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Repeal and Replace? Immediate Considerations for the Massachusetts Health Care Market

The 2010 passage of the Patient Protection and Affordable Care Act (ACA)[1] is heralded as a landmark in health care reform, expanding coverage nationally by implementing market-based reforms, including state health insurance exchanges for consumers to shop for and purchase coverage, federal subsidies for low-income individuals buying insurance on the exchanges, and enhanced federal funding for state Medicaid expansion. In many states, the ACA provided opportunities for individuals to access previously unattainable coverage, and the numbers of uninsured across the country dramatically decreased.

But the effect of the ACA in Massachusetts was more nuanced. Massachusetts paved the way for national health care reform with the passage of Chapter 58 of the Acts of 2006, An Act Providing Access to Affordable, Quality, Accountable Health Care (Chapter 58), a comprehensive reform bill that required state residents to obtain health insurance, required employers with eleven or more employees to offer health insurance, authorized the creation of the quasi-public Massachusetts Health Connector (Health Connector) to develop a marketplace for consumers to compare options and purchase coverage, provided subsidies to low-income individuals, and made changes to the Massachusetts Medicaid program.[2] While the ACA was, in many areas, modeled on Massachusetts reform, its passage required significant changes to the health care market in Massachusetts to conform to federal requirements – including the overhaul of state factors traditionally used to establish premium rates, as well as a complete redesign of consumer products necessitated by new requirements for mandated benefits packages, cost-sharing limits, and value standards under the ACA. Despite the changes required under the ACA, Massachusetts has retained many of the foundations built through Chapter 58, which remain fundamental to continuing a stable market.

As the Trump Administration and Republican Congress begin work to deliver on President Trump's campaign promise to repeal and replace the ACA, special attention must be paid to the Massachusetts health care market. As the Commonwealth seeks to retain the gains in coverage and affordability realized under state and federal health reform, much will be contingent on the elements that may be included in any ACA replacement. In the immediate debate over "repeal and replace," three key considerations for Massachusetts arise:

- Preservation of the individual mandate,
- Continuation of federal subsidies at current levels, and
- Establishment of a reasonable time period for the implementation of any changes to the marketplace that will disrupt care for consumers.

The threat to these essential provisions became imminent when President Trump issued an Executive Order on the night of his inauguration, stating his Administration's intention to pursue "prompt" repeal of the ACA. The broad language of the Order directs the Secretary of the United States Department of Health and Human Services, and other relevant federal agencies, to "exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, health care providers, health insurers, patients, recipients of health care services, purchasers of health insurance, or makers of medical devices, products, or medications." This instruction creates an environment of extreme uncertainty and has the strong potential to disrupt care and coverage for all enrollees by allowing for the immediate revocation of provisions in the ACA that are essential to a stable marketplace.

This OnPoint will examine the impact of the ACA on the Massachusetts health care market and what the future holds in the event the Administration delivers on its promise to repeal and replace.

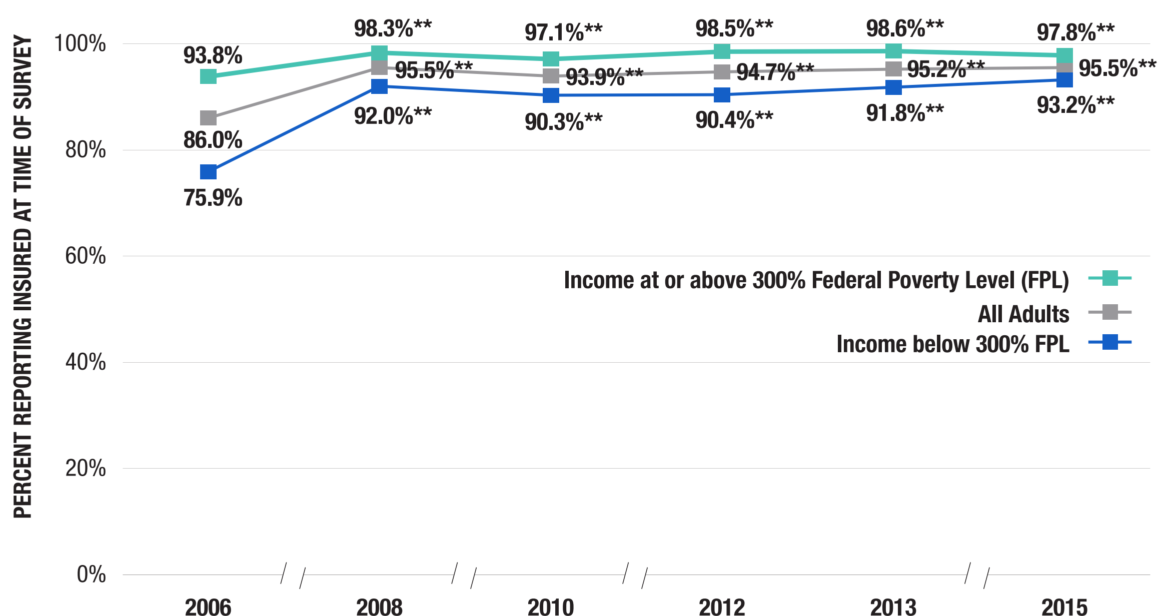
The ACA's Impact in Massachusetts: Coverage Expansion and Financial Assistance

