Comparison of Senate and House Proposals

Senate Bill	House Bill	Comments
Public health council – board members are: • Commissioner (chair) • Chancellor UMMS • Dean of HSPH • Dean of BUSPH • CEO of an acute care hospital to be appointed by MHA • CEO of SNF appointed by MECF • Nurse appointed by MONE • RN from ballots sent to all registered nurses licensed by BORN • MCHWN • 2 MDs appointed by MMS • 10 nonproviders: appointed by EA; VA; HCFA; CPME; MPHA, 2 from MA health disparities council (created later in bill)	Public health council – board members are: • Commissioner (chair) • 14 members **appointed by the governor** for terms of 6 years., including: • chancellor of UMMS • dean of the HSPH • dean of the BUSPH • Six of the appointed members shall be providers of health services: CEO of an acute care hospital nominated by the MHA; CEO of a SNF nominated by the MECF; a nurse nominated by the MNA a registered nurse nominated by BORN who shall be the highest vote-getter on a mail ballot sent to the address of record of all registered nurses the Executive Director of the MCHWN and 2 shall be physicians, 1 of whom shall be a primary care physician, nominated by the MMS • Five of the appointed members shall be non-providers: 1 shall be nominated by the secretary of elder affairs, 1 shall be nominated by the secretary of veterans' services, 1 shall be from a consumer health organization, 1 shall be an expert in the prevention of medical errors; and 1 shall be nominated by the MPHA	
Support efforts to enroll eligibles who are not yet enrolled. Health Care Access and Investments Trust Fund to be available to	Line item for MassHealth enrollment outreach grants for FY 2006 is modified to support awards in areas of high uninsured populations or limited providers, with the proviso	

Senate Bill	House Bill	Comments
provide incentives for Medicaid providers to increase enrollment in program (see ##7A and 7B below and II, #1B below).	that the funds will be awarded to defined community groups to provide enrollment assistance, education and outreach directly to consumers who may be eligible for MassHealth or for subsidized health care coverage or who may require individualized support for a variety of reasons **Note:** No change in the funding level approved in c. 45 of the Acts of 2005 EOHHS mandated to seek an 1115 waiver to implement provisions of the act and to seek to maximize FFP for all programs under the act where available. EOHHS to report quarterly on the status of the waiver application to House and Senate Ways and Means Committees and Joint Committee on Health Care Financing	
Medicaid to cover all adults with dependent children up to 200% FPL Eligibility for children ages birth to 18 extended to 300% FPL EOHHS mandated to seek to maximize SCHIP reimbursement and to report quarterly on the status of federal SCHIP reimbursement to House and Senate Ways and Means Committees and Joint Committee on Health Care Financing Medicaid may not impose more restrictive disability standard than that used by the federal Eligibility for HIV positive individuals is extended to 200% of FPL	Medicaid to cover all adults with dependent children up to 200% FPL Eligibility for children ages birth to 18 extended to 300% FPL EOHHS mandated to seek to maximize SCHIP reimbursement and to report quarterly on the status of federal SCHIP reimbursement to House and Senate Ways and Means Committees and Joint Committee on Health Care Financing Eligibility for HIV positive individuals is extended to 200% of FPL **Establishes eligibility for adults 19-64 without dependent children, who otherwise would not be**	

