

# An Update on Massachusetts Health Care Reform



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# Overview

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- ❑ Building Blocks, driving forces, vision
- ❑ Individual mandate
- ❑ Employer contribution
- ❑ Government responsibility
  - Commonwealth Care
  - Commonwealth Choice
- ❑ How is it going?
  - Coverage
  - Access to services
  - Cost
- ❑ Lessons and sustainability

# Building Blocks

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- Relatively low rate of uninsured
- History of health coverage expansions
- Broad Medicaid program
  - 1115 waiver implemented in 1996
- Uncompensated Care Pool
  - Funded in part by assessment on health plans and hospitals; paid by employers
- Strong safety net providers
- Highly regulated small group and individual health insurance markets

# Driving Forces

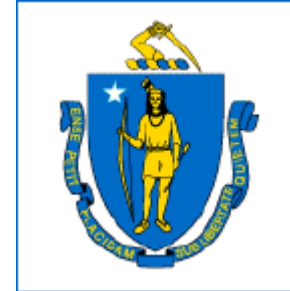
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- Increasing number of people without coverage
- Medicaid waiver renewal, \$385 million at risk
- Leadership by Governor, Senate President and Speaker of House
- Affordable Care Today (ACT) Coalition (ballot initiative, religious organizations, grassroots)
- BCBSMA Foundation's *Roadmap to Coverage* initiative: begun in early 2004
- Open process, interest group engagement, and decision to build off status quo and not deal with cost.

# Massachusetts Vision

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- Shared responsibility
  - Individual
  - Employer
  - Government
- Build upon the existing base
- Shift from safety net to insurance
- Keep stakeholders connected



# Individual Mandate

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- Mandate requires specific coverage but applies only if affordable
- No insurance by December 31, 2007 loss of personal tax exemption (\$200)
- Tax year 2008 half the monthly cost of acceptable low-cost insurance (\$2000 or more)



# Minimum Creditable Coverage

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- Minimum standard required to meet the mandate
  - Includes Drug Coverage
  - Covers preventive physician visits prior to any deductible
  - Annual out-of-pocket cap 5K, 10K family
  - Deductibles cannot exceed \$2,000 individual and \$4,000 family unless with an MSA
  - No limits on per year or per sickness
  - Can have a lifetime cap (360,000 subscribers do)

# Affordability

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- ❑ Mandate applies to 99% of adults
- ❑ Commonwealth Care Subsidies are considered affordable
  - No premium: < 150% poverty level
  - Reduced premiums: 150% - 300% FPL
- ❑ Sliding Scale levels of affordability > 300% FPL
- ❑ Responsible for full premium at incomes of:
  - \$50,000 for individuals
  - \$80,000 for couples
  - \$110,000 for families
- ❑ Starting July 1, the lowest premiums will range from \$39 to \$116 per month

# Mandate Compliance 2007

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- ❑ Of 3.34 million filers 95% had coverage
- ❑ Just 1.4% failed to report status
- ❑ 2%, 62,000 uninsured but could not afford according to affordability guidelines
- ❑ 2.5% subject to penalty (118,000 but 51,000 didn't have tax liability)
- ❑ 2,460 asked for exemption and 72% were granted

# Employer Assessment

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- ❑ Politically most contentious, vetoed and overridden
- ❑ Fair Share Assessment \$295 per uninsured FTE
- ❑ Employers w/11 or more workers
- ❑ Employers are safe if 25% of employees are covered and they pay for 33% of coverage

# Real Employer Contribution

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- ▣ Assessment brings in \$20 million
- ▣ 159,000 more employee have signed up for insurance at work
- ▣ This added an estimated \$1 billion in additional employer contributions

# Government Responsibility

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- ❑ MassHealth (Medicaid) expansions
- ❑ Commonwealth Care Health Insurance Program
- ❑ Established “Health Care Connector” to oversee the system
- ❑ Additional insurance reforms
- ❑ Establish “Cost and Quality” Commission



