
# Massachusetts Health Care Reform

## May 8, 2006

# The healthcare status quo is unsustainable

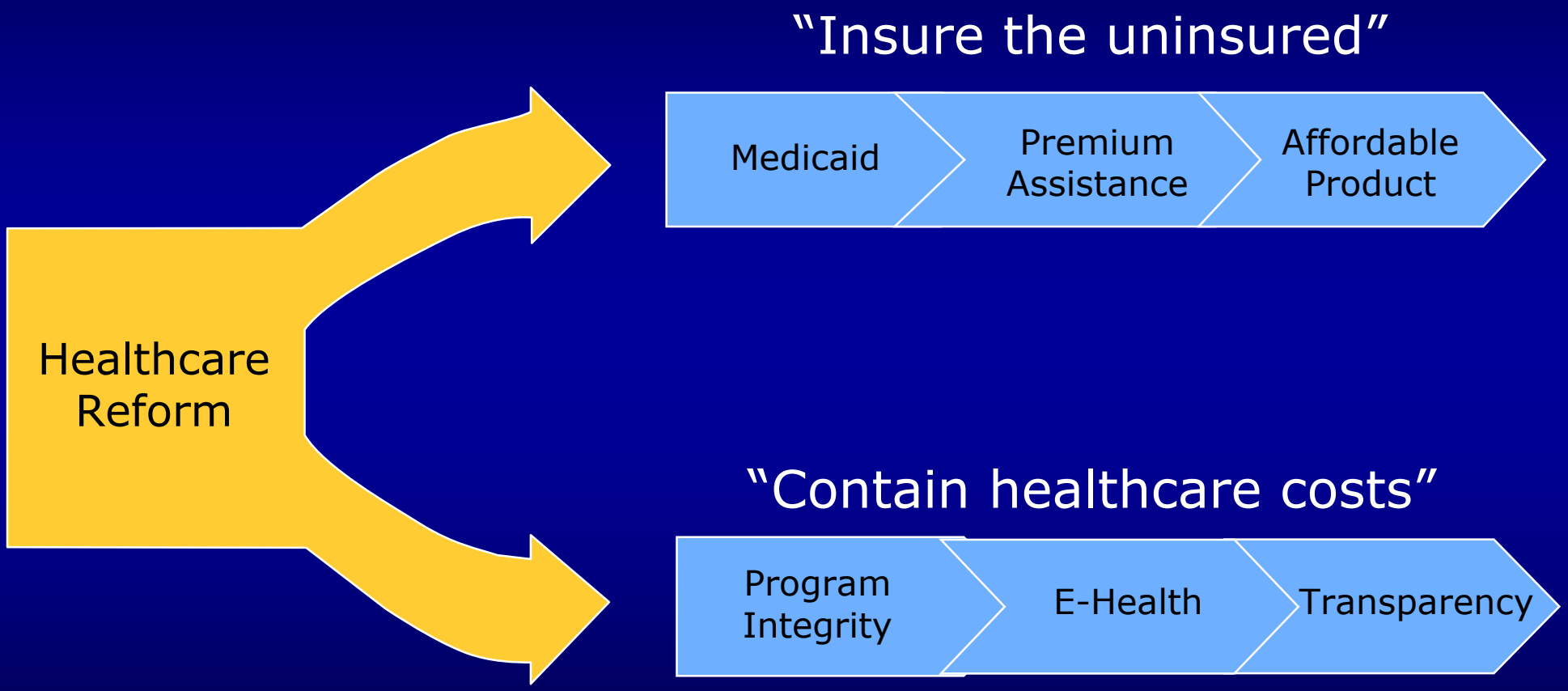
- Double-digit, annual increases in insurance premiums
- Half a million uninsured in Massachusetts, 40 million nationwide
- Many businesses, particularly small businesses, are dropping health insurance benefits due to costs
- Significant barriers to entry for individuals and small businesses who want to buy coverage
  - Part-timers, contractors, workers with more than one job
  - Participation and contribution rate requirements
- Limited information available to consumers and businesses that would allow for informed cost and quality decisions
- Hospitals mandated to provide emergency care (EMTALA)
  - $1.2 billion spent by state to reimburse free care in MA
  - No consequences to individuals who choose to free-ride – they get care

