



Massachusetts Health Care Reform:

Using an 1115 Waiver to Provide Private Insurance to the Uninsured and to Contain Costs

Presentation to the National Health Policy Forum

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Chapter 58 of the Acts of 2006

An Act Providing Access to Affordable, Quality, Accountable Health Care

- Signed by Governor Romney on April 12, 2006 (passed by General Court on April 4, 2006)
- Provides access to affordable health insurance coverage to all Massachusetts residents
 - Modernizes health insurance laws
 - Removes barriers to purchasing health insurance
 - Redirects existing government assistance for uncompensated care to health insurance premium subsidies (institutions to individuals)
 - Requires individual responsibility
 - Requires employer responsibility
- Builds upon 1115 Waiver extension approved by CMS on January 26, 2005

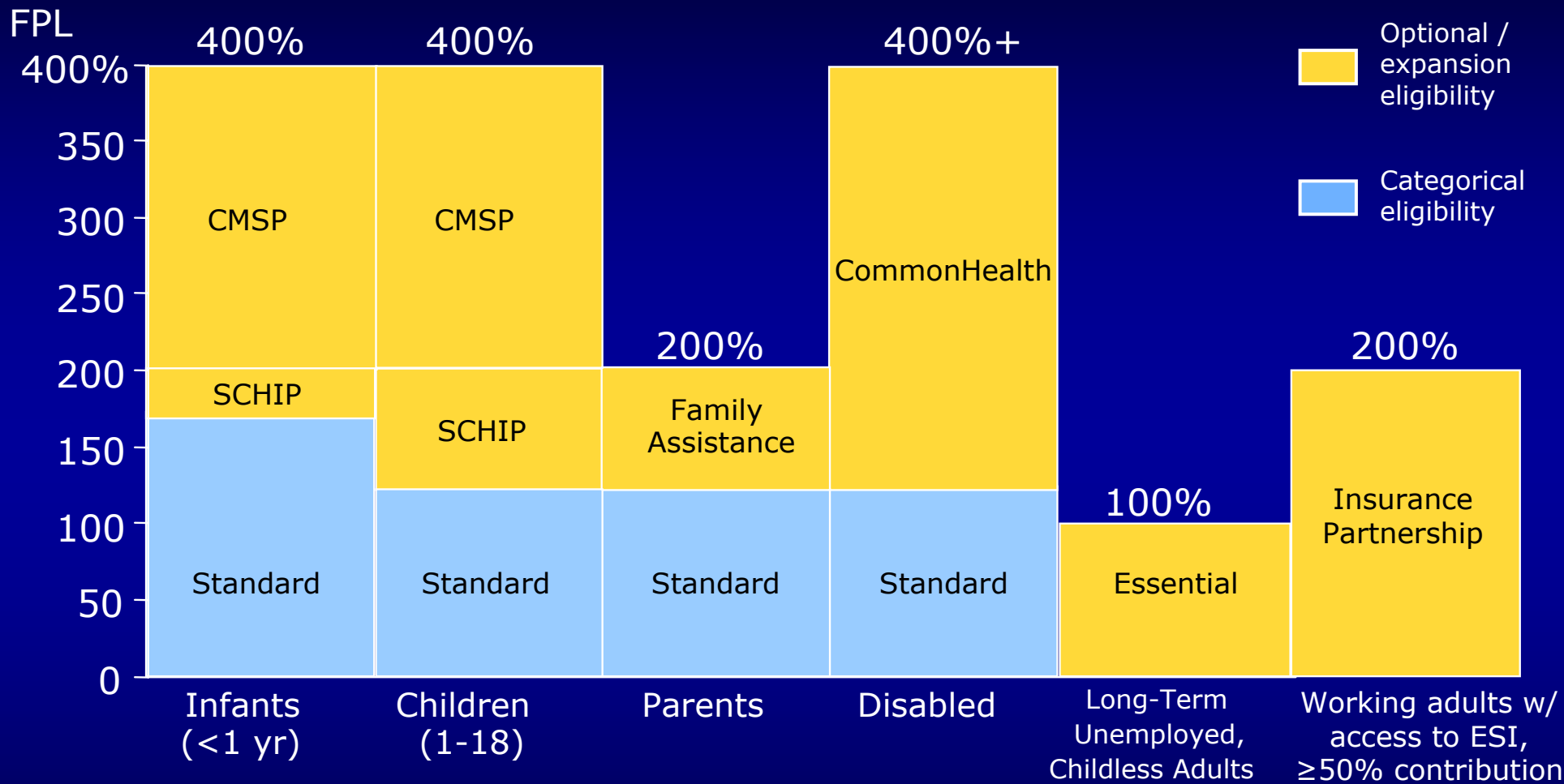
Context for Health Care Reform

- MA has one of lowest rates of uninsurance in the country due to:
 - Generous employer-based coverage (70% of all employers subsidize insurance for employees)
 - Significant MassHealth expansions since 1997 (currently over 1,030,000 members)
- But...number of uninsured rising due to double-digit annual increases in health insurance premiums
- \$700M in federal and state money invested in uncompensated care pool; but leads to cost-shifting to insured and incentives to bill pool rather than MassHealth
- Bipartisan desire, leadership, collaboration, and compromise
- 1115 Waiver extension provided opportunity and mechanism for reform

