



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

July 07, 2014

Quick Links

[MA-ACA Website](#)



These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

Grant Announcements

Comparative Health System Performance in Accelerating Patient Centered Outcomes Research (PCOR) Dissemination, §6301. Announced June 25, 2014. Funding is available to identify, classify, track and understand various healthcare delivery systems in order to better target PCOR dissemination so that systems can more quickly adopt high-performance practices and improve patient outcomes.

Eligible applicants include state and county governments; federal government agencies; public and private institutions of higher education; faith-based or community-based organizations; Native American/Indian Tribal Governments and Native American/Indian Tribally Designated Organizations. \$10,500,000 in total is available for three awards.

Applications are due October 17, 2014.

This announcement may be viewed at: GRANTS.NIH.GOV

The Patient Centered Outcomes Research Institute (PCORI), created under ACA §6301, is an independent nonprofit organization, tasked with conducting patient-centered outcomes research and studies.

For more information about PCORI, visit: PCORI

Grant Activity

For information about ACA grants awarded to and grant proposals submitted by the Commonwealth, visit the Grants page of the **Massachusetts National Health Care Reform website** at: www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html

Guidance

7/1/14 HHS/CMS issued a correction to the final rule called "Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Correcting amendment." The correction fixes technical errors in the [final rule](#) (which was published in the Federal Register on October 30, 2013).

The final rule finalizes standards to protect federal funds and ensure that health insurance issuers and Exchanges (also known as Marketplaces) comply with federal policies so that consumers have access to health insurance.

The rule outlines oversight and financial integrity guidelines with respect to Exchanges, Qualified Health Plan (QHP) issuers in Federally-facilitated Exchanges (FFE), and states with regard to the operation of risk adjustment and reinsurance programs (also known as premium stabilization programs). Under the rule, HHS creates oversight of advance payments of the premium tax credit and cost-sharing reductions including requirements governing the maintenance of records, annual reporting of summary statistics, and audits.

Additional provisions are established for special enrollment periods, HHS-approved survey vendors that may conduct enrollee satisfaction surveys on behalf of QHP issuers in Exchanges, and oversight of QHP issuers in an FFE. The rule strengthens financial integrity provisions and protections against fraud and abuse (consistent with Title I of the ACA) as laid out in a [proposed rule](#) "Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards" (published in the Federal Register on June 19, 2013).

The rule also amends standards and adopts provisions in the "Amendments to the HHS Notice of Benefit and Payment Parameters for 2014" [interim final rule](#) (published in the Federal Register on March 11, 2013), related to risk corridors and cost-sharing reduction reconciliation.

Starting October 1, 2013, qualified individuals and qualified employees could purchase private health insurance coverage through competitive marketplaces called Affordable Insurance Exchanges, or "Exchanges" (also called Health Insurance Marketplaces). The ACA established Affordable Insurance Exchanges (§1311(b)) to provide individuals and small business employees with access to health insurance coverage beginning January 1, 2014, where low and moderate income Americans will be eligible for premium tax credits (§1401, §1411) to make purchasing a health plan more affordable by reducing out-of-pocket premium costs.

QHPs are health plans that have been certified by an Exchange, provide essential health benefits (§1301) and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts). A QHP must have a certification by each Exchange in which it is sold. ACA §1311 and subsequent regulations provide that, in order to be certified as a QHP and operate in the Exchanges that will be operational in 2014, a health plan must be accredited on the basis of local performance by an accrediting

entity recognized by HHS.

The premium tax credit is designed to make purchasing a health plan on the Exchange affordable for low and moderate income Americans by reducing a taxpayer's out-of-pocket premium cost. To be eligible to receive the premium tax credit, individuals and families must have incomes between 100%- 400 % FPL (or between 0% - 400% FPL if lawfully present and ineligible for Medicaid) and be enrolled in a qualified health plan (QHP) through an exchange. The individual must also be ineligible for government sponsored insurance and not have access to employer sponsored insurance that meets definitions of affordability and minimum essential coverage as established by ACA §1401. Advance payments are made monthly under ACA §1412 to the issuer of the QHP in which the individual enrolls. ACA §1402 provides for the reduction of cost sharing for certain individuals enrolled in QHPs offered through the Exchanges and §1412 provides for the advance payment of these reductions to issuers.