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# Commonwealth Care

# Commonwealth Care



- ❑ Sliding scale premium to 300% of FPL (not Medicaid eligible)
- ❑ At or below 150% FPL: no premium/co-insurance
- ❑ 150 to 300% FPL sliding scale premium/no coinsurance (27K individual 60K family)
- ❑ Provided by existing Medicaid managed care plans (3 yr. exclusive if conditions are met)

# Commonwealth Care Benefits

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- ❑ Inpatient services in hospitals
- ❑ Preventive and primary care (check-ups and physicals)
- ❑ Medical care from a specialist in a doctor's office, community health center or hospital
- ❑ Emergency care
- ❑ Vision care
- ❑ Prescription drugs
- ❑ Inpatient and outpatient mental health and substance abuse services



# Commonwealth Care Premium Subsidies

<i>Income Bracket (fpl)</i>	<i>Monthly Premium as % of gross income</i>	<i>Monthly Premium</i>
100.1-150% FPL	1 Adult: 0% 2 Adults: 0%	1 Adult: \$0 2 Adults: \$0
150.1-200% FPL	1 Adult: less than 2.8% 2 Adults: less than 4.2%	1 Adult: \$35 2 Adults: \$70
200.1-250% FPL	1 Adult: 3.8% 2 Adults: 5.6%	1 Adult: \$70 2 Adults: \$140
250.1-300% FPL	1 Adult: 4.7% 2 Adults: 7.0%	1 Adult: \$106 2 Adults: \$212

100% FPL    Family of 1 is \$9,804  
                   Family of 2 is \$13,200

300% FPL    Family of 1 is \$29,412  
                   Family of 2 is \$39,600

# Commonwealth Care Co-payments

<i>Service</i>	<i>Below 100% FPL</i>	<i>100 to 200% FPL</i>	<i>200 to 300% FPL Low Premium Option</i>
<i>Office Visit PCP/Specialist</i>	\$0/\$0	\$5/\$10	\$10/\$20
<i>Outpatient Surgery</i>	\$0	\$50	\$100
<i>X-Ray/Labs</i>	\$0	\$0	\$0
<i>Inpatient</i>	\$0	\$50	\$100
<i>Prescription Drugs (1 Month supply)</i>	\$1/\$3 generic/brand	\$5/\$10/\$30 generic/preferred/non- preferred	\$10/\$20/\$430 generic/preferred/non- preferred
<i>Emergency</i>	\$0	\$50 waived if admitted	\$75 waived if admitted
<i>Outpatient mental health/substance abuse</i>	\$0	\$10	\$20
<i>Maximum out-of- pocket</i>		\$250 Inpatient/out surg. \$250 Pharmacy	\$500 Inpatient/out surg. \$500 Pharmacy \$500 DME/supplies etc. \$750 Total cap by request

# Insurance Reforms

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- ❑ Combine individual/group markets (save 15% non-group, add 1.5% to small group)
- ❑ Low cost, reduced benefit plan for 19 to 26 year olds
- ❑ Young adults can be covered under parents' plan until age 25
- ❑ Section 125, Cafeteria Plans are required for businesses over 10 employees to enable pre tax payments
- ❑ Moratorium on new mandated health benefits until 1/1/2008 or until government review of all mandated benefits in effect as of 1/1/2006



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# Commonwealth Choice

# Commonwealth Choice Goals

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- ❑ Select and offer high value plans
- ❑ Align choice of plan designs and carriers with consumer demand
  - Market data
  - Consumer focus group results
- ❑ Enhance simplicity of consumer shopping experience
- ❑ Minimize risk selection
  - Inside and outside of the Health Connector
  - Among participating health plans
- ❑ Maintain continuity of coverage for existing 17,000+ Commonwealth Choice members

