

COVERAGE OPTIONS FOR MASSACHUSETTS: LEVERAGING THE AFFORDABLE CARE ACT

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ABOUT MANATT HEALTH SOLUTIONS

Manatt Health Solutions (MHS) is the interdisciplinary health policy and business strategy advisory division of the law firm of Manatt, Phelps & Phillips, LLP. As an integrated law and consulting firm, Manatt offers a unique combination of legal, policy, and operational expertise drawn from a team of attorneys, policy advisors, business strategists, project managers, and financial analysts with extensive experience working with foundations, federal and state governments, providers, health plans, and other industry leaders.

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EXECUTIVE SUMMARY

Massachusetts continues to lead the nation in both health care coverage and delivery system reform. Since the 2006 passage of Chapter 58, its state health care reform law, Massachusetts has achieved near universal coverage through a combination of expanded Medicaid, private market reforms, and individual subsidies to purchase coverage in the nation's first marketplace, the Health Connector (Connector). With the passage of the Affordable Care Act (ACA) in 2010, Massachusetts began the task of tailoring its reforms to the requirements of the ACA. At the same time, the state tackled rising health care costs by passing Chapter 224 of the Acts of 2012, which set ambitious goals for private sector payers, providers, and state agencies to rein in costs through payment and policy innovations.

Today, as its Medicaid and marketplace systems continue to stabilize and the state enters its third year under Chapter 224, the time is ripe for the Commonwealth to evaluate ACA coverage programs in the context of its coverage and delivery system goals. The ACA offers two relevant vehicles: section 1331, the Basic Health Program (BHP); and section 1332, Waivers for State Innovation. These sections of the law allow Massachusetts to modify ACA coverage, subsidy, and insurance market requirements to address the state's unmet coverage and delivery system goals; section 1332 also allows the state to propose targeted fixes to features of the ACA that impede smooth operation.¹ Notably, Massachusetts has already acted to ensure more affordable coverage than would otherwise be available under the ACA by using Medicaid (called MassHealth in the Commonwealth) funding through its 1115 waiver to supplement marketplace subsidies for individuals with family incomes above MassHealth eligibility levels up to 300 percent of the federal poverty level (FPL).

To make coverage more affordable for individuals with incomes between 133 and 200 percent of the FPL, section 1331 gives states the option to establish a BHP for these individuals who would otherwise be eligible for coverage through the marketplace. States electing to pursue the BHP, which to date are Minnesota and New York, receive federal funding equal to 95 percent of the amount of the federal premium tax credits and cost-sharing reductions that would have been available had the individuals purchased coverage through the marketplace. States were able to implement the BHP beginning in January 2015 through approval of a "BHP Blueprint" by the Department of Health and Human Services (HHS).

Section 1332 permits states to request from HHS and the Treasury Department waivers of certain requirements of the ACA, with waivers first effective in 2017. Specifically, states may propose alternatives to four pillars of the ACA and various related provisions:

- **Individual mandate.** States can modify or eliminate the tax penalties that the ACA imposes on individuals who fail to maintain health coverage.

¹ It should be noted that states have significant flexibility to structure their coverage programs and insurance markets without pursuing a Basic Health Program or section 1332 waiver. (E.g., states may tie certification of qualified health plans to quality targets or payment reform, offer certain plan levels in their marketplaces, add state subsidies, merge individual, small group, and/or large group markets, and modify the essential health benefits benchmark.)

- **Employer mandate.** States can modify or eliminate the penalties that the ACA imposes on certain employers who fail to offer affordable coverage to their employees.
- **Benefits and subsidies.** States may modify the rules governing the establishment of qualified health plans (QHPs) and their covered benefits as well as those related to premium tax credits and reduced cost sharing. States that reallocate premium tax credits and cost-sharing reductions may receive the aggregate value of those subsidies.
- **Marketplaces.** States can modify or eliminate the marketplaces as the vehicle for determining eligibility for tax credits and enrolling consumers in coverage.

While the scope of 1332 waivers offers broad opportunities for state innovation, HHS also imposes important guardrails to ensure that the ACA's coverage goals are met. States must provide coverage that is at least as “comprehensive” and “affordable” as coverage offered through the marketplace and must ensure that at least as many people are covered as would have been in the absence of the waiver. Additionally, 1332 waivers must not increase the federal deficit. Regulations jointly promulgated by HHS and the Treasury provide detailed information about the waiver application process—but notably *not* about the substantive requirements of section 1332. Finally, section 1332 requires HHS and the Treasury to develop a plan for coordinating and consolidating the 1332 waiver process with Medicaid, a critically important point for Massachusetts given the importance of the MassHealth program and funding to the coverage continuum.

Through some combination of section 1331 BHP authority, a section 1332 Innovation Waiver, and the state's section 1115 MassHealth waiver, Massachusetts has the opportunity to reconfigure its coverage continuum to maximize coverage access, affordability, and continuity for its residents and address targeted ACA rules that have proven problematic in the Commonwealth. Among the more comprehensive reforms, the state may consider new approaches to:

- **The subsidy continuum.** The state could utilize a section 1332 waiver—perhaps in combination with an 1115 waiver—to smooth subsidy “cliffs,” or significant changes in costs as a result of modest changes in income, for low- and moderate-income individuals.
- **Plan purchasing and certification.** The state could establish either a BHP product under section 1331 or a BHP-like product through a 1332 waiver for certain subsidy-eligible populations. Such a new product could be operated through MassHealth managed care plans or through health plans offering coverage through the Connector. Massachusetts could also use section 1332 authority to permit provider-led entities, such as Accountable Care Organizations (ACOs), to be certified to offer QHP or BHP products.
- **The Connector's role and responsibilities.** Under section 1332, Massachusetts could modify the functions of the Connector, augmenting or narrowing Connector functionality or eliminating the Connector altogether.
- **Payment and delivery system reform.** The state could design a new program, using a combined section 1332 and 1115 waiver, through which a single set of plans or ACOs and providers serve most, if not all, of the state's insurance affordability program enrollees. By implementing a strong purchasing strategy across as many as 1.7 million lives, the Common-

wealth could gain substantial market power, which could be leveraged to accelerate payment and delivery system reform and ensure higher-value coverage.

The Commonwealth might also pursue targeted policy fixes including:

- **Fixing the “family glitch”** that prevents dependents from accessing federal tax credits when an employed family member has access to “affordable” employer-sponsored insurance. The problem with the current system is that “affordability” of employer-sponsored insurance for spouses and dependents is based on the cost of *individual* coverage—not on the cost of family coverage.
- **Reaching the remaining uninsured** by testing new insurance products targeted to hard-to-reach uninsured populations or using a “premium assistance” or voucher approach to help certain uninsured but employed individuals purchase employer-sponsored coverage. The state might also consider reconfiguring coverage options for certain immigrant populations who are currently unable to apply for and purchase health insurance coverage.
- **Aligning and streamlining subsidy eligibility and enrollment rules** through a combined 1332 and 1115 waiver that addresses conflicts in eligibility standards and verification rules across coverage programs.
- **Aligning state and federal individual responsibility requirements** through a 1332 waiver that modifies the rules of the federal individual mandate or eliminates it entirely (while maintaining the state individual mandate).

Massachusetts is familiar with innovation. Indeed, the state has led the nation in expanding coverage and reforming its payment and delivery models, with considerable success. The ACA provided the state with new tools and new funding, while also imposing new requirements. Now, almost 10 years after the passage of Chapter 58 and five years after the passage of the ACA, the state has the opportunity to reevaluate its system of coverage and consider the changes required to assure a more rational and affordable continuum of coverage for its residents as well as a stronger foundation for reform of its payment and delivery systems.

This issue brief reviews the coverage goals that Massachusetts may seek to address through a BHP or 1332 waiver, the federal requirements related to these vehicles for innovation, and specific coverage program modifications that the state may consider in order to further tailor health care reform in the Commonwealth.

INTRODUCTION

Massachusetts leads the nation in health insurance coverage and is among the states leading delivery system and payment reform. In 2006, the Commonwealth enacted Chapter 58, a comprehensive health care reform law that extended coverage to more than 96 percent of Massachusetts residents through expansion of its Medicaid program, MassHealth, and also engendered a series of private market reforms, an individual mandate, and subsidies for residents to purchase coverage in the nation's first marketplace, the Health Connector (Connector). Building on this foundation of near universal coverage, state policy makers tackled payment and delivery system reform by enacting Chapter 224 of the Acts of 2012. Chapter 224 set ambitious goals for Massachusetts' government and private sector payers, providers, and state agencies to rein in health care costs through payment and policy innovations, improve access, and enhance quality.

Enacted in 2010, the federal Affordable Care Act (ACA) borrowed liberally from Massachusetts' state reform model. However, it was sufficiently different from Chapter 58 that the state spent the four years leading up to the law's implementation tailoring its state reforms to the federal rules. As new ACA-compliant systems and policies continue to stabilize and the Commonwealth enters its third year under Chapter 224's payment and delivery system mandates, Massachusetts is well positioned to assess and continue shaping its post-ACA coverage continuum to cement gains and accelerate payment and delivery system reforms for the benefit of all of its residents.

