National Health Care Reform

And Its Impact on Massachusetts

Analysis by the

Center for Health Law and Economics

University of Massachusetts Medical School

October 28, 2009

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Key Issues of Interest to Massachusetts in National Health Reform Bills

1. **State opt-out provision:** It is not clear that Massachusetts could qualify for an opt-out waiver under the language of the SFC opt-out provision. That waivers would not be available until 2015 is a hindrance, and it is not obvious that Massachusetts would be able to meet the 10-year budget neutrality requirement with its current programs. (See accompanying page on the state opt-out.)

2. **Access to Enhanced Medicaid FMAP:** The House and SFC bills provide for enhanced federal match for populations newly eligible for Medicaid because of higher income thresholds or broadened eligibility categories. Because Massachusetts' income eligibility is already at or higher than proposed levels for all affected populations, Massachusetts would be one of only two states with no "newly eligible" recipients. Under the SFC bill, Massachusetts would receive only very limited additional federal funds (0.15% Medicaid FMAP increase from FFY 2014 through 2019). Under the House bill, the state would receive enhanced FMAP for childless adults between 100% and 133% FPL who currently are covered under the Waiver. Both bills include a maintenance of effort (MOE) requirement, which would be extremely challenging with little to no additional federal assistance. [The state is currently bound by an MOE requirement—with enhanced FMAP—from the federal economic stimulus bill. Once this enhanced FMAP expires in 2011, the state will face a financial cliff.]

3. **Premium subsidies for Exchange plans:** It is not clear that Massachusetts be able to continue its relatively more generous level of subsidy. In addition, it is unclear how the Commonwealth Care subsidy method (making up the difference between the enrollee premium contribution and the total premium, for each plan type) interacts with the proposed federal subsidy methods (expectation that an enrollee would pay a certain percentage of income – as much as 12.5% in HELP bill – toward premium, depending on income)?

4. **Affordability standard gap:** The HELP and SFC bills generally define "affordability" as a higher percentage of income, particularly at lower levels of income, than do current Massachusetts rules; the House bill leaves affordability undefined. Adoption of a federal affordability standard could result in people who are now exempt from the mandate in Massachusetts being penalized for not having coverage.

5. **Role of an "Exchange":** All bills allow for state-based exchanges; the SFC bill, though, envisions a less activist one, allowing the exchange only to rate plans' relative quality and prices, but not to negotiate rates. Requiring the Connector to become an SFC version of an exchange might deprive consumers of some representation and market power.

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6. **CHIP kids movement to Exchange:** The House bill would move all CHIP enrollees into Exchange plans when the current CHIP authorization expires. If the state wanted to maintain the same level of coverage for these children (which it likely would), the state would need to wrap to the Exchange plan, which is administratively complex. The HELP bill would give CHIP eligibles the option of enrolling in a Gateway (Exchange) plan, which could create adverse selection. The SFC bill would maintain CHIP, as is, through 2019. Though there are potential state cost savings from moving children into Exchange plans (and children could stay in the same coverage as their parents), the benefit and cost-sharing protections of the current CHIP program could be lost. State officials see the SFC version as preferable.

7. **Employer responsibility:** The HELP bill contains an employer responsibility provision comparable to the fair share contribution in Massachusetts; the SFC provision is comparable to the Massachusetts free rider surcharge. Both bills would exempt more Massachusetts employers than do current state rules – 25 or fewer employees in the HELP bill, 50 or fewer in the SFC, compared with fewer than 11 in Massachusetts. The House bill includes an extensive employer "pay or play" provision that would greatly expand the financial responsibility of employers (with payrolls greater than $250,000) who do not currently offer coverage.

8. **"Cadillac" plan tax really an "Accord" tax:** Average premiums in Massachusetts will approximate the threshold level for taxing high cost health plans in the SFC bill by 2016, meaning insurers will owe an excise tax on half of their business, including most small business insurance products.

9. **Rate bands:** The variance in premiums allowed under Massachusetts' small group modified community rating rules is narrower than the rate bands in the proposed bills (the House bill is closest to Massachusetts). The SFC bill appears to allow states to set regulatory requirements that "exceed federal requirements," which may give Massachusetts the ability (though it is not clear from the language in the SFC bill) to maintain its existing rate bands.

10. **Provider payments:** Provisions in the bills to shrink Medicare and Medicaid DSH payments as the number of uninsured goes down do not acknowledge the likely continuation of unreimbursed costs resulting from Medicaid shortfalls and underinsurance. Low income people with basic insurance plans likely will not be able to afford cost sharing requirements when they require extensive care; DSH payments should offset these costs.

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Issues of concern with the "State Opt-Out" provision in the Senate Finance Committee's Bill

1. Process: Medicaid-like waiver process is a cumbersome process for states to have to use to opt out of federal requirements.
2. Timing: Waivers are not available until 2015, meaning Massachusetts would have to operate under federal rules (which may conflict with current state programs) for up to 2 years.
3. Scope: The Secretary's discretion is vague and broad in determining the scope of the waiver, including which Federal laws and requirements will not apply to the State.
4. Criteria:
    a. The methods by which a state would be evaluated against the waiver criteria are undefined.
    b. The budget neutrality requirement is problematic: it is not clear what the base year is, and it is not obvious that Massachusetts' programs as they are currently structured would be able to demonstrate budget neutrality. The 10-year time horizon also would be difficult to meet because of the uncertainties inherent in such a long time period.