The Uninsured in Massachusetts

• Total Commonwealth Population:		6,400,000
• Currently insured (93%)		5,940,000
- Employer, individual, Medicare or Medicaid		
• Currently uninsured (7%)		<u>460,000</u>
- $\leq 100\%$ FPL	Medicaid Eligible but unenrolled	106,000
- $\sim 100-300\%$ FPL	Premium Assistance	150,000
- $> 300\%$ FPL	Affordable Private Insurance	204,000

Current MassHealth <65 eligibility: substantial optional and expansion populations



- **Standard:** Traditional Medicaid program and benefits
- **SCHIP:** State Children’s Health Insurance Program, including buy-in to parent s’ plan if available
- **CommonHealth:** Sliding scale premium program for the working disabled
- **Children’s Medical Security Plan (CMSP):** State-only funded preventive care program
- **Insurance Partnership:** Premium assistance to purchase of employer based insurance

Changes to Medicaid

- Creates a MassHealth Payment Policy Advisory Board
- Expand covered benefits to
 - Restore optional benefits cut during budget crisis (dental, chiropractors, vision, orthotics, detox)
 - Add coverage for tobacco cessation and wellness program
- Increase enrollment in MassHealth Essential (long term unemployed) to 60,000
- Increasing the SCHIP income limit to 300% for kids up to 18
 - Estimates range from 27,000 to 40,000 potential SCHIP eligibles
 - Family Assistance benefit package and use of employer sponsored insurance where available
 - Anti-crowd-out provisions
- Increases the Insurance Partnership program eligibility to 300% FPL
 - Improves program integrity by eliminating employer subsidy to sole proprietors