Senate Bill	House Bill	Comments
Medicaid may not impose more restrictive disability standard than that used by the federal government **Restores Medicaid benefits for legal immigrant adults** EOHHS to adopt regulations that restrict eligibility or covered services only after public notice and hearing **Medicaid office authorized to establish clinical eligibility for a long term care benefit. Financial eligibility for benefit: up to 300% of federal benefit level under SSI and an asset test of not less than $10,000. Persons eligible for the benefit are to provided a choice of care setting that is least restrictive and most appropriate. Funding for benefit to follow the individual as setting of care changes. Medicaid mandated to submit an 1115 waiver request for the program by 7/1/06, which waiver is to maximize FFP and meet budget neutrality requirements**	**eligible, with incomes up to 100% of FPL** Precludes Medicaid from imposing more restrictive disability criteria for applicants than those authorized by Title XVI **Authorizes participation in MassHealth Essential for "special status" immigrants who otherwise satisfy MassHealth eligibility criteria and are either 65 or older or 19-64 and disabled** EOHHS to adopt regulations that that restrict eligibility or covered services only after public notice and hearing	
Medicaid to cover all federally optional services for adults that were included in the state plan on 1./1/02 EOHHS to adopt regulations that that restrict eligibility or covered services only after public notice and hearing **Medicaid to reimburse providers for all medically necessary non-emergency**	**Restores comprehensive adult dental benefits to 1/1/02 levels, effective 7/1/06** **EOHHS precluded from making any change relating to the provision of behavioral health services to Medicaid enrollees, or to recommend any such changes, before 3/1/06.** EOHHS to investigate and **study** creation of selective provider networks, "including geography and cultural	

Senate Bill	House Bill	Comments
ambulance and wheelchair van trips provided to enrollees of MassHealth Basic and MassHealth Essential, regardless of coverage type or enrollment in MMCOs. Reimbursement to these providers not to exceed $300,000 in aggregate each fiscal year. Medical necessity to be determined by certification from physician, PA, NP, etc., with provider responsible for completing form EOHHS to conduct **study** to determine costs of providing MassHealth benefits to primary care givers who care for disabled elderly parents or family members on a full-time basis, with report due by 7/1/2006 Medicaid to conduct **pilot program** to provide EOB receipts to a sample of MassHealth beneficiaries following receipt of services	competence of providers" and report by 1/1/07 to House and Senate Ways and Means Committees and Joint Committee on Health Care Financing	
EOHS to establish a 2-year pilot program for smoking and tobacco use cessation treatment and information as a MassHealth covered service. EOHHS to report annually (recipient of these reports not specified) on number of participants, number who quit smoking, and Medicaid expenditures tied to tobacco use by enrollees • Comptroller to transfer $7 million from Health Care Security Trust (Tobacco Settlement funds) to General Fund in each of FY 2007 and FY 2008 to fund	**EOHHS mandated to implement a wellness program for MassHealth enrollees, effective 7/1/06. Program to encourage activities leading to "desired health outcomes," including smoking cessation. MassHealth premiums are to be reduced proportionately to extent of enrollee compliance with the program. EOHHS to report annually to House and Senate Ways and Means Committees and Joint Committee on Health Care Financing on number of enrollees participating, number meeting at least 1 wellness goal, premiums collected, and reduction of premiums resulting from meeting wellness goals**	

Senate Bill	House Bill	Comments
program	EOHS to establish a 2-year pilot program for smoking and tobacco use cessation treatment and information as a MassHealth covered service. EOHHS to report annually (recipient of these reports not specified) on number of participants, number who quit smoking, and Medicaid expenditures tied to tobacco use by enrollees Comptroller to transfer $7 million from Health Care Security Trust (Tobacco Settlement funds) in each of FY 2007 and FY 2008 to fund program	
EOHHS directed to seek federal approvals via state plan waiver to increase enrollment caps on certain programs as follows: • an additional 1600 people (for a maximum of 15,600) in CommonHealth, effective 7/1/2006 • an additional 250 people (for a maximum of 1300) in Family Assistance HIV+ program, effective 7/1/2006 • an additional 16,000 (for a maximum of 60,000) in MassHealth Essential, **effective 7/1/2006**	EOHHS directed to seek federal approvals via state plan waiver to increase enrollment caps on certain programs as follows: • an additional 1600 people (for a maximum of 15,600) in CommonHealth, effective 7/1/2006 • an additional 250 people (for a maximum of 1300) in Family Assistance HIV+ program, effective 7/1/2006 • an additional 16,000 (for a maximum of 60,000) in MassHealth Essential, federal approval to be sought **within 30 days of effective date of act**	
MassHealth eligibles seeing admission to nursing homes to receive pre-admission counseling via EOEA for long term care services, including an assessment of community-based service options. Persons seeking admission on private-pay basis may voluntarily undergo this pre-admission counseling EOHHS not to make any change to the financing, operation or regulation of, or contracts pertaining to, provision of behavioral	MCOs with NCQA accreditation for Medicaid product lines deemed to satisfy applicable standards of Medicaid office EOHHS not to make any change to the financing, operation or regulation of, or contracts pertaining to, provision of **behavioral health** services under Medicaid, SCHIP or expansion programs, and is not to recommend or procure any such changes, including from CMS, until it submits a report outlining the proposed changes, together with the reasons and an explanation of the benefits of the changes, to	

