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OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

# MARKET STABILITY WORKGROUP

Tuesday, May 1, 2018
8:00 – 10:00 a.m.
The Institute for the Study & Practice of Non-Violence

# RI Market Stability Workgroup: Eight Week Syllabus

| Topic(s) for Discussion | Meeting Date |
|---|---|
| **Meeting 1**<br>Introductions + Setting the Stage | Wednesday, April 18 |
| **Meeting 2**<br>What has been accomplished + What is at risk in RI | Wednesday, April 25 |
| **Meeting 3**<br>**National Survey of State Actions + Considerations** | **Tuesday, May 1** |
| **Meeting 4**<br>Policy Deep Dive: the “carrot” approach | Tuesday, May 8 |
| **Meeting 5**<br>Policy Deep-Dive: the “stick” approach | Tuesday, May 15 |
| **Meeting 6**<br>Overview of Factors Influencing Premiums | Tuesday, May 22 |
| **Meeting 7**<br>Moving Toward Final Recommendations | Tuesday, May 29 |
| **Meeting 8**<br>Reaching Final Recommendations | Tuesday, June 5 |

# Addressing Feedback from Previous Sessions

- A white paper on 1332 enabled reinsurance programs was sent out in advance of today's meeting

- A preliminary overview of policy options has been provided to you today.  This morning we are going to take a look at reinsurance, the individual and employer mandates and short-term plans.

# Today's Agenda

## Purpose of Today's Meeting

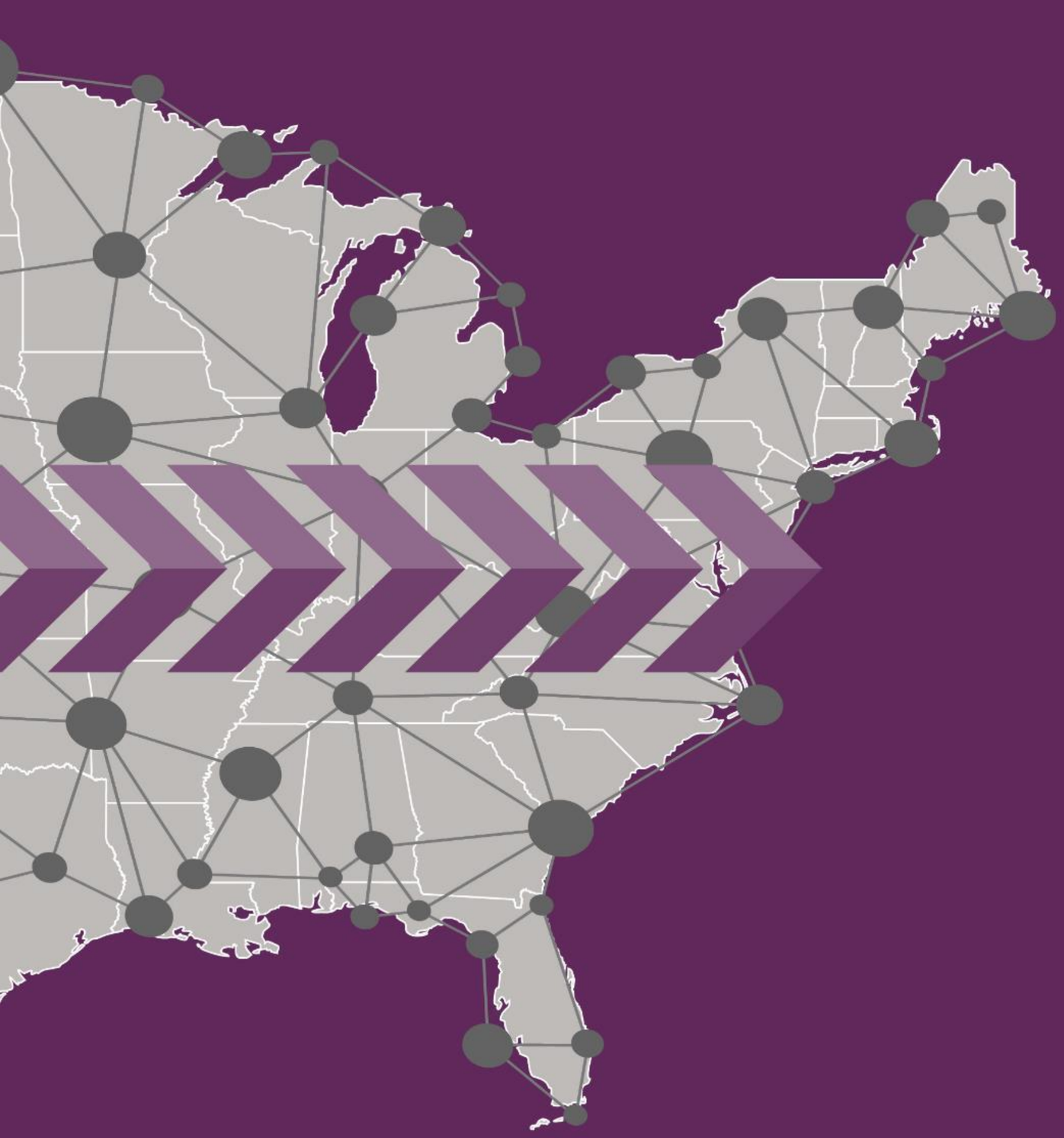
- Create common understanding of Congressional reform proposals and state responses to federal changes
- Explore the Massachusetts experience with a state-level mandate

## Today, we ask that you

- Begin discussion of policy components and combinations that resonate with you
- Identify areas of focus for deep dives in next two meetings

## Agenda for Today

- Action across the nation, both state and federal
- The Massachusetts experience
- Discussion



# Individual Market Stability:

## Definitions and Remedies

Dan Meuse
Princeton University

**May 1, 2018**

STATE Health & Value STRATEGIES

*Driving Innovation Across States*

*A grantee of the Robert Wood Johnson Foundation*

# About State Health Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

**Questions?** Email Heather Howard at heatherh@Princeton.edu.

# Agenda for Conversation

- Quick review of “Market Stability”
- What did Congress discuss as market stability solutions?
- What have states done to stabilize their market?
- 1332 waivers – Basics and Uses

# Market Stability

There is no accepted definition or score to determine the stability of a health insurance market, as perceived by the consumer.