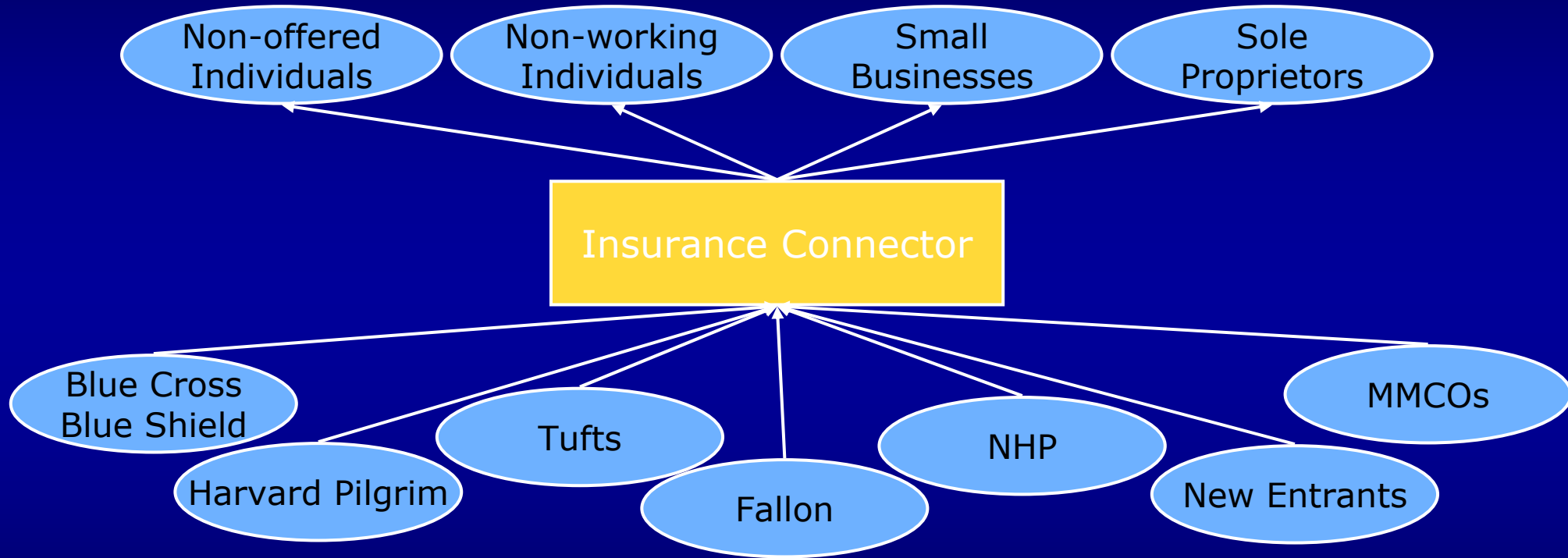
Insurance Market Reforms

- Merges non-group and small-group markets to pool risk and create more affordable choices for individuals and small businesses seeking to buy insurance
- Creates specialized products for young adults (19-26) and extends dependent coverage through age 25
- Permits deductible levels consistent with federal Health Savings Account laws
- Places moratorium on new mandated benefits until at least January 1, 2008 (dependent on impact study)
- Requires employers with more than 10 FTEs to create Section 125 “cafeteria” plans enabling employees to use pre-tax dollars to pay health insurance premiums

The “Connector”

- Independent public authority
- Will administer the Commonwealth Care with involvement by MassHealth (e.g., determine premium assistance levels; premium collections and subsidy administration)
- Will facilitate purchase of affordable health insurance plans that meet quality and other standards set by the Connector Board
- Eligibility: Non-working individuals, non-offered employees of large employers, and employees of small employers (50 or less)
- Non-traditional workers can purchase portable insurance
- Connector can aggregate contributions from multiple employers
- Small businesses can offer choice of affordable products to employees on pre-tax basis

The Connector simplifies the purchase of good value insurance



Low-income uninsured, non-Medicaid population is insurable

- Substantially younger than the average population
- Predominantly male and single
- Representative of statewide mix of race and ethnicity
- 82% are high school graduates, of which 15% have college degrees
- 78% are working, with the majority working full-time
- Like others, these individuals respond very well to insurance-like features

Commonwealth Care Health Insurance Program

- Private insurance-based premium assistance program for uninsured individuals at or below 300% FPL and not eligible for other public programs
- Crowd-out provisions (e.g., employer must not have provided coverage for which employee is eligible in previous 6 months *and* for which employer paid more than 20% of premium for family coverage or 33% of premium for individual coverage)
- Administered by the Connector
- Affordable products with no deductibles offered by private plans – MMCOs for first three years if meet enrollment benchmarks
- CWC premium assistance is eligible for FFP from the “Safety Net Care Pool” created by the 1115 Waiver extension
- Comprehensive outreach and education campaign
- Specialized program for individuals below 100% FPL