Senate Bill	House Bill	Comments
health services under Medicaid, SCHIP or expansion programs, and is not to recommend or procure any such changes, including from CMS, until it submits a report outlining the proposed changes, together with the reasons and an explanation of the benefits of the changes, to the Joint Committees on Mental Health and Substance Abuse and Health Care Financing, but not prior to 2/15/2006 MCOs with NCQA accreditation for Medicaid product lines deemed to satisfy applicable standards of Medicaid office	the Joint Committees on Mental Health and Substance Abuse and Health Care Financing, but not prior to 2/15/2006	
Renames Insurance Partnership as Health Care Plus EOHHS mandated immediately to seek federal approval to eliminate enrollment caps on program Eligibility: up to 300% of FPL Increase in eligible employers: from max of 50 to max of 75 Locus of administration: Labor and Workforce Development with assistance from Medicaid Office Health Safety Net Office is mandated to administer a demonstration program of health care coverage for fishermen	**Eliminates current Insurance Partnership and replaces it, effective 7/1/06, with premium subsidy program called Commonwealth Care Health Insurance Program** Eligibility: individuals and sole proprietors, up to 300% of FPL, with additional requirements concerning residency and disqualification if access available to other sources of insurance coverage Must be residents or special status immigrants Administered by the board of the Commonwealth Health Insurance Connector (the "Connector") in conjunction with Medicaid and the Health Safety Net Office Funds for program subject to appropriation from the Commonwealth Care Fund . If director of Connector determines that amounts in the Fund are insufficient to meet projected costs of enrolling new eligible individuals, secretary is to impose a cap on enrollment Health Safety Net Office is mandated to administer a	

Senate Bill	House Bill	Comments
	demonstration program of health care coverage for fishermen	
Premium support based on fixed dollar amounts, not graduated by income level Increase of 50% in available premium support for individuals and families Provision for future inflation adjustments in support amounts	Premium support paid directly to carriers **Premium support funded by appropriation from commonwealth care fund** Board annually is to develop sliding scale premium contribution schedule for enrollees and publish schedule by each September 30, beginning 9/30/2006 Board to develop plan for outreach, education and retention of health care services and wellness programs to reach eligible population and eliminate health care disparities	
No provisions	Connector to procure insurance plans eligible for premium assistance in accordance with criteria it sets, provided that criteria are to include consideration of appropriate geographic distribution of providers Participation only in qualified plans with no annual deductibles	
MassHealth Insurance Reimbursement Account – from appropriations and FFP - as at present Companion appropriations bill provides $10 million from Health Care Access and Investments Trust Fund for reinsurance program and $10 million for premium support program	Funding to come from Commonwealth Care Bill provides $25 million for start-up/marketing costs for Connector and Commonwealth Care program	
No provisions	Medicaid MCOs have potential for exclusivity to receive the premium support for up to 3 years depending on their success in enrolling eligibles Final payments to contractors for Commonwealth Care	

