the Medical Security Program that provided subsidies for the cost of COBRA continuation coverage. It also appears that those in existing programs will have to reapply

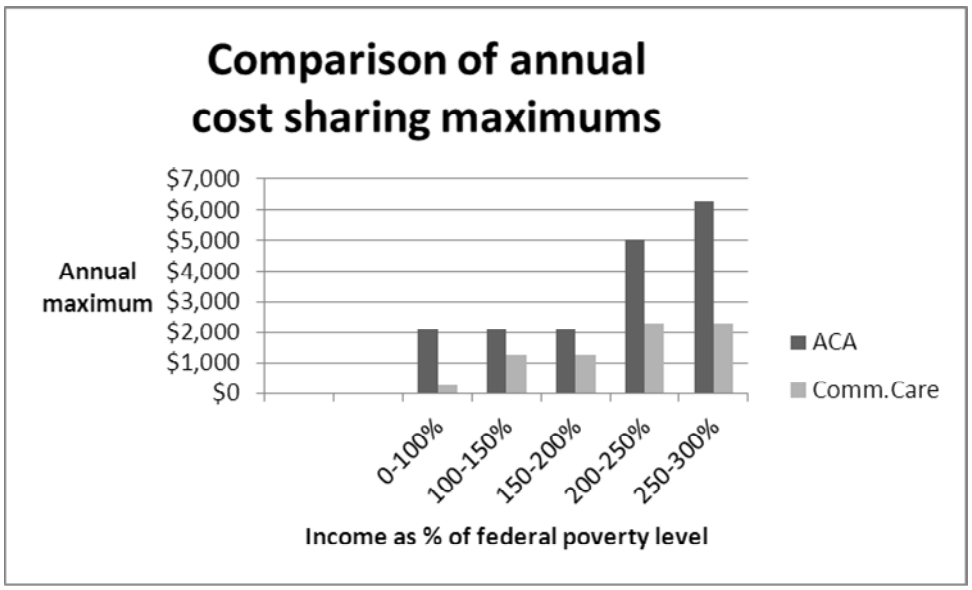
for subsidized coverage after October 2013 in order to continue coverage without interruption in 2014. Outreach and education will be important to a successful transition.

Figure 1 Comparison of annual premium contributions for an individual in Commonwealth Care & with federal premium tax credits under the ACA (based on 2013 federal poverty guidelines)



Source: Connector 2013 Affordability Schedule and § 1401 of ACA

Figure 2. Comparison of maximum out of pocket cost sharing for an individual in Commonwealth Care in 2013 with cost-sharing reduction federal subsidies under the ACA in 2014



Source: Commonwealth Care Benefits, Plan Types 1-3 (2013); HHS Notice of Benefit and Payment Parameters, 78 Fed. Reg. 15410, 15483, Table 21 (March 11, 2013).

3. Individuals should be able to apply for all new and existing coverage through a simple, stream-lined new system that replaces the Virtual Gateway

The ACA will change the way people apply for assistance, how long before benefits begin, how eligibility is verified, what notices look like and where appeals are filed. It requires coordinated eligibility and enrollment among all insurance affordability programs including MassHealth programs and premium tax credits and cost-sharing reduction subsidies. New systems must be in place by October 2013 to allow for enrollment effective January 2014 and will replace the Virtual Gateway. Individuals must be able to apply for all programs through one common application in multiple ways: on-line, by telephone, by mail or in-person. Applicants will be able to set up their own on-line accounts to apply for and manage their benefits.

Massachusetts is developing a new common application on-line and on paper for use starting in October 2013 that will be used in conjunction with a single, integrated process to determine eligibility for the full range of health coverage programs. With federal financial support, Massachusetts is developing a new web-based platform for eligibility determination and enrollment, known as the **Health Insurance Exchange/Integrated Eligibility System (HIX/IES).**

By 2014, the goal of HIX is to allow consumers to shop for health insurance, apply for financial assistance and enroll in private and public plans in real-time. The IES will determine eligibility for the Medicaid and CHIP programs -either directly or by 'talking' to MassHealth's existing eligibility system, MA21. It will also determine tax credit eligibility for employers and employees shopping for private health insurance through the Exchange, and more. In the future, the HIX/IES system will expand to allow consumers to apply for other public assistance programs such as SNAP and TANF.

In order to allow for real-time eligibility determination, the new system will be able to verify more information electronically. The state will be verifying information on the application through a new federal data "hub" with federal sources such as the Internal Revenue Service, Social Security and the Department of Homeland Security as well as state-based sources of data. If eligibility factors cannot be verified electronically, the ACA establishes a process for individuals to be enrolled and allowed additional time to supply missing information or resolve inconsistencies. The new system will be using newly designed notices. States will also have flexibility to determine how to coordinate appeals between Medicaid and the Exchange.