## Symptoms

- Extreme rate increases (>20%)
- Carriers leaving market
- Bare coverage areas

## What leads to symptoms?

- High risk / High utilization risk pool
- Small pool of lives
- Payment discrepancies between carriers
- Population churn (Both into/out of market and among carriers)
- External policy decisions

# Federal Response

- Alexander/Murray, Collins, Costello
  - Federal Reinsurance
  - CSR Replacement

Did not pass – Alexander and Murray have abandoned efforts

# State Responses

- Reinsurance
- State-level Mandate Penalty
- Short Term Plan Regulation
- Policy Abandonment

# State Responses

## Reinsurance

Alaska, California, Colorado, District of Columbia, Hawaii, Iowa, Louisiana, Maine, Maryland, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, Oklahoma, Oregon, Pennsylvania, Vermont, Washington, Wisconsin

## State Mandate

California, Connecticut, District of Columbia, Hawaii, Minnesota, New Jersey, Vermont, Washington

## Action on Underwritten Products

Arkansas, California, Colorado, Indiana, Maryland, New York, New Jersey, Oregon

# Reinsurance

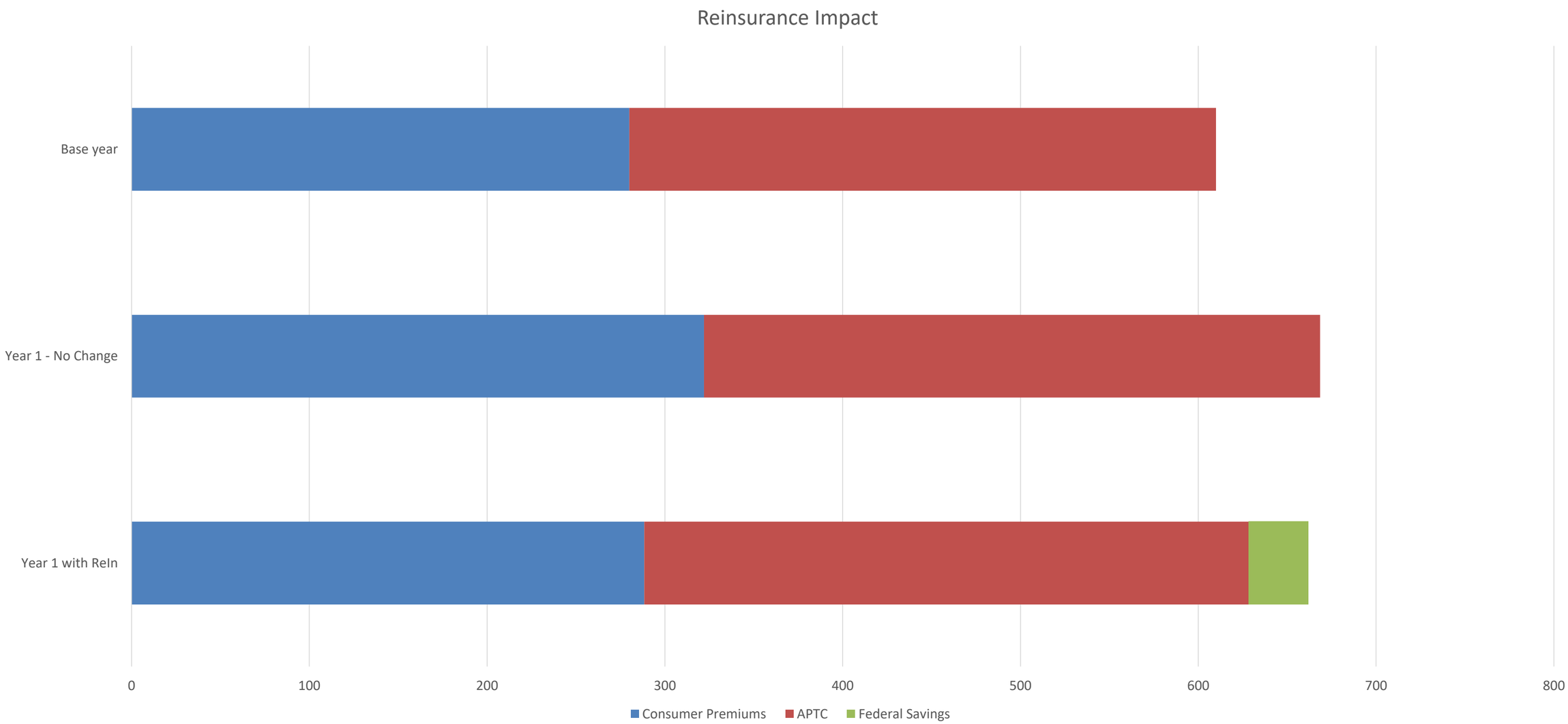
# Overview

- Reinsurance is efficient mechanism for spreading the costs of high cost enrollees
- Temporary Federal reinsurance program kept premiums down for first three years of ACA
- Three states were approved for 1332 reinsurance waivers in 2017 (AK, MN, OR), several considering in 2018 (WI, ME, MD, NJ – LA, CO, VA)
- Elimination of mandate penalties for 2019 will build pressure for premium relief, especially for unsubsidized individuals
- Congress considered a second round of federal funding for reinsurance

# Benefits of Reinsurance

- Proven track record of reducing premiums by guaranteeing carriers don't face large losses
- Increased insurer participation
  - insurer participation declined when federal reinsurance ended
- Reduced market volatility

# Reinsurance Premium Impact Model



# Overview of Three Approved 1332 Waivers

| | Alaska | Minnesota | Oregon |
|---|---|---|---|
| **Approval Date** | 7/11/17 | 9/22/17 | 10/19/17 |
| **Reinsurance Type** | Condition Based | Attachment Based | Attachment Based |
| **Targeted Premium Reduction** | 20% | 20% | Approximately 7% |
| **Reinsurance Funding** | | | |
| **2018 Total Reinsurance Program Funding[1]** | $60 M | $271 M | $90 M |
| **Federal Pass Through Funding for 2018** | $58 M | $131 M | $54M |
| **2018 State Funding Required** (after pass through funding) | $2 M | $140 M | $36 M |
| **Percent of Program Covered by Federal Dollars[2]** | 97% | 48% | 61% |
| **Authorizing Legislation** | Reinsurance Program; Health Ins. Waivers. HB 374. 29th Legis., 2nd Session | Minnesota Premium Security Plan. Chapter 13, HF 5, 90th Legis., Regular Session | Enrolled. HB 2391. 79th Leg, 2017 Regular Session |