Suggestions for a revised "State Opt-Out" provision

1. Timing: Initial opt-out should begin in 2013 for states that meet the criteria as of the date of enactment; other states could apply to opt out beginning in 2015. There should be an option to renew in 2019 and every 5 years thereafter. The process should enable states to obtain a waiver before federal health reform provisions begin to be implemented, and should continue through the years projected by the CBO.
2. Scope:
    a. A state "shall" (rather than "may") be granted a waiver if it meets the criteria.
    b. States should have the option to opt out of any and all provisions of the Act.

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Summary of key topics in national health care reform bills relevant to the future of Massachusetts reform

Topic	Comment
State "opt-out" waiver	It is not clear that Massachusetts could qualify for a waiver under the language of the SFC opt-out provision. That waivers would not be available until 2015 is a hindrance, and it is not obvious that Massachusetts would be able to meet the 10-year budget neutrality requirement with its current programs.
Public program expansion – Medicaid	Overall positive that it would support MassHealth 1115 Waiver. Allowing choice between Medicaid and Exchange for people with incomes between 100% and 133% FPL could be administratively complex.
Public program expansion – CHIP, or subsidize children in Exchange	Unclear whether children are better off in Exchange or in CHIP. There are good arguments for both options.
Enhanced federal match for Medicaid and CHIP	Massachusetts would not be able to access significant additional Medicaid federal matching funds under the SFC bill, because past expansions mean no "newly eligible" now. Under the House bill, Massachusetts would receive an additional $350m-$450m per year in federal matching funds for childless adults between 100% and 133% of FPL. SFC bill includes CHIP federal match increase from 2014-2019.
State maintenance of effort (MOE) requirement	If Connector is deemed a "fully operational" exchange under SFC provision, MOE requirement could sunset before 2013. Medicaid MOE is perpetual in House bill.
Premium subsidies for Exchange plans	Massachusetts subsidies are more generous; all bills envision low-income consumer contributions to premiums that may be unrealistic.
Individual mandate	Affordability standard is higher in HELP bill, generally higher in SFC bill; might result in fewer exemptions from individual mandate in Massachusetts.
Employer responsibility	House "pay or play" provision would greatly expand financial responsibility of employers not offering coverage. HELP and SFC bills define "small" employers exempt from requirements at a larger size than Massachusetts' <11 FTE.
Connector/Exchange/Gateway role	All bills allow (or require) state-based Exchanges. The SFC version is more of a "yellow pages" model, in which the Exchange does not coordinate risk pooling or negotiate with plans, as the other two bills allow.
Provider payments	Proposed reductions in Medicare and Medicaid DSH may not have a great effect on Massachusetts because the triggers for reducing DSH protect states that have already significantly reduced the number of uninsured and that and that use DSH to expand coverage through a Section 1115 waiver (though the language does require some clarification). As a matter of general principal, the bills do not acknowledge a continuing need for DSH to compensate for unreimbursed costs resulting from Medicaid underpayments and high cost sharing requirements in basic coverage plans. Provisions for payments to primary care physicians might either increase payments (House) or prevent an increase (SFC) in Massachusetts.
Excise tax on high cost health plans	This revenue source is present only in SFC bill. As written, an excise tax could affect as many as half of insurance plans in Massachusetts by 2016.
Minimum creditable coverage	Generally, all bills are reasonably consistent with Massachusetts approach in defining the benefit packages, cost sharing limits and other features of an MCC plan. Main variances are in the treatment of annual and lifetime limits (Mass. allows some annual limits, with conditions), and the portion of the market to which MCC applies.

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Potential Impact on Massachusetts of National Health Care Reform bills

		Congressional Bill Provisions				
Issue	**Issue Description**	**House (HR 3200)**	**Senate HELP**	**SFC**	**Current MA**	**Impact on Massachusetts**
State Opt-Out Waiver	Allows a state, under certain conditions, to opt out of some requirements of the federal law			Opportunity for states to opt out of certain aspects of the Act through a process that resembles a Medicaid Section 1115 waiver process beginning in 2015, two years after most of the Act would become effective. States must demonstrate that health care coverage would be at least as comprehensive as a qualified health plan offered through the Exchange, would lower the growth in health care spending, improve delivery system performance, provide affordable choices, expand protection against excessive out-of-pocket spending, provide coverage to the same		It is not clear that Massachusetts could qualify for a waiver under the language of the SFC provision. That waivers would not be available until 2015 would severely weaken its usefulness to Massachusetts. The budget neutrality time horizon is very long. The waiver provision would benefit Massachusetts more if it were available for "any and all" provisions of the Act.