To minimize gaps in coverage and simplify enrollment for mixed families with family members in both MassHealth and QHPs, the Office of Medicaid is trying to align its rules with those of the Exchange. When there is no data match, it is proposing to enroll individuals based on self-attestation for up to 90 days while awaiting verification. It is also proposing to terminate Medicaid benefits at the end of the month to allow for enrollment in the Exchange on the first of the following month. To minimize "churning," it is also proposing to reinstate benefits retroactively to the date of termination if an annual renewal form is returned within 90 days of termination for failure to return the form.

Replacing the Virtual Gateway with HIX/IES will require retraining the many providers who now assist applicants with on-line applications. The ACA requires various kinds of consumer assistance including in-house call centers and customer service support and external "navigators" and certified application counselors. Currently, the Health Care for All Helpline has contracted with the state Medicaid agency to provide consumer assistance with grant funding from the ACA, and the Connector has just released a request for proposals for navigators to help people enroll through the Exchange.

Key decisions: *The state has already decided on an integrated eligibility approach, but faces a host of other implementation decisions*. For example, it has decided to use its own common application form rather than the federal form, but must design it and obtain approval from the federal agency. It must decide how to verify information including what data sources to use pre- and post-enrollment, and when to accept a data match as "reasonably compatible" with information on the application or when to ask for further verification. It must design comprehensible notices, and assure that all its communications are accessible to people with disabilities and people who are limited English proficient.

Bottom line: The new integrated eligibility system holds great promise for a simplified, stream-lined, consumer-friendly process that greatly improves on the status quo. However, even if there are no major design flaws, transition to a new system is likely to create considerable confusion in the short term. It will also require a steep learning curve for state officials and for advocates in the community, and that in turn may exacerbate the unreasonably long call wait times at the MassHealth Enrollment Centers.

4. Financial eligibility will be determined using a new methodology based on federal income tax definitions and concepts

The ACA will also require a change in the methodology used to determine income for new programs and for many people currently eligible for MassHealth. The new way of counting income is based on federal income tax treatment and is called the **Modified Adjusted Gross Income (MAGI)** methodology. The idea of using a tax-based method of counting income was to allow for a more streamlined process of determining eligibility for both Medicaid and the new tax-based insurance affordability programs. Using the same methodology also provides for a more seamless transition among programs as an individual's income changes.

The MAGI methodology will be used to determine financial eligibility for new premium tax credits, *and* for most people on MassHealth. States are not required to apply the new methodology to individuals who are eligible for Medicaid based on disability or being age 65 or older or for whom no income determination by the Medicaid agency is needed such as for SSI recipients. MAGI methodology will change both who is included in the household, and how to count the income of household members.

Medicaid determinations based on MAGI will differ from MAGI determinations applicable to premium tax credits through the Exchange in several ways. Medicaid will still use current monthly income while the Exchange will use expected annual income for the calendar year in which benefits are requested. Medicaid regulations have created household rules for non-tax-filers and

other exceptions to the basic Exchange rule of counting the taxpayer and tax dependants in the household. Also Medicaid will apply a standard disregard equal to 5 percentage point of the FPL for the applicable family size. This effectively raises the 133% FPL income standard for the new Medicaid eligibility group to 138% FPL.

Many common types of income now counted by MassHealth will no longer count under MAGI such as child support received and a child's earnings that are below the filing threshold. Under the household composition rules for non-filers, the Medicaid MAGI rules define a household the same way that current MassHealth rules do. However, tax filers and tax dependants may be in different households under MAGI than under current MassHealth rules. For some taxpayers, the difference in household size may be an advantage, but for others it may be a disadvantage.

> **Key decision**: *How to design a new eligibility system to use MAGI methodology and coordinate with the Exchange.* Medicaid is not required to use MAGI for the disabled, but the Task Force is proposing to use the 5% FPL income disregard and other aspects of MAGI for counting income of individuals with disabilities. Funding for this proposal was not included in the House budget; Senate action is expected in May. The Task Force is also recommending amendments to the 1115 demonstration to enable HIX/IES to make a determination for all those now in the MA-21 eligibility system in January 2014 without requiring a new application, and to continue to provide MassHealth for recipients of TAFDC and EAEDC based on DTA's determination of eligibility.
>
> **Bottom line:** MAGI methodology will be far more complex than the current MassHealth gross income rules. On the other hand, the way income is treated using the MAGI methodology seems to be a positive change for most people. Everyone will benefit from the new standard disregard of 5% of FPL. On the other hand, the change in the household composition rules is more likely to create winners and losers. For example, adult tax dependants who will now be included in the same household as a parent are likely to be worse off than if they were treated as a separate household in accordance with current MassHealth rules, but the parent with a larger household and the same income may be better off.

For more information, see the MLRI paper called, "Understanding the Affordable Care Act: How MassHealth will count income 2014."

5. Individuals with disabilities who have both MassHealth and Medicare will be passively enrolled into managed care plans integrating services under both programs, but with the right to opt-out.