While the ACA has established a national health coverage model, it affords states some flexibility to tailor their approaches to coverage—including whether to expand Medicaid and implement a state-based marketplace or rely on the federally facilitated marketplace. Starting in 2015, states may exercise the option under section 1331 of the law to implement a Basic Health Program (BHP) as a more affordable coverage vehicle for certain individuals with incomes below 200 percent of the federal poverty level (FPL). State innovation opportunities will take a giant leap forward in 2017 when section 1332 of the ACA, Waivers for State Innovation, goes into effect. Section 1332 invites states to propose alternative ways to meet the ACA's coverage goals as long as the alternative approaches are budget-neutral to the federal government.

This issue brief reviews the flexibilities afforded to states through sections 1331 (BHP) and 1332 (State Innovation Waivers) of the ACA. In addition, it identifies opportunities the Commonwealth may wish to pursue through these vehicles to advance its own coverage, fiscal, and policy priorities, including improving affordability and ease of access to coverage for low-income residents, continuing the expansion of insurance coverage for hard-to-reach populations, and evaluating and revisiting pre- and post-ACA reforms like the individual mandate to determine the “best fit” for Massachusetts. In evaluating these coverage opportunities, the Commonwealth will also want to consider whether and how they enable or impede the health care delivery system and payment reforms and the state's ultimate goal of containing costs and improving access and quality for all residents.

MASSACHUSETTS COVERAGE CONTINUUM

Today, through a combination of government-subsidized and private coverage, more than 96 percent of Massachusetts residents have health insurance.² Employer-sponsored insurance remains the dominant source of health coverage in the Commonwealth, covering almost 60 percent of residents in 2014.³ However, more than a quarter of residents—1.7 million—are enrolled in insurance affordability programs, including MassHealth and federal and state subsidies, to purchase private coverage through the Connector.⁴ MassHealth covers the vast majority of this population, as most residents under age 65 with incomes less than 133 percent of the FPL qualify for the program. MassHealth also insures children with family incomes up to 300 percent of the FPL, as well as disabled adults and other special populations above 133 percent of the FPL.

With implementation of the ACA, Commonwealth residents with incomes above MassHealth eligibility levels of up to 400 percent of the FPL have access to federal advanced premium tax credits (APTC) and cost-sharing reductions (CSR) to purchase private coverage through the Connector.⁵ Federal subsidies supplanted the state-subsidized Commonwealth Care program, which was established in 2006 by Chapter 58 for residents with incomes of up to 300 percent of the FPL. However, because the ACA's subsidies are less generous than those of Chapter 58, Massachusetts replaced Commonwealth Care with ConnectorCare, a new state program that utilizes federal and state MassHealth funding to supplement federal subsidies.⁶

A PRIMER ON ACA SUBSIDIES

Advanced premium tax credits (APTC) are income-based, sliding-scale tax credits that can be used as soon as an individual enrolls in coverage to lower his/her monthly premium costs. An individual who qualifies for APTC may choose how much of the tax credit to take in advance to apply to the monthly premium. If the amount of advance payments an individual receives in a year is *less than* the tax credit she is due, then she will receive the difference as a refund when she files her taxes. If the advance payments are *greater than* the tax credit due, she must repay the excess advance payment with her tax return.

A **cost-sharing reduction (CSR)** is a discount that lowers the amount individuals have to pay out-of-pocket for deductibles, coinsurance, and copayments. Individuals qualify for CSR if their income is below a certain level and they select a certain level of health plan through the marketplace.

² Laura Skopec, Sharon Long, Susan Sherr, David Dutwin, and Kathy Langdale, *Findings from the 2014 Massachusetts Health Insurance Survey*, Urban Institute, SSRS, and Center for Health Information and Analysis, May 2015.

³ Ibid.

⁴ *The Governor's FY 2016 Budget Proposal for MassHealth (Medicaid) and Health Reform Programs*, Massachusetts Medicaid Policy Institute (MMPI), April 2015; Massachusetts Health Connector, *February Health Connector Summary Report*, March 2015. Per 42 CFR 435.4, insurance affordability programs include a state's Medicaid program, Children's Health Insurance Program, Basic Health Program, and programs that make advanced premium tax credits and cost-sharing reductions available to qualified individuals purchasing coverage in a marketplace.

⁵ Cost-sharing reductions are available only to residents with incomes between 100 and 250 percent of the FPL who enroll in a silver-level plan through the Connector.

⁶ In 2012, the Commonwealth passed Chapter 96 of the Acts of 2012, which allowed the state to supplement federal subsidies for residents with incomes below 300 percent of the FPL. (This law also authorized the creation of a Basic Health Program.) The most recent MassHealth waiver renewal (in 2014) includes five years of financing for "wrap" subsidies to ensure that Commonwealth Care can essentially live on as ConnectorCare.

Massachusetts residents with incomes above 400 percent of the FPL are able to shop for and enroll in coverage options through the Connector or outside the Connector. Finally, Medicare covers approximately 16 percent of Commonwealth residents, primarily those aged 65 or older and those with disabilities.⁷

While Massachusetts has already achieved coverage levels that surpass those in other states, coverage reform in the Commonwealth is far from complete. The array of subsidy programs in the state provides a comprehensive but fragmented coverage framework. For consumers seeking individual, non-group coverage, income and certain other characteristics determine their eligibility for one or more coverage programs. Access to this array of coverage options may start with a single application for eligibility, but once eligibility is determined, the coverage programs are siloed: each has a distinct enrollment process and benefit design, different (though in some cases overlapping) health plans, and diverse provider networks. Even within MassHealth there is significant fragmentation. See Exhibit 1 for details. Enrollees are covered through a variety of managed care and fee-for-service programs that are not aligned in many key respects.

A PRIMER ON MASSHEALTH PROGRAMS

MassHealth Standard offers a wide range of health care benefits, including primary care services, hospital services, behavioral health care, and long-term services and supports (LTSS), to members including pregnant women, children, people with disabilities, and the elderly.

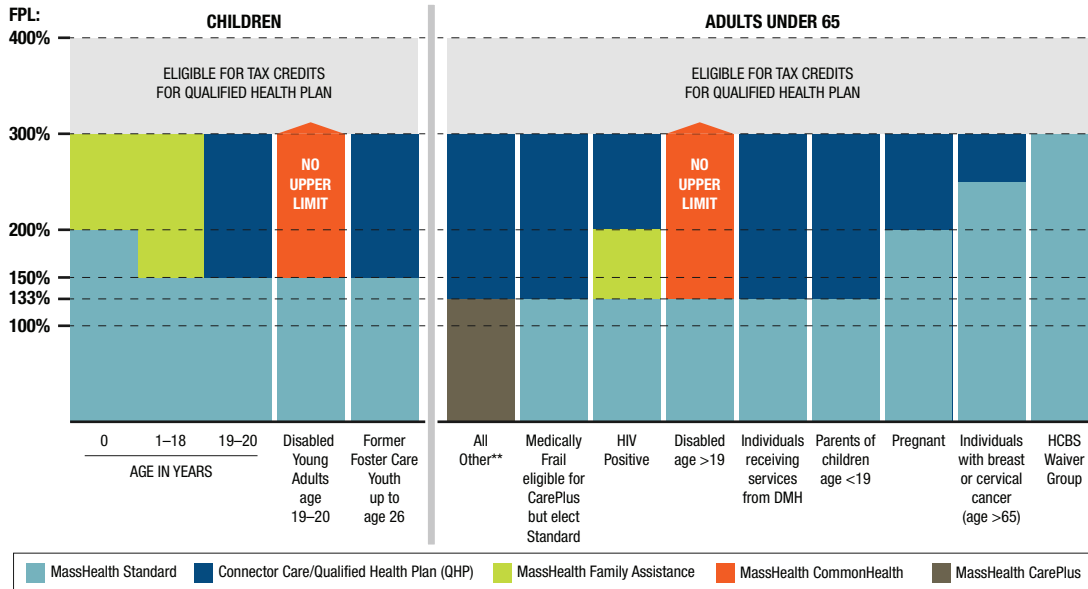
MassHealth CommonHealth offers benefits similar to MassHealth Standard to disabled adults and children with incomes that are too high to qualify for MassHealth Standard.

MassHealth Family Assistance offers a more limited set of benefits to members with HIV/AIDS and incomes between 133 and 200% of the FPL who do not otherwise qualify for MassHealth, as well as to children in families with incomes between 150 and 300% of the FPL.

MassHealth CarePlus, the newest MassHealth program, offers a range of services to adults aged 21 to 64 whose income is at or below 133% of the FPL and who do not qualify for MassHealth Standard.

⁷ Laura Skopec, Sharon Long, Susan Sherr, David Dutwin, and Kathy Langdale, *Findings from the 2014 Massachusetts Health Insurance Survey*, Urban Institute, SSRS, and Center for Health Information and Analysis, May 2015. Some residents have more than one type of coverage (e.g., both MassHealth and Medicare) and, as a result, may be counted more than once.