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Issue	Issue Description	House (HR 3200)	Senate HELP	SFC	Current MA	Impact on Massachusetts
				number of uninsured as under the Act, and be budget neutral to the Federal government over 10 years. The Secretary of HHS would have discretion to determine the scope of and approve the waiver		
Public program expansions	Expansion of mandatory Medicaid eligibility to new categorical group (childless adults) and higher incomes than are currently allowed	Expand Medicaid to all *non-elderly* individuals, including childless adults, up to 133% FPL Newly eligible childless adults may enroll in Exchange plan if they were enrolled in qualified health coverage in 6 months before Medicaid eligibility Mandatory coverage for all newborns with inadequate coverage (100% FMAP) Optional coverage for low-income HIV+ individuals and for family planning services for low-income women	Expand Medicaid to all *non-elderly* individuals, including childless adults, up to 150% FPL (although Medicaid is not in Committee's jurisdiction) These individuals must enroll in Medicaid and are not eligible for subsidies (credits) to purchase coverage through a Gateway (Exchange)	Expand Medicaid to all *non-elderly* individuals, including childless adults, up to 133% FPL on 1/1/2014 (states can opt to cover childless adults through SPA in 2011) In 2014, non-pregnant adults between 100%-133% FPL can choose Medicaid or coverage through Exchange. If choose Exchange: • State "clawback": state must pay Exchange average cost of coverage for individuals in same Medicaid eligibility	MA already covers these non-elderly populations at or below 133% FPL through Medicaid state plan or waiver. MA already provides premium assistance for most enrollees, if cost-effective.	Would shift some people/spending to Medicaid State Plan (base) v. Waiver (so would create some budget neutrality savings and Safety Net Care Pool spending room under the Section 1115 MassHealth waiver). May elect to do State Plan Amendment in 2011 to get these savings sooner All bills are helpful to MA, but if HELP's 150% FPL is still on the table, that would create more budget neutrality room as those folks would shift to base For individuals 100%-133% FPL who choose the Exchange – this is not a savings because

Issue	Issue Description	House (HR 3200)	Senate HELP	SFC	Current MA	Impact on Massachusetts
				category • Child can enroll in Exchange with state wrap (incl. EPSDT) and Medicaid cost-sharing rules Newly eligible adults are guaranteed benchmark coverage that at least meets MCC States must provide premium assistance to Medicaid beneficiaries with access to ESI if cost-effective States can provide coverage for those above 133% FPL through traditional Medicaid or wrap (these individuals may get Exchange premium credits too)		of "clawback", and EPSDT wrap for kids is administratively complex
Public program expansions	CHIP program structure and eligibility	Requires all CHIP enrollees to enroll in Exchange plans in Year 1 of Exchange (as long as capacity and transition plans in place)	Option for CHIP eligibles to enroll in CHIP or in a Gateway	Maintains current CHIP program and structure through 2019 CHIP-eligible kids who	MA generally covers children from 150-300% FPL in CHIP (capture some parents thru Family Assistance	Different perspectives on whether children are better off in Exchange or CHIP: Exchange: stay with parents;

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		[**E&C amendment:** not until Secretary certifies that Exchange coverage is at least comparable to the coverage of average CHIP plan in effect in 2011 and transition plans in place] Doesn't require state wrap to Exchange for kids	(Exchange) plan Doesn't require state wrap to Gateway (Exchange) for kids	can't enroll due to CHIP allotment cap are eligible for premium credits in Exchange CHIP eligibility based on existing income eligibility rules, including income disregards	Premium Assistance)	state savings if federally subsidized. But… if state decides to provide a wrap to maintain same level of coverage as CHIP, would be administratively complex. CHIP: CHIP benefit and cost-sharing protections; continuity of care/services Additionally, allowing choice between CHIP and Exchange could lead to adverse selection.
Federal Match for Medicaid and CHIP	States currently receive federal matching dollars for state Medicaid expenditures that can range from 50% to 83% of program expenditures (CHIP provides an enhanced matching rate, which is 30% higher than a state's Medicaid matching rate)	Enhanced FMAP for Medicaid coverage expansions (except optional ones – e.g., HIV+ and family planning): • 100% FMAP [**House Committee on Energy and Commerce (E&C) amendment:** 100% FMAP thru 2014 and then 90% FMAP]		Medicaid: - In 2014, enhanced FMAP for *newly eligible* (e.g., at/below 133% FPL and not previously eligible for benchmark coverage or eligible for a capped program but not enrolled as of enactment): • 27.3% FMAP increase for states already covering parents or childless adults at or above 100% FPL (Expansion	Currently, MA receives a 50% FMAP for Medicaid program expenditures and 65% FMAP for CHIP program expenditures	Negative: Despite meeting the SFC definition of an "Expansion state," MA would have no "newly eligible" populations under the SFC bill as it already covers all populations up to 133% FPL (and 150% FPL) in Medicaid (state plan or Waiver). Therefore, MA would not receive any enhanced Medicaid FMAP for populations the state already has been covering since at least 2006 (earlier in most