Senate Bill	House Bill	Comments
	program are subject to a risk adjustment methodology developed by GIC. Commonwealth Care Fund may be used for transitional supplemental rate payments for all MCOs that met enrollment goals and other criteria set by the Connector board and the director of the Health Safety Net Office to maximize enrollment into health insurance for current users of the UCP	
Bill does not consolidate **small group and non-group.** The provisions of the earlier version of the bill that differentiated between very small groups (up to 5 employees) and larger have been eliminated in the final approved version of the bill, except with respect to reinsurance (see below). The final version makes no changes to c. 176J other than those specifically noted in this description Carriers may submit for Seal of Approval from Exchange (see below) Note that bill allows Sub-Exchanges to function as the Exchange in offering health benefit plans if authorized by DoI . Exchange may administer its responsibilities through use of sub-contracted entities, defined as locally incorporated and governed organizations with at least 10 years experience in the small group market and that have served as intermediaries in that market under c. 176J	**Consolidates small group and non-group; however, an** existing non-group plan, while closed to new subscribers (other than dependents of subscribers) as of 12/31/2005, is allowed to continue in effect until the number of subscribers is not more than 25% of the plan's 12/31/2004 subscriber total Carriers may submit for Seal of Approval from Connector (see below) Connector to offer plans beginning 10/1/06. Eligibility: individuals and groups of not more than 50 employees Carrier may deny enrollment to an eligible individual or eligible small business with 5 or fewer eligible employees unless the individual or small business enrolls through an intermediary or the Connector, in which case the carrier must enroll the individual or business. Carrier must treat all similarly situated eligible individuals and eligible small businesses in a similar manner Creation of Health Access Bureau in DOI to oversee small group/individual market and affordable health plans. Costs of Bureau to be assessed to carriers	

Senate Bill	House Bill	Comments
	Seal of Approval Plans offered under 176J are available to satisfy individual mandate (see below) Bill provides for open enrollment for eligible individuals and dependents, as defined in c. 176J, from 9/1/06 through 11/30/06, with no pre-existing limitations or waiting periods for anyone who enrolls in this period	
Non-group (individual) coverage carriers offering guaranteed issue plans (GIPs) may offer up to 6 alternative plans GIPs with benefits and cost-sharing requirements, including deductibles, that differ from the standard GIP. Carrier may offer 1 alternative plan that was the plan offered on 1/1/06, as it may be modified from time to time in the ordinary course of business. Up to two of the alternative GIPs can include "reasonable and medically appropriate" annual limits on physician office and outpatient coverage (see below) Commissioner of Insurance must approve all alternative plans. Commissioner will approve plan if: • it is consistent with carrier's licensing statute • contains a clear and concise disclosure statement describing scope and limitations of benefits, including explaining cost-shares • offers a 10-day free "look back" period Commissioner to issue regs setting parameters for cost-sharing and benefit limits so as to	Seal of Approval plans to satisfy definition health benefit plan under c. 176J, s. Bill specifies that nothing in legislation is to interfere with a person's right to receive chiropractic benefits under c. 175, s. 108D	

Senate Bill	House Bill	Comments
reduce adverse selection between carriers offering same type of alternative plan HMOs may offer alternative plans if provisions described below are satisfied Seal of Approval plans to provide coverage for:(1) preventive and primary care, (2) emergency services, (3) surgical benefits, (4) hospitalization, (5) ambulatory care, (6) mental health services to the extent mandated for commercial insurers, provided that, if the Seal of Approval plan limits coverage for outpatient physician office visits, it may limit coverage for outpatient mental health services to the same extent, (7) services for pregnant women, infants and children services to the extent required of commercial carriers, (8) prenatal care, childbirth and postpartum care services to the extent required of commercial carriers, (9) cytologic screening and mammographic examination services equivalent to the extent required of commercial carriers, and (10) early intervention services to the extent required of commercial carriers. (11) diabetic supplies was added by amendment		
Non-group carriers, including HMOS, may offer, in addition to standard GIP, up to 6 alternative GIPs See above regarding scope of coverage of these alternative GIPs and below regarding high deductible features of same Seal of Approval plans are to provide "good	Seal of Approval plans are to provide "good value" to consumers (undefined term) and high quality Carriers given flexibility in benefit design, including ability to adjust for: • age	