EXHIBIT 1. MASSACHUSETTS INSURANCE AFFORDABILITY PROGRAMS



*FPL = federal poverty level

** Includes members previously eligible for MassHealth Basic and Essential with a majority from Essential.

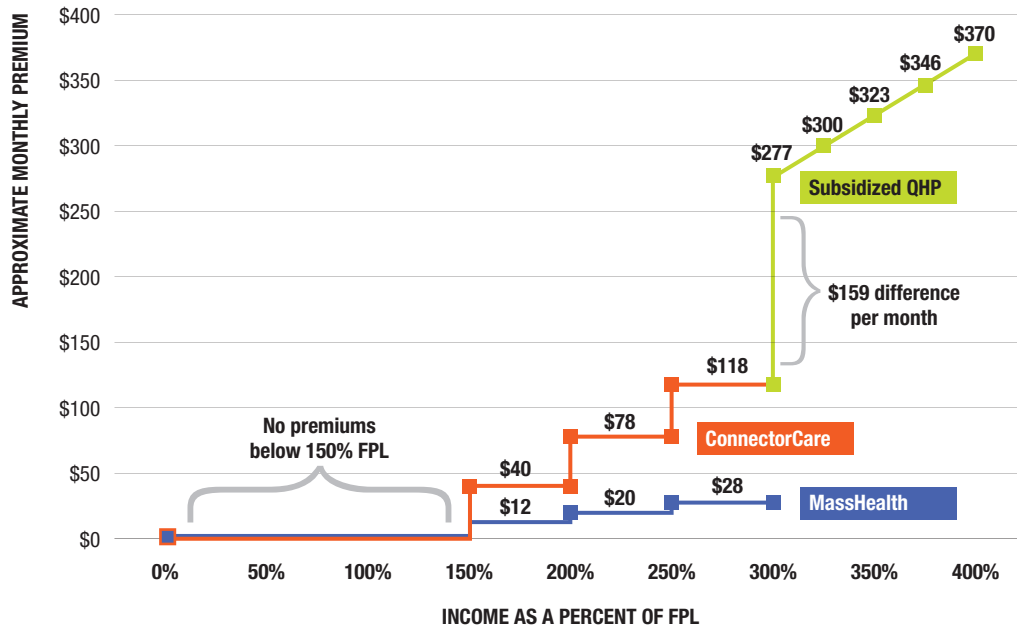
Notes: Several MassHealth programs are no longer available effective 1/1/2014 including MassHealth Basic and Essential, Insurance Partnership, Healthy Start, Prenatal, Commonwealth Care, and the Medical Security Program. Populations previously covered by these programs will now be covered by MassHealth Standard, CarePlus, and Connector Care.

In general, the eligibility level for seniors age 65 and older is 100% of FPL and assets of up to \$2,000 for an individual or \$4,000 for a couple. More generous eligibility rules apply for seniors residing in nursing facilities or enrolled in special waiver programs.

Source: *MassHealth, The Basics*. MMPI, April 2014.

From the consumer perspective, the fragmented coverage continuum is confusing and impedes continuity of care—especially for “mixed families,” who have members eligible for more than one coverage program, and for consumers who experience changes in program eligibility year to year or mid-year. Depending on their program eligibility, Massachusetts residents navigate a distinct set of plans, providers, and benefits. For example, a mother and child with a total family income of \$23,500 (just below 150 percent of the FPL) may receive coverage from ConnectorCare and MassHealth Standard (respectively). Should their income increase during the year to \$24,000 (just above 150 percent of the FPL), the child’s program eligibility would shift to MassHealth Family Assistance. In that case, over the course of a year, this family would encounter three different coverage programs, with varying plans, provider networks, benefits, and cost-sharing levels. The slight increase in family income means the child would no longer receive certain benefits, such as early and periodic screening, diagnosis, and treatment services (EPSDT). It also means the mother would need to begin paying a monthly premium for the child. Consumers in Massachusetts may face subsidy “cliffs”—steep increases in premiums and cost sharing as a result of modest increases in income. An increase in annual income of just \$250, for example, from just *below* 300 percent of the FPL (ConnectorCare coverage) to just *above* 300 percent of the FPL (subsidized marketplace coverage) could mean an increase in premium of almost \$160 per month, from \$118 to \$277. See Exhibit 2.

EXHIBIT 2. PREMIUM SUBSIDY CLIFFS: INCREASES IN INDIVIDUAL MONTHLY PREMIUMS BY INCREASES IN INCOME



Premiums in MassHealth vary and many populations are exempt; the MassHealth amounts shown above 150% of the FPL are premiums per child in the MassHealth Family Assistance program.

ConnectorCare premiums also vary; the amounts shown are lowest cost ConnectorCare plan premiums in 2014.

For subsidized qualified health plan (QHP) coverage, the amount of tax credit varies with income such that the premium an individual must pay for the second lowest cost silver plan would not exceed a specific percentage of his/her income (adjusted for family size); for individuals with incomes between 300 and 400% of the FPL, the percentage is 9.5%, so the amounts shown are equal to 9.5% of income at 300-400% of the FPL in 2014.

From providers' perspective, the Commonwealth's coverage framework segments consumers in a way that adds complexity and complicates their ability to align incentives, manage care, and improve care delivery and costs. Within MassHealth, providers navigate multiple managed care models, including MassHealth-contracted managed care organizations (MCOs); the Primary Care Clinician (PCC) program—which is co-administered by MassHealth and its behavioral health vendor, the Massachusetts Behavioral Health Partnership (MBHP)—and several small but growing programs for individuals eligible for both Medicaid and Medicare, including the Program of All-Inclusive Care for the Elderly (PACE), Senior Care Options (SCO), and the OneCare program. Each of these programs has its own set of health plans, quality incentives, and payment structures. Inconsistency across quality and performance measures is a significant challenge for providers, as demonstrating achievement of the programs' standards may require different types and sources of data. Diffusion of requirements may dilute provider incentives, especially given the extensive time and resources that are required for quality and performance measurement. Consequently, such a fragmented approach is detrimental to delivery system and payment reform. Diverse programs develop diverse approaches to reform and hinder the progression and alignment of alternative payment methods, quality improvement, and cost-containment—all central goals of Chapter 224.

While coverage is fragmented for many, it is inaccessible altogether for some who experience financial and immigration-related barriers. Racial/ethnic and geographic coverage disparities per-

sist in the state, and recent estimates indicate that nearly 250,000 residents remain uninsured.⁸ Low-income and Hispanic residents are more likely to be uninsured than their higher-income and non-Hispanic counterparts, and in 25 neighborhoods across the state, the uninsurance rate is greater than 20 percent.^{9,10} Further, the remaining uninsured are those most difficult to enroll. Most are male, low- or middle-income, and employed. Affordability remains a significant concern for both uninsured and insured residents of the Commonwealth.¹¹ In 2013, nearly 40 percent of insured adults in Massachusetts reported that health care costs had caused financial and/or nonfinancial problems for them and their families.¹² This is higher among low-income adults (i.e., those with income at or below 300 percent of the FPL), of whom nearly 50 percent reported that health care costs had caused financial and/or nonfinancial problems for them and their families.¹³

Finally, sustaining public coverage remains a major concern for the Commonwealth. Covering 1.7 million—or one in four—state residents, MassHealth is the foundation of the Massachusetts coverage continuum. With projected gross spending of \$15.8 billion in state fiscal year 2016, including approximately \$169 million for the ConnectorCare program, MassHealth makes up 41 percent of the state budget.¹⁴ While the state will receive over \$8 billion in federal reimbursement for the program, the fiscal sustainability of MassHealth and maximizing federal funds to support the coverage framework are perennial tests for the state.

In sum, there are significant opportunities in the Commonwealth to align and streamline coverage, not only in order to increase consistency among coverage programs and improve access for consumers but also to accelerate payment and delivery system reform. The two sections of the ACA that provide Massachusetts with the most significant flexibility to modify its coverage continuum to address these challenges are sections 1331 and 1332. These sections of the law enable Massachusetts to modify ACA coverage, subsidy, and insurance market requirements to address the state's unmet goals related to coverage access and affordability, sustainability, and payment and delivery system reform in 2016 and beyond.¹⁵

8 Laura Skopec, Sharon Long, Susan Sherr, David Dutwin, and Kathy Langdale, *Findings from the 2014 Massachusetts Health Insurance Survey*, Urban Institute, SSRS, and Center for Health Information and Analysis, May 2015.

9 Ibid.

10 Sharon Long and Thomas Dimmock, *The Geography of Uninsurance in Massachusetts, 2009–2013*, Urban Institute, Blue Cross Blue Shield of Massachusetts Foundation, April 2015. Note that the uninsurance rate presented is among nonelderly residents, as elderly residents are generally covered by Medicare.

11 *Health Reform in Massachusetts: Assessing the Results*, Blue Cross Blue Shield of Massachusetts Foundation, March 2014.

12 Sharon Long and Thomas Dimmock, *Health Insurance Coverage and Health Care Access and Affordability in Massachusetts: Affordability Still a Challenge*, Urban Institute, Blue Cross Blue Shield of Massachusetts Foundation, and Robert Wood Johnson Foundation, November 2014.

13 Ibid.

14 *House of Representatives FY2016 Budget Proposal for MassHealth (Medicaid) and Health Reform Programs*, MMPI, May 2015.