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				States) • 37.3% FMAP increase for other states • 100% FMAP for “high need” states (low Medicaid enrollment and high unemployment) from 2014-2018 • FMAP rates then adjusted between 2014-2019, until all states get 32.3% FMAP increase for newly eligibles Also, FMAP increase of 0.15% to offset additional state costs due to Medicaid MOE from FFY 2014 (10/1/2013) through 9/30/2019) CHIP – Current CHIP match from FFY 2010-2013. In FFY 2014: 23% increase in CHIP match		cases) Positive: Under the House bill, MA would receive enhanced FMAP for childless adults between 100% and 133% of FPL (est. $350m-$450m per year) Medicaid match for kids(?) jumps from 50% to 50.15% from 2014 until 12/31/2019 CHIP match jumps from 65% to 88% from 2014 until 12/31/2019.

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Issue	Issue Description	House (HR 3200)	Senate HELP	SFC	Current MA	Impact on Massachusetts
				rate through 9/30/2019		
State Maintenance of Effort (MOE) requirement	State must "maintain" its Medicaid and/or CHIP eligibility levels (through state plan or Waiver)	In general, must maintain Medicaid and CHIP eligibility levels, methodologies and procedures that were in place as of 6/16/2009 to continue receiving FMAP CHIP MOE expires when Exchange operational and transition plan for children in place Medicaid MOE does not expire		In general, must maintain existing income eligibility levels for all Medicaid populations, from enactment until Exchange is fully operational (~7/1/2013) Exemptions: • Except for those at/below 133% FPL, for which MOE expires on 1/1/2014 • Except for kids, for which MOE expires on 10/1//2019 (like CHIP) Between 1/1/2011 and 12/31/2014, state exempt from MOE for optional non-pregnant, non-disabled adults >133% FPL IF state certifies (on/after 12/31/2010) that it is		SFC provision allows Medicaid MOE requirement to expire. Could even argue that our "Exchange" is fully operational sooner than 2013 (so MOE sunsets sooner). But, SFC "MOE exception" from 2011-2014 is positive for MA. MOE requirement in general is burdensome with little or no additional federal assistance, particularly because of current MOE requirement of ARRA, the enhanced FMAP for which expires in 2011. While CHIP MOE is longer in SFC, there is a large enhanced FMAP increase

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				currently experiencing budget deficit or projects to have one in the following SFY (SFY 2012) MOE for CHIP income eligibility from enactment through 9/30/2019 (although could expand coverage)		
Eligibility for Premium Subsidies for Exchange plans	For low-income individuals not eligible for Medicaid and other public programs (and mostly with no access to ESI), federal subsidies – in the form of premium caps based on % of income the cost represents – are available to help them purchase private HI offered through the Exchange/Gateway	Premium credits for individuals in Exchange-participating plans between 133%-400% FPL (includes those lawfully present) Credits on sliding scale basis from 1.5% of income at 133% FPL to 11% (**E&C amendment: 12%**) of income at 400% FPL (see schedule) Cost-sharing credits available too (see schedule). Limits annual out-of-pocket expenses to $5,000 for individual and $10,000 for family Generally not available for	Individual affordability credits for individuals 150-400% FPL (includes those lawfully present) Credits on sliding scale from 1% of income at 150% FPL to 12.5% of income at 400% FPL administered by the Gateways Additional limits on cost-sharing	Premium credits available on sliding scale for those with incomes between 133% and 300% FPL beginning in 2013 (includes those lawfully present); those between 300-400% FPL eligible for credit at that limits liability for premiums to 12% of income In 2014, credits (starting at 2% of income at 100% FPL) also available to those between 100%-133% FPL who choose coverage through Exchange Credits not available to	CommCare subsidies extend to adults ineligible for Medicaid up to 300% FPL (and not offered ESI in last 6 months for which employer pays certain % of premium) Subsidy financed by state & federal governments • full subsidy for those below 150% FPL ($0 premiums) • partial subsidy based on income for those between 150-300% FPL	On the subsidy side, MA provides more premium protection. In all of the federal bills, responsibility for paying premiums starts below 150% FPL. At 300% FPL, premiums in MA are capped at ~5% of income. SFC and House bills are 12% and 9% of income at 300% FPL, respectively

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		employees with access to "affordable" employer coverage No federal affordability credits for undocumented aliens	Generally not available for employees with access to "affordable" employer coverage	individuals <100 FPL, who are eligible for Medicaid Cost-sharing assistance available for those between 100%-150% FPL (subsidized up to 90% of benefit costs of the plan) and 150%-200% FPL, (80% of benefit costs of the plan) Generally not available for employees with access to "affordable" employer coverage unless employer plan does not have the actuarial value of at least 65% or if the employee share of the premium > 10% of income	(premiums up to 300% available at a max. of **5%** of income though more expensive options are also available) Can apply for co-pay waivers, but no co-pay subsidies	
Individual Mandate	Requires certain individuals to obtain minimal level of HI coverage or be subject to tax penalty	Penalty if individual does not have "acceptable health coverage" = 2.5% of modified adjusted gross income, not to exceed average national premium for basic coverage. (prorated by period of time lacking insurance)	Penalty is no more than $750 per person Penalize parents of dependents without coverage Exemptions: • If unaffordable	Penalty = excise tax of $750 per adult in household with the penalty being phased in as follows: for $0 in 2013; $200 for 2014; $400 for 2015; $600 in 2016 and $750 in 2017	Penalty scaled by income (and assessed for each month without MCC): • 0 – 150% FPL: $0 • 150.1 – 200% FPL: $17/month; $204/yr • 200.1 – 250% FPL:	Kids exempt in MA (and House), but not in HELP or SFC Penalty is higher in House "Affordability" standards either not defined or may