Expanded Coverage for Massachusetts Residents

The Individual Mandate and Guaranteed Issue

Perhaps one of the most vital provisions of both Chapter 58 and the ACA is the requirement that all adult residents purchase and maintain affordable health insurance coverage or pay a financial penalty.[3] This is known as an individual mandate. In Massachusetts, the individual mandate quickly increased the number and percentage of Massachusetts residents with health insurance, and served to stabilize the numbers of insured residents in the Commonwealth since its implementation in 2007.[4] Coverage for adults ages 19 to 64 rose from 86% in 2006 to a nationwide record of 97% in 2016.[5]

HEALTH INSURANCE COVERAGE FOR ADULTS AGES 19 TO 64 IN MASSACHUSETTS, 2006–2015



Source: 2006–2015 Massachusetts Health Reform Survey (N=18,286). The survey was not fielded in 2011 or 2014.
Data for 2007 and 2009 not shown.
Note: These are simple (unadjusted) estimates.
*(**) Significantly different from the value in 2006 at the .05 (.01) level, two-tailed test.
^(^^) For 2013 and 2015: Significantly different from the value in 2012 at the .05 (.01) level, two-tailed test.
#(##) For 2015: Significantly different from the value in 2013 at the .05 (.01) level, two-tailed test.
[6]

Massachusetts state law and the ACA also established protections for consumers with pre-existing conditions.[7] Specifically, health plans are prohibited from denying coverage to individuals with health problems or from charging these sick members a higher premium based on their medical expenses; this is referred to as guaranteed issue.[8] As a result of the individual mandate and guaranteed issue, healthier people in the state purchased coverage in the individual insurance market and individuals with pre-existing conditions were able to access more affordable coverage. The combination of these two requirements serves to make health insurance more affordable for all and risk more manageable for insurers.[9,10]

A health insurance market operates most efficiently when enrollment levels are high and the risk profile of enrollees is balanced between healthy and sick individuals.[11] Therefore, the maintenance of the state's individual mandate is critical to incentivize Massachusetts residents to obtain coverage; the enrollment of healthier individuals allows for reduced premiums for members with serious health care needs because the cost of their care is spread among all enrollees.[12] In the absence of a provision compelling individuals to obtain health insurance, younger and healthier men and women will be more likely to forgo coverage, leaving those who need health insurance because they have illnesses to pay more of the cost of care. Increased premium rates would continue to discourage those in good health from purchasing health insurance and make it more difficult for the remaining individuals to find products they are able to afford, perpetuating a cycle referred to in the industry as a "death spiral."[13]

While employer-sponsored coverage remains the primary source of health insurance for most Massachusetts residents, barriers to coverage existed for some populations prior to implementation of Chapter 58 and the ACA.[14] With the establishment of an individual mandate and the increased availability of government subsidies to purchase coverage, enrollment levels continued to improve through affordable options offered on the state Exchange and through MassHealth expansion.

State Health Exchanges

The state's health insurance marketplace, the Massachusetts Health Connector, was created in Chapter 58, giving Massachusetts consumers the ability to compare health plans and shop for coverage online. The ACA also included a requirement for states to implement an "Exchange" to facilitate the purchase of health insurance in each state. Health insurance products offered to consumers on the Commonwealth's Exchange must meet robust state and ACA standards relative to quality, value, and benefits. In Massachusetts, health plans submit their offerings for certification through the Health Connector's Seal of Approval Process.

