Massachusetts Health Reform

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Speaker Salvatore F. DiMasi

Highlights of Chapter 58

- Covers 95% of the uninsured in 3 years
- Preserves federal Medicaid funding
- Simplifies health insurance for small businesses
- Reforms Uncompensated Care
- Promotes financial stability of health care system
- Rewards cost-effective, high quality care
- Encourages shared responsibility: government, individuals, employers, health care providers

Background

- Rising number of uninsured
- Soaring health insurance premiums
- MassHealth Section 1115 Waiver
- Modernized health committee structure

Social Compact

"Voluntary association of individuals…

... all shall be governed by certain laws for the common good."

Source: Preamble, Constitution of the Commonwealth of Massachusetts

Health Care Coverage – Today

- Approximately 550,000 people are uninsured in Massachusetts.
- Most are people with less access to Employer Sponsored Insurance:
  - Low-income
  - Part-time and seasonal workers
  - Single, childless adults
  - Young adults just starting out

Strategies to improve coverage

- Commonwealth Health Insurance Connector:
  - New State Authority
  - Makes it easier to find affordable policies
  - Reduces administrative burden for small business
  - Allows more people to buy insurance with pre-tax dollars
  - Allows part-time and seasonal employees to combine employer contributions in the Connector
  - Allows for portability for policies

More Strategies to improve coverage

- Market Reforms:
  - Merger of the non-group and small-group markets
  - Prior to merger, state will commission study of merger in context of the law's provisions
- New Products:
  - Existing high-deductible plans can now be tied to Health Savings Accounts
  - Family plans to allow young adults to stay on the policy for two years beyond loss of dependent status, or until age 25, whichever occurs first
  - Insurers can develop special products for 19-26 year olds, offered through the Connector

More Strategies to improve coverage

- Subsidies:
  - Commonwealth Care Health Insurance Program (CCHIP): Sliding-scale subsidies to individuals with incomes below 300% of the Federal Poverty Level (FPL)($48,000 for a family of 3)
  - Insurance Partnership Program: Eligibility for employee participation raised from 200% to 300% FPL
- Medicaid:
  - Coverage of children up to 300% FPL – parents can buy cheaper individual or couples' policies
  - Restore all benefits cut in 2002- including dental and vision services

Plan meets terms of Medicaid waiver renewal

- Spending on Medicaid for FY07 and FY08 projected to be within federal spending cap
- Reflects shift toward spending federal "safety net care" funds on coverage for individuals instead of institutions serving the uninsured
- Waiver signed by Sec. Leavitt on July 26th

Reforms Uncompensated Care Pool

- Eliminates current Pool as of Oct.1, 2007
- Replaces it with Safety Net Care (SNC) Fund
- Administered by SNC Office, in Medicaid
- SNC Office develops standard fee schedule to reimburse uncompensated care
- As Pool use drops, money shifted to subsidy program

Promotes stability of health care system

- Support for safety net hospitals as they adjust to change from "Free Care" reimbursements to subsidized insurance premiums
- Medicaid providers receive overdue rate increases over next three years
  - At level of $540M for hospitals & physicians across the state
- Move to Safety Net Care standard fee schedule
- Essential Community Provider grant program to provide targeted support to safety net hospitals and community health centers

Rewards cost-effective, quality care

- Medicaid rate increases are tied to achieving performance goals in FY08 and FY09
- Health Care Quality and Cost Council created to set quality improvement and cost containment goals
- Council will host website offering provider cost and quality data to consumers
- Connector will promote "high value" insurance products

Shared Responsibility

- Individuals:
  - As of July 1, 2007, individuals must have health insurance
  - Individuals who cannot afford insurance, as determined by the Connector, are not penalized
  - Income tax forms will include a question about insurance status for the tax year. DOR will verify coverage through an insurance industry database
  - Penalties for not having insurance:
    - Tax year 2007: loss of the personal exemption
    - Subsequent tax years: A fine equivalent to 50% of the monthly cost of health insurance for each month without insurance

Pre-Chapter 58
Role of Employers in Worker Health

- 70% of all employers offer health insurance
- 96% of employers >50 offer health insurance
- Employers who PROVIDE coverage help pay the cost of free care through an insurance surcharge
- Employers who DO NOT provide coverage don't pay this surcharge
- Now, ALL employers are asked to contribute to the cost of providing health care to the uninsured

Fair Share Contribution

- Employers who don't make a "fair and reasonable" contribution will be required to make a per-worker "fair share" contribution
  - Contribution represents the cost of free care used by the employees of non-contributing employers
  - Contribution capped at $295 per full-time-equivalent employee, per year
- Businesses with 10 or fewer employees will be exempt from the contribution
- Pro-rated for temporary or seasonal employees who work for at least 30 days in a year

Offer of IRS Section 125 Plan

- Effective Jan. 1, 2007
- All employers with 11 or more workers must offer a "cafeteria plan," as defined in Section 125 of the I.R.S. code
- Allows workers to purchase health insurance with pre-tax dollars
- The plan must be filed with the Connector

Free Rider Surcharge

- Employers with 11 or more employees who do not "offer to contribute toward, or arrange for the purchase of health insurance" may be assessed a "free rider" surcharge, IF:
  - Their employees access free care a total of five times per year in the aggregate or one employee accesses free care more than three times

Public Health & Prevention

- $20M in funding for public health and prevention programs
- Wellness program participation and smoking cessation can reduce premiums for certain MassHealth members
- Insurers may offer discounted premiums to non-smokers

Health Disparities

- Includes measures aimed at reducing racial and ethnic disparities:
  - Requires hospitals to collect and report on health care data related to race, ethnicity and language
  - Medicaid "pay for performance" measures include reducing racial and ethnic disparities
  - Studies a sustainable Community Health Outreach Worker Program to help eliminate health disparities and remove linguistic barriers to care
  - Creates a Health Disparities Council, to continue the work of the Special Commission on Racial and Ethnic Health Disparities

Sustainable Funding

- Federal matching $$ leveraged to enhance some state spending
- Uncompensated Care $$ redeployed
- Employer contributions
- $125M from the General Fund

Vetoes & Overrides

- On April 12, 2006, Gov. Romney vetoed 8 sections, including:
  - MassHealth coverage for certain disabled & elderly immigrants with no sponsor deeming
  - Restoration of MassHealth adult dental and other optional state services cut in 2002
  - Employer Fair Share Contribution
  - Consultation with legislature on MassHealth demonstration waiver negotiations with CMS
- All vetoes were overridden

Implementation Issues