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		Exemptions: • Dependents not penalized • Financial hardship, but affordability standard not specified • Religious objections (as defined by Medicare) • Native Americans • Coverage gap: lapses TBD by Secretary/Health Choices Commissioner • Non-resident aliens Penalties applied through tax filing	(≥ 12.5% on AGI) • Native Americans • No explicit religious exemption • Coverage gap of <90 days • No gateway in state Penalties applied through tax filing	Penalize parents of dependents without coverage Exemptions • Affordability: if lowest cost premium (net subsidies & employer contribution, if any) is >8% of their AGI. • Household income is <100% FPL • Religious objections (as defined by Medicare) • Coverage gaps: less than 3 months • Hardship situations as determined by Sec HHS • Undocumented aliens • American Indians/Alaskan natives Penalties applied through tax filing	$35/month, $420/yr • 250.1 – 300% FPL: $52/month, $624/yr • Above 300% FPL (18-26): $52/month, $624/yr • Above 300% FPL (27 and above): $89/month, $1,068/yr Dependents not penalized Exemptions: • Affordability based on schedule – lower pct of income for lower incomes; max at 8.3% of income for individual at midpoint of highest bracket (about 450% FPL) • Religious objections (not defined, but voided if medical services used) • Coverage gaps: > 63 days	result in more penalties in MA

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Issue	Issue Description	House (HR 3200)	Senate HELP	SFC	Current MA	Impact on Massachusetts
					• Hardship • Children Enforced by DOR through tax-filing process. Connector and DOR collaborate to develop appropriate forms, processes, etc.	
Employer Responsibility	Requirements for certain employers to contribute to employee health expenses (includes small business)	Contribute at least 72.5% of lowest cost premium (or 65% for family plan) OR Pay penalty of 8% of payroll Exemptions: • Sliding scale for the pay or play assessment for small employers with annual payroll < $500,000:exempt; • $ 500,000 - $585,000: 2% of payroll; • $ 585,000 - $670,000: 4% of payroll • $670,000-$750,000: 6% of payroll • Exempt employers negatively affected by job losses resulting from requirement. Require employers that offer coverage to automatically enroll into the employer's lowest cost	Employers > 25 employees who do not offer qualifying coverage or pay less than 60% of their employees' monthly premiums are subject to $750 annual fee/uninsured full-time employees and $375/uninsured part-time employees. Prorated for part-year lapses Beginning in 2013 penalty amounts will be adjusted using the CPI for urban consumers	The SFC Bill does not require employers to offer health insurance. But in Jan 2013 employers with at least 50 employees who do not offer coverage will have to reimburse the federal gov't for each employee receiving a subsidy in the exchange equal to 100% of the average subsidy up to a maximum of $400 times all FTEs in the firm. Exemptions: • No fee for an employee enrolled in Medicaid • Small employers with ≤ 50 FTEs, or maybe up to 100 employees, depending on current state law	No employer requirement to offer insurance, however, incentives/sticks to encourage Fair Share Contribution If >50FTEs, must satisfy one of the following conditions: • Provide 33% of premium health insurance to 25% of FTEs enrolled in HI plan; or • 75% of enrollees are enrolled in health plan If >=11 FTEs <=50 FTEs, must satisfy one of the following conditions: • 33% of premium, or	House "pay or play" provision would greatly expand financial responsibility of employers not offering coverage. HELP and SFC bills define "small" employers exempt from requirements at a larger size than Massachusetts' < 11 FTE

Issue	Issue Description	House (HR 3200)	Senate HELP	SFC	Current MA	Impact on Massachusetts
		plan for any individual who does not elect coverage under the employer plan or does not opt out	Employers can elect to auto-enroll; no requirement	Employers w/>200 employees must automatically enroll employees into their health plans.	• 25% of FTEs are enrolled in HI plan If fail above test(s), pay fine which is the lower of (1) $295 per employee or (2) the sum of the Fair Share Employer Contribution and the Per Employee Cost of Unreimbursed Physician Care Free Rider Surcharge If >=11 FTEs, must establish Section 125, or pay fee if employee receives State funded Health Services that total at least $50,000 in a fiscal year Individuals are not automatically enrolled in ESI, but if they opt not to enroll in ESI that is offered a HIRD form must be completed	
Employer subsidies	Tax subsidies for employers to encourage purchase/provision of	Full credit of 50% of premium costs paid by employers with 10 or fewer employees and avg wages ≤ $20K. Partial credit for	For small employers, a health options program credit. Tax credit of $1,000/FTE	Tax credit up to 35% premium costs for any small business in 2011-2012, then 50% starting 2013 for employers with	• MA employers may participate in the Insurance Partnership	Federal tax subsidies could motivate more Massachusetts small employers to offer