Senate Bill	House Bill	Comments
value" to consumers (undefined term) Plans obtained via the Exchange should be with pre-tax dollars Carriers not allowed to impose pre-existing condition exclusions or waiting period of more than 3 months following enrollee's effective date of coverage with respect to so-called Trade Act/Health Coverage Tax Credit Eligible Persons	• tobacco use • wellness, and • "benefit level adjustments" in plan design, including with regard to health delivery networks Pre-existing conditions and waiting periods allowed, consistent with HIPAA Emergency services to be covered during waiting periods See above regarding open enrollment period Plans obtained via the Connector should be with pre-tax dollars Seal of Approval plans are to meet definition of health benefit plan in c. 176J, s. 1 Carrier may apply group size adjustment otherwise used for individuals to each employee of a small group that does not meet its participation or contribution requirements DOI annually to establish and publish minimum standards and guidelines for use by all carriers. Qualified student health plans and plans for young adults not subject to the same minimum standards and guidelines. DOI to consult with the Connector.	
All carriers may market only plans that include coverage for: (a) pregnant women, infants and children; (b) prenatal care, childbirth and postpartum care; (c) cytologic screening and mammographic examination; (d) diabetes-related services, medications and supplies, (e)	Plans eligible for Seal of Approval may exclude mandated benefits imposed subsequent to 1/1/06 Establishes a moratorium on all new mandated benefits. No end date for moratorium	

Senate Bill	House Bill	Comments
early intervention services; and (f) mental health services, **but** if the policy limits outpatient physician office visits, then the policy **may** limit mental health benefits to same level of coverage Diabetic supplies added by amendment. While all plans must provide the coverage noted above, carriers are allowed to market plans that do not include any of the other mandated benefits as long as they offer at least one plan that covers all mandated benefits No plan approved by Commissioner of Insurance in accordance with preceding provisions of this #3D are available to an employer who has provided an accident and health policy to any employee within 12 months See also discussion of commercial market below A Seal of Approval plan may not be disapproved solely because it does not include coverage for 1 mandated benefit, but the carrier is to offer a plan that has a prescription drug benefit option Through 12/31/08 any plan receiving Seal of Approval may exclude new mandated benefits implemented after 1/1/06		
For non-group, up to 3 GIPs offered by carriers, including HMOs, may include high deductible features	Plans that satisfy individual mandate, which 176J plans will do, may include a high deductible option HMOs allowed to establish deductible levels consistent	

Senate Bill	House Bill	Comments
	with those applicable to HSA accounts, but maximum deductible cannot be greater than the minimum required under the federal HSA rules	
No provision	Seal of Approval plans not required to meet any health care delivery design in any other law (including presumably any willing provider laws) Carriers may make "benefit level adjustments" in plan design, including with regard to health delivery networks See below for new plan for young adults	
Reinsurance boards under cc. 176J and 176M required to submit to DoI by 7/1/06 plans to terminate their operations. Plans are subject to approval of Commissioner and are to be fully implemented within 12 months following approval. Programs are supplanted by reinsurance program provided for under bill Reinsurance Trust Fund (see below) applied to provide reinsurance for carriers: • providing plans for small groups of up to 5 employees and • providing GIPs under 176M Reinsurance benefit: 90% of claims costs with thresholds and reinsurance limits to be determined by Commissioner. Initial threshold is 100K and initial limit is $500K. Commissioner to increase thresholds and limits annually by an amount "consistent with medical	Eliminates current reinsurance programs under cc. 176J and 176M DOI to monitor the competitiveness of the insurance market and make an annual determination as to whether a reinsurance program is necessary. If it is, then DOI is to establish a program in accordance with what are described as "recommendations" but that in effect would re-establish the current 176J program	