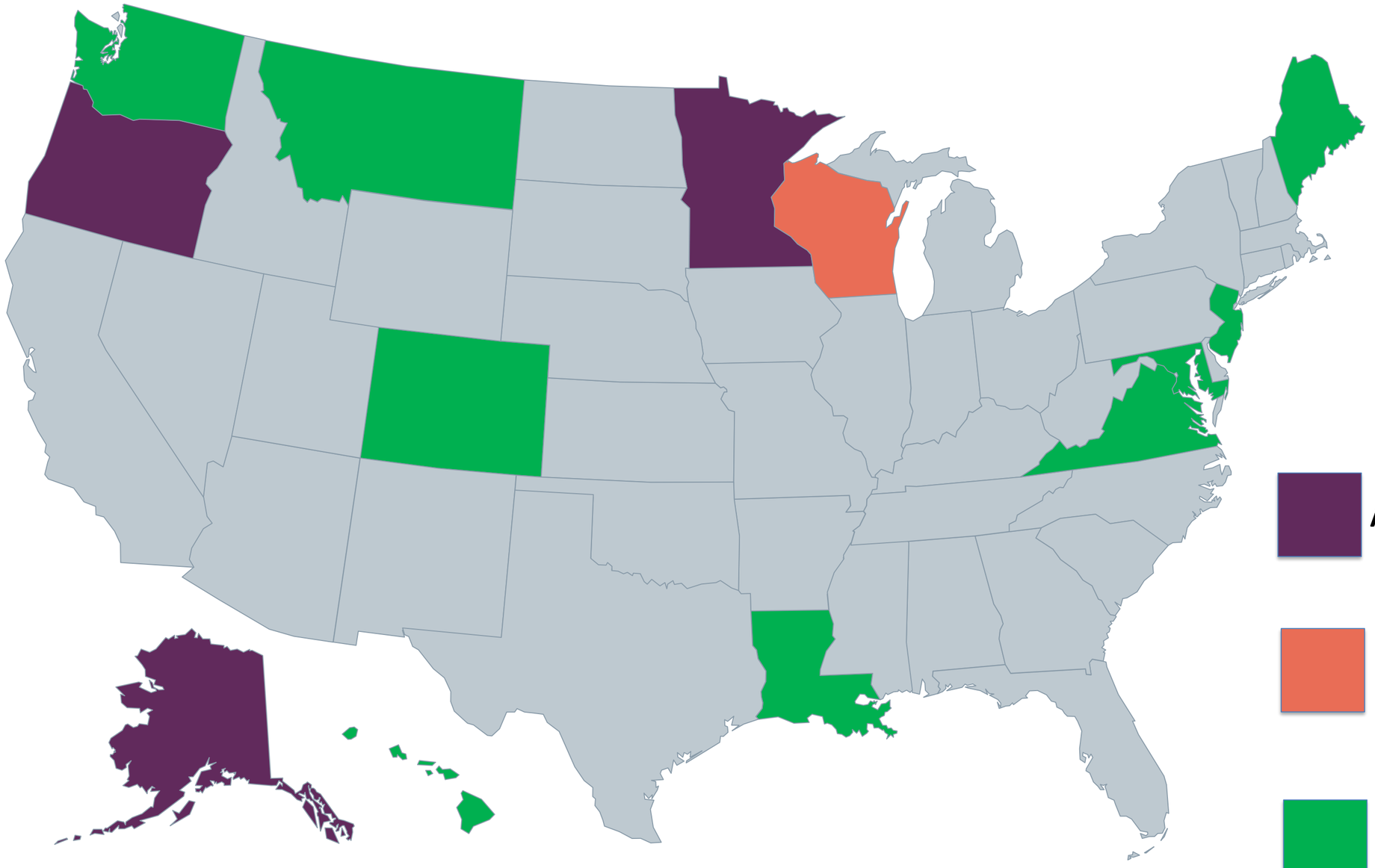
1) These amounts are set by the states, which have the flexibility to decide on the size of reinsurance program, typically based on what percentage of premium reduction they have targeted. 2) If state uses all of the federal funds to replace state dollars, this is the percentage of the total program covered by federal dollars.

# Primer on State Planning for 1332 Application

- Market assessment
- Scale of program
- State financing
- Legislative approval
- Infrastructure
- Timeline
- Federal funding

Early planning positions states to respond successfully to federal policy shifts

# Reinsurance Activity Map



Active Reinsurance

Current Application

Actively seeking legislation or application

# 1332 Waivers

# 1332 Waiver Basics

- Flexibility to waive major ACA coverage provisions and try out solutions tailored to the state's specific needs
- Opportunity to stabilize insurance market and reduce premiums
- Access to federal funds that would otherwise be coming into the state through ACA programs

1332 Waivers are a tool to achieve a policy goal – not a policy solution

# What can be waived?

- Coverage structures (QHPs, EHBs, Metal levels)
- Subsidy structures (APTC, CSR)
- SHOP, Marketplace, Employer Mandate

***Market fairness rules cannot be waived***

# Limits on Waivers (Guardrails)

**Affordability**

Coverage under the waiver must be as affordable as without the waiver

**Comprehensiveness**

Coverage under the waiver must be as comprehensive as without the waiver

**Coverage Scope**

A comparable number of lives must be covered under the waiver as without the waiver

**Deficit Neutrality**

The waiver cannot add to the deficit of the United States

# State Individual Mandate

# Tax Bill's Repeal of Individual Mandate

- The tax bill repeals the ACA's individual mandate penalty, effective January 1, 2019
- CBO estimates 10% premium increase, 13 million lose coverage
- Massachusetts' mandate, included in 2007 health reform, is still in effect

# Option: States May Consider a Mandate

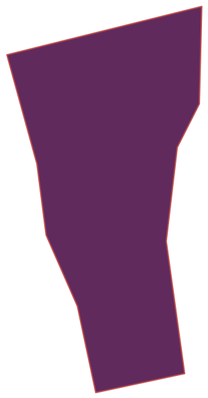
- Replaces federal policy
- Favorable fiscal calculus
- Tool for limiting substandard plans
- Creates outreach opportunities
- Expands 1332 options by improving baseline
- Manageable implementation

# State-level Insurance Mandate

## New Jersey

- Modeled on federal penalty (same structure and amount)
- Proceeds from penalty would go to trust fund to cover share of reinsurance costs
- Passed by both houses and awaiting governor’s signature

# State-level Insurance Mandate



## Vermont

- Open statutory construction – details on penalty amount, enforcement, exemptions left to board
- Currently in legislative conference committee

# State-level Insurance Mandate

## Maryland

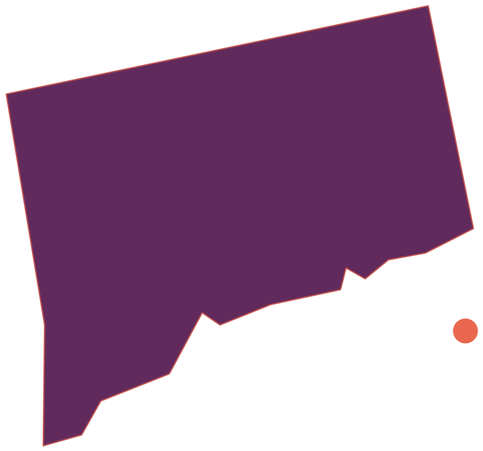
- Modeled on federal penalty (same structure and amount)
- Proceeds from penalty would follow the person and could be used to purchase coverage
- Legislation failed in 2018

# State-level Insurance Mandate

## District of Columbia

- Included in Mayor's budget
- Maximum penalty pegged to cost of average bronze plan
- Proceeds are to be used for insurance affordability and outreach
- Still under discussion