# Commonwealth Choice

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- ❑ Enrollment not strong but growing
  - 17,000 total enrollment May 2009
    - ❑ 11,000 Individual (non-group market)
    - ❑ 4,000 Young Adult Plan
- ❑ Cannot compete on price
- ❑ Average price increase 6.5%, top increase over 10%
- ❑ 21 different Gold, Silver, Bronze plans
- ❑ Weak Value proposition for small businesses

# Proposed Revisions

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- Reduce plans to 9
  - 1 Gold 7,000 total enrollment May 2009
  - 3 Silver
  - 3 Bronze
  - 2 Young Adult Plan (separate pool and capped benefits)
- Improve web and outreach
- Update options particularly the most popular bronze plans

# Bronze – Proposed Designs

<b>Benefit Category</b>	<b>Bronze A</b>	<b>Bronze B</b>	<b>Bronze C (HSA-compliant)</b>
Annual Deductible (Ind/Fam)	\$250/\$500	\$1,000/\$2,000	\$2,000/\$4,000
Annual Out-of-Pocket Maximum (Ind/Fam)	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000
PCP Office Visit	\$25	\$25	\$25 after Ded
Specialist Office Visit	\$40	\$40	\$25 after Ded
Rx Deductible	\$250/\$500	\$100/\$200	None
Rx Copayments	\$15/ 50%/50% co-ins	\$15/\$30/\$50	\$15/ 50%/50% co-ins
ER Copayments	35% co-ins after Ded	\$150 after Ded	\$100 after Ded
Inpatient Admission	35% co-ins after Ded	25% co-ins after Ded	20% co-ins after Ded
Outpatient Surgery	35% co-ins after Ded	25% co-ins after Ded	20% co-ins after Ded



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**How is it going?**

# Coverage Gains

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- 97.4% insured
- Uninsured reduced to 7.5% in first year down to 2.6% second year
- Lowest uninsured rate in U.S.
- Speed of enrollment increased cost projections
  - Enhanced contribution to safety net care pool
  - Eliminated hospital and physician rate increases
  - One time tax on health plan reserves

# Estimate of Newly Covered 2008

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<i>Category</i>	<i>People</i>
<i>Commonwealth Health</i>	176,000 (41%)
<i>MassHealth (Medicaid)</i>	72,000 (16%)
<i>Employer Coverage</i>	159,000 (36%)
<i>Non-group Individual</i>	32,000 (7%)
<i>Total</i>	440,000

Source: Commonwealth Health Care Connector  
October 2008

# Financing

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- ❑ Dec. 22, 2008 Federal government waiver approval
- ❑ 36% reduction in the free care pool, money now used to subsidize individual coverage
- ❑ Federal matching will be available to continue coverage for all newly eligible groups
- ❑ Budget neutrality challenging but doable