Senate Bill	House Bill	Comments
cost trends in the small group market" Carrier's premiums must reflect this anticipated reimbursement Reinsurance Trust Fund advisory board created to advise DOI and DHCFP on administration, oversight and operation of Fund, including with regard to assessment methodologies, funding and disbursement levels		
Reinsurance Trust Fund funded from "free rider assessments" Companion appropriations bill provides $10 million from Health Care Access and Investments Trust Fund for reinsurance program and $10 million for premium support program	Not applicable	
No provisions	DOI, with advice and consent of the Connector's director, to implement a plan specifically for individuals 19-26 without access to other coverage. Premiums for program to be established in a manner consistent with requirements of c. 176J Coverage to include "reasonably comprehensive" coverage for IP and OP hospital services and physician services for physical and mental illness. At least one product must have coverage for outpatient drugs Plans covering young adults may impose reasonable cost shares and use control techniques "commonly used" in the health insurance industry, including tiering and selective contracting	
No provisions	Connector, in consultation with executive office of	

Senate Bill	House Bill	Comments
	economic development, to design and administer a pilot program to assist businesses with less than 50 employees to purchase health insurance for its employees. Program may include economic and other incentives to provide coverage for employees with household incomes below 400% of FPL	
Transfers from Stabilization Fund to Exchange: • $1.5 million for purposes of educating and increasing awareness of uninsured resident as to options for becoming insured through Exchange • $4.5 million for administrative and operating expenses Small Group Reform Board (SGRB) created Among its functions are to: • Recommend additional steps for further stabilizing premiums for small group and non-group insurance • Conduct study of impact and benefits of expanding small group market to employers with up to 75 employees	Structure of Connector: Board to consist of 13 members: • Ex officio: Medicaid director, secretary of A&F, Commissioner of Insurance • 10 governor appointees, including member in good standing of American Academy of Actuaries, an employee health benefit specialist, health economist, 1 each representing organizations providing legal assistance to low-income residents, health consumer orgs, small business, organized labor, public health organizations, and organizations concerned with the health of racial and ethnic minorities, and a provider of health care to low-income families Executive Director of GIC to supervise the administrative affairs, general management and operations of the Connector, and serve as its secretary Bill provides $25 million for start-up/marketing costs for Connector and Commonwealth Care program	
Specific provisions affecting commercial insurance, Blue Cross, HMOs in addition to changes to 176J and 176M described below Bill extends mandatory dependent coverage by commercial insurers, Blue Cross and HMOs for college age non-student dependents up to the age	DOI, in consultation with Connector, annually to establish and publish minimum standards and guidelines for each type of health benefit plan except qualified student health plans and plans for young adults. Bill extends mandatory dependent coverage by commercial insurers, Blue Cross and HMOs for dependents to the age of 25 or 2 years past loss of dependent status under Internal	