# The Uninsured in Massachusetts

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

Note: Based on August 2004 Division of Health Care Finance statewide survey

# A "fully insured" population is the cornerstone to controlling health care costs



# Healthcare reform law's objectives

# Insurance market reforms

| Existing Market | Reformed Market |
| --- | --- |
| Dysfunctional individual market | Individual/small market merger |
| Limited take-up of HSAs | HMO products with HSAs |
| "Any willing provider" | Value-driven networks |
| Bad value for younger adults | 19-26 year-old market |
| No consequence for lifestyle choices | Tobacco usage is a rating factor |
| Hard cut-offs for dependent status | More flexible up to 25 years-old |
| Growing list of mandatory benefits | Two year moratorium |
| Optional, smaller risk pools | Mandatory, larger risk pools |

# These reforms coupled with other product development can lower existing premiums

| | |
|---|---|
| **Today's average small group monthly premium** | **$350** |
| • Value driven networks | 10-20% |
| • HMOs with HSAs/Deductibles | 5-22% |
| • Moderate co-pays | 4-9% |
| • Further pharmacy benefit management | 1-5% |
| **Potential Monthly Premium for Affordable Plan** | **$154-280** |

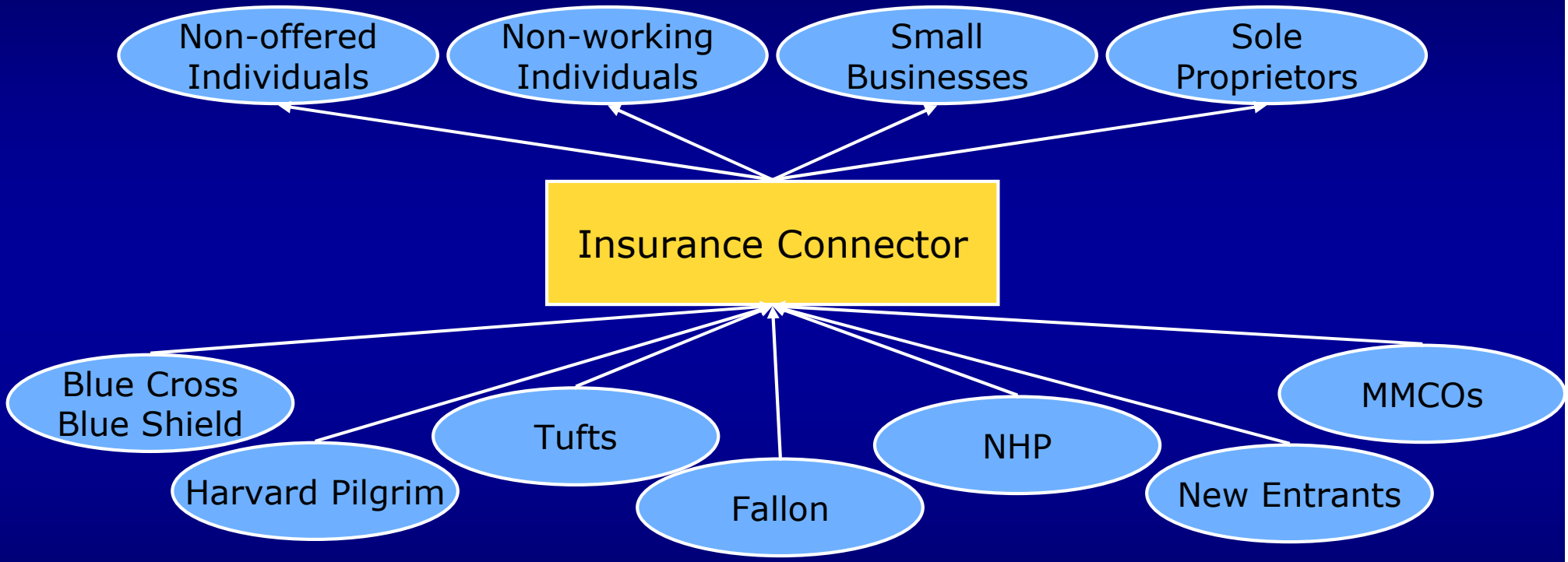
# Insurance reform allows products that represent good value, and are comprehensive