# State-level Insurance Mandate



## Connecticut

- Two bills proposed
- In one, proceeds from penalty would follow the person and could be used as HSA-style account. Other bill sent funds to general fund
- Legislation failed in 2018

# Short-Term Limited Duration Health Plans

# Key Provisions of Proposed Regulations on STLD Plans

- Reverses 2016 rule's 3-month duration limit
  - Return to pre-ACA definition (policy less than 12 months)
  - Renewable (but with medical underwriting)
- Revises consumer disclosure to say
  - Coverage not required to comply with ACA
  - No eligibility for SEP
  - Not MEC (potential mandate penalty in 2018)
- Effective date – 60 days after final rule

# STLD Plans: Potential Impacts

- Impact compounded by zeroing out mandate penalty
- Smaller, sicker individual market enrollment
  - HHS estimates 100-200k enrollment loss; Urban Institute estimates 2.1 million
  - Higher premiums for ACA-compliant plans
  - Higher federal outlays for APTCs ($96-$168M estimate)
  - Fewer plan choices
- Consumer-level impacts
  - Young, healthy get cheaper options (if unsubsidized)
  - Old, sick, or seeking comprehensive coverage pay more
  - Increased financial liability if get sick, injured
  - History of deceptive marketing tactics

# Issues, Implications for States

- States retain primary role as regulator of STLD plans
- Comments requested on
  - Effective date
  - Appropriate duration for STLD policies
  - Conditions for renewal & reapplication
  - Any estimates of impact on STLD and ACA-compliant markets, including premiums and federal APTC spending

# State Options to Protect Markets and Consumers

- Protect market stability*
  - Ban outright
  - Require compliance with all individual market rules
    - NY, NJ
  - Require compliance with selected individual market rules, i.e., benefit mandates, underwriting limits
    - AR
  - Limit duration, renewability
    - OR, CO, IN, MD
  - Require contributions to reinsurance

*Depending on state, some options can be implemented administratively, some will need legislation.

# State Options to Protect Markets and Consumers

- Improve consumer disclosures & increase oversight
  - Monitor, respond to deceptive marketing
    - See e.g. consumer fraud alerts in IN, IA, AK, WY
    - Secret shopper scans
  - Require more, better consumer information
    - i.e. prominent disclosures on marketing materials, broker websites

# Policy Abandonment

# Eschewing the ACA

**Iowa** – Developed a “new” model of coverage that is not defined as health insurance under the ACA – Underwritten products, no protections for pre-existing conditions

**Idaho** – Governor and insurance commissioner encouraged health plans to submit plans for sale that do not comply with ACA standards.

**Tennessee** – Supports “Grandmothered” Plans through farm bureau. Plans are not fully ACA compliant and draw healthy lives out of marketplace risk pool

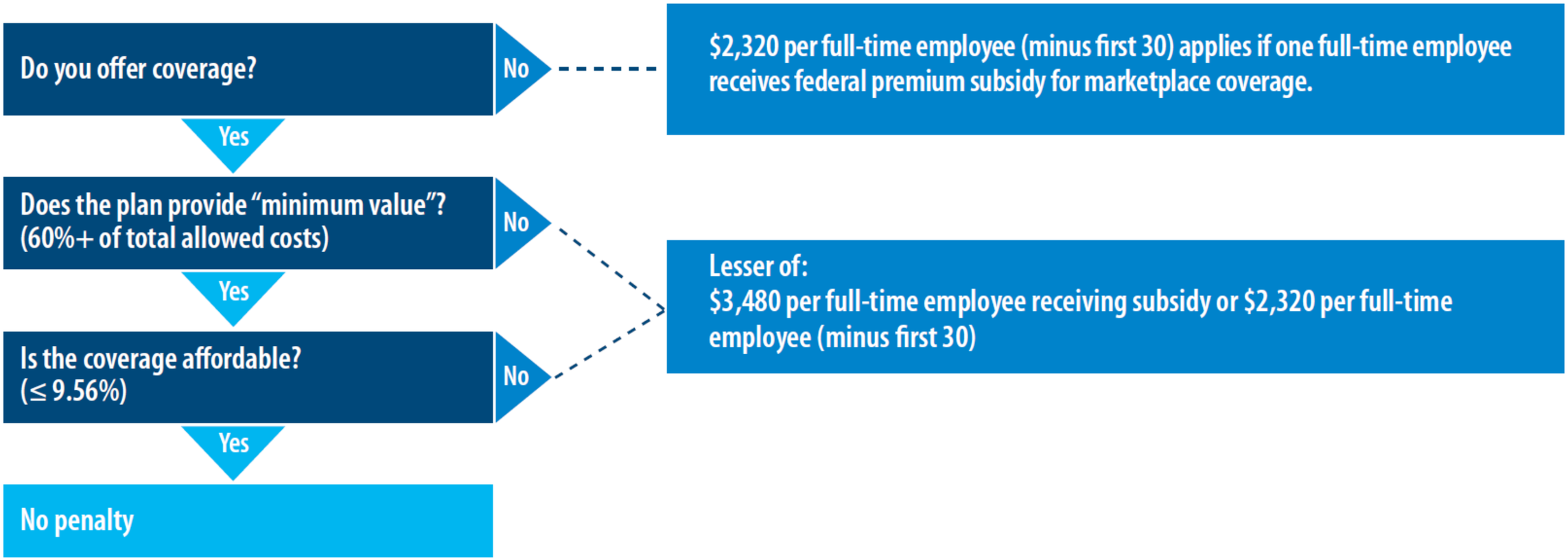
# Employer Mandate

# Employer Mandate Basics

Employers with at least 50 full-time equivalent employees face annualized penalty per full-time employee if any employee receives APTC

Limited relief until Tax Year 2017. Now in full enforcement.

# Employer Mandate Basics



# Employer Mandate Effects

- Limited research and data available due to lack of enforcement.
- Anecdotal impacts on employment (hours offered and staffing size) at the enforcement trigger
  - FTE is 30+ hours/week
  - PLUS total hours of service of non-FTE per month divided by 120

# State Based Employer Mandate

**Hawaii** – 1974 law included employer mandate. Law also created standardized plans for all employers in state. Hawaii secured an ERISA exemption and 1332 waiver to protect program

**Massachusetts** – Reform in 2006 included a “Fair Share Contribution” for employers that did not offer coverage. Repealed in 2013 in advance of ACA Employer mandate. New 2017 contribution supplement for employers with employees in coverage with financial assistance

# Thank you

**Dan Meuse**
Deputy Director, State Health & Value Strategies
dmeuse@princeton.edu
609-258-7389
www.shvs.org

MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

# Massachusetts's Experience with a State Individual Mandate

AUDREY MORSE GASTEIER
Chief of Policy and Strategy

*Discussion with Rhode Island Market Stability Work Group*
*Tuesday, May 1, 2018*

# Background on MA Individual Mandate

***Massachusetts has been administering its own individual mandate since July 1, 2007. It was included as a part of Massachusetts's own health reform law, passed in 2006.***

- In 2006, Massachusetts enacted a comprehensive package of landmark health care reforms designed to expand health coverage.
- Among these reforms was a requirement that adult state residents enroll in affordable health coverage or face a penalty. The Massachusetts Health Connector and the Department of Revenue (DOR) have worked together since then to implement this "individual mandate."
- The individual mandate reflected the guiding principle of shared responsibility that governed the Commonwealth's first-in-the-nation health reform effort.
- The mandate went into effect on July 1, 2007, coupled with a comprehensive public awareness campaign.
- In 2015 (the most recent year for which we have tax data), only 3% of adult tax filers reported not carrying coverage that met state standards.
- The mandate is comprised of three key policy components: coverage standards, affordability standards, and penalties/exemptions.