Senate Bill	House Bill	Comments
of 25 who are unemployed and have no other form or type of health insurance coverage Bill also establishes new provisions regarding long-term care insurance that are not summarized in these materials Exchange Seal of Approval may serve as basis for benefit design in general commercial market as well as small group/non-group Provider contracts must require exclusive use of Medicare diagnostic and procedures coding standards and guidelines, as updated from time to time. They must also require exclusive use of Medicare's standardized paper claim forms an electronic claims formats. Changes are to adopted in their entirety for use under such contracts, within 30 days following publication by CMS. By 4/1/06 the Commissioner to issue regs implementing these requirements (to be effective in all such contracts by 10/1/07) with prior consultation with interested parties, including MHA, MMS, MABHS, MAHP and one state licensed insurance plan that is not a member of MAHP	Revenue Code whichever first occurs Bill eliminates surcharge payor assessment, conditioned on implementation of assessment on employers (see below). DOI mandated to have health insurers submit information to allow it to determine if premiums are being "appropriately adjusted" to account for savings from the repeal of the surcharge. If it deems it necessary to make this determination, DOI may perform a market conduct study to examine premiums charged by health insurers after July 1, 2006. (A market study allows DOI to issue orders requiring the information to be submitted and to perform audits to make its determination.) DOI authorized to order any health insurer to adjust premiums to take the savings into account if it has not otherwise done so Bill also provides that a commercial insurer, BCBSMA, or an HMO providing coverage to an employer must assure that the employer offers the coverage to all of its full-time employees who live in MA. The employer may not make a smaller contribution percentage amount to an employee than it makes to any other employee who receives an equal or greater total hourly or annual salary, but the plan benefit structure may establish separate contribution percentages for employees covered by collective bargaining agreements	
All carriers may market only plans that include coverage for: (a) pregnant women, infants and children; (b) prenatal care, childbirth and postpartum care; (c) cytologic screening and mammographic examination; (d) diabetes-related services, medications and supplies, (e) early intervention services; and (f) mental health services, **but** if the policy limits	No specific provision for use of Connector or Seal of Approval outside of Commonwealth Care program and small group/individual plans Bill specifies that nothing in legislation is to interfere with a person's right to receive chiropractic benefits under c. 175, s. 108D	

Senate Bill	House Bill	Comments
outpatient physician office visits, then the policy **may** limit mental health benefits to same level of coverage While all plans must provide the coverage noted above, carriers are allowed to market plans that do not include any of the other mandated benefits as long as they offer at least one plan that covers all mandated benefits No plan approved by Commissioner of Insurance in accordance with preceding provisions of this #4B are available to an employer who has provided an accident and health policy to any employee within 12 months HMOs authorized to establish "reasonable" annual limits on coverage for physician office visits, OP lab and diagnostic services and other OP services ("reasonableness" presumed if HMO demonstrates actuarially that the unit of service limit is not more than 2x the average expected utilization for the category of service, or that the annual dollar limit on a category of service is not less than 4x the average expected level of incurred claims for the category of service)		
See #4B above regarding ability of carriers to market plans without mandated benefits SGRB to review mandated benefits (see 3L above) Bill requires that no action is to be taken on any	Establishes a moratorium on all new mandated benefits. No end date for moratorium	

Senate Bill	**House Bill**	**Comments**
bills proposing to establish new mandated benefits that are referred to any of the joint committees or the Ways and Means Committees in 2005 and 2006. Instead any such bills are to be referred to the SGRB. The moratorium will be in effect until the earlier of the SGRB report or 1/1/07 DHCFP also mandated to undertake detailed analysis of existing mandated benefits, with authority to gather extensive information in support of study Note: Relationship between SGRB and DHCFP studies not clear Companion appropriations bill provides $100,000 from Health Care Access and Investments Trust Fund for study of health care mandates, provided that the study is also to analyze the cost impact and economic effect of implementing an individual mandate		
Contributions to HSA accounts deductible from MA taxes HMOs allowed to establish deductible levels consistent with those applicable to HSA accounts HMOs authorized to establish "reasonable and actuarially sound" co- insurance for covered services	Contributions to HSA accounts deductible from MA taxes HMOs allowed to establish deductible levels consistent with those applicable to HSA accounts, but maximum deductible cannot be greater than the minimum required under the federal HSA rules	
No specific provision	No specific provision, but see discussion of Seal of Approval in #3 above	
"Free rider" surcharge" on "non-providing	Bill provides for contributions by employers to	