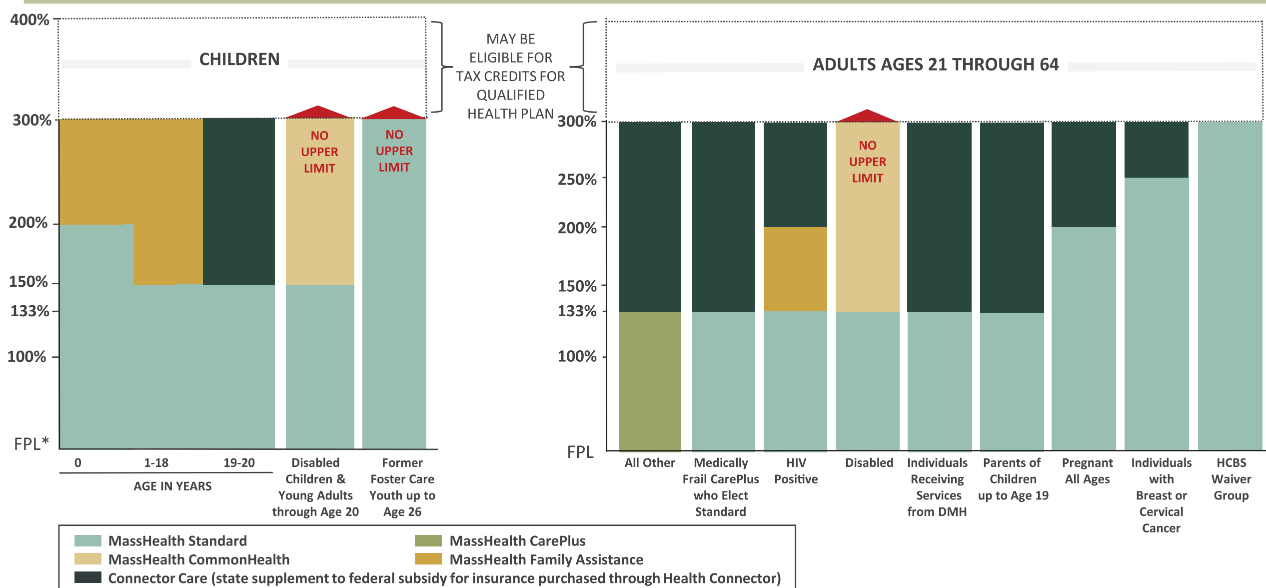
With an infusion of $188.3 million[15] in federal grant funding to bring the Massachusetts Exchange into an ACA-compliant marketplace, the Commonwealth made major investments to improve the Health Connector website's infrastructure, enhance the functionality of the application and eligibility determination processes, and allow for compatibility with several federal agency data and information banks.[16] The Commonwealth faced significant challenges to implement the new system, including the construction of a new consumer-facing portal and back-end integration between the Exchange and the health plans for enrollment and payment processes. As a result, the transition of existing enrolled members to coverage that met the standards established by the ACA was gradual. However, these changes have assisted in increasing access to coverage for all state residents. Today, our state's Connector website is fully operational and provides positive shopping and enrollment experiences for consumers.

Medicaid Expansion

Since the passage of the ACA, large groups of individuals have gained access to Medicaid coverage through changes in eligibility and increased federal funding. Prior to the ACA, Medicaid eligibility was based on population group rather than an individual's income level. Low-income children, pregnant women, the elderly, or persons with disabilities could qualify for Medicaid coverage, but adults without dependent children were ineligible regardless of their income. States could petition the federal government to expand their Medicaid coverage to additional populations by applying for a federal waiver known as a Section 1115 Medicaid Demonstration Waiver. Through the waiver process, Massachusetts had expanded its Medicaid coverage to include all children with family incomes up to 300% of the Federal Poverty Level (FPL), low-income employees of small businesses, and long-term unemployed individuals.