# Coverage Standards

***In order to satisfy the individual mandate requirements, state residents must enroll in a health plan that meets Minimum Creditable Coverage ("MCC") standards.***

- Some plans are deemed categorically compliant with MCC, per statute (e.g., Medicare, Medicaid, Qualified Health Plans sold through the Marketplace)
  - Note: Unlike the federal "Minimum Essential Coverage" definition, employer coverage is not automatically deemed MCC
- For plans that are not defined as categorically compliant, standards set in MCC regulations address related to
  - Covered benefits (e.g., ambulatory services, prescription drugs)
  - Cost sharing (i.e., caps on deductibles and out of pocket spending)
- If a plan does not precisely meet certain standards outlined in regulation but still provides robust coverage overall, the Health Connector has a process by which a plan sponsor can apply for and receive designation as an MCC-compliant plan.

# Penalties

***State residents determine if they owe a penalty for not complying with the state individual mandate when they file their state income tax return.***

- Since 2008, penalties for non-compliance with the state's individual mandate have been set at half of the lowest cost Health Connector plan available to the individual, pursuant to the formula set by statute.
  - Because the Health Connector offers a $0 plan to individuals under 150% FPL, no penalties apply to individuals in that income range
- The penalty schedule is published by DOR in a Technical Information Release (TIR) and reprinted in the state income tax form.
- Beginning in 2014, Massachusetts allowed for the "netting out" of any owed federal penalty from any owed state penalty, in order to avoid "double penalizing" any residents.

| Massachusetts Individual Mandate Penalties - 2017 | | | | | |
|---|---|---|---|---|---|
| Income category | 150.1-200% FPL | 200.1-250% FPL | 250.1-300% FPL | Above 300% FPL - Age 18-30 | Above 300% FPL – Age 31+ |
| Penalty | $21/month $252/year | $41/month $492/year | $62/month $744/year | $74/month $888/year | $96/month $1,152/year |

# Other uses of the individual mandate

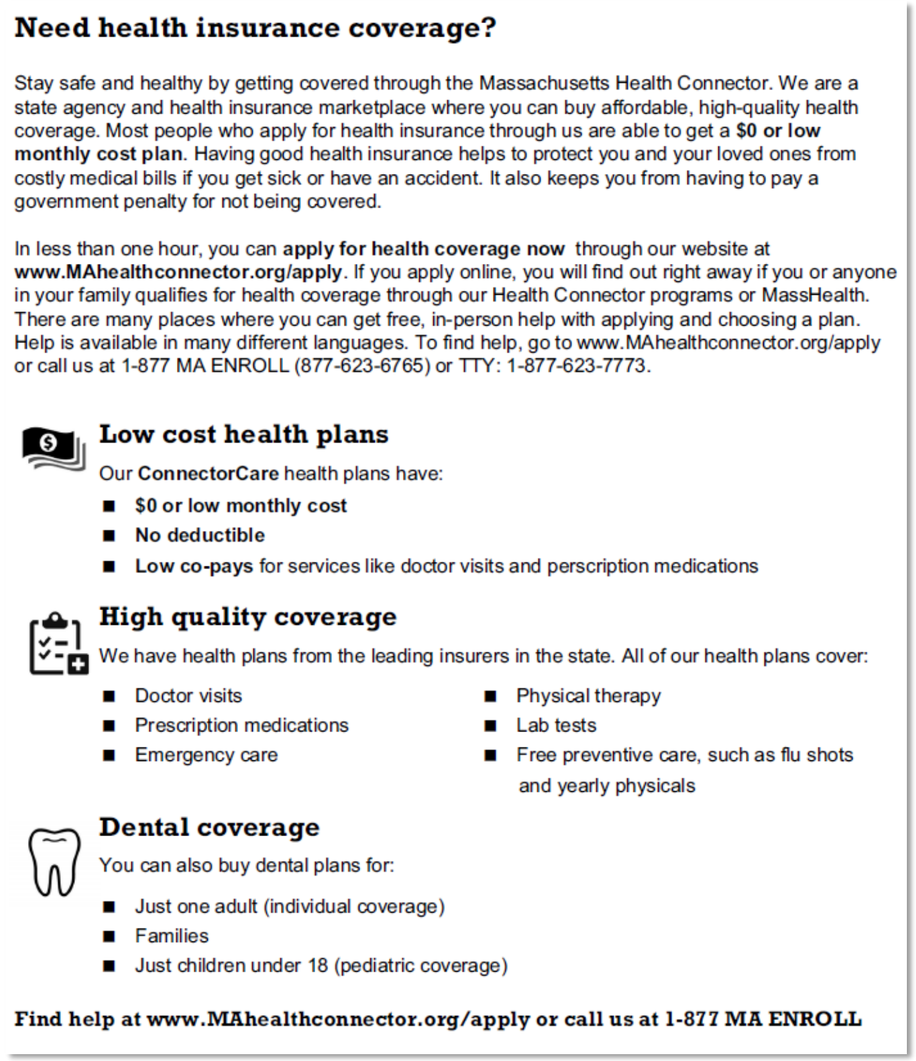
# Outreach Uses of State Mandate

***Administration of a state-level individual mandate has afforded Massachusetts the opportunity to analyze and use detailed administrative data on health insurance coverage of its residents.***

- Analyses of state tax data has allowed the Health Connector to better understand the demographics of adult tax filers who remain without coverage. These insights have allowed us to further tailor our outreach and communications to the uninsured

- Starting in 2015, Massachusetts began sending direct mail to individual tax filers who reported being without MCC to provide them practical information about how to get coverage, allowing the ability to move from proxy-based general outreach to targeted outreach

- In December, the Commonwealth sent a mailing (see right) to ~129K residents who had reported full-year uninsurance during 2016



**Need health insurance coverage?**

Stay safe and healthy by getting covered through the Massachusetts Health Connector. We are a state agency and health insurance marketplace where you can buy affordable, high-quality health coverage. Most people who apply for health insurance through us are able to get a **$0 or low monthly cost plan**. Having good health insurance helps to protect you and your loved ones from costly medical bills if you get sick or have an accident. It also keeps you from having to pay a government penalty for not being covered.