The ACA established three risk-mitigation programs to stabilize premiums in the individual insurance market and minimize the effects of adverse selection that may occur as insurance reforms and the Exchanges launch in 2014. These programs include transitional reinsurance (§1341), temporary risk corridors programs (§1342), and a permanent risk adjustment program (§1343) to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk borne by issuers. The transitional reinsurance program and the temporary risk corridors program, which begin in 2014, are designed to provide issuers with greater payment stability as insurance market reforms are implemented. The reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting risk of high-cost enrollees. The risk corridors program, which is a federally administered program, will protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains.

Read the correcting amendment (which was published the Federal Register on July 2, 2014) at:
www.gpo.gov/fdsys/pkg/FR-2014-07-02/pdf/2014-15560.pdf

6/27/14 IRS/Treasury issued final regulations called "Tax Credit for Employee Health Insurance Expenses of Small Employers." According to the IRS, the final regulations pertain to the tax credit available to certain small employers that offer health insurance coverage to their employees. The credit is provided under section 45R of IRS Code, as required under ACA §1421. The regulations affect small employers, both taxable and tax-exempt.

A small business tax credit is available to certain small employers with fewer than 25 full-time equivalent employees making an average of about \$50,000 a year of less and who also pay at least half of the cost of individual coverage in a qualified health plan (QHP) that is offered through an Exchange for their employees. The tax credit is available to both qualified employers who currently offer coverage and those that want to begin offering coverage and is meant to offset some of the costs associated with doing that. The eligibility rules refer to the number of full-time equivalent employees, not the number of employees; credits or partial credits are available to employers with 10 or fewer full-time equivalent employees. The tax credit is worth up to 50% of the employer contribution toward employees' premium costs (up to 35% for tax-exempt employers).

Under the rules an Exchange refers to a Small Business Health Options Program (SHOP) Exchange. 1311(b)(1)(B) requires that the SHOP assist qualified small employers in facilitating the enrollment of their employees in programs (QHPs) offered in the small group market.

Additional information on the small business tax credit can be found at: www.healthcare.gov/will-i-qualify-for-small-business-health-care-tax-credits/

Read the final regulations (which were published in the Federal Register on June 30, 2014) at:
www.gpo.gov/fdsys/pkg/FR-2014-06-30/pdf/2014-15262.pdf

6/27/14 CMS/HHS issued a proposed rule called "Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including

Standards Related to Exchanges.” This proposed rule specifies additional options for annual eligibility redeterminations and renewal and re-enrollment notice requirements for qualified health plans (QHPs) offered through the Exchange. The options would be effective beginning with annual redeterminations for coverage for plan year 2015.

According to CMS/HHS, the proposed rule also provides additional flexibility for State-based Exchanges to propose particular approaches that meet the specific needs of their state while simplifying the renewal and enrollment process for consumers.

Furthermore, as indicated by the agency, under the proposed rule approximately 95% of individuals who enrolled in an insurance plan through the federal insurance website healthcare.gov will be notified that their insurance will automatically renew in 2015. Automatic renewals will apply to individuals with income in 2013 below 500% FPL. Consumers will need to update their information with CMS/HHS if they want to change health plans, if they have life changes such as marital status or income changes and if they don't authorize the renewal of their subsidies.

In 2015 consumers whose updated income information suggests they will not continue to qualify for a tax credit in 2015 will be automatically enrolled in their current plan without a tax credit. Consumers in the Federally-facilitated Exchange will receive notices from the Exchange informing them how to update their information to get a tailored and updated tax credit that keeps up with any income changes. State-based Exchanges may use similar methods.

Comments are due July 28, 2014.

Read the proposed regulations (which were published in the Federal Register on July 1, 2014) at: www.gpo.gov/fdsys/pkg/FR-2014-07-01/pdf/2014-15362.pdf

6/27/14 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on several information collection activities, including the following three collections.

Comments are due July 28, 2014 on all items.