# Access and use of care 2006, 2007, 2008

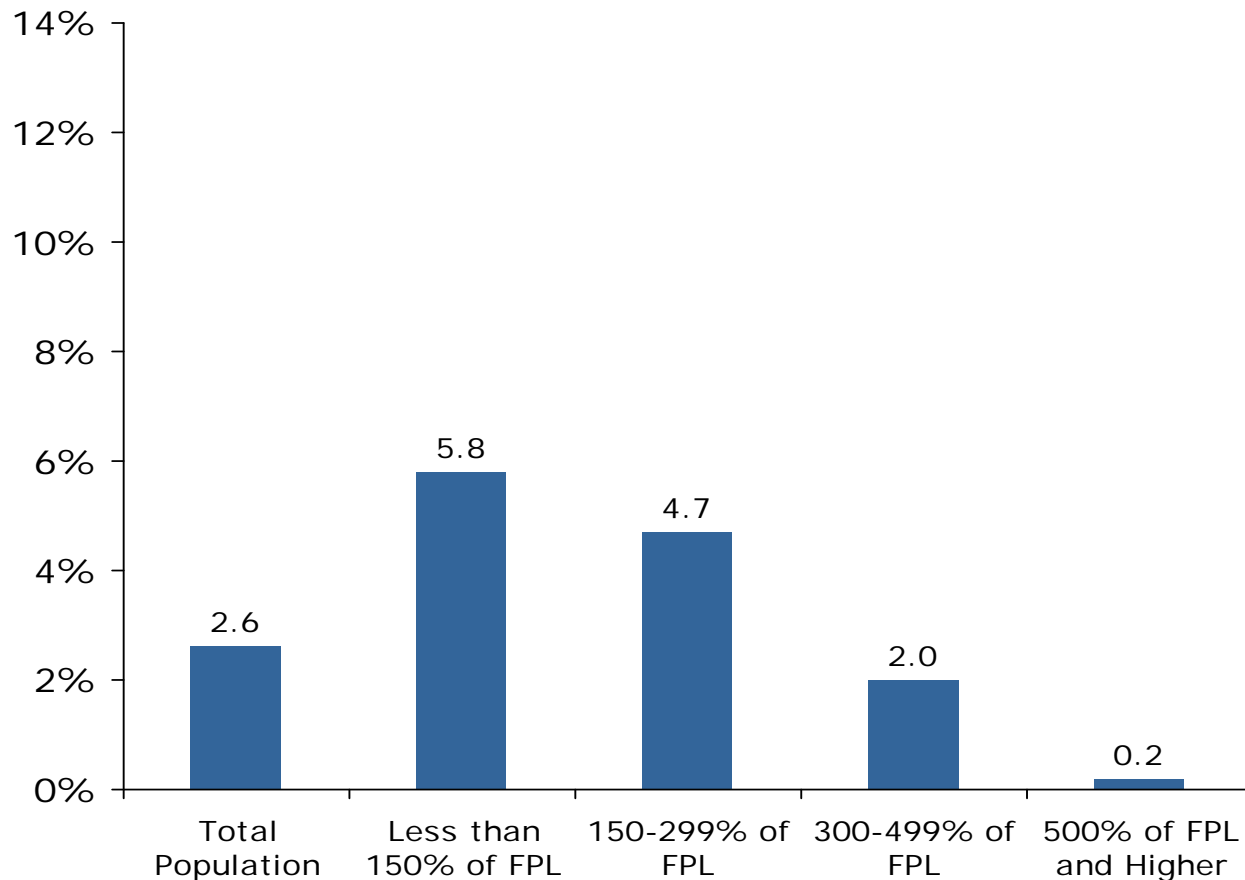
<i>Adults</i>	<i>Fall 2006</i>	<i>Fall 2007</i>	<i>Fall 2008</i>	<i>Change 06 - 08</i>
<b><u>Usual source of care</u></b> (all adults)	86.4%	88.7%*	91.3%***	<b>+4.9%</b>
Adults below 300% FPL	79.3%	83.2%	86.2%***	<b>+6.9%</b>
<b><u>Any physician visit prior year</u></b>	80.0	81.5	83.9***	<b>+3.9</b>
Adults below 300% FPL	75.2	76.6	78.7***	<b>+3.5</b>
<b><u>Didn't get needed care prior year</u></b>	25.4	21.0***	21.6	<b>-3.8</b>
Adults below 300% FPL	35.3	29.5	31.7	<b>NS</b>
<b><u>Any Dental care visit prior year</u></b>	67.8	72.0**	75.5***	<b>+7.7</b>
Adults below 300% FPL	48.9	58.5***	63.9***	<b>+15.0</b>
<b><u>Didn't get needed Dental care</u></b>	12.7	9.3**	10.9	<b>-1.8</b>
Adults below 300% FPL	20.8	13.6***	16.8	<b>-4.0</b>

Source: Long and Masi, Urban Institute Ma Health Reform Surveys, 06, 07, 08, *Health Affairs* 5/28/09.