In less than one hour, you can **apply for health coverage now** through our website at **www.MAhealthconnector.org/apply**. If you apply online, you will find out right away if you or anyone in your family qualifies for health coverage through our Health Connector programs or MassHealth. There are many places where you can get free, in-person help with applying and choosing a plan. Help is available in many different languages. To find help, go to www.MAhealthconnector.org/apply or call us at 1-877 MA ENROLL (877-623-6765) or TTY: 1-877-623-7773.

**Low cost health plans**

Our **ConnectorCare** health plans have:

- **$0 or low monthly cost**
- **No deductible**
- **Low co-pays** for services like doctor visits and perscription medications

**High quality coverage**

We have health plans from the leading insurers in the state. All of our health plans cover:

- Doctor visits
- Prescription medications
- Emergency care
- Physical therapy
- Lab tests
- Free preventive care, such as flu shots and yearly physicals

**Dental coverage**

You can also buy dental plans for:

- Just one adult (individual coverage)
- Families
- Just children under 18 (pediatric coverage)

**Find help at www.MAhealthconnector.org/apply or call us at 1-877 MA ENROLL**

# Common Benefits Floor and Reinvestment of Revenue

***MCC has allowed Massachusetts to promote and encourage the concept of a minimum benefits floor across market segments. As market rule changes are being proposed federally, Massachusetts's MCC standards give us an extra policy tool to help ensure coverage standards are not eroded.***

- Our mandate requires all adults to carry coverage that meets certain standards, whether they obtain their coverage in the non-group market, from a public program, or through their employer.
- Massachusetts's MCC standards include required covered services that are nearly identical to the ACA's Essential Health Benefits (EHB) package.

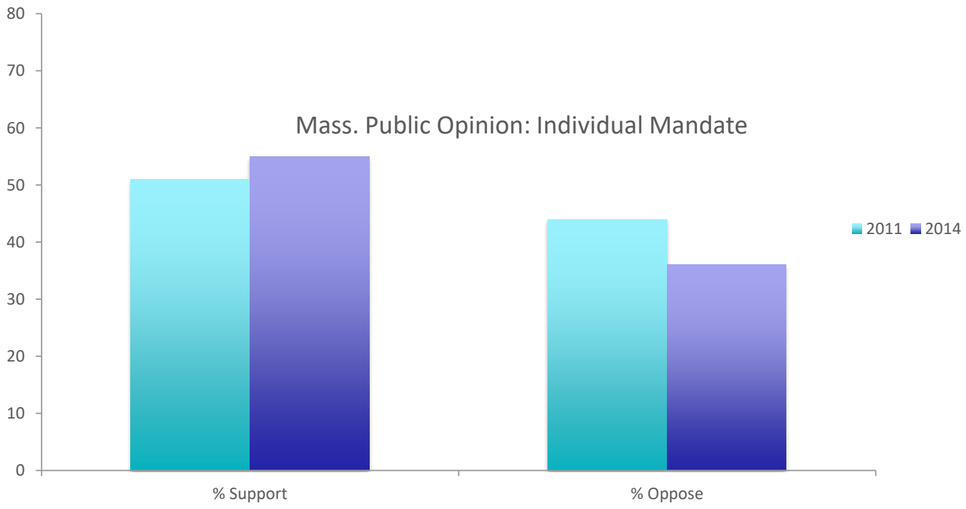
***While revenue generation is not the purpose of the state's individual mandate, penalty revenue helps the state fund affordable coverage programs.***

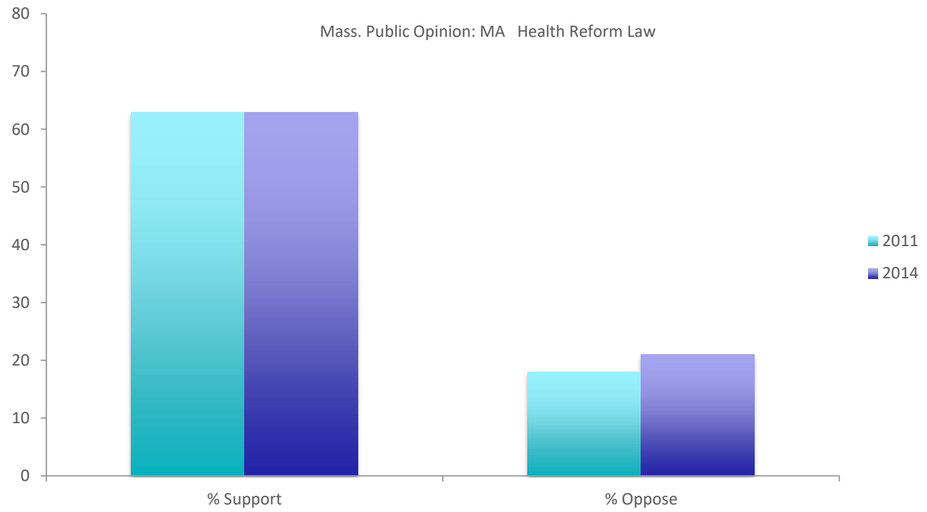
- Overall, the individual mandate penalizes roughly 50,000 taxpayers per year and has generated on average $18M per year in revenue
- Penalty revenue goes to the Commonwealth Care Trust Fund (CCTF) and is used to pay for "state wrap" subsidies that are used to further reduce premium and cost sharing for Health Connector enrollees, augmenting APTC and – prior to October – federal CSR

# Market Support and Public Perceptions

***The Massachusetts carrier market is broadly supportive of the mandate, and the mandate has not proven to be particularly controversial among the Massachusetts public.***

- The Massachusetts individual mandate was introduced in 2007 with relatively little commotion
- It has become seamlessly woven into the fabric of our health care landscape
- Support for MA health reform as an overall construct has remained high
- We receive minimal public comments when we adjust policy features of the mandate, and rarely encounter complaints on the mandate as a concept




Source: Boston Globe/Harvard School of Public Health, PUBLIC PERCEPTIONS OF THE MASSACHUSETTS HEALTH INSURANCE LAW, May 27 – June 2, 2014

# Other Developments in MA Health Care Financing Landscape

- The Employer Medical Assistance Contribution (EMAC) was created in 2014 after the repeal of the Massachusetts Fair Share Contribution (FSC) requirement. EMAC applies to employers with more than five employees in Massachusetts and applies regardless of whether the employer offers health coverage to its employees.
- The current EMAC contribution rate is 0.34% up to the annual wage cap of $15,000, with a potential maximum cost of $51 per employee per year.
- For the wages paid in the years 2018 and 2019, the EMAC contribution will increase to 0.51% up to the annual wage cap of $15,000, which increases the potential maximum cost per employee to $77 per employee per year.
- **A New Employer Medical Assistance Contribution Supplement** applies to employers with more than five employees in Massachusetts, whose non-disabled employees obtain health insurance either from MassHealth or ConnectorCare. The non-disabled employee must be enrolled in MassHealth (excluding the premium assistance program) or subsidized coverage through the Massachusetts ConnectorCare program for more than eight weeks during the quarter. The contribution is 5% of annual wages for each non-disabled employee, up to the annual wage cap of $15,000, for a maximum of $750 per affected employee per year. The contribution does not apply to employees who earn less than $500 in wages per quarter.
- The revenue will be deposited into the Commonwealth Care Trust Fund, and will be used to help support the state share of costs for MassHealth and ConnectorCare.