15 States have significant flexibility to structure their coverage programs and insurance markets *without* pursuing a Basic Health Program or section 1332 waiver. (E.g., states may tie certification of qualified health plans to quality targets or payment reform, offer certain plan levels in their marketplaces, add state subsidies, merge individual, small group, and/or large group markets, and modify the essential health benefits benchmark.)

ACA FLEXIBILITIES FOR STATE COVERAGE INNOVATION

THE BASIC HEALTH PROGRAM

Section 1331 of the ACA provides states with the option to establish a BHP for residents with incomes below 200 percent of the FPL who are Medicaid-ineligible and would otherwise qualify for subsidies in the marketplace.¹⁶ As such, the BHP sits between Medicaid and the marketplace, and while states have significant flexibility in how to establish a BHP, their programs must fit within this broader construct of insurance affordability programs. To design and implement an alternative coverage mechanism, states pursuing the BHP option receive 95 percent of the amount of federal tax credits and cost-sharing reductions that would have been provided to eligible individuals had those individuals enrolled in coverage through the marketplace. See Exhibit 3 for more information.

EXHIBIT 3. OVERVIEW OF THE BASIC HEALTH PROGRAM

ELIGIBLE INDIVIDUALS

- These individuals have incomes below 200 percent of the FPL and would otherwise be eligible to purchase coverage in the marketplace. They include:
 - Citizens or lawfully present non-citizens who have incomes between 133 percent and 200 percent of the FPL and do not qualify for federally funded Medicaid, Children’s Health Insurance Program (CHIP), or other minimum essential coverage, and
 - Lawfully present non-citizens who have incomes below 133 percent of the FPL but are unable to qualify for federally funded Medicaid due to their non-citizen status (e.g., aliens with special status [AWSS] in Massachusetts).

REQUIREMENTS

- Coverage must be at least as comprehensive and affordable as subsidized coverage in the marketplace (e.g., BHP benefits must include at least the 10 essential health benefits in the ACA).
- Monthly premiums and cost sharing must not exceed what an otherwise qualified individual would have paid in the second-lowest-cost silver plan on the marketplace.¹⁷

COORDINATION WITH OTHER PROGRAMS

- States must coordinate BHP administration with Medicaid, CHIP, the marketplace, and other state-administered programs to maximize the efficiency of such programs and improve continuity of care.
- For many programmatic features of the BHP (e.g., eligibility verification, redetermination, network adequacy, enrollment periods), states may choose among Medicaid, CHIP, and marketplace rules.

FUNDING

- States receive federal funding equal to 95 percent of the amount of the aggregate premium tax credits and cost-sharing reductions that would have been available to individuals had they purchased coverage through the marketplace. Instead of providing funds to individuals in the form of tax credits and cost-sharing reductions, the federal government provides funds (95 percent of the value) to the state.

continued

16 In Massachusetts, this would include approximately 120,000 individuals. See Massachusetts Executive Office of Health and Human Services, *Roadmap to 2014: Subsidized Insurance Workgroup Update*, Quarterly Stakeholder Meeting, December 21, 2011.

17 Marketplace plans are separated into four categories, or “metal levels”—bronze, silver, gold, and platinum—based on the percentage the plan pays of the average overall cost of providing essential health benefits to enrollees. On average, the percentages the plans will pay are 60 percent (bronze), 70 percent (silver), 80 percent (gold), and 90 percent (platinum). Tax credit amounts are calculated using the premium of the second-lowest-cost plan in the silver category.

EXHIBIT 3. OVERVIEW OF THE BASIC HEALTH PROGRAM *(continued)*

FUNDING *(continued)*

- States may use these funds only to reduce premiums and cost sharing and/or provide additional benefits for eligible individuals enrolled in the BHP. Funds cannot be used for program administration.
- The federal payment methodology includes:
 - The Department of Health and Human Services (HHS) is developing rating categories (called “rate cells”) that break down the potentially eligible population by various factors, including age range, geographic area, coverage category, household size, and income level.
 - HHS then calculates a payment rate for each rate cell by multiplying the sum of 95 percent of the tax credits and cost-sharing reductions (adjusted for risk and other factors) by the projected number of enrollees within each rate cell. The total amount that goes to the state is equal to the sum of the payment amounts for all the rate cells, reconciled retrospectively based on actual enrollment, coverage category, household size, and income level.

IMPACT ON MARKETPLACES

- The BHP population constitutes a separate risk pool and must be risk-adjusted separately; it therefore will reduce the size of a state’s individual market risk pool (or, in Massachusetts’ case, the state’s individual/small group risk pool).¹⁸
- The BHP may be administered by the marketplace or Medicaid; if the latter, implementation of the BHP could affect marketplace sustainability.

EFFECTIVE DATE

- States were allowed to begin implementing a BHP in January 2015.

FEDERAL APPROVAL PROCESS

- To establish a BHP, a state must submit for HHS approval a “Blueprint” that describes the state’s program design choices and includes a full description of the operations and management of the program and its compliance with federal rules.¹⁹ A state must also submit a BHP funding plan.
- The BHP Blueprint must be signed by the state’s governor or by an official whom the governor has delegated to sign it. In the Blueprint, the state must identify the agency responsible for program administration, operations, and financial oversight.²⁰

STATE EXPERIENCE WITH THE BHP

Only two states have pursued a BHP: Minnesota and New York.

- Minnesota’s BHP began in January 2015; its Medicaid agency is responsible for BHP administration. As of March, more than 100,000 residents were enrolled in the BHP.²¹
- New York began phased-in enrollment in its BHP in April 2015. Its BHP administrative agency is the department responsible for its marketplace, Medicaid, and CHIP programs. It has estimated that more than 460,000 residents will be enrolled in the BHP as of January 2016.²²

Both states had previously covered a majority of their BHP-eligible populations through a Medicaid waiver using state funds and, as a result, are expecting substantial state savings. One study found that adopting the BHP would save New York \$954 million annually.²³

18 Chapter 58 merged the state’s non-group (individual) and small group markets beginning in 2007.

19 The sections of the BHP Blueprint reflect the final rule that codified program establishment standards, eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and HHS oversight.

20 Neither the BHP federal statute nor the final rule explicitly requires that states pass legislation allowing for establishment of a BHP. However, the final rule does reference “legislative and budget authority” in several contexts. Given the implications for state budgets, it is likely that states will have to pass legislation to authorize a BHP. (Both Minnesota and New York passed legislation to do so; Massachusetts did as well in 2012, though it has not yet pursued the option.)

21 *Family Self-Sufficiency and Health Care Program Statistics*, Minnesota Department of Human Services Reports and Forecasts Division, May 3, 2015.

22 *Basic Health Program*, New York State Department of Health Presentation to Health Plans, January 8, 2015.

23 *Covering More New Yorkers While Easing the State’s Budget*, Community Service Society and New York State Health Foundation, January 2012

SECTION 1332 WAIVERS

Section 1332, which goes into effect in 2017, permits states to waive many of the coverage provisions of the ACA, including those related to the individual and employer mandates, benefits and subsidies, and the establishment and role of the marketplaces (both the individual and Small Business Health Options Program [SHOP] marketplaces). To the extent a state waives the ACA's subsidies (i.e., the tax credits and cost-sharing reductions), the state may receive 100 percent of those dollars to apply to its own coverage structure. To be approved, however, a 1332 waiver must not increase the federal deficit and must assure that coverage is as affordable and comprehensive and is provided to as many individuals as it would be absent the waiver.

States may pursue a 1332 waiver to implement major changes to ACA policy and programs in order to meet state-specific coverage or fiscal goals. Alternately, they may use a 1332 waiver to make targeted “fixes” to specific ACA policies that they find problematic.

At the outset, it should be noted that HHS has issued only one set of regulations related to section 1332. These regulations focus on the administrative process for securing a 1332 waiver and offer little guidance on the substantive requirements that a state will need to meet. Although additional guidance is anticipated, its release is not expected until after the U.S. Supreme Court decision in *King v. Burwell*.²⁴ At issue in this case is whether the federal government can provide tax credit subsidies to coverage purchased through the federally facilitated marketplace. A decision that is adverse to the federal government may influence regulations on 1332 waiver timing, process, and authority, as states relying on the federally facilitated marketplace may seek to leverage section 1332 to secure continued access to federal subsidy dollars.

MASSACHUSETTS INSURANCE MARKET REFORMS

The ACA required Massachusetts to adjust various parts of its pre-ACA insurance market reforms, such as its definition of “small group” and its rating requirements on plans. The state may wish to address these market reforms as it considers leveraging the flexibilities afforded by the ACA. While this issue brief focuses on coverage, and therefore does not tackle these market reforms explicitly, we note that section 1332 does allow for a waiver of the ACA’s “small group” definition but not its rating requirements.

²⁴ *David King, et al., Petitioners v. Sylvia Burwell, Secretary of Health and Human Services, et al.*, U.S. Supreme Court, Docket No. 14-114.