Under the ACA, states were permitted to expand their Medicaid programs based on income rather than by population categories, allowing coverage for most individuals at or below 133% of the FPL. The federal government would provide enhanced funding, known as a Federal Medical Assistance Percentage (FMAP), to expansion states. Massachusetts had been receiving 50% FMAP on most Medicaid expenditures before ACA expansion but began receiving 75% on average in 2014, with an expected increase to 90% for some populations by 2020.[17]

MASSHEALTH ELIGIBILITY UNDER ACA



FPL = income as percent of federal poverty level; in 2015 100% FPL for a family of four was $24,250.
NOTE: In general, the eligibility level for seniors age 65 and older is 100 percent of FPL and assets of up to $2,000 for an individual or $3,000 for a couple. More generous eligibility rules apply for seniors residing in nursing facilities or enrolled in special waiver programs. [18]

Since the full implementation of the ACA, MassHealth enrollment has risen from 1.4 million to 1.9 million, representing a nearly 30% increase. Twenty-one percent of state residents now receive MassHealth as their primary coverage.[19] This surge in enrollment is attributed to a shift away from commercial coverage offered by employers due to changes to the employer mandate.[20] The state requirement that employers offer insurance was repealed in 2013 as lawmakers worked to bring Massachusetts into compliance with the ACA, and a parallel federal mandate that fines employers with over 50 employees that do not offer insurance was delayed until 2016.[21] Between 2011 and 2015, the number of full-time employees not covered by employer-sponsored insurance has grown by 15%.[22] This enrollment growth has contributed to increased spending on the MassHealth program, and Governor Baker and his Administration have offered a proposal in the fiscal year 2018 budget to deal with the $600 million increase. The proposal establishes tighter employer responsibility requirements, including a $2,000 annual assessment per full-time equivalent employee for companies that do not offer their employees health insurance. This assessment would apply to businesses with 11 or more full-time employees that do not cover at least 80% of their workers and share at least $4,950 of the premium cost for full-time workers (defined as those who work 35 hours or more per week).[23]

Medicaid spending represents nearly 40% of the state's budget, and the Medicaid program brings in more than 90% of all federal revenues received by the state.[24] But even at current levels of federal subsidies, higher enrollment in the MassHealth program puts fiscal pressure on the state. While federal approval of the state's most recent Section 1115 Medicaid Demonstration Waiver secures $1.8 billion in funding for a redesign of the state's Medicaid program and authorizes more than $52.4 billion to the MassHealth program over the next five years, any federal funding for state Medicaid programs is at risk under the new federal Administration and a Congress with a different health policy agenda.[25,26]

Federal Financial Assistance for Consumers

The ACA altered the way consumers pay for their coverage, with the implementation of several measures aimed at providing increased financial assistance through federal funding, including the provision of Advance Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs), and by expanding Medicaid coverage. The greatest threat of a broad repeal of the ACA is the elimination of these significant financial subsidies received by the state's enrollees to help reduce the cost of their health care coverage. This direct financial assistance makes health care more affordable for lower-income enrollees who might not purchase coverage without this support. The impact on the cost of health care cannot be overstated: with repeal of the individual mandate and federal ACA funding, premiums across the country would be 50% higher in the first year after the marketplace subsidies were eliminated, and they are projected to double by 2026.[27] Federal spending on Medicaid, APTCs, and CSRs in Massachusetts would decrease by $38 billion over the first 10 years after repeal.[28]

Federal and State Subsidies Offsetting the Cost of Purchasing Coverage: Options Available through the Health Connector

When Massachusetts residents began shopping for coverage on the Health Connector, they could access unsubsidized coverage through the Commonwealth Choice program and subsidized health insurance through the Commonwealth Care program for adults with incomes at or below 300% of the FPL who were not eligible for MassHealth or other insurance. While the Health Connector was responsible for implementing Commonwealth Care, the federal funding to support this initiative was granted under the state's Section 1115 Medicaid Demonstration Waiver.[29]

With the passage of the ACA, the Health Connector has restructured the way federal and state subsidies are distributed, eliminating the Commonwealth Care program and developing a new subsidized insurance program for adults with income levels at or below 400% FPL. Today, the Health Connector offers coverage through Exchange products with federal assistance to defray the costs of premiums and cost sharing in the form of APTCs and CSRs.[30]