Read the notice at: www.gpo.gov/fdsys/pkg/FR-2014-06-27/pdf/2014-15073.pdf

In [item #3](#) HHS/CMS is seeking comments on the extension of a currently approved information collection activity related to the Basic Health Program Report for Health Insurance Exchange Premium.

The BHP program, as authorized by §1331 and subsequent guidance, provides states the option to establish a health benefits coverage program for low-income individuals who would otherwise be eligible to purchase coverage through the Health Insurance Exchange. Under the BHP rules, citizens or lawfully present non-citizens who do not qualify for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage and have incomes between 133% FPL and 200% FPL are eligible for the BHP.

The BHP is federally funded by determining the amount of payments that the federal government would have made through the premium tax credit and cost sharing reductions (CSR) for individuals enrolled in BHP had they instead been enrolled in an Exchange. To calculate the amounts for each state, HHS/CMS is asking states for "reference premiums" for the second lowest cost silver plans in each geographic area in a state, as those amounts are a basic unit in the calculation of tax credits and CSRs under the Exchanges. Furthermore, reference premiums are critical components of the BHP payment methodology. According to HHS/CMS, the agency has the required data to establish reference premiums for states with Exchanges that are operated by the Federally Facilitated Exchange (FFE) or are operated in partnership with the FFE, although the agency is seeking such information from the 17 states that are operating State Based Exchanges.

The ACA established Affordable Insurance Exchanges (§1311(b)) to provide individuals and small business employees with access to health insurance coverage beginning January 1, 2014, where low and moderate income individuals would be eligible for premium tax credits (§1401, §1411) to make purchasing a qualified health plan (QHP) more affordable by reducing out-of-pocket premium costs. QHPs are health plans that have been certified by an Exchange, provide essential health benefits (§1301) and follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts).

Beginning January 1, 2015, states will have an option to establish a BHP for certain individuals who meet the income criteria and would otherwise be eligible to obtain coverage through the Exchange. BHP benefits are required to include at least the ten essential health benefits specified in §1301. BHP monthly premiums and cost sharing cannot exceed what an eligible individual would have paid if the eligible individual were to receive coverage from a QHP through the Exchange. A state that operates a BHP will receive federal funding equal to 95% of the amount of the premium tax credits and the cost sharing reductions that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in QHPs through the Exchange.

In [item #5](#) HHS/CMS is seeking comments on the revision of a previously approved information collection activity related to Exchange and Insurance Market Standards for 2015, specifically standards for Consumer Assistance Tools and Exchange Programs for Certified Application Counselors.

ACA §1311(d) and §1311(i) direct all Exchanges to award grants to Navigators and establish certified application counselor programs that will provide unbiased information to consumers about health insurance, the Exchange, QHPs, and insurance affordability programs including premium tax credits, Medicaid and the Children's Health Insurance Program (CHIP). These consumer assistance tools will provide outreach and education efforts and assistance applying for health insurance coverage. Non-Navigator assistance personnel (also known as in-person assistance personnel) perform generally the same functions as Navigators, but aren't funded through Navigator grants. For example, certified application counselors (who perform many of the same functions as Navigators and non-Navigator assistance personnel) are funded by the Exchange in which they operate through other sources. If states choose not to run either a State-Based Exchange or a State-Federal Partnership Exchange, HHS will operate a Federally-facilitated Exchange (§1321). Note that Massachusetts currently runs a State-Based Exchange.

Under the ACA, enrollment assistance can be provided by: Navigators, in-person assistance personnel, or certified application counselors. In addition, agents and brokers can also help consumers enroll in new insurance options. Furthermore, under the ACA, Exchanges are required to have a certified application counselor program.

HHS issued [regulations](#) in July 2013 that finalize the requirement that certified application counselors in all Exchanges are required to be recertified on at least an annual basis and successfully complete Exchange-required recertification training. The final regulations create conflict-of-interest, training and certification, and meaningful access standards applicable to Navigators and non-Navigator assistance personnel in Federally-facilitated Exchanges, including State Partnership Exchanges, and to non-Navigator assistance personnel in State-based Exchanges that are funded through federal Exchange Establishment grants.