Issue	Issue Description	House (HR 3200)	Senate HELP	SFC	Current MA	Impact on Massachusetts
	HI for employees	employers up to 25 employees and avg wages of less than $40K Create a temporary reinsurance program for employers providing coverage to retirees 55-64. Program reimburses employers for 80% of retiree claims between $15K - $90K	($2,000/FTE with family coverage) if ≤ 50 full-time employees AND pay an average wage of < $50K AND must pay at least 60% of employees health expenses Bonus for each add'l 10% above 60% of health expenses paid by employers Not awarded for > 3 consecutive yrs Self-employed are eligible for credit if they did not receive premium credits for purchasing coverage thru the Gateway Create a temporary reinsurance program for employers providing coverage to retirees 55-64. Program reimburses employers for 80%	no more than 25 FTEs in exchange; tax exempt small employers get a smaller credit (25%, then 35%) Credit amount phased out by employer size between 10-25 FTEs and $20K-$40K average annual wages Create a temporary reinsurance program for employers providing coverage to retirees 55-64. Program reimburses employers for 80% of retiree claims between $15K - $90K	Program (IP), which provides partial subsidies to small employers (up to 50 FTEs) to offset their costs of group health insurance purchased for employees that meet the eligibility requirements	coverage.

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Issue	Issue Description	House (HR 3200)	Senate HELP	SFC	Current MA	Impact on Massachusetts
			of retiree claims between $15K - $90K. Once State Gateway is established, program will end			
Connector/ Exchange/ Gateway role	The federal bills each establish an entity similar to the MA Connector, but the bills establish somewhat different roles for this entity	There is one national Exchange; states have the option of establishing a state Exchange The Exchange sets standards and negotiates with plans The Exchange coordinates affordability credits and pays to health plans The Exchange coordinates Risk Pooling: receives payments from insurers and makes payments to insurers Individuals make payments directly to insurers	Establishes Gateways in each state The Gateway sets standards and negotiates with plans The Gateway coordinates affordability credits and pays to health plans The Gateway coordinates Risk Pooling: receives payments from insurers and makes payments to insurers Individuals make payments directly to insurers Gateway may impose a 4% surcharge on insurers to cover Gateway's costs	Requires an Exchange in each state All non-group and small group plans offered in state must be available through Exchange. Exchange rates plans' quality and price relative to other plans in same benefit level. (no negotiation) The Exchange or state Medicaid agency conducts eligibility determinations for tax credits and subsidies. [Treasury Dept coordinates credits and pays to health plans.] No risk pooling Treasury Dept collects payments from individuals (through payroll deductions from employed individuals) and	Connector established in 2006; has similar role to Exchange/Gateway Negotiates with plans re: premiums, benefit structure, member services, etc. Collects government premium contributions and pays to MCOs. Risk Pooling Individual pay premium contribution to the Connector and Connector forwards to MCOs Provides certification to individuals who cannot afford any locally available plan that meets minimal creditable	Allowing the Connector to retain the authority to select the plans that it offers, to set standards for these plans, and to negotiate with plans gives individuals stronger representation in the market place

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Issue	Issue Description	House (HR 3200)	Senate HELP	SFC	Current MA	Impact on Massachusetts
			"Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title."	makes payments to insurers Provides certification to individuals who cannot afford any locally available plan that meets minimal creditable coverage	coverage	
Provider Payments	**Medicare Disproportionate Share (DSH) Payments** The bills may reduce the payment rate adjustments that Medicare makes to hospitals in order to offset the higher cost of treating low income Medicare patients and to help offset the cost of uncompensated care	HHS must recommend to Congress by 1/1/16 the appropriate amount of Medicare DSH to meet the two purposes If the national uninsurance rate decreases by 8% by 2014, then Medicare DSH should be adjusted, based on HHS's analysis, beginning in 2017	Not addressed	Medicare DSH payments are divided into two parts: (1) the "empirically justified" (as defined by MedPAC), 25% of current Medicare DSH payment; and (2) an additional payment consisting of the remaining 75% of aggregate payments, reduced annually by the proportional decline in the uninsured rate and distributed among all hospitals according to each hospitals share of total uncompensated care. [NOTE: This interpretation is based on our best reading of the intent of the bill, though an apparent drafting error makes it ambiguous.]	Medicare DSH payments to Massachusetts hospitals are relatively small	House version is more helpful to Massachusetts because it recognizes the original purposes of Medicare DSH: to offset the higher costs of treating low income Medicare patients and the cost of uncompensated care In the SFC bill, total Medicare DSH payments are (apparently) tied to declines in the national uninsured rate, so Medicare DSH payments to MA hospitals could go down even if there is no change in the MA uninsured rate.