EXHIBIT 4. OVERVIEW OF SECTION 1332 STATE INNOVATION WAIVERS

ACA PROVISIONS THAT CAN BE WAIVED

States may propose innovations and alternatives—broad or targeted—to four areas of the ACA's coverage scheme. Specifically, states may modify or eliminate:

- **Individual mandate** (*Title I, Subtitle E, Section 1501/5000A of the Internal Revenue Code of 1986*), the tax penalties that the ACA imposes on individuals who fail to maintain health coverage.
- **Employer mandate** (*Title I, Subtitle E, Section 1513/4980H of the Internal Revenue Code of 1986*), penalties that the ACA imposes on certain employers who fail to offer affordable coverage to their employees.
- **Benefits and subsidies** (*Title I, Subtitle D, Part 1 and Subtitle E, Section 1401/36B of the Internal Revenue Code of 1986 and Section 1402*), the rules governing the establishment of qualified health plans (QHPs) and their covered benefits as well as those related to premium tax credits and reduced cost sharing. States that reallocate premium tax credits and cost-sharing reductions may receive the aggregate value of those subsidies.
- **Marketplaces** (*Title I, Subtitle D, Part 2*) as the vehicle for determining eligibility for tax credits and enrolling consumers in coverage.

REQUIREMENTS

Waivers must meet the following four requirements:

- **Comprehensive coverage.** The state must provide coverage that is “at least as comprehensive” as coverage would be absent the waiver.
- **Affordable coverage.** The state must provide “coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable” as coverage absent the waiver.
- **Scope of coverage.** The state must provide coverage to “at least a comparable number of its residents” as would have been covered without the waiver.
- **Federal deficit.** The waiver must not increase the federal deficit.

FUNDING

If the state elects to waive the tax credits and cost-sharing reductions, it may receive 100 percent of their value (as opposed to 95 percent under the BHP) that would have gone to state residents absent the waiver. Current guidance does not indicate whether there will be a funding reconciliation process similar to that for the BHP; funding-related guidance is anticipated in the future, however.

COORDINATION WITH OTHER WAIVERS

Section 1332 requires HHS to develop a process for coordinating and consolidating the 1332 waiver process with waiver processes for Medicaid, Medicare, CHIP, and other federal laws relating to the provision of health care services (though section 1332 does not create any new waiver authority for those other programs).

EFFECTIVE DATE

States may obtain 1332 waivers beginning January 1, 2017. States may submit a waiver application to HHS prior to this date, but the waiver's provisions may not be effective until 2017. States may also submit limited or narrow 1332 waivers and amend them later to tackle more comprehensive reforms.

continued

EXHIBIT 4. OVERVIEW OF SECTION 1332 STATE INNOVATION WAIVERS *(continued)*

FEDERAL APPROVAL PROCESS

The federal regulations regarding section 1332 that have been released to date focus on the waiver application process, rather than the substance of the waiver. HHS has yet to release a waiver application template. The regulations include the following information about 1332 waiver process:

- **Timing.** Waiver applications must include an implementation timeline, and states are not precluded from submitting waiver applications prior to 2017 in order to have them effective in 2017. The initial term of the waiver may not exceed five years, although waivers are renewable.
- **Impact of waiver.** The waiver application must include actuarial and economic analyses documenting compliance with approval standards. The application must also include a 10-year budget plan and explain how the waiver will impact implementation of other ACA provisions.²⁵
- **State authority.** States must demonstrate to HHS that they have authority to apply for and implement the 1332 waiver; in its waiver application, a state must provide a comprehensive description and copy of the enacted state legislation that authorizes implementation of its proposed waiver.
- **Public input.** Before submitting the waiver application, states must conduct public hearings on the draft waiver. Once the state has submitted an application, there is a federal public notice and comment process.

STATE INTEREST IN 1332 WAIVERS

Several states have begun considering pursuing a 1332 waiver.

- In March 2015, the **Arkansas** Senate introduced a bill authorizing state agencies to submit a 1332 waiver and creating a Health Insurance Innovation Legislative Steering Committee.²⁶
- In February 2015, the **Minnesota** Department of Human Services submitted a report on 1332 waiver opportunities to the state legislature (as required by state statute). The state anticipates development of a waiver plan and timeline to begin in 2015.
- In 2014, the legislature in **Hawaii** created a State Innovation Task Force to develop a 1332 waiver; lawmakers in **New Mexico** are considering a bill that would create a similar task force.

BHP AND 1332 CONSIDERATIONS FOR MASSACHUSETTS

Sections 1331 (BHP) and 1332 (State Innovation Waivers) offer two vehicles by which Massachusetts may seek to modify certain ACA rules and requirements to advance policy, programmatic, and fiscal objectives related to coverage in the Commonwealth. As discussed above, key challenges with the state's current continuum of coverage that could be addressed through one or both of these vehicles include the lack of one fully integrated eligibility and enrollment system and process for all consumers, regardless of income; subsidy cliffs that can impose significant changes in costs as a result of modest changes in income; and inconsistency among coverage programs in plans, providers, and benefits, which can adversely impact care continuity and coordination—especially for “mixed families” or residents experiencing changes in eligibility.

In addition, section 1332 may be used to modify certain ACA requirements, including the individual and employer mandates. Following is a discussion of areas in which the Commonwealth might use BHP or 1332 authority to advance its coverage goals.

²⁵ Neither the 1332 statute nor the regulation appears to attempt to reconcile how meaningful a 10-year budget plan can be if the waiver is being approved for only five years. The second half of the budget may be contingent on the terms of any waiver renewals.

²⁶ Senate Bill 828, State of Arkansas 90th General Assembly, Regular Session, 2015.

RECONFIGURING THE COVERAGE CONTINUUM

Using section 1332’s State Innovation Waiver authority, the Commonwealth can redesign its coverage continuum to address the issues identified previously: the need to make coverage more affordable, to streamline benefits, health plans, and provider networks, and to align and standardize plan and provider requirements across a new continuum to accelerate delivery system and payment reform. The Commonwealth would be even more empowered to “think outside the box” with regard to the reconfiguration of its coverage continuum by devising a combined 1332 and 1115 waiver, as section 1332 allows. With 1.7 million enrollees, MassHealth funds and administers coverage for the overwhelming majority of individuals enrolled in the Commonwealth’s subsidized coverage continuum; this, along with the flexibility afforded by section 1332, provides the Commonwealth with a significant opportunity to craft a purchasing strategy for its residents that aligns quality, payment, and cost-containment requirements in a cohesive, integrated coverage model.²⁷ One vision for a reconfigured coverage continuum in Massachusetts that uses a combined 1332 and 1115 waiver is a radically simplified model in which:

- Eligibility and enrollment systems for insurance affordability programs are fully integrated, supporting a single process for all consumers, regardless of income;
- Subsidy cliffs are smoothed so that consumers do not face steep increases in premiums and cost sharing as a result of modest increases in income;
- The same plans, providers, and benefits are available to all consumers, regardless of income and coverage program; and,
- Quality standards, payment incentives and cost-containment goals are aligned across plans and providers supporting and advancing the Commonwealth’s payment and delivery reform goals.

Key features of and considerations related to this new model are described below.

WHAT REQUIRES A WAIVER?

While many initiatives intended to revamp the coverage continuum will require 1332 or 1115 waiver authority, some efforts to tackle inconsistency among coverage programs may be done without a waiver. Rethinking the subsidy continuum (e.g., changing premium and cost-sharing amounts to eliminate subsidy cliffs and make coverage more affordable for lower-income populations) would, at minimum, require a 1332 State Innovation Waiver; if it were to affect subsidies for residents with incomes below 138 percent of the FPL, it would require an 1115 Medicaid waiver as well. But the Commonwealth could align quality standards and provider network requirements across programs today, without a waiver. The need for a waiver—and determination of which kind—depends on the state’s approach to coverage reform. The state may find that crafting a 1332 State Innovation Waiver provides a new opportunity and momentum to advance a broader set of coverage reforms—including those that do not on their own require waiver authority.

²⁷ Patricia Boozang, Stephanie Anthony, Dori Glanz, *The Future of MassHealth: Five Priority Issues for the New Administration*, MMPI, Blue Cross Blue Shield of Massachusetts Foundation, Manatt Health Solutions, December 2014.

New Subsidy Approach

The state could use section 1332 authority together with its 1115 MassHealth waiver to align and integrate coverage for the vast majority of individuals enrolled in subsidized or public coverage. With a 1332 waiver, the Commonwealth could access the federal subsidy funds that would otherwise be available to Medicaid-ineligible residents with incomes up to 400 percent of the FPL who purchase coverage through the marketplace. By combining 1332 and 1115 waivers, the state could pool these marketplace subsidy funds with the federal and state Medicaid dollars that are currently spent on a portion of the MassHealth population (e.g., childless adults in MassHealth CarePlus, parents in MassHealth Standard, some young adults and children) and the current ConnectorCare population. This substantial aggregated funding could be reallocated through a new subsidy approach that is designed to ensure coverage affordability and smooth cost-sharing cliffs for the maximum possible number of Commonwealth residents.

With a 1332 waiver, Massachusetts could:

- Reset the income parameters for eligibility for subsidies (i.e., make them broader or narrower);
- Incorporate new enhanced subsidy eligibility criteria for special populations, such as pregnant women; and
- In light of its payment and delivery system reform goals, provide consumers with financial incentives (i.e., through subsidies) to enroll in plans with better quality and higher rates of adopting alternate payment methods.

In addition to enabling a new subsidy approach, section 1332 provides the opportunity to expand eligibility for subsidies and subsidy levels for some of the Commonwealth's remaining uninsured, including, for example, certain low-income immigrants who are currently ineligible for subsidized or public coverage.