# Questions?

# Additional Information and Contact Information

***Contact information:***

Audrey Morse Gasteier
Audrey.Gasteier@state.ma.us

***Reports and data:***

The Massachusetts Individual Mandate: Design, Administration, and Results:
https://www.mahealthconnector.org/wp-content/uploads/Individual-Mandate-Report-Nov2017.pdf

More reports and data: https://www.mahealthconnector.org/about/policy-center/reports-publications#individualmandatedata

# Discussion

- Today's discussion was focused on policy options around:
  - reinsurance,
  - individual and employer mandates and
  - short-term plans.
- Do any of these options align with the Workgroup's charge?
- Which other policy options are attractive to the group? What would you like to learn more about?
- Are there other policy options not mentioned or listed you would like us to consider?

# PUBLIC COMMENT?

# THANK YOU

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STATE OF RHODE ISLAND

# Appendix

# The Affordability Schedule

***The affordability schedule determines whether an individual must pay a penalty for not having Minimum Creditable Coverage (MCC).***

- Supports consumers as they make choices about coverage and their household budgets by defining the maximum amount they would be expected to contribute toward coverage or face a penalty
- Does not require employers, issuers or other coverage providers to offer plans deemed affordable by the schedule or subject them to penalties if individuals fail to enroll in the affordable coverage they offered
- The Health Connector has historically aligned base enrollee premiums for subsidized individuals up to 300% of the federal poverty level (FPL) with the state's affordability schedule, such that Massachusetts's ConnectorCare program, which supplements ACA subsidies with state-funded premium and cost sharing subsidies, is considered affordable, but it is not required to do so under the law
- Does not affect the assessment of a federal penalty for failing to enroll in coverage

# 2018 Affordability Schedule for Individuals

| CY 2018 Affordability Schedule: INDIVIDUALS | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| Income Bracket | | | | Monthly Dollar Amount | |
| % of FPL | Bottom | Top | Monthly Affordability Standard | Bottom | Top |
| 0 - 150% | $0 | $18,090 | 0% | | |
| 150.1 - 200% | $18,091 | $24,120 | 2.90% | $44 | $58 |
| 200.1 - 250% | $24,121 | $30,150 | 4.20% | $84 | $106 |
| 250.1 - 300% | $30,151 | $36,180 | 5.00% | $126 | $151 |
| 300.1 - 350% | $36,181 | $42,210 | 7.45% | $225 | $262 |
| 350.1 - 400% | $42,211 | $48,240 | 7.60% | $267 | $306 |
| Above 400% | $48,241 | | 8.05% | $324 | |

Note: The state also develops schedules for couples and families that are based on the same amounts.

# Coverage Standards

***Plans deemed categorically compliant with MCC, per statute:***

- Medicaid (MassHealth)
- Medicare
- Qualified Health Plans, as certified for sale by the Health Connector
- Military and veterans' coverage
- Federal employee health plans
- Peace Corps, VISTA, AmeriCorps, and National Civilian Community Corps Coverage
- Federally qualified high deductible health plans (HDHPs) provided they are coupled with a health savings account or health reimbursement account
- Student health plans
- Tribal or Indian Health Service plans
- Health Care Sharing Ministries

# Coverage Standards (Cont'd)

***For plans that are not defined as categorically compliant, standards set in MCC regulations related to covered benefits must be met in order to be considered compliant.***

- Ambulatory services, including outpatient, day surgery and related anesthesia
- Diagnostic imaging and screening procedures, including x-rays
- Emergency services
- Hospitalization
- Maternity and newborn care, including pre- and post-natal care
- Medical/surgical care, including preventive and primary care
- Mental health and substance abuse services
- Prescription drugs
- Radiation therapy and chemotherapy

Note: Differences from EHB are de minimus – on benefits covered, they specifically relate to habilitative services.

# Coverage Standards (Cont'd)

***For plans that are not defined as categorically compliant, standards set in MCC regulations related to cost sharing must be met in order to be considered compliant.***

- MCC-compliant plans must encompass a broad range of services, and they apply to all members covered by the plan.
- Further, MCC regulations prohibit annual benefit limits on core services and set out parameters for out of pocket spending.
- Compliant plans must cap deductibles at $2,000 for individual coverage and $4,000 for family coverage, with separate prescription drug deductibles capped at $250 for individual coverage and $500 for family coverage.
- The maximum out of pocket amount for a compliant plan may not exceed the maximum defined by the U.S. Department of Health and Human Services each year. (In 2018, this is $7,350 for an individual, and $14,700 for a family.)