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Issue	Issue Description	House (HR 3200)	Senate HELP	SFC	Current MA	Impact on Massachusetts
	Medicaid Disproportionate Share (DSH) Payments Medicaid DSH pays hospitals for unreimbursed costs of treating low-income Medicaid and uninsured patients. Federal rules cap each state's total DSH spending	HHS must report to Congress by 1/1/16 on the extent to which there is a continued need for Medicaid DSH, and whether DSH is distributed appropriately across states Directs HHS to reduce Medicaid DSH by $1.5b in 2017; by $2.5b in 2018; and by $6.0b in 2019. Directs HHS to impose the largest DSH reductions on states that have the lowest percentages of uninsured individuals OR do not target DSH to hospitals with high inpatient Medicaid and high uncompensated care	Not addressed.	Once a state's uninsured rate decreases 50% below the uninsured rate as of the date of enactment, the state DSH cap would be decreased by 50%. If the state's uninsured rate continues to decrease, the DSH cap could be reduced to as low as 35% of cap at date of enactment "Any portion of the state's allotment that is currently being used to expand eligibility through a section 1115 waiver is exempt from such reductions."	Massachusetts's DSH spending is included in its 1115 Medicaid waiver. The current waiver allows MA to spend up to $1.7 billion over 3 years for the Health Safety Net (HSN), supplemental payments to safety net hospitals, payments to institutions for mental diseases (IMDs) and DPH & DMH hospitals	These changes may limit MA's ability to make DSH payments to hospitals, which could have a negative effect on MA hospitals Under SFC, MA DSH devoted to Safety Net Care Pool spending on CommCare is not at risk To fully support the safety net, Medicaid DSH should continue to pay hospitals for unreimbursed costs of treating low-income Medicaid and uninsured patients, plus unreimbursed costs for treating low income patients who obtain private health insurance subsidized by the federal government. (That is, Medicaid DSH should offset hospitals' costs for treating underinsured individuals who cannot afford cost sharing requirements.)
	Geographic Variation in Medicare Hospital	HHS will contract with the IOM to evaluate geographic		Requires HHS to provide a plan to Congress by	The current Medicare wage area adjustment	These changes may decrease payments to Massachusetts

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	Payments	adjusters used by Medicare in payment methods for all provider types HHS is directed to revise geographic adjustment factors, taking the IOM's recommendations into account. Funding is available to make these changes until 1/1/14 HHS may not change provider rates to be less than what they would have been without this change		2011 on how to comprehensively reform the Medicare wage index system	generally results in higher payments to MA hospitals	hospitals Any revisions in the wage area index should recognize the difference in the cost of labor in different areas of the country
	Physician Payments	Increases Medicaid payments for primary care to 80% of Medicare by 2010; 90% of Medicare in 2011; 100% of Medicare by 2012. States receive 100% FMAP on the rate increases Provides a 5% increase in physician payments to geographic areas that fall in the lowest 5th percentile in utilization; measured by per capita spending adjusted to eliminate the effect of geographic adjustments in payment rates		Geographic adjusters in 2010 would be 75% local and 25% national; in 2011 50% local and 50% national; but all areas would be held harmless from negative adjustments Result would be an increase in physician payments in low cost areas, while payments in high cost areas would not change Directs HHS to analyze geographic cost differences and	MA currently pays an average of 78% of Medicare rates for primary care; the House bill would increase payments to 100% The current Medicare geographic adjustment generally results in higher payments to MA physicians	House provision would increase Medicaid payments for primary care SFC provision could prevent MA physicians from receiving Medicare payment increases

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				implement a new adjustment system by 1/1/12		
Provider Payments	Global Payments demo			Establishes a Medicaid Global Payment demonstration project in up to 5 states from 2010-2012, under which a large safety net hospital system would be paid a global capitation instead of FFS	MA Payment Reform Commission recommended developing a global payment methodology in MA.	The SFC demonstration project could help further the development of a global payment methodology in MA
Revenues - Excise Tax on "Cadillac" Plans	One of the proposed sources of funds for health reform is a tax on health insurance premiums above a certain threshold. The intention is to discourage insurers from offering extremely rich benefit plans.			Imposes a 40% tax on the amount ESI premiums exceed a threshold of $8000 for an individual plan and $21,000 for a family plan beginning in 2013. Threshold is higher for high-cost states for first 3 years (20% higher in 2013, 10% higher in 2014, and 5% higher in 2015)	MA does not have a similar tax.	This tax would disproportionately hit MA because of our higher health care costs We estimate that in 2016 the threshold will be approximately equal to the MA average premium, so insurers will owe an excise tax on half of their business, including most small business insurance
Minimum Creditable coverage	Definition of the benefit packages, cost sharing limits and other features of coverage that qualify as complying with the	"Essential benefits package" allows no annual or lifetime limits, which could supersede MA regulation that allows some limits (956 CMR 5.03(f)). A state may	Specifies comprehensive coverage, but criteria that "Essential health care benefits	"Essential benefits coverage" in *individual and small group markets* allows no annual or lifetime limits of any benefits, and no cost	MA: MCC requires comprehensive coverage, including prescription drugs, with similar limits to the bills on out of pocket	Main variances between MA and the bills are in treatment of annual and lifetime limits (MA allows some annual limits, with conditions), and the portion of the market to

