Massachusetts Health Care Reform Bill Summary

The Massachusetts Health Care Reform bill (Chapter 58 of the Acts of 2006) aims to provide health insurance coverage to almost all residents of Massachusetts through a combination of Medicaid expansions, subsidized private insurance programs, and insurance market reforms. The bill, in the version passed nearly unanimously by the state legislature and signed into law by Governor Romney on April 12th, places responsibility for financing the expanded health coverage to varying degrees on the following parties:

- individuals, through an individual mandate which requires residents to purchase health coverage as long as "affordable" coverage is available or face tax penalties,
- state and federal governments, through Medicaid expansions and subsidies and significant re-direction of Uncompensated Care Pool and Disproportionate Share Hospital funds, and,
- employers, through a "fair share contribution" and a "free rider surcharge" for certain employers with employees receiving substantial free care services.

Individual Mandate

The bill creates new responsibilities for residents of Massachusetts to obtain health insurance coverage if "affordable" coverage is available to them. A new state entity called the "Connector" will be responsible for setting a schedule of affordability, based on the percentage of income eligible to be spent on health care, and defining "minimum creditable coverage" for purposes of enforcing the individual mandate. On their annual tax returns, MA residents must demonstrate that they have had health insurance meeting "minimum creditable coverage" standards during all months of the previous year, excluding any lapse in coverage of 63 days or less. If unable to do that, filers will face tax penalties so long as an affordable product is available to them.

The penalty for the first year of the mandate (effective July 1, 2007 – December 31, 2007) will be to forego the state personal income tax exemption.[1] Starting in the second year (calendar year 2008) and going forward, the penalty will not exceed 50% of the cost of the minimum insurance premium for creditable coverage available to the individual. The Department of Revenue will assess the penalty for each of the months during which the individual did not have coverage. Coverage will be verified through a database of

[1] Filers must demonstrate that they had coverage on December 31st, 2007 or see a reduction in their tax return of roughly $150.

insurance coverage maintained by a new Health Care Access Bureau located in the Division of Insurance. All penalty funds collected will be deposited into the Commonwealth Care Trust Fund to support the Commonwealth Care premium subsidy program described below.

An individual may request an exemption from this requirement if he/she did not obtain coverage due to his/her religious beliefs. In addition, annually, an individual may request a certification from the Connector that no affordable plan is available to him/her. The individual may appeal denials of such requests.

MassHealth Expansions

To support low-income populations in an environment with an individual mandate, the bill expands MassHealth eligibility and creates a new subsidized insurance program, called Commonwealth Care Health Insurance Program. In addition, the bill appropriates $3M for outreach to persons eligible for MassHealth but not yet enrolled. MassHealth eligibility and benefits are expanded in the following ways.

<u>MassHealth Eligibility Expansions</u>

- Children: Expands MassHealth for children up to 300% FPL.
- Essential: Increases the caseload cap for the MassHealth Essential program for below poverty long-term unemployed from 44,000 to 60,000[2]
- Legal Immigrants: codifies provisions in previous budgets allowing senior and disabled legal immigrants who don't qualify for federal Medicaid reimbursement to receive MassHealth Essential benefits
- HIV: Permanently codifies eligibility for the HIV waiver program to persons with incomes up to 200% FPL and increases the caseload cap from 1,050 to 1,300.
- CommonHealth: Increases the caseload cap for CommonHealth from 14,000 to 15,600.
- Insurance Partnership (IP)[3]: Expands the IP to employees with incomes up to 300% FPL, with the stipulation that self-employed individuals will only be able to obtain the employee subsidy (and will no longer be able to also obtain the employer incentive payment). In addition, the IP subsidies must be consistent with and no greater than those available through Commonwealth Care.

<u>MassHealth Benefits Restoration and Expansion</u>

- Restoration of benefits for adults including dental, vision, level IIIB detox, prosthetics and chiropractic care.
- Two-year smoking cessation pilot to be funded with a $7M transfer from the Health Care Security Trust Fund.