\* (\*\*)(\*\*\*) regression adjusted significance at the .10, (.05) and (.01) levels

# Uninsured by Income 2008

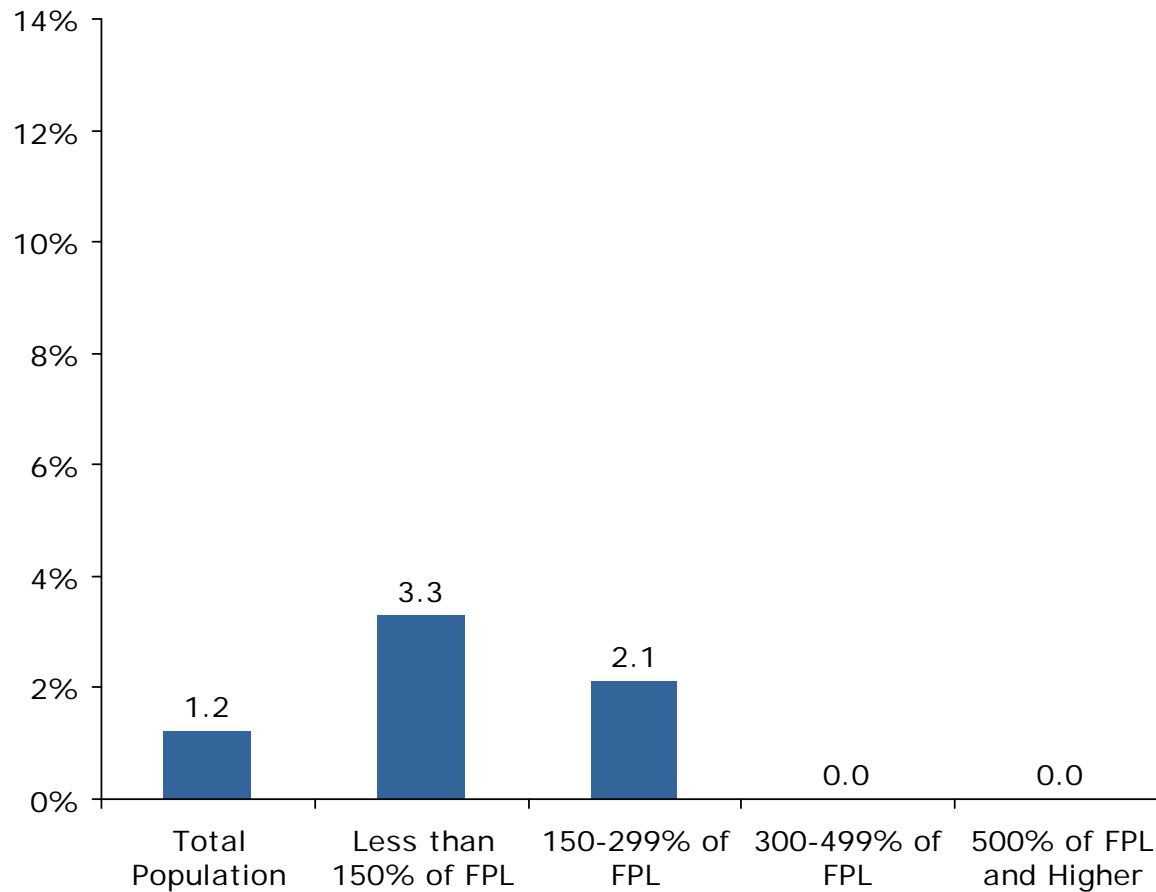
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Source: Urban Institute calculations based on Massachusetts Health Insurance Survey; MA Division of Health Care Payment and Finance