Senate Bill	House Bill	Comments
employers" • "non-providing employers" are employers of 50 or more that have employees accessing Medicaid or free care unless the employer is a party to a collective bargaining agreement addressing employees' accessing free care or offers to pay or arrange for coverage for employees who access free care or are on Medicaid (other than by agreeing to pay into the UCP for eligible free care)	Commonwealth Care Fund. See #5B below for description of level of financial obligation Bill also provides that a commercial insurer, BCBSMA, or an HMO providing coverage to an employer must assure that the employer offers the coverage to all of its full-time employees who live in MA. The employer may not make a smaller contribution percentage amount to an employee than it makes to any other employee who receives an equal or greater total hourly or annual salary, but the plan benefit structure may establish separate contribution percentages for employees covered by collective bargaining agreements	
DHCFP to file a report by 2/1/06 on feasibility of requiring all MA residents to obtain employer-based insurance Companion appropriations bill provides $100,000 from Health Care Access and Investments Trust Fund for study of health care mandates, provided that the study is also to analyze the cost impact and economic effect of implementing an individual mandate Municipalities obliged to offer employees opportunity to purchase health insurance through a plan administered by the municipality; provided that this requirement is not to replace or void terms or agreements within an existing collective bargaining agreement nor prohibit any		

Senate Bill	House Bill	Comments
public employee union from bargaining collectively regarding health insurance benefits regardless of collective bargaining agreements		

Senate Bill	House Bill	Comments
If an employee of a "non-providing employer" (or employee's dependent) accesses health care services, DHCFP assesses a "free rider" surcharge on the "non-providing employer" equal to 100%-150% of free care cost, plus an administrative surcharge Assessment based on a number of factors, including size of group, frequency of employees/dependents accessing free care or Medicaid, income and asset level of employees accessing care	Subject to the conditions described below in this #5B, employers of more than 10 employees are subject to a contribution requirement determined by multiplying wages (see below) paid employees in MA by a defined percentage, as follows Employers with more than 10 and fewer than 99 employees: Eff. 7/1/06: 3% Eff. 1/1/07: 4% Eff. 7/1/07: 5% Employers with more than 100 or more employees: Eff. 7/1/06: 5% Eff. 1/1/07: 6% Eff. 7/1/07: 7% Note: The final House bill, strictly speaking, does not impose contribution requirement on employers with 99 and 100 employees Wage base for contribution excludes wages above Social Security maximum contribution and benefit base Obligation reduced by tax deductible employer payments for employee/family health benefits, including payment or reimbursement of premiums and contributions to HSA accounts Relief for substantial hardship available, although no criteria are set out for determining	
Up to $50 million generated from the employer and employee assessment to go to into	Assessments go into Commonwealth Care Fund (see #7A below)	

Senate Bill	House Bill	Comments
Reinsurance Trust Fund (see #7 below); anything above that to the General Fund		
Employers to file "Health Insurance Responsibility Disclosure" form with DHCFP Whistleblower protections for individuals who cause "non-providing employer" to pay surcharge	Surcharge payor liability eliminated, except as provided, on a contingency basis, below. DOI mandated to have health insurers submit information to allow it to determine if premiums are being "appropriately adjusted" to account for savings from the repeal of the surcharge. If it deems it necessary to make this determination, DOI may perform a market conduct study to examine premiums charged by health insurers after July 1, 2006. (A market study allows DOI to issue orders requiring the information to be submitted and to perform audits to make its determination.) DOI authorized to order any health insurer to adjust premiums to take the savings into account if it has not otherwise done so If action is taken to restrain ability to assess employer contributions, then provisions are suspended; if Attorney General certifies a final adjudication precluding these contributions from being assessed, then surcharge payor assessment that had applied to the UCP but is otherwise abolished by this bill comes back into effect for purposes of funding the Commonwealth Care Fund Provisions of bill relating to employer contributions are deemed severable in the event any are found to be invalid	
Use of "free rider" assessments on so-called "voluntarily uninsured patients" to generate funds for Reinsurance Trust Fund used for reinsurance of plans covering groups of up to 5 employees under 176J and individuals under	Reliance on individual mandate to get to "universal" coverage Efforts to define affordable coverage via programs administered through the Connector	

Senate Bill	House Bill	Comments
176M Companion appropriations bill provides $100,000 from Health Care Access and Investments Trust Fund for study of health care mandates, provided that the study is also to analyze the cost impact and economic effect of implementing an