[2] Currently there are roughly 12,800 individuals on the MassHealth Essential waitlist.
[3] The Insurance Partnership Program provides small employers (<50 employees) with an incentive payment for contributing at least 50% towards the cost of health insurance coverage for their low-income employees and provides employees with subsidies towards the purchase of employer-sponsored insurance.

Commonwealth Care Health Insurance Program

A new public entity called the Connector (described further below), in consultation with the Office of Medicaid, will administer the Commonwealth Care Health Insurance Program (C-CHIP), a program of subsidized private health insurance for Massachusetts residents, including qualified non-citizens, with household incomes less than 300% of the federal poverty level.[4] Applicants must have resided in Massachusetts for at least the previous 6 months and be ineligible for MassHealth or Medicare. To help reduce the potential for employers dropping coverage, applicants will only be eligible if employer coverage was unavailable in the last 6 months (with an employer contribution of at least 33% of an individual policy and 20% of a family policy). However, the Connector board may waive this requirement and allow employee to purchase coverage through the Connector instead of through his/her employer as long as the employer pays the Connector an amount equal to the employer's median contribution for its full-time employees. Such payment will offset the C-CHIP premium subsidy.

Subsidy Schedule

Enrollees of C-CHIP will pay a sliding scale premium, if their income is above 100% FPL, and face no premium if their income is below 100% FPL. The premium fee schedule will be established by the Connector by September 30th, 2006 and will be updated annually thereafter.

Benefit Package and Plans

The C-CHIP benefit package and cost sharing for individuals with incomes below 100% FPL will be similar to MassHealth Essential (i.e., comprehensive benefits including mental health, substance abuse, and dental, and co-pays only for pharmacy and non-emergency use of the emergency department). The products for individuals with incomes above 100% FPL must meet requirements to be established by the Connector and cannot include annual deductibles.

For the first roughly 3 years of the program (October 1, 2006 - June 20, 2009), C-CHIP coverage will be available exclusively through MassHealth-contracted managed care organizations (MCOs) – Boston Medical Center (BMC) HealthNet Plan, Cambridge Health Alliance's Network Health, Neighborhood Health Plan, and Fallon Community Health Plan. This exclusivity will apply as long as the plans are collectively able to achieve C-CHIP enrollment targets (40,000 at 12 months after implementation and 80,000 after 24 months).

Funding

Funding for C-CHIP will come from a re-direction of existing funds spent on the uninsured through the Uncompensated Care Pool and DSH program, as well as new state and federal matching funds. (See funding sources and uses table at the end of this summary for further details.) If funds available do not meet projected costs of enrolling new eligible individuals, the Executive Director of the Connector may suspend enrollment into C-CHIP.

[4] 300% FPL is $29,412 for an individual and $60,012 for a family of 4.

Commonwealth Health Insurance Connector

Central to the bill is the creation of the Commonwealth Health Insurance Connector. The Connector will be a newly created, independent public entity responsible for creating a mechanism for individuals without access to employer-sponsored insurance and small employer groups (with <50 employees) to purchase health insurance products through payroll deductions (i.e., with pre-tax funds). The Connector will facilitate employer contributions for both full-time and part-time employees and for those working for more than one company. Eligible to purchase through the Connector will be non-working individuals, employees at companies that do not offer insurance, employees not eligible for employer-sponsored insurance, small businesses with fewer than 50 employees, and self-employed individuals.

Health insurers with 5,000 or more small-group enrollees as of December 31, 2006, must file a plan with the Connector by October 1, 2007 and annually thereafter for consideration for the Connector seal of approval. Plans offered through the Connector must meet certain coverage requirements, be licensed by the Division of Insurance[5], and cannot include deductibles greater than the maximum annual contribution to a Health Savings Account permitted by the IRS ($2,700 for an individual, $5,450 for a family). High deductible plans must also include a companion health savings account.

Open Enrollment Period

To facilitate the purchase by and timely coverage of the currently uninsured, insurers offering through the Connector are prohibited from imposing a waiting period or pre-existing condition exclusions for anyone who purchases through the Connector during the open enrollment period (March 1, 2007 – May 31, 2007), regardless of whether or not he/she had creditable coverage for the previous 18 months.