These are just a few options among many—and varying—approaches the state could consider in designing a new approach to its subsidized coverage. Each option requires careful assessment of its potential impact on coverage access and affordability for all populations affected, as well as evaluation of its performance on the four 1332 waiver requirements.

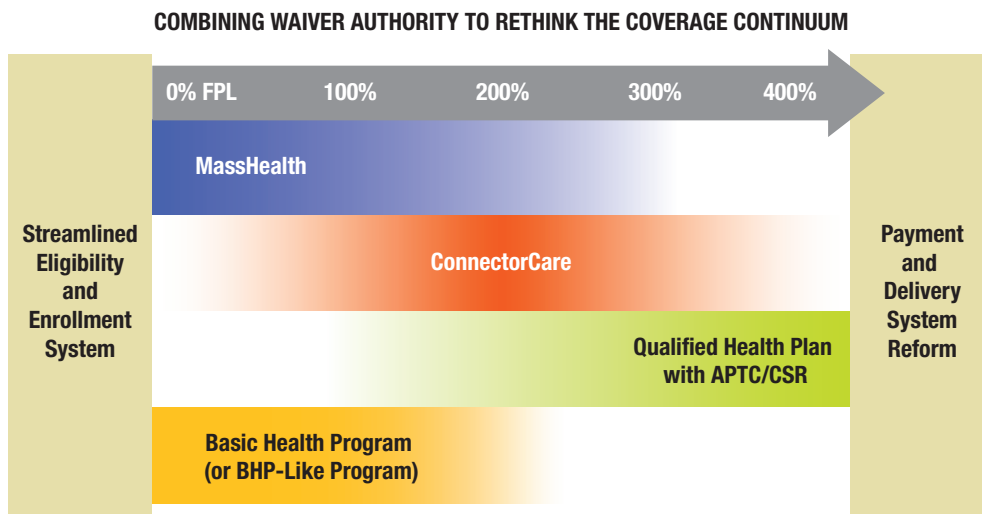
Plan “Purchasing” and Certification Requirements

The Commonwealth may also consider modifying QHP benefits, actuarial values, and certification rules, or departing from the requirement to offer QHPs at the ACA-prescribed metal levels for all or a portion of its subsidized population. Among the changes the state could pursue are the following:

- Massachusetts could use federal advanced premium tax credit and cost-sharing reduction (APTC/CSR) funds, along with federal and state dollars currently used to fund ConnectorCare, to establish a BHP-like program, whereby the state would procure, as it does in its MassHealth managed care program, a new product for consumers who are subsidy-eligible at current or newly defined income eligibility levels. Such a program could cover a broad swath of insurance affordability program beneficiaries through a single set of plans, providers, and benefits, allowing consumers to stay enrolled in the same plan, with the same provider and benefits, even when they experience income or other changes. Specifically:

- The state could leverage section 1331 to pursue development of a BHP in 2016, consistent with BHP regulations and with funding equal to 95 percent of the value of federal APTC/CSR. Benefits of this approach include that the BHP rules are already public and that the program is provided for in state statute and therefore would not require submission of a waiver to the federal government.
- Alternately, the state could use section 1332 authority in 2017 to create a “BHP-like” program. Benefits of this approach include more program design flexibility (relative to both current coverage programs and that allowed under a BHP) and, importantly, that the state would receive 100 percent of APTC/CSR value for program funding, rather than the 95 percent available under the BHP.
- Section 1332 authority could also be used to permit provider-led entities, such as Accountable Care Organizations (ACOs), to be certified to offer QHP or BHP products. Such an approach would align with the Commonwealth’s plan to permit ACO participation in MassHealth.²⁸
- The Commonwealth might also consider leveraging both 1332 and 1115 waiver authority to adopt a BHP-like program or MassHealth premium assistance program to enroll individuals eligible for MassHealth, ConnectorCare, and QHPs in the same plans or ACOs, with the same benefits and provider networks.
- Finally, a coordinated 1332 and 1115 waiver could be used to create QHP or BHP-like products in which “mixed families”—those with coverage through more than one insurance affordability program—may enroll.

EXHIBIT 5. REEVALUATING THE COVERAGE CONTINUUM IN MASSACHUSETTS



²⁸ MassHealth does not currently contract with ACOs, but it intends to do so in the future. See [Public Stakeholder Session: Creating a Sustainable MassHealth Program](#), April 6, 2015.

Role and Responsibilities of the Connector

Just as section 1332 provides flexibility for the Commonwealth to redesign the coverage continuum, it similarly provides opportunity for the state to rethink administration of the continuum. Specifically, under section 1332, Massachusetts could modify the functions of the Connector with respect to QHP certification, eligibility and enrollment, and subsidy administration. Indeed, the state could decide to augment the role and responsibilities of the Connector, expanding, for example, its role in offering low-income consumers (covered through MassHealth programs) the ability to shop and enroll in coverage or, as part of its continuum redesign, eliminate the Connector entirely and transition eligibility and enrollment and subsidy program administration to MassHealth or some other existing or new entity.

Implications for Payment and Delivery System Reform

Through a combined 1332 and 1115 waiver, the Commonwealth could design a new program through which a single set of plans or ACOs and providers serve most, if not all, of the state's insurance affordability program enrollees. As described above, such a program could incorporate a more rational subsidy approach, not be constrained by current program requirements, and be administered by a single entity. By implementing a strong purchasing strategy across as many as 1.7 million lives, the Commonwealth could gain substantial market power, which could be leveraged to accelerate payment and delivery system reform and ensure higher-value coverage.

The use of purchasing to drive value and savings has been realized by the Connector (albeit over a relatively small number of lives). In state fiscal years 2011 and 2012, the Connector achieved a five percent reduction in the rate paid to plans participating in the Commonwealth Care program through a creative procurement strategy that encouraged aggressive bidding by plans and tied membership to low bids.²⁹ The Commonwealth could drive major system change by utilizing this experience to devise a purchasing strategy that covers an expanded number of lives.

To further support widespread change in the delivery of care and payment, the state could develop uniform plan or ACO requirements and performance measures related to implementation of alternate payment methods. It could establish quality and cost containment initiatives across its plans, its providers, and the consumers they serve—in both the public and the private markets. Such efforts might involve incentives for consumers to enroll in high-performing plans or ACOs, such as enhanced subsidies for enrolling in plans or ACOs with low avoidable admission rates, high adoption of alternative payment methods, and competitive rates. This could represent an expansion of the Connector's past success in slowing cost growth.³⁰

State Fiscal Considerations

By combining state and federal dollars currently funding MassHealth, ConnectorCare, and APTC/CSR and employing an effective purchasing strategy that leverages the substantial enrollment of MassHealth to drive more competitive rates among QHPs (or BHP plans), the state might be able to generate savings through smarter allocation of federal dollars. Indeed, another benefit of a waiver that incorporates both section 1332 and the state's MassHealth 1115 waiver is the po-

²⁹ Massachusetts Health Connector, *Report to the Massachusetts Legislature: Implementation of Health Care Reform Fiscal Year 2012*, December 2012.

³⁰ Ibid.

tential opportunity to demonstrate budget neutrality across the entire coverage continuum, including taking into account the savings related to the system-wide impact of payment and delivery system reform. For example, a state's 1115 waiver program may lower federal costs related to premium tax credits, but such federal savings are not currently factored into calculations of 1115 waiver budget neutrality, because they are not savings to the Medicaid program. The Commonwealth could take the position that such savings should be taken into account in determining budget neutrality in a consolidated 1115 and 1332 waiver. However, it is unclear from existing guidance whether HHS will permit states to demonstrate “cross-waiver” budget neutrality. This key question must be answered by (and perhaps negotiated with) the federal government in the coming months as states craft their approaches to 1332 waivers.

Federal Guardrail Considerations

The federal government has offered little guidance to date on how the waiver requirements under section 1332 will be interpreted and how it will determine whether states have met them. At a minimum, Massachusetts would have to demonstrate that its revised approach to coverage and subsidies makes coverage at least as affordable and accessible to the same (or a greater) number of people as under existing ACA rules, without increasing the federal fiscal obligation. It remains unclear how the federal government will make these comparisons (e.g., what assumptions will be made in determining the number of people that would have been covered absent a waiver) or what the basis of comparison will be for determining the federal fiscal impact of waivers.

TARGETED POLICY FIXES TO ADDRESS COVERAGE GAPS

In addition to or in lieu of the overarching and more comprehensive reforms discussed above, there are a number of targeted policy fixes that the Commonwealth might pursue through a 1332 waiver to address discrete coverage or affordability gaps.

Fixing the “Family Glitch”

The family glitch occurs when low- to moderate-income families are prohibited from obtaining federal tax credits to purchase health coverage through the Connector because one or more members of the family are deemed as having access to “affordable” employer-sponsored insurance. The problem with this is that “affordability” of employer-sponsored insurance for spouses and dependents is based on the cost of *individual* coverage—not on the cost of family coverage. For example, if an employer offers a woman insurance deemed affordable by the ACA but does not provide it for her family, her family is ineligible for subsidized coverage through the Connector, no matter the family’s income. In Massachusetts, most children in families experiencing the “family glitch” will be eligible for MassHealth, but spouses and some children remain uninsured—or left to bear the high costs of coverage—without access to tax credits.