Health Safety Net Trust Fund

- Successor to Uncompensated Care Pool (UCP), beginning October 1, 2007 (HRY 2008)
 - HRY 2007 – remains unchanged from HRY 2006
- HSN Office will establish reimbursement rates for acute hospitals and CHCs for services provided to uninsured
- Claims-based, FFS, and based on Medicare reimbursement principles
- Eligibility, payment methodologies, reimbursement rates, and shortfall allocation are all TBD
- Contemplates using existing non-federal share of UCP
- Expectation that dollars here go down as CWC premium assistance goes up

The Personal Responsibility Principle

- Given Medicaid, premium assistance and affordable insurance products will be available, all citizens will have access to health insurance they can afford
- In this new environment, people who remain uninsured would be unnecessarily and unfairly passing their healthcare costs to everyone else
- Personal responsibility means that everyone should be insured or have the means to pay for their own healthcare

Personal responsibility: health insurance is the law

- Statewide open-enrollment period in March 2007
 - Both Commonwealth Care and whole insurance market
- Beginning on July 1, 2007 all Massachusetts residents will be required to have health insurance
- Enforcement mechanisms
 - Indicate insurance policy number on state tax return
 - Loss of personal tax exemption for tax year 2007
 - Fine for each month without insurance equal to 50% of affordable insurance product cost for tax year 2008

Employer assessment

- Levies an incremental fee on companies with 11 or more FTEs that do not offer and contribute to the cost of health insurance
 - Requires “fair and reasonable” contribution, to be defined in regulations
 - If not “contributing”, then employer pays \$295 per year for each FTE
 - Example: Company with 800 employees, 400 full-timers receiving health insurance, 400 part-timers not offered health insurance
 - Company would not pay any fee
- A free rider surcharge applies to any company with 11 or more FTEs whose employees collectively use more than \$50,000 of free care in one year
 - Does not apply if company makes a section 125 benefit plan available
 - No contribution required
- Requires all companies with 11 or more FTEs to set up a section 125 cafeteria plan such that part-timers and contractors can purchase insurance with pre-tax dollars
 - No contribution required