2016 FEDERAL POVERTY LEVEL (FPL) GUIDELINES

Household size	ConnectorCare Plan Type 1 (0-100% FPL)	ConnectorCare Plan Type 2A (100-150% FPL)	ConnectorCare Plan Type 2B (150-200% FPL)	ConnectorCare Plan Type 3A (200-250% FPL)	ConnectorCare Plan Type 3B (250-300% FPL)	Tax credit only (300-400% FPL)
1	$11,880	$17,820	$23,760	$29,700	$35,640	$47,520
2	$16,020	$24,030	$32,040	$40,050	$48,060	$64,080
3	$20,160	$30,240	$40,320	$50,400	$60,480	$80,640
4	$24,300	$36,450	$48,600	$60,750	$72,900	$97,200
For each extra person, add:	$4,160	$6,240	$8,320	$10,400	$12,480	$16,640
Lowest monthly premium for ConenctorCare	$0	$0	$43	$83	$124	Tax credit amount varies

[31]

Advance Premium Tax Credits (APTCs)

Individuals who purchase coverage directly through the Health Connector have access to APTCs as provided for in the ACA.[32] Individuals can use the credits to reduce health insurance premiums, either by applying the tax credit to their monthly premium or receiving the credit at tax filing time. Eligibility and the amount of APTCs available are calculated according to the enrollee's estimated household income for the upcoming year. In Massachusetts, households earning up to 400% FPL are eligible for this credit. In 2016, 258,000[33] Massachusetts enrollees took advantage of APTCs to help defray the costs of health care, at an average monthly credit of $190. This represents an estimated $360 million in federal tax credits to consumers in the Commonwealth.[34]

Cost Sharing Reductions (CSRs)

The ACA also established CSRs, additional funding available to some enrollees receiving APTCs to be used for reducing out-of-pocket costs, including deductibles, copayments, and coinsurance.[35] To be eligible, individuals and families with incomes up to 250% FPL ($60,625 for a family of four in 2015) must enroll in a Silver-tiered health plan through the Health Connector's ConnectorCare program. Health plan enrollees who qualify for CSRs also benefit from a lower out-of-pocket maximum, the total amount they would otherwise have to pay out-of-pocket for covered medical services per year. When a member reaches his or her out-of-pocket maximum, the health plan pays 100% of all covered services.

ConnectorCare

CSRs are available only to individuals enrolled in coverage through the state's ConnectorCare program, established in 2015. ConnectorCare plans offer the same benefits as other coverage on the Health Connector; however, these plans are offered with lower monthly premiums, lower out-of-pocket costs, and no deductibles, as a result of the federal subsidization in the form of CSRs and additional state funding.[36] Massachusetts dedicates additional state dollars to "wrap" around the ACA tax credits, CSRs, and offset federal matching funds available from MassHealth's 1115 waiver to further reduce the financial exposure to ConnectorCare enrollees. Individuals earning up to 300% of the FPL are eligible for ConnectorCare. In 2016, there were 244,400[37] enrollees in a ConnectorCare plan, representing 78% of all commercial health plan members who obtained coverage in the individual market through the Health Connector.[38]

Consequences of Repeal: Millions Lose Coverage

Congressional Republicans have clearly stated that they intend to repeal the individual mandate at the federal level, which could lead to the loss of coverage for a large percentage of Massachusetts residents. Various proposals from Administration officials and legislators for the elimination of federal subsidies available under the ACA, as well as a potential revamping of Medicaid funding from Section 1115 Medicaid Demonstration Waiver dollars to Medicaid block grants, raise concerns about the viability of continued access to affordable coverage for residents currently receiving APTCs, CSRs, or coverage under the state's Medicaid expansion.

A repeal of the ACA's individual mandate, in combination with the elimination of the ACA's expansion of Medicaid eligibility and federal subsidies available to individuals who purchase coverage through an Exchange, is estimated to increase the number of people without health insurance coverage by 59 million in 2026, representing 21% of Americans under age 65.[39] Fewer than 2 million people would be enrolled in the individual market in 2026.[40] The adverse impact on Massachusetts is estimated to be an immediate 273% increase in the number of uninsured individuals if the individual mandate, along with federal funding under the ACA, is repealed.[41]

Where Do We Go from Here? Recommendations for Maintaining Market Stability and Universal Health Coverage in the Commonwealth

Our state policymakers and stakeholders must work collaboratively to ensure maintenance of a robust individual mandate, continued federal financial support at current levels, and a sufficient time frame for the implementation of changes that will affect consumers' ability to access affordable care. Failure to do so will mean that millions of individuals could lose important health care coverage.