To address this issue, Massachusetts could use section 1332 authority to define affordability of employer-sponsored insurance for dependents on the basis of *family* coverage, rather than individual coverage.

A clear benefit of fixing the family glitch is the opportunity for the Commonwealth to make coverage more affordable for more residents—potentially bringing in more uninsured and certainly making coverage more affordable for dependents of employed individuals with access to insurance through their employers. Unpublished estimates from the Urban Institute’s Health Insurance

Policy Simulation Model suggest that a change in the definition of affordability to address the family glitch would make approximately 55,000 more Massachusetts residents eligible for tax credits.³¹ Under the current coverage rubric, however, there is a potential state fiscal implication to fixing the family glitch: to the extent that individuals become newly eligible for tax credits, they also become eligible for ConnectorCare and may strain the state's 1115 budget neutrality. In addition, this raises a potential flag for section 1332's fiscal requirement, as the federal funding obligation for these families would increase.

Reaching the Remaining Uninsured

Using the section 1332 waiver, Massachusetts may be able to test new approaches to reaching and covering the remaining uninsured in the state. As noted above, these include low-income and Hispanic residents, residents of certain geographic areas, and low- to middle-income workers. The Commonwealth would have the flexibility under section 1332 to develop and test more innovative insurance products targeted to one or more of these uninsured populations. The state may also be able to use a premium assistance or voucher approach to help certain uninsured residents purchase employer-sponsored coverage.

Using 1332 and 1115 waiver authorities, the Commonwealth may also consider reconfiguring coverage options for certain immigrant populations who are unable to apply for and purchase health insurance coverage today, even using their own money to do so. There is no federal guidance that speaks to the use of 1332 waivers to expand coverage to immigrants who are currently ineligible. However, under section 1332, the Commonwealth may waive a provision of the ACA that limits access to marketplace coverage to U.S. citizens and immigrants who are "lawfully present."³² It should be noted that immigrant eligibility for QHPs is also discussed in ACA section 1411, which explicitly prohibits federal payments and APTC/CSR to individuals who are not lawfully present in the U.S., and that this section is *not* designated as one that may be waived under section 1332. Given the conflicting statutory framework, further federal guidance is needed from HHS to determine whether it would be permissible for the state to waive section 1411 using section 1332 waiver authority. If Massachusetts is unable to waive the marketplace immigrant eligibility requirements, then it may consider providing subsidies to these ineligible uninsured immigrants with state-only dollars.

Align and Streamline Subsidy Eligibility and Enrollment Rules

Differences in eligibility and verification rules for MassHealth and Connector subsidies can delay eligibility determinations, impede automated determinations (meaning that the consumer or an eligibility worker may have to take some manual action outside the automated application and eligibility system), and impact coverage for some Massachusetts residents. These differences also make the task of programming and maintaining automated rules for eligibility and enrollment systems enormously complex. The Commonwealth could use a 1332 waiver in combination with its 1115 waiver to align and integrate the eligibility and enrollment rules and processes across its coverage continuum. Areas for alignment include:

³¹ The Urban Institute's Health Insurance Policy Simulation Model assumes that employees with an affordable offer of single coverage would not gain eligibility but their family members would.

³² ACA §§ 1312, 1411.

- Current versus annual income budget periods:** Income eligibility for new MassHealth applicants is based on current monthly income.³³ The income budget period for subsidized tax credits is projected annual income. The misalignment of income budget periods across the coverage continuum is both administratively complex and confusing to applicants. For example, an individual must provide information on the single streamlined application that describes his or her current income, total expected income for the current calendar year, and total expected income for the next calendar year. Applicants who experience fluctuations in income from month to month, such as seasonal workers, may be ineligible for MassHealth in the month they apply even though their projected annual income falls below MassHealth eligibility levels. Under those circumstances, federal Medicaid eligibility rules require states to apply a budget period based on projected annual income rather than current monthly income, so that the applicant is determined Medicaid-eligible. The Commonwealth could utilize its 1115 waiver to align MassHealth budget periods with subsidized tax credits' budget periods. This would simplify eligibility determinations across insurance affordability programs and avoid the need to administer two distinct sets of eligibility rules as well as one-off "exception" eligibility logic.
- Household composition and countable income:** Generally, there is alignment in Modified Adjusted Gross Income (MAGI) rules for income and household composition across Medicaid and subsidized tax credits. However, federal Medicaid regulations require the application of certain exceptions that complicate eligibility determinations. For example, some individuals, such as children claimed as a tax dependent by a non-custodial parent or a grandparent, are exempt from the MAGI household-composition rules.³⁴ Income is also counted differently in some circumstances when determining Medicaid eligibility, such as the treatment of lump sum payments.³⁵ Massachusetts could use its 1115 waiver to align the existing Medicaid household or income rules with the tax subsidy eligibility rules.
- Renewal verification:** Under current verification requirements, the Commonwealth has considerable flexibility to determine sources of income verification for Medicaid renewal but virtually no flexibility with regard to income verification for APTC/CSR. Federal regulations require that the state use IRS data accessed through the federal hub even if the state has more current income data from the enrollee, including self-reported and previously verified data.³⁶ States are even barred from using other credible data sources in cases where no IRS data is available. The Commonwealth could use 1332 authority to propose alternative renewal verification processes for APTC/CSR to allow for more flexibility and align with its MassHealth verification rules.

Align Individual Responsibility Requirements

To continue promoting comprehensive coverage and benefits through its minimum creditable coverage (MCC) requirements, the Commonwealth decided to maintain its individual mandate

³³ 42 U.S.C. 1396a(a)(14)(H)(i); 42 C.F.R. § 435.603(h). States may also take into account reasonably predictable changes in income (i.e., seasonal work, a promise of future employment, or an anticipated layoff) when determining Medicaid income eligibility at application. Medicaid beneficiaries renewing their coverage may use the projected annual income budget period.

³⁴ 42 C.F.R. § 435.603(f).

³⁵ 42 C.F.R. § 435.603(e).

³⁶ 45 C.F.R. § 155.335.

alongside the ACA requirement, meaning that its residents are subject to two mandates—each with a distinct set of rules.³⁷ One key difference between the two mandates is the type of coverage required to satisfy the mandate. The state standard generally requires individuals to have more robust and comprehensive coverage than that which is required to satisfy the federal mandate; this is a key reason the Commonwealth has opted to retain its state-level mandate.

State officials have been working for years to align various other components of the two mandates (including, for example, the definition of affordable coverage), but considerable variation remains. Under section 1332, Massachusetts could further harmonize the individual responsibility rules by modifying those of the federal mandate or eliminating the federal mandate altogether.

Currently, several key aspects of the state and federal mandates differ—in some cases dramatically.³⁸ (See box below.) These differences have created an administrative burden and complexity for state officials and confusion for consumers. The federal affordability standard also subjects residents to a more regressive standard of affordability than the state standard: all non-exempt residents for whom the premium for lowest-cost coverage is less than or equal to eight percent of family income face a penalty under the ACA if they do not have health insurance coverage, regardless of their income level. Massachusetts' affordability standard is progressive, varying with income and household configuration.

DIFFERENCES BETWEEN THE FEDERAL AND MASSACHUSETTS INDIVIDUAL MANDATES

- **The type of coverage required.** The ACA requires residents to maintain minimum essential coverage (MEC), which does not include specific benefit requirements; moreover, employer-sponsored insurance and large-group plans satisfy MEC without any benefit requirement. Under the state mandate, residents must enroll in minimum creditable coverage (MCC), which requires coverage for specific categories of services, regardless of the source of coverage.
- **Exemptions.** The ACA and Chapter 58 exempt different populations from their mandates; for example, children are exempted from the state mandate but not from the federal one. The processes and criteria for granting exemptions based on financial hardship or religious objection also differ. Currently, state exemptions have no effect on federal penalties and vice versa.
- **Affordability standards.** Under the ACA, coverage is considered unaffordable if the premium for lowest-cost coverage is greater than eight percent of family income. The Commonwealth applies a progressive affordability standard, one that varies with income and household configuration.
- **Penalties.** Federal and state penalties differ in both methodology and amount. For example, the state penalty increases with income for the lowest-income groups and also with age for higher-income groups. The federal penalty is either a flat dollar amount or a percentage of household income (whichever is greater).

Though the state has made adjustments to its own affordability standard to align it with that of the federal mandate (while maintaining some degree of progressivity), it could utilize a 1332 waiver to instead adjust the federal affordability standard, so that a single, more progressive definition of affordability would apply beginning in 2017. The Commonwealth could also modify

³⁷ The state has established an approach such that any tax filers subject to both the federal and state penalty are not required to pay aggregated penalties. Rather, if an individual's state penalty exceeds his/her federal penalty, he/she pays the difference between the two to the state. If an individual's federal penalty exceeds his/her state penalty, the state penalty is waived.