# Coverage Standards (Cont'd)

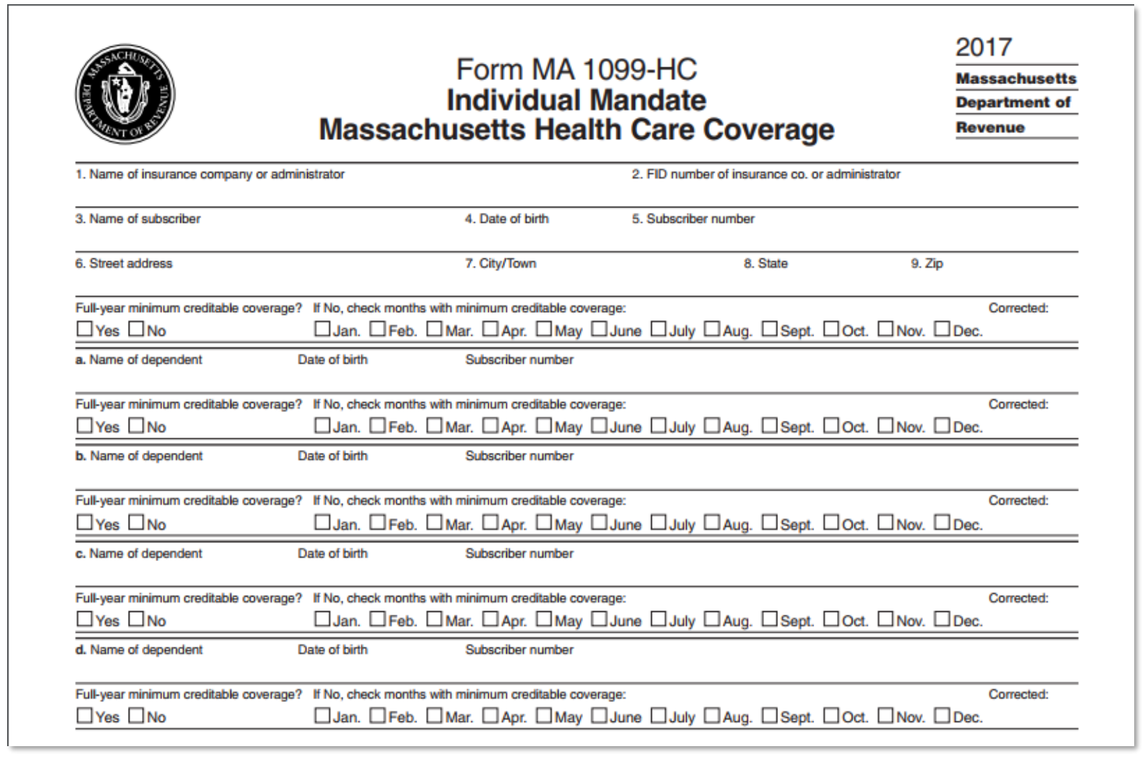
***Plans that do not meet the exact MCC standards prescribed in regulation can still pursue and be deemed compliant, if approved by the Health Connector.***

- If a plan does not precisely meet certain standards outlined in regulation but still provides robust coverage overall, the Health Connector has a process by which a plan sponsor can apply for and receive designation as an MCC-compliant plan.
- Certain deviations from regulatory requirements will not – as a policy matter -- be considered, such as failure to provide a broad range of services, imposition of lifetime limits, or failure to provide services (such as maternity care) to all dependents.
- The Health Connector generally receives several hundred such applications per year.

# Reporting and Administration

***Coverage reporting to operationalize and enforce the mandate requires activity on the part of plan sponsors/employers, health plans, and residents.***

- Plan sponsors (employers) or health plans must send enrollees evidence of each month during the calendar year in which they were enrolled in MCC for at least 15 days.
  - This report is known as the 1099-HC and is sent in January for individuals to use when filing their state income tax returns
- As a practical matter, 1099s are usually sent by health plans (or third party administrators of self-insured plans) rather than the employer.



Form MA 1099-HC
**Individual Mandate**
**Massachusetts Health Care Coverage**

2017
**Massachusetts Department of Revenue**

1. Name of insurance company or administrator
2. FID number of insurance co. or administrator
3. Name of subscriber
4. Date of birth
5. Subscriber number
6. Street address
7. City/Town
8. State
9. Zip

Full-year minimum creditable coverage? ☐Yes ☐No
If No, check months with minimum creditable coverage: ☐Jan. ☐Feb. ☐Mar. ☐Apr. ☐May ☐June ☐July ☐Aug. ☐Sept. ☐Oct. ☐Nov. ☐Dec.
Corrected:

**a.** Name of dependent — Date of birth — Subscriber number
Full-year minimum creditable coverage? ☐Yes ☐No
If No, check months with minimum creditable coverage: ☐Jan. ☐Feb. ☐Mar. ☐Apr. ☐May ☐June ☐July ☐Aug. ☐Sept. ☐Oct. ☐Nov. ☐Dec.
Corrected:

**b.** Name of dependent — Date of birth — Subscriber number
Full-year minimum creditable coverage? ☐Yes ☐No
If No, check months with minimum creditable coverage: ☐Jan. ☐Feb. ☐Mar. ☐Apr. ☐May ☐June ☐July ☐Aug. ☐Sept. ☐Oct. ☐Nov. ☐Dec.
Corrected:

**c.** Name of dependent — Date of birth — Subscriber number
Full-year minimum creditable coverage? ☐Yes ☐No
If No, check months with minimum creditable coverage: ☐Jan. ☐Feb. ☐Mar. ☐Apr. ☐May ☐June ☐July ☐Aug. ☐Sept. ☐Oct. ☐Nov. ☐Dec.
Corrected:

**d.** Name of dependent — Date of birth — Subscriber number
Full-year minimum creditable coverage? ☐Yes ☐No
If No, check months with minimum creditable coverage: ☐Jan. ☐Feb. ☐Mar. ☐Apr. ☐May ☐June ☐July ☐Aug. ☐Sept. ☐Oct. ☐Nov. ☐Dec.
Corrected:

# Taxpayer Process

***The state income tax return includes a "Schedule HC" that helps taxpayers report coverage, determine penalties that may apply to gaps in coverage, and request an appeal of any penalty owed.***

- On the Schedule HC, uninsured taxpayers determine whether affordable coverage was available to them through an employer, through the subsidized ConnectorCare program, or on the unsubsidized non-group market
- Worksheets are provided to answer affordability questions and to calculate the penalty

**Schedule HC** Affordability as Determined By State Guidelines

Do NOT complete if you are not subject to a penalty.

**NOTE:** This section will require the use of worksheets and tables. You **must** complete the worksheet(s) to determine if health insurance was affordable to you during the 2016 tax year.

**10** Did your employer offer affordable health insurance that met the minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 10? ▸ **10** You: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If your employer did not offer health insurance that met the minimum creditable coverage requirements, you were not eligible for health insurance offered by your employer, you were self-employed or you were unemployed, fill in the **No** oval.

If you answer **No**, go to line 11. If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

**11** Were you eligible for government-subsidized health insurance as determined by completing the Schedule HC Worksheet for Line 11? ▸ **11** You: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If you answer **No**, go to line 12. If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

**12** Were you able to purchase affordable private health insurance that met the minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 12? ▸ **12** You: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If you answer **No**, you are not subject to a penalty. **CONTINUE COMPLETING YOUR TAX RETURN.** If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

# Appeals and Hardship Waivers

***The Health Connector administers and sets rules for hardship waivers and appeals.***

- Short coverage gaps of up to three months are allowed without penalty.
- Exemptions from the mandate are available for individuals who claim a sincerely held religious belief as the reason for remaining uninsured.
- Additionally, the Health Connector can waive the penalty if the individual appeals claiming a “financial hardship.” A hardship includes circumstances such as eviction or foreclosure, shutoff of utilities, or sudden increase in expenses due to disaster, death in the family, domestic violence or unanticipated family care.
- Appeals are heard by independent hearing officers engaged by the Health Connector. On average, the Health Connector has reviewed ~2,400 hardship appeals each year since 2007
  - The numbers have declined in recent years, to an average of approximately 1,300, probably because persons subject to the federal credit could offset their state penalty, if any, thus reducing the number of people who were subject to a state penalty.