The ACA created a new federal office to coordinate Medicare and Medicaid for individuals eligible for both programs (the dually eligible) including authorizing demonstrations to integrate Medicare and Medicaid services. Massachusetts has operated an integrated managed care program for dually eligible individuals age 65 or older called the Senior Care Options (SCO) program since 2002. It is now planning to offer Integrated Care Organizations (ICOs) to over 100,000 dually eligible individuals with disabilities age 21-64 starting as early as summer 2013. Unlike the SCO which is

entirely voluntary, the ICO program, after an initial voluntary enrollment period, is planning to automatically enroll all dually eligible individuals with disabilities subject to their right to affirmatively opt-out at any time.

The benefits covered by the ICOs will include all services now covered by MassHealth Standard and Medicare and additional services including full dental, enhanced behavioral services and supports, respite care, peer support, home modifications, personal care services for cueing and supervision and more. Each enrollee will have a care team who will help develop an individualized care plan. An independent coordinator will assist with long term services and supports. Until a plan is developed, existing services will remain in place. The state has already signed a Memorandum of Understanding with the federal agency, and has received bids from ICOs subject to each ICO completing a readiness review and signing a 3-way contract with both the state Medicaid agency and the federal Centers for Medicare and Medicaid Services.

The duals demonstration was developed with extensive participation by people with disabilities, advocates and providers over several years. An Implementation Council made up of stakeholders meets regularly to advise on the many remaining implementation issues including the adequacy of rates and provider networks and development of an external Ombudsman. Outreach and education to dually eligible individuals is also a key concern given the passive enrollment and opt-out feature.

> **Key decisions:** *Developing the demonstration has involved a host of decisions about enrollment, benefits, delivery systems, and monitoring.* State authorizing legislation and the memo of understanding with CMS were signed in 2012. The state recently released proposed regulations and advocates asked that more protections described in the various demonstration documents be set out in the regulations to ensure clarity and enforceability. The 3-way contracts with the ICOs, and a contract with an Ombudsman organization also remain to be completed.
>
> **Bottom line:** The ICO demonstration promises enhanced services, improved coordination and person-centered care for over 100,000 individuals with disabilities and complex care needs. However, there are fears that ICOs may have financial incentives to skimp on needed care that will be difficult to monitor or prevent. Further, without adequate outreach and education, passive enrollment may disrupt care for individuals who are not aware that their providers have changed. Continued vigilance during implementation will be important to the success of the demonstration.

6. The federal individual mandate will subject more low income people to potential tax penalties than the Massachusetts individual mandate.

While both the federal and state individual mandate protect individuals who cannot afford coverage from tax penalties, state law has a more realistic view of what is affordable to low income families. The federal mandate exempts those with income too low to be required to file a return ($9,750 for a single person under age 65 not claimed as a tax dependant for tax year 2012) while Massachusetts exempts individuals with income at or under 150 % of poverty ($16,764 for an individual in tax year 2012). The federal mandate does not penalize taxpayers who would have to

spend more than 8% of their income to purchase insurance. The Massachusetts' affordability protection is based on a sliding scale. Under the state mandate, individuals with income over 150% but not over 300% of poverty are not penalized if insurance would cost more than Commonwealth Care premiums, about 2.1% - 5% of income in tax year 2012. In 2016 when full penalties kick-in, people under 250% of poverty will face larger penalties under the federal mandate than under state law. Both mandates allow for individual hardship appeals.

The state set up an advisory group on the individual mandate that recommended retaining the state penalty but reducing the amount of the state penalty by any federal penalty assessed against the same taxpayer. The Connector has also amended its regulations on minimum creditable coverage and the 2013 Affordability Schedule to more closely align with the ACA in preparation for 2014. In 2013, the Connector Affordability Schedule for those under 300% of poverty will remain the same, but for those over 300% of poverty, affordability will be capped at 10% of income. In 2014, the cap will be 8 % of income.

Key decisions: *Whether to repeal or amend the Massachusetts individual mandate and whether and how to offer any financial relief to low-income taxpayers.* The Task Force has proposed retaining the individual mandate but providing limited relief to taxpayers by allowing any federal penalty amount to offset a state penalty. However, there has been no proposal to relieve low income taxpayers who are exempt from state penalties but may be subject to a federal penalty. Also, when the Connector moves to a percentage of income Affordability Schedule in 2014, it will have to decide whether to retain a progressive scale based on income or adopt the ACA's 8% of income standard.

Bottom line: More low income people will face tax penalties under the ACA than those who experienced penalties under state health reform, and the amount of ACA penalties are higher for people at the lower end of the income scale.

For more information:

Federal Website: www.healthcare.gov

State Website: www.mass.gov/nationalhealthreform

www.mass.gov/masshealth/duals

Send questions or comments regarding this paper to Vicky Pulos, vpulos@mlri.org, 617-357-0700 Ext. 318

For other MLRI papers related to Understanding the Affordable Care Act, visit the health section of www.masslegalservices.org