We recommend:

1. **Preservation of the individual mandate in state law**

   Support of the maintenance of the state's individual mandate is necessary to avoid a collapse of the individual market. An individual mandate provides a strong incentive for younger and healthier people to purchase coverage and ensures that the cost of coverage will not be negatively affected by the consequences of adverse selection. Without a mandate, the young and healthy are more apt to opt out of the market. If only higher-cost individuals remain in coverage, premiums must increase to cover the cost of care for an enrollee population with higher claims and expected medical needs. If the cost of coverage becomes out of reach for lower-income individuals, then quality care also becomes unattainable.

   The most critical concern to all stakeholders is the continuation of coverage for all Massachusetts individuals, employees, and families currently enrolled in coverage through the state. At a time when the Commonwealth's attention is focused on measures to reform the health care payment system in a manner that rewards high-quality, efficient care and to make health care more affordable for employers and consumers, state policymakers must recognize the importance of maintaining the state's statutory individual mandate and the existing penalties associated with a lapse in coverage.

2. **Continuation of federal subsidies in order to maintain coverage gains and avoid subjecting enrollees to greater financial exposure**

   The rising cost of health care is a challenge facing all stakeholders in the health care system. Ensuring that consumers continue to have access to affordable coverage is dependent on the preservation of full subsidization from the federal government. Federal financial support to assist individuals in purchasing coverage includes APTCs and CSRs, as well as federal funds dedicated to the state's innovative Medicaid expansion

and ConnectorCare program. In the absence of these federal subsidies, low-income individuals and households are unlikely to be able to continue with their coverage.

Further, preservation of the state's recently approved Section 1115 Medicaid Demonstration Waiver coverage is essential for individuals in ACA expansion and ConnectorCare populations. Should the Medicaid expansion be repealed, or the structure of federal reimbursement for state Medicaid be altered, fedral funding for these individuals would be eliminated, and it would be up to the state to make up the difference. Governor Baker, in his recent letter to Congressional leadership, expressed serious concern that a shift to block grants or per capita spending to states as a replacement for the current FMAP funding for MassHealth enrollees would result in reduced federal funds, shifting costs to the states ("States would most likely make decisions based mainly on fiscal reasons rather than the health care needs of vulnerable populations and the stability of the insurance market."[42]). The state must continue to strongly advocate for sustained funding at existing levels to ensure residents of the Commonwealth continue to have access to affordable coverage choices.

3. Establishment of a reasonable transition period for the implementation of any significant changes that will impact the marketplace or require operational adjustments

Since the enactment of the ACA, health plans have worked continuously to implement a host of new federal and state requirements to ensure that all products and business practices meet ACA standards. During this time, plans have expended millions of dollars on new IT systems and infrastructure improvements to support the sale of ACA-compliant products and to effectuate eligibility and rate verification, enrollment processing, and electronic data exchange for transacting business with the Health Connector and its vendors. Consumers now enjoy a significantly improved shopping and enrollment experience using the state Exchange. However, it took many months for the state to effectuate a successful transition of 400,000 Exchange enrollees into the appropriate health plans. Inadequate preparation after a repeal of ACA provisions could lead to the same types of disruptions and difficulties that consumers experienced in 2014.

Sufficient implementation time will help avoid a disruption in care for consumers. In his letter to Congressional leadership, Governor Baker recognized the need for "ample lead-time in order to ensure that employers, insurers, and individuals are able to prepare and possibly alter their choices without undue disruption."[43] Health plans must design and finalize products to be offered on the Exchange for calendar year 2018 by this spring, typically in April. Premium rates for 2018 must be calculated and submitted by July 1 for approval by the Division of Insurance. These fast-approaching deadlines put significant pressure on health plans, given the current environment of extreme uncertainty. Sudden and significant changes have the potential to jeopardize coverage for a large number of enrollees who may be required to complete an application, receive a program determination, select a health insurance product, and make a payment for the first month's premium within a very short time frame in order to successfully enroll in a new health plan for coverage. Therefore, a phaseout of any enacted ACA repeal or amendments over an extended time period, ideally three years, will better protect the stability of our market. A lengthy transition period will provide health plans with the time to develop and price new products and give consumers and employers an opportunity to fully understand the options available to them.

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