# Uninsured Children by Income 2008

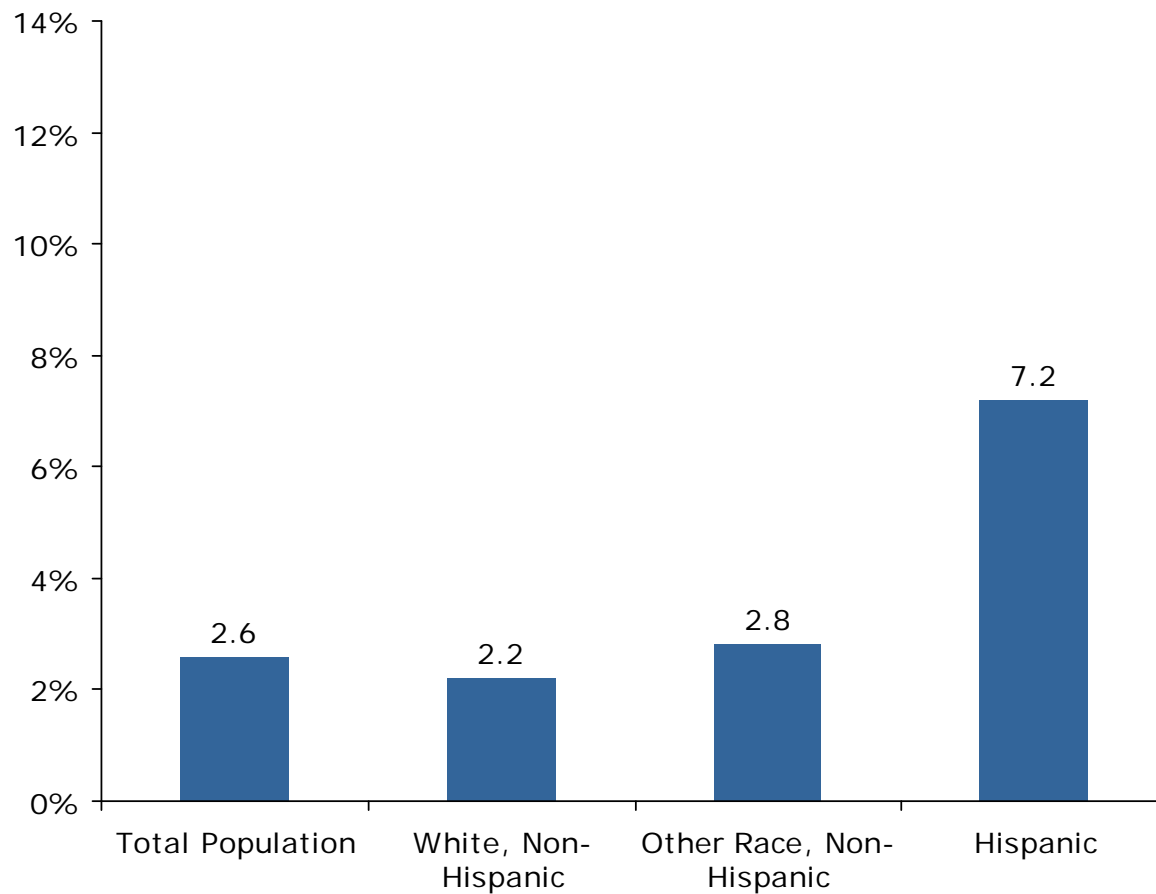
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Source: Urban Institute calculations based on Massachusetts Health Insurance Survey; MA Division of Health Care Payment and Finance

# Uninsured by Race 2008

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Source: Urban Institute calculations based on Massachusetts Health Insurance Survey; MA Division of Health Care Payment and Finance

# Access to Primary Care 2006 and 2008

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<i>Physicians no longer accepting new patients</i>	<i>Fall 2006</i>	<i>Fall 2008</i>	<i>Change 06 - 08</i>
<b><u>Family Medicine Physicians</u></b>	25%	35%	<b>+10%</b>
<b><u>Internal Medicine Physicians</u></b>	31%	48%	<b>+17</b>

Source: Massachusetts Medical Society 2008 Physician Workforce Study , 2009.