Connector Administration

Actions of the Connector may take effect immediately and need not be published or posted; however, meetings must be open to the public. The one exception is that the law specifically state that "minimum creditable coverage" requirements for purposes of the individual mandate must be defined in regulation. In addition, the Connector may adopt other regulations as it deems necessary.

The Board of the Connector[6] will evaluate health plans and establish a "seal of approval" designating plans which provide "good value" and "high quality." As a means to

[5] MCOs operated by Boston Medical Center and Cambridge Health Alliance are exempt from DOI licensure requirements in their offering of C-CHIP products.

[6] The Board of the Connector will be chaired by the Secretary of Administration and Finance and include 11 members, with 3 appointed by the Governor (including an actuary, a health economist, and a representative of small business), 3 by the Attorney General (including an employee health benefits plan specialist, a representative of a health care consumer organization, and a representative of organized labor), as well as the Director of Medicaid, the Commissioner of Insurance, and the Executive Director of the Group Insurance Commission. *[Note: there is one additional member who is not specified in the*

promote selective contracting and reduce premium costs, plans available through the Connector will not have to meet the provider network requirements in other health insurance statutes.

The Connector's administrative and operational expenses will be funded both through a one-time transfer of $25M from the General Fund, as well as through a surcharge uniformly applied to all participating health plans. Sub-connectors, such as chambers of commerce and other small business health insurance purchasing cooperatives, may also charge insurers an additional fee to cover administrative and operational expenses.

Insurance Reforms

Merger of Small and Non-group Markets

The bill merges the small-group and non-group insurance markets by ending new enrollments into non-group products as of July 1, 2007. A Special Commission will study the impact of the merger of the non-group and small-group health insurance markets on the cost of premiums charged to individuals and small groups and make recommendations to support planning for the transition. A report from the Commission will be presented to the legislature by December 31, 2006.

Young Adults

The bill also permits health insurers to offer products to Young Adults only, ages 19 – 26 years, who do not otherwise have access to employer-sponsored health insurance. Such products will be sold only through the Connector. The benefit package for these products must be "reasonably comprehensive" including inpatient and outpatient hospital services and physician services for physical and mental illness. Health insurers offering Young Adult products must include outpatient prescription drug coverage in at least one Young Adult product offering. Insurers may impose coinsurance, deductibles, copayments and tiered provider networks and selective contracting.

In addition to creating new products for young adults, young adults will be able to stay on their parent's health insurance until they turn 25 or for two years past loss of dependent status, whichever is earlier.

Moratorium on New Mandated Benefits

The legislation includes a moratorium on new mandated benefits effective until the later of January 1, 2008 or when a comprehensive review of mandated benefits has been completed by the Division of Health Care Finance and Policy.

Health Care Safety Net Trust Fund

As of October 1, 2007, the current Uncompensated Care Pool is phased out and any remaining funds are transferred to a new fund called the Health Safety Net Trust Fund to be administered by the newly created Health Safety Net Office within the Office of

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legislation.] The Secretary of Administration and Finance will appoint an Executive Director to the Connector to oversee operations and administration.

Medicaid. The fund will be maintained through a continuation of payments made by acute hospitals and surcharge payers and federal disproportionate share hospital funds.

The Health Safety Net Office will promulgate regulations pertaining to reimbursable services, standards for medical hardship and collection of emergency bad debt. Hospitals will be reimbursed at Medicare rates allowing for adjustments for differences in benefits, populations served, and other factors. Community Health Centers (CHCs) will be reimbursed at a rate no less than the Medicare Federally Qualified Health Center (FQHC) rate, with additional payments for services not included in the Medicare rate such as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. In the event that a shortfall in revenue exists, the Health Safety Net Office will allocate that shortfall proportionally by hospital free care reimbursement claims. The bill anticipates the transfer of funds to the C-CHIP program as use of free care declines with increased health insurance coverage.