| | Existing Market | Reformed Market |
|---|---|---|
| Primary care | Yes | Yes |
| Hospitalization | Yes | Yes |
| Mental Health | Yes | Yes |
| Prescription Drugs | Yes | Yes |
| Provider network | "Open Access" | Defined |
| Annual deductible | "First Dollar Coverage" | $250-$1,000 |
| Co-pays | Low ($0,10,20) | Moderate ($0,20,40) |
| Monthly Premium | $350 | $215 |

# The Connector is an efficient nexus between buyers and sellers

- Small businesses will be able offer multiple affordable products to their employees
  - Premiums paid with pre-tax dollars
  - Eliminates minimum participation and contribution hurdles
- Market signaling: ease of purchase and good value
- Purchase of insurance by the individual, not the employer
  - Employer shifts to defined contribution model
  - Employee and individual choose and own the insurance
- Mechanism for reaching non-traditional workers
  - Part-timers and seasonal workers
  - Contractors and sole-proprietors
  - Individuals with more than one job
- Health insurance will be portable between small businesses

# The Connector makes it work



# Commonwealth Care makes private insurance affordable for eligible individuals

- Redirects **existing** spending on the uninsured away from opaque bulk payments to providers to direct assistance to the individual
- Premium assistance up to 300% of the Federal Poverty Level (FPL)
  - Zero premium for individuals under 100% FPL
  - Premiums increase with ability to pay up to 300% FPL
  - No cliff; glide-path to self-sufficiency
  - No deductibles permitted for low-income individuals
- Private insurance plans offered exclusively through Medicaid Managed Care Organizations (MMCOs) for first two years
- The Connector will serve as the exclusive administrator of Commonwealth Care premium assistance program
  - Works closely with Medicaid program to determine eligibility
- SCHIP and Insurance Partnership programs expand to achieve the same objective

# Commonwealth Care: Sliding scale premium assistance example

| FPL | Single Person Income | Weekly Premium* | % of Income |
|---|---|---|---|
| <100% | $9,800 | Free | NA |
| 150% | $14,700 | $6.92 | 2.4% |
| 200% | $19,600 | $11.54 | 3.1% |
| 250% | $24,500 | $18.46 | 4.0% |
| 300% | $29,400 | $32.31 | 5.7% |

*All numbers assume **NO** pre-tax treatment and **NO** employer contribution

# Employers will remain the cornerstone for the provision of health insurance

- Existing IRS/ERISA provisions
- Existing and new state non-discrimination provisions
- 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
  - -Free rider surcharge could apply for those companies without section 125 cafeteria plan
- Uncompensated Care Pool Assessment on companies not offering employer-sponsored health insurance
  - -Tied to the use of "free-care" by uninsured employees
  - -Maximum assessment is $295/employee
  - -Offering employer to be determined by regulation

# The law contributes to market stability by addressing cost shifting

- Medicaid rate increases to hospitals and physicians
  - -Tied to pay-for-performance measures
- Enroll eligible individuals in the Medicaid program
  - -On-line, streamlined application process
  - -Outreach grants
  - -77K in the last twelve month period
- Reforms the Uncompensated Care Pool reimbursement mechanisms
- Section 125 cafeteria plan requirement
- Personal responsibility

# 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

# The law contains strong cost-containment provisions

- Cost and Quality Council with new power to collect price and quality data
  - Hospital, physician, specialist, procedure, complications, volume, etc.
- Path to creating data necessary for real consumer engagement
- 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
- $5 million investment in Computerized Physician Order Entry systems
- Pay for performance required in the Medicaid program
  - Utilization of electronic medical record as a proscribed variable
  - Coordination with private payers to ensure rational approach

# The new paradigm is financially sustainable