# Provider Shortage

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- ❑ Regional variation (Southeastern and Western Massachusetts)
- ❑ Community health centers
  - Average 2 FTE physician vacancies
  - 100 FTE vacancies statewide
- ❑ In 2008 24% report trouble obtaining necessary care, up from 16% 2007
- ❑ 71% of doctors hard time making timely referrals

Sources: Survey of Community Health Centers 2007, Massachusetts Medical Society Workforce Study, 2008

# Cost to Consumers

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- ❑ 11% of unmet need due to cost
- ❑ 18% have trouble paying medical bills
- ❑ 20% are paying medical bills over time
- ❑ Affordability
  - High out of pocket payments (chronically ill)
  - High premiums
    - ❑ Over 300% FPL and responsible for full premium
    - ❑ Age 55-65
  - Continued Medical Debt

Sources: Mass Health Reform Survey Urban Institute, Fall 2008; JSI, Access to Health Care in MA, Spring 2009.



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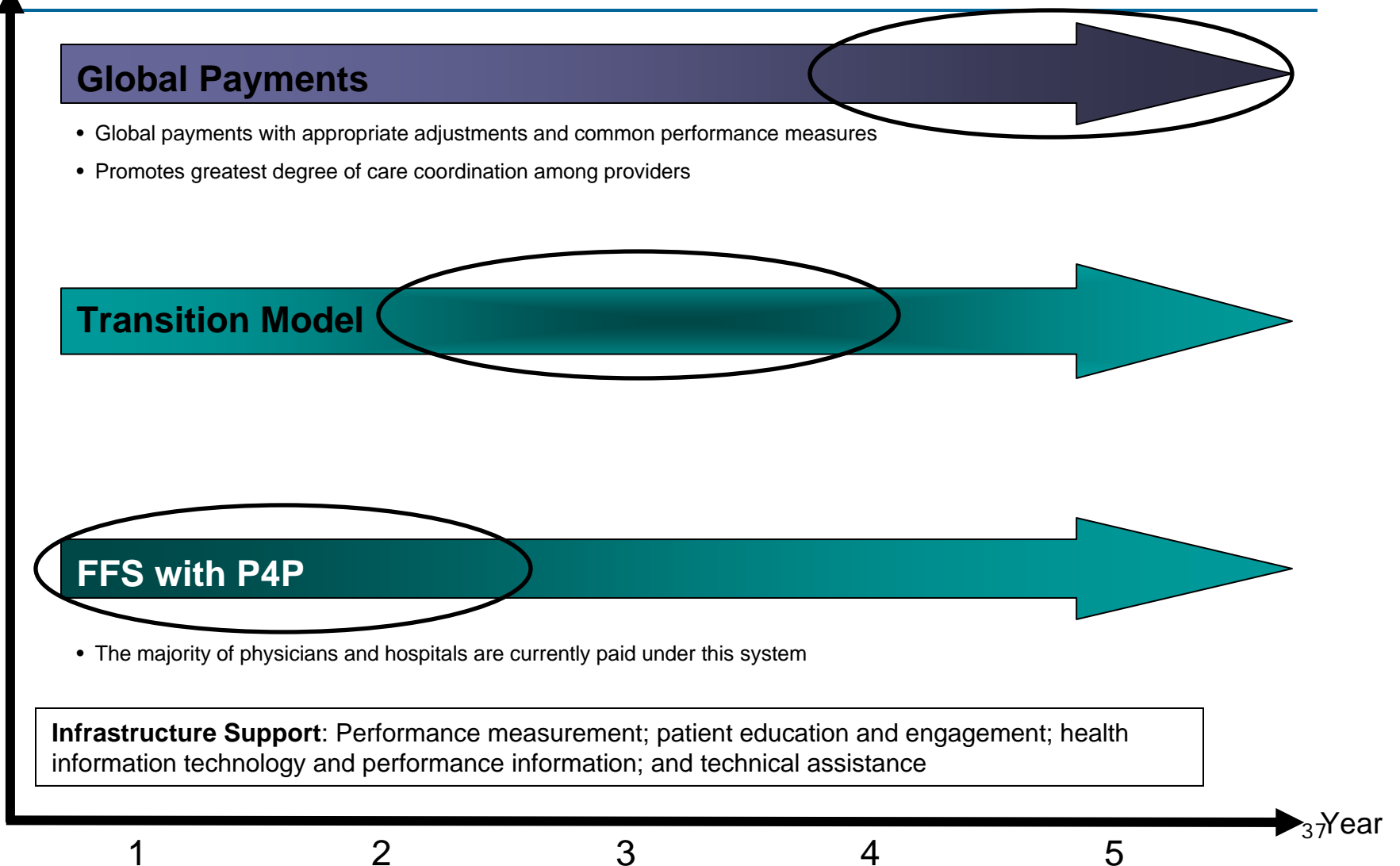
# Cost Containment