Additional information about the various consumer assistance personnel can be found at: www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/AssistanceRoles_06-10-14-508.pdf

In [item #7](#) HHS/CMS is seeking comments on the revision of a previously approved

information collection activity related to ACA Exchange Functions, specifically Standards for Navigators and Non-Navigator Assistance Personnel.

Pursuant to ACA §1311 as described above, HHS [regulations](#) require Navigators, as well as those non-Navigator personnel, to inform consumers of the functions and responsibilities of Navigators and non-Navigator assistance personnel and obtain authorization for the disclosure of consumer information to the Navigator or non-Navigator assistance personnel prior to obtaining the consumer's personally identifiable information. Under the ACA, navigators and non-Navigator assistance personnel are also required to maintain a record of the authorization provided in a form and manner as determined by the Exchange.

6/27/14 HHS/CMS issued a separate notice under the PRA seeking comments on a new information collection related to ACA-associated cost sharing reduction reconciliations.

As required under ACA §1401, 1411, and 1412 an Exchange makes an advance determination of tax credit eligibility for individuals who enroll in a qualified health plan (QHP) through the Exchange and pursue financial assistance.

Using information available at the time of an individual applicant's enrollment, the Exchange determines whether the individual meets income and other requirements for advance payments and the amount of the advance payments that can be used to pay premiums. Advance payments are made periodically to the issuer of the QHP in which the individual enrolls (§1412). §1402 provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange and §1412 provides for the advance payment of these reductions to health insurance issuers. Furthermore, QHP issuers will receive estimated advance payments of cost-sharing reductions throughout the year. Each issuer will then be subject to a reconciliation process at the end of the benefit year to ensure that HHS reimburses each issuer only for final cost sharing amounts.

According to HHS/CMS, this information collection establishes the required data elements that a QHP issuer would report to HHS in order to establish the cost-sharing reductions provided on behalf of enrollees.

Comments are due August 26, 2014.

Read the notice at: www.gpo.gov/fdsys/pkg/FR-2014-06-27/pdf/2014-15075.pdf (see item #1)

6/26/14 IRS/Treasury issued final regulations called "Disregarded Entities; Religious and Family Member FICA and FUTA Exceptions; Indoor Tanning Services Excise Tax." The regulations affect disregarded entities responsible for collecting the indoor tanning services excise tax and owners of those disregarded entities. In June 2012, IRS/Treasury issued a [notice of proposed rulemaking](#) and [final and proposed regulations](#). According to the agency, the June 2014 final regulations adopt the previous regulations without substantive changes.

Effective July 1, 2010, ACA §10907 imposed a 10% excise tax on indoor tanning services. In general, providers of indoor tanning services collect the tax from consumers at the time the tanning services are purchased and the provider then pays over these amounts to the government. The tax does not apply to phototherapy services performed by a licensed medical professional on his or her premises. There is also an exception for certain physical fitness facilities that offer tanning as an incidental service to members without a separately identifiable fee.

Read the June 2014 final regulations at: www.gpo.gov/fdsys/pkg/FR-2014-06-26/pdf/2014-14967.pdf

For more information on the excise tax, visit the IRS website at: www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Indoor-Tanning-Services-Tax-Center

Prior guidance can be found at: www.hhs.gov/healthcare/index.html

Upcoming Events

Integrating Medicare and Medicaid for Dual Eligible Individuals (also known as One Care) Implementation Council Meeting

Friday, July 25, 2014
1:00 PM -3:00 PM
1 Ashburton Place, 21st Floor
Boston, MA

A meeting agenda and any meeting material will be distributed prior to the meetings.

Meetings of the Implementation Council are open to stakeholders and members of the public with an interest in One Care. Reasonable accommodations are available upon request. Please contact Donna Kymalainen at Donna.Kymalainen@umassmed.edu to request accommodations.

Bookmark the **Massachusetts National Health Care Reform website** at: [National Health Care Reform](#) to read updates on ACA implementation in Massachusetts.

Remember to check the Mass.Gov website at: [Dual Eligibles](#) for information on the "**Integrating Medicare and Medicaid for Dual Eligible Individuals**" initiative.

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