Care Management Demonstrations

In addition to reimbursing hospitals and CHCs for free care, $6M from the Health Safety Net Trust Fund will be expended annually to fund case management and other demonstration projects aimed at reducing fund liability. Such demonstration projects will focus on persons with chronic illness, particularly those with substance abuse and psychiatric disorders, by enrolling patients in CHCs and community mental health centers coordinating with local hospitals.

Essential Community Provider Trust Fund

The Health Safety Net Office will also be responsible for administering the Essential Community Provider Trust Fund, a program of grants to hospitals and CHCs to support improvements in their ability to provide "community-based care, clinical support, care coordination services, disease management services, primary care services, and pharmacy management services."

Employer Responsibilities

Fair Share Assessment

Employers with more than 10 full-time equivalent employees must either make a "fair and reasonable premium contribution"[7] for their employees or pay a per-employee contribution at a time and in a manner prescribed by the Department of Labor. This "fair share employer contribution" will be prorated by the number of hours worked by employees (to account for part-time and seasonal employees), calculated based on the amount of uncompensated care provided to employees of non-contributing employers in the previous year, and capped at $295 per full-time employee per year.

Section 125 Plans

In order to promote access to purchasing health insurance with pre-tax funds, all employers with more than 10 employees will be required by January 1, 2007 to offer

[7] The definition of "fair and reasonable premium contribution" will be set by the Division of Health Care Finance and Policy.

Section 125 plans. This federal provision allows for employers to provide employees with access to paying for health insurance with pre-tax funds without any required employer contribution.

Free Rider Surcharge

Starting October 1, 2007, employers (with more than 10 employees) who do not comply with the requirement to offer a Section 125 plan, may also be charged a "free rider surcharge" if:

- one of their employees or dependents of an employee receives health care services paid for as free care on 3 or more occasions during any hospital fiscal year, OR if there are 5 or more occurrences of health care services paid for as free care by all employees in aggregate during any fiscal year, AND
- the total costs of such free care is $50,000 or more.

The Division of Health Care Finance and Policy will set the "free rider surcharge" amount between 10% and 100% of the cost of such free care to the state.

MassHealth Provider Support and Other MassHealth Provisions

The bill also includes support for some providers the form of MassHealth rate increases, with a stipulation that hospitals meet performance goals related to quality, efficiency, the reduction of racial and ethnic disparities, and improved patient outcomes in order to obtain rate increases.

MassHealth Provider Rate Support and Supplemental Payments

- Mandates that hospitals and physicians be provided rate increases as follows:
  - FY07 - $13.5 M for physicians; $76.5 M for hospitals
  - FY08 - $27 M for physicians; $153 M for hospitals (over FY06)
  - FY09 - $40.5 M for physicians; $229.5 M for hospitals (over FY06)
- Starting in FY08, hospital rate increases will be dependent on meeting quality standards and achievement of performance benchmarks, including the reduction of racial and ethnic disparities in the provision of health care. Such benchmarks will be developed by the Executive Office of Health and Human Services, in consultation with the Health Care Quality and Cost Council. Hospitals may appeal this requirement for the first year only.
- Maintains $287M in supplemental payments to Boston Medical Center (BMC) and Cambridge Health Alliance (CHA) for FY07 – FY09. For FY07, $87M is targeted for the MassHealth MCOs, with the rest unspecified. For FY08 and FY09, 25% of the funding is contingent on successful enrollment of uninsured into the C-CHIP insurance plans operated by BMC and CHA's Medicaid MCOs, as well as quarterly reporting to EOHHS on the use of the supplemental funds.

Other MassHealth Provisions

Members will be provided with lower cost sharing responsibilities if they demonstrate healthy behaviors such as smoking cessation, diabetes screening, teen pregnancy prevention, cancer screening and stroke education.

Other Features

The bill also expands and restores public health spending and creates a number of commissions and councils as shown in the table below.