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	individual mandate. Bills are generally consistent with Massachusetts	require more, but must hold Feds harmless for additional premium credits	package" must meet to be considered minimum qualifying coverage would be determined by regulation and is not in legislation. A state may require that a qualified health plan offer additional benefits, at the state's expense and with no additional federal subsidy	sharing for preventive services. Package may not be more extensive than "typical employer plan." MCC for large group only requires no cost sharing for preventive services and an out-of-pocket limit equivalent to HSA limits, and prohibits "unreasonable" annual or lifetime limits.	spending. Applies to coverage in all markets (small and large group) for individuals subject to the mandate	which MCC applies. SFC bill could potentially allow large group plans that do not meet the current MA MCC standards
Insurance consumer protections	Standards for insurance plan marketing, grievances and appeals, information transparency, etc. Traditionally the province of state insurance regulators. Provisions in reform bills distinguish between plans within and outside the exchange	New Health Choices Comm'r sets standards for marketing; internal claims and appeals processes; binding external grievance processes; transparency and "plain language disclosure" for plans **inside** the exchange. Comm'r can decide which of these also apply to qualified plans **outside** the exchange. Potential conflict with state consumer protection rules. Also sets stds. for timely payment and coordination/subrogation of benefits	State regulators perform traditional functions re consumer protection and market conduct for plans **outside** the Gateway. Secretary regulates market conduct **inside** the Gateway for qualified plans	State insurance commissioners continue to provide oversight of plans with regard to consumer protections. Directs NAIC to develop model reg re rating, issuance and marketing, which would become the federal *minimum* standard. (If NAIC does not act, HHS Sec. issues reg.) State must adopt model or equivalent (consistent with intent and same level of consumer protections). If state does not conform, conflicting state laws	Massachusetts insurance statutes establish the appropriate standards for insurance plan marketing, grievance and appeals, information transparency, etc.	Federal rules, as established by the NAIC or HHS, may create criteria that prohibit or create barriers to the implementation of state law [As an example, Massachusetts requires that a health plan complete all internal appeals of a denied service within 30 days of the denial. The NAIC has required in the past that there be two levels of internal appeals before a denial be considered by an external reviewer. If Massachusetts health plans were required to have two levels of review, it may create

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				would be preempted. All insurance entities (no distinction between in and out of exchange) would be subject to state regulatory requirements that exceed federal consumer protection requirements		obstacles to completing all internal appeals within 30 days of a denial.]
Insurance market reforms	Changes to structure of markets, rating rules, requirements of insurers. Some reforms apply to all insurers, other only to small group and individual markets	Guaranteed issue/renewal and no pre-ex exclusions for *all* qualified plans. Rating: Age (2:1 band), area and family enrollment allowed. Transparency: Insurers required to report MLR and be limited to set amt (E&L Comm. Specifies 85%). Only one plan in MA below 85% MLR in last report, most were well above. Silent on national and interstate plans	Guaranteed issue/renewal for *all* individual and group markets. Rating: Age (2:1), tobacco (1.5:1), area, family, actuarial value, health promotion pgm allowed. Transparency: Report spending of premium revenue on clinical services (MLR), quality improvement, taxes & fees, all other non-claims costs. Silent on national and interstate plans	Guaranteed issue/renewal in individual and small group market only (*as in Mass.*). Rating: Age (4:1 band), tobacco use (1.5:1), area, family allowed. (*Broader variation allowed than in Mass.)* Transparency: report proportion of premium dollars spent on items other than medical care. Allows insurers to offer national plans with uniform benefits, exempt from state benefit requirements. Must be licensed in states where offered; **states may opt out, by action of legislature.** States may also form interstate "health care choice compacts" and allow insurers to see in any	Individual and small group market merged. Guaranteed issue/renewal in small group market only. Limited pre-existing condition exclusions allowed. Rating bands: Age, industry, participation rate, wellness pgm, tobacco (overall 2:1 band), plus adjustments allowed for benefit level, area, family, intermediary and group size allowed outside of rate band. Transparency: MLR reported as part of financial reporting; DHCFP publishes Massachusetts law currently only permits carriers to offer coverage to eligible individuals and	If Massachusetts must follow the federal rating rules, certain groups' rates may go up Allowing interstate and national plans would permit Massachusetts residents to purchase plans that may not be consistent with Massachusetts mandated benefit, eligibility and rating rules. Although the state may opt out – by action of the legislature – until this occurs, persons choosing such plans will only benefit from the consumer protections of the state in which the plan is issued, not the state in which they live

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				state that is part to it. Insurers subject only to the laws and regs of state *where policy is written or issued.* Individual policies only. Insurer must notify consumer that policy may not be subject to the rules of the state in which the purchaser resides	eligible small employers based on Massachusetts mandated benefit, eligibility and rating rules	

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