Transparency in Quality and Cost

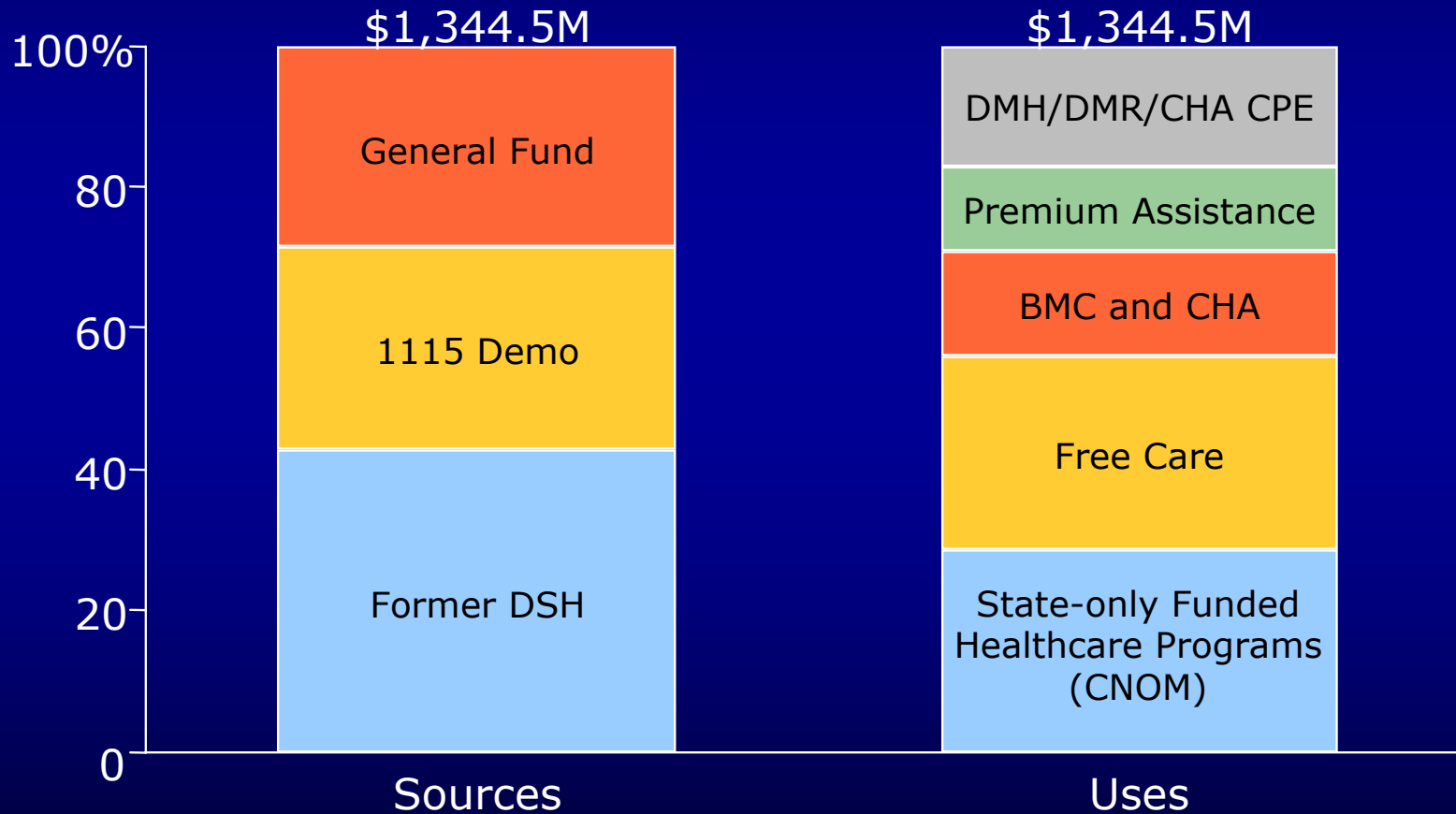
- Creates Health Care Quality and Cost Council
- Set quality improvement and cost containment goals for Commonwealth
- Collect cost, price and quality data from providers, pharmacies, payers and insurers
- Must develop web site for consumers
- Resides in EOHHS but governed by a Board with public and private members

Role of the 1115 Waiver in Health Care Reform

- MCO Supplemental Payments to BPHC and CPHC authorized in initial waiver (SFY 1998-2002) and allowed through first renewal (SFY 2003-2005) via waiver of UPL for Medicaid managed care organizations
- For waiver extension (SFY 2006-2008), CMS requires all MMCO payments to be actuarially sound (replaces MCO UPL) in accordance with BBA managed care regulations; and CMS questions source of non-federal share of the MCO supplemental payment (an IGT)
- Romney Administration and CMS negotiate end to MCO supplementals (and IGT) starting in SFY 2007 and ability to keep federal portion of supplemental payments (\$385M in SFY 2005) if state redirects certain spending from uncompensated care to insurance-based system of care
- Creation of Safety Net Care Pool capped annually at \$1.344B, derived from SFY 2005 MCO supplemental payment amount (\$770M) and state's SFY 2005 aggregate annual DSH limit (\$574.5M)
- State must come up with new non-federal dollars to replace IGT to be able to draw down FFP – CMS authorizes use of existing state health spending as costs not otherwise matchable (CNOM)

The new paradigm is financially sustainable

Safety Net Care Pool: Sources and Uses FY07



E-Health initiatives hold great promise for better, more efficient care

- Electronic Medical Records
 - Massachusetts E-Health Collaborative implementing electronic medical record system pilot programs in three regions
 - Integrate an entire “community of care” from primary care to acute hospitalization
 - \$50 million seed investment by Blue Cross/Blue Shield of MA Foundation
- Investment in Computerized Physician Order Entry systems (CPOE)
- Pay for performance mandated in the Medicaid program based on quality
 - Ties rate increases for acute hospitals to quality improvement goals
 - Utilization of electronic medical record as a proscribed variable
 - Coordination with private payers to ensure rational approach