New Councils/ Commissions	**Purpose**
Health Care Quality and Cost Council	To establish health care quality improvement and cost containment goals intended to lower or contain the growth in health care costs while improving quality, including reducing racial and ethnic health disparities. To implement a consumer health information website providing comparative quality and cost information.
Health Care Quality and Cost Advisory Committee	To allow the broadest possible involvement of health care industry and other stakeholders in the establishment of quality goals and review of progress of the Council.
MassHealth Payment Policy Advisory Board	Review and evaluate rates and payment systems and recommend Medicaid rates and methodologies that provide fair compensation, high quality, safe, effective, timely, efficient, culturally competent and patient-centered care.
Special Commission to Study Feasibility of Reducing or Eliminating Employer Contribution to Uncompensated Care Pool	Evaluate the amount of reimbursements provided from the uncompensated care pool, or any successor fund (i.e., Health Safety Net Trust) for any given year compared to the amount of reimbursements provided for the previous year to determine whether a decrease or elimination of the employer contribution is possible.
Health Disparities Council	To make recommendations regarding the reduction and elimination of racial and ethnic disparities in health care and outcomes, methods to increase diversity in the health care workforce, and other recommendations to areas impacting health disparities such as environment and housing.
Special Commission to Examine Merging of the Small and Non-group Insurance Markets	To conduct a study examining impact of merging non-group and small-group markets on premiums charged to individuals and small groups. And to study the potential impact of reinsurance on the new merged markets.

Financing
The Health Care Reform bill will be financed mainly through a re-distribution of existing monies spent on the uninsured and underinsured through the Uncompensated Care Pool and Disproportionate Share Hospital payments. In addition, approximately $400 million in new funding streams will be created including: general fund appropriation ($125 million per year), employer fair share and free rider assessments (which are projected to decrease over time as insurance coverage increases), and new federal matching funds on Medicaid expansions and other new Medicaid spending eligible for federal match.

The table below details funding sources and uses, and shows projections of savings in the first two years of the program with losses in the third year (FY09).

Massachusetts Health Care Reform Bill Spending Projections (in millions)*			
Sources	**FY07**	**FY08**	**FY09**
Federal Safety Net Revenue	605.0	610.5	610.5
New Federal Medicaid Match	184.6	242.1	299.6
Hospital Assessment	160.0	160.0	160.0
Payor Assessment	160.0	160.0	160.0
Free Rider Surcharge	50.0	40.0	25.0
Fair Share Assessment	45.0	36.0	22.5
General Fund	125.0	125.0	125.0
Total Revenues	1329.6	1373.6	1402.6
Uses			
Existing Obligations			
MCO Supplemental Funding	287.0	180.0	160.0
Free Care Pool/Safety New Fund	610.0	500.0	320.0
Subtotal	897.0	680.0	480.0
New Spending			
Children to 300%	18.2	27.4	37.4
Restored MassHealth Benefits	48.0	53.0	58.0
Medicaid Provider Rate Increases	100.0	180.0	270.0
Commonwealth Care Subsidies	160.0	400.0	725.0
Subtotal	346.2	660.0	1090.4
Total Spending	1,243.2	1,340.4	1,570.4
Net Balance	+106.4	+33.2	-167.9

*Funding for other MassHealth expansions (e.g., Essential, enrollment cap increases) will be included in the state fiscal year 2007 budget and are not included in the table above.

Implementation Timeline

Below are key dates and implementation activities.

July 1, 2006
- Connector Board appointed
- MassHealth eligibility and benefit expansions and enrollment cap increases implemented

October 1, 2006
- C-CHIP for <300% implemented
- Employer fair share contribution implemented

January 1, 2007
- Employers with >10 employees must offer Section 125 plans

April 1, 2007
- Open enrollment for non-subsidized plans through Connector
- Young Adult plans available through the Connector

July 1, 2007
- Individual mandate implemented
- End of new enrollments into non-group market

October 1, 2007
- Health Care Safety Net Trust Fund implemented
- Free rider surcharge implemented
- MassHealth hospital rate increases dependent on quality/performance

January 1, 2008
- Individual mandate penalty raised to 50% of minimum premium

July 1, 2008
- MassHealth 1115 waiver extension scheduled to expire (waiver extension request must be sought at least 6 months prior)