³⁸ Linda Blumberg and Lisa Clemans-Cope, *Reconciling the Massachusetts and Federal Individual Mandates for Health Insurance: A Comparison of Policy Options*, Blue Cross Blue Shield Foundation of Massachusetts Foundation, December 2012.

or eliminate other aspects of the federal mandate, such as the type of coverage required or the populations exempted. To preserve the comprehensive level of coverage and benefits achieved under the state's mandate, Massachusetts may choose to adopt a single set of rules that encompasses the state's more robust MCC regulations in lieu of federal MEC requirements. It could also align the populations exempted under the two laws. (No waiver would be required to eliminate a state-only exemption, such as the exemption of children from the state mandate.)

Finally, instead of waiving pieces of the federal mandate, Massachusetts could waive the ACA individual mandate in its entirety. There would be no implications for the comprehensiveness or affordability of coverage (as the state's MCC requirement is more robust than the federal MEC requirement and the cost of coverage would likely not be affected) and little impact on the number of individuals covered (given how effective the state's mandate has been).³⁹ However, there would be an impact on the federal deficit. A waiver of the federal mandate and its penalties would return all penalty revenue back to the state but would increase the federal deficit by eliminating its penalty revenue (which increases over time).⁴⁰ Consequently, to meet section 1332's fiscal requirement, Massachusetts would need to combine a waiver of the federal mandate with some other waiver component or find a way to "share" the penalty revenue it gains with the federal government.

CONCLUSION

By using some combination of a section 1332 State Innovation Waiver, the section 1331 BHP authority, and its MassHealth 1115 Waiver, the Commonwealth has the opportunity to reconfigure the coverage continuum to maximize coverage access, affordability, and continuity for its residents. Massachusetts can combine state and federal dollars currently funding MassHealth, ConnectorCare, and APTC/CSR to develop a new, more rational approach to subsidies; create a BHP or a BHP-like program for some or all of its subsidy populations; leverage its purchasing power across MassHealth and ConnectorCare to align plans, providers and benefits; and use a more integrated coverage continuum as a platform to accelerate delivery system and payment reform. At the same time, the state may be able to generate savings through smarter allocation of federal dollars and by leveraging the significant enrollment volume of MassHealth and ConnectorCare to drive better premium pricing in its QHP or BHP products.

Even as the federal government develops the specifics of section 1332 authority, Massachusetts could begin to develop its own State Innovation Waiver approach so that the waiver can be ready for implementation in 2017.

³⁹ The number of Massachusetts residents subject to penalty is affected by whatever affordability standard and set of exemptions are adopted by the state. These may affect the number of people who choose to purchase coverage, though the change in scope of coverage would likely be minimal.

⁴⁰ In 2012, state revenues from the penalty were \$22 million.

APPENDIX: GLOSSARY OF TERMS

Advanced Premium Tax Credits (APTC): Income-based, sliding-scale tax credits that can be used as soon as an individual enrolls in coverage to lower his/her monthly premium costs. An individual who qualifies for APTC may choose how much of the tax credit to take in advance payment to apply to the monthly premium each month, up to a maximum amount (which is determined based on income and other factors). If the amount of advance payments an individual receives in a year is less than the tax credit she is due, then she will receive the difference as a refund when she files her taxes. If the advance payments are greater than the tax credit due, she must repay the excess advance payment with her tax return.

Accountable Care Organization (ACO): An organization of coordinated health care providers that agrees to be accountable for the quality and cost of overall care for an assigned population of patients. This type of payment and delivery model seeks to tie provider reimbursement to quality metrics and reductions in the total cost of care.

Alternative Payment Methods (APM): Methods of provider reimbursement that vest financial responsibility and performance accountability with providers.

Basic Health Program (BHP): A state option under health reform that gives states 95 percent of what the federal government would have spent on subsidies for adults whose family incomes are between 133 percent and 200 percent of the federal poverty level and on legal resident immigrants who have incomes below 133 percent and who have been in the U.S. for less than five years (and therefore do not qualify for Medicaid). See Exhibit 3 for details.

Coinsurance: A percentage of a medical bill that the patient must pay after the deductible, up to a certain limit; this must be paid before any policy benefit is payable by a health plan. Coinsurance usually contribute toward any policy out-of-pocket maxima whereas copayments do not.

Commonwealth Care: A state-subsidized program established in 2006 by Chapter 58 for Massachusetts residents with incomes up to 300 percent of the FPL; because federal subsidies supplanted this state-subsidized program and because the ACA's subsidies are less generous than those of Chapter 58, Massachusetts replaced Commonwealth Care with ConnectorCare.

ConnectorCare: A new state program that offers subsidized insurance to residents with incomes of up to 300 percent of the FPL. ConnectorCare plans have relatively low monthly premiums and low out-of-pocket costs, with no deductibles. They are most similar to the Commonwealth Care plans that were formerly offered through the Health Connector. ConnectorCare utilizes federal and state funding to supplement federal subsidies.

Copayment or copay: A payment defined in an insurance policy and paid by an insured person each time a medical service is accessed; not all plans include copayments.

Cost-Sharing Reduction (CSR): A discount that lowers the amount individuals have to pay out-of-pocket for deductibles, coinsurance, and copayments. Individuals qualify for CSR if their income is below a certain level and they select a certain level of health plan through the marketplace.

Deductible: The amount an insured person owes for services before his/her plan begins to pay for care. For example, if a person's deductible is \$1,000, the plan will not pay anything for services that are subject to the deductible until that person has paid the \$1,000 deductible. The deductible may not apply to all services.

Dual-Eligible Beneficiaries: Individuals qualifying for both Medicare and Medicaid benefits.

Federal Poverty Level (FPL): A measure of income level issued annually by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits. In 2014, the FPL for an individual living in the 48 contiguous states was \$11,670.

Fee-For-Service (FFS): A method in which providers are paid for each service performed. Examples of services include tests and office visits.

Insurance Affordability Programs (IAPs): Include a state's Medicaid program, Children's Health Insurance Program (CHIP), Basic Health Program, and programs that make advanced premium tax credits and cost-sharing reductions available to qualified individuals purchasing coverage in a marketplace.

Long Term Care (LTC): Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living, or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.

MassHealth: MassHealth is Massachusetts' Medicaid program. It includes the following programs:

- MassHealth Standard offers a wide range of health care benefits, including primary care services, hospital services, behavioral health care, and long-term services and supports, to members including pregnant women, children, people with disabilities, and the elderly.
- MassHealth CommonHealth offers benefits similar to MassHealth Standard to disabled adults and children with incomes that are too high to qualify for MassHealth Standard.
- MassHealth Family Assistance offers a more limited set of benefits to members with HIV/AIDS and incomes between 133 and 200 percent of the FPL who do not otherwise qualify for MassHealth, as well as to children in families with incomes between 150 and 300 percent of the FPL.
- MassHealth CarePlus, the newest MassHealth program, offers a range of services to adults aged 21 to 64 whose income is at or below 133 percent of the FPL and who do not qualify for MassHealth Standard.

Medicaid: A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and, in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States have choices in how they design their programs, so Medicaid varies from state to state.

Medicare: A federal program of health care coverage for the elderly and disabled.

Medicaid Managed Care Organization (MMCO): One of MassHealth's managed care programs. MassHealth administers its MMCO program (one of the nation's oldest) through contracts with six MMCOs: Boston Medical Center HealthNet Plan, Celticare, Fallon Community Health Plan, Health New England, Neighborhood Health Plan, and Network Health.

Network: The facilities, providers, and suppliers a health insurer or plan has contracted with to provide health care services.

Out-of-Pocket: Expenses incurred by a beneficiary that are not covered by any insurance plan. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services, plus all costs for services that aren't covered.

Out-of-Pocket Maximum: The most a patient will have to pay for covered medical expenses in a plan year through deductible and coinsurance before his/her insurance plan begins to pay 100 percent of covered medical expenses.

Payer: In health care, an entity that assumes the risk of paying for medical treatments. This can be an uninsured patient, a self-insured employer, or a health plan or MCO.

Primary Care Clinician (PCC) Plan: One of MassHealth's managed care programs. The PCC Plan is co-administered by MassHealth and its behavioral health vendor, the Massachusetts Behavioral Health Partnership (MBHP), a subsidiary of ValueOptions. The MBHP is contracted on a per member per month (PMPM) basis to provide and manage behavioral health care services for PCC Plan enrolled members and to provide network, quality, and care management for the PCC Plan overall, extending beyond behavioral health. MassHealth contracts directly with primary care clinicians and pays them an enhanced fee-for-service rate. Acute hospital services provided on both an inpatient and an outpatient basis are paid for under a direct contract between a hospital and MassHealth. Specialty physician and all other non-behavioral health services are paid for on a fee-for-service basis according to rates set by regulation.

Provider: A provider of health care services, such as a physician, nurse, hospital, skilled nursing facility, or home health agency.

Provider Network: A group of medical providers who have agreed to serve a health plan or medical facility's members or patients.

Qualified Health Plan (QHP): An insurance plan under the ACA that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A QHP will have a certification by each marketplace in which it is sold.

Section 1115: A section of the Social Security Act that gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs.

Section 1332: A section of the ACA entitled “Waivers for State Innovation” that allows states to waive key pillars of the law beginning in 2017. See Exhibit 4 for details.

Subsidized Coverage: Health coverage that is obtained through financial assistance from programs to help people with low and middle incomes.