# Special Commission on the Health Care Payment System Vision Statement

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- ❑ Transition from F.F.S. to a more efficient payment system
- ❑ Payments should cover cost of efficiently provided care
- ❑ Uniform payments adjusted for risk
- ❑ Minimize unnecessary administrative costs
- ❑ Reduce per capita costs and growth
- ❑ Transparency
- ❑ Phase in changes

# Delivery system transition towards global payments



Source: Special Commission on Health Care Cost Containment, April 10, 2009

# The Creation of Accountable Care Organizations (ACOs)

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- **Providers:** Form ACOs to
  - manage patient care
  - accept global payments
  - allocate payments among its providers.
- **Payers:** Health plans, MassHealth, Commonwealth Care, and Medicare (pending waiver) will contract directly or indirectly with ACOs in global payment arrangements
- **Consumers:** Select a primary care provider/medical home to coordinate care

# Principals of “Shared Savings”

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- ❑ Payers and ACOs establish budget targets and total spending per member
- ❑ Continued F.F.S
- ❑ End of year reconciliation: actual and targeted spending
- ❑ If spending is less than target and quality measures are met ACO, payers, employers and consumers may “share” the savings

# Lessons

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- ❑ Bipartisan
- ❑ Build off the status quo
- ❑ Keep stakeholders connected
- ❑ Coverage first can drive cost, quality, and access to care discussions
- ❑ Individual mandate essential if building off the status quo, unreasonable without safeguards
- ❑ Health care delivery system change required for cost containment and long term sustainability



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## About the Speaker

### **An Update on Massachusetts Health Reform June 18, 2009**

**Michael Doonan, Ph.D.**, is an assistant professor at the Heller School for Social Policy and Management at Brandeis University. He is the Executive Director of the Massachusetts Health Policy Forum and Director of the Council for Health Care Economics and Policy. His Ph.D. from Brandeis is both in Political Science and Health Services Research. His research and publications focus on issues related to access to health care, Medicaid, SCHIP, federal/state relations, prescription drugs, public health, and the economics of health system change.

Michael worked as program specialist for the Centers for Medicare and Medicaid Services (CMS), in the area of Medicaid managed care and state health care reform. He served as a member of President Clinton's Health Care Taskforce working primarily on the Low-Income and Working Families work group, and as a member of the Taskforce Speakers Bureau. Michael also worked as a fellow for the U.S. Senate Finance Committee as they considered national reform in 1994. He began his career as a legislative aide for Senator John Kerry where he worked on health and environmental issues. He has a master's degree in public administration from The George Washington University and an undergraduate degree in political science from St. Anselm College.

The Massachusetts Health Policy Forum was created in 1998 to bring public and private health care leaders together to engage in focused discussion on critical health policy challenges facing the Commonwealth of Massachusetts. Modeled after the successful National Health Policy Forum of George Washington University, the Massachusetts Forum conducts approximately four forums per year for an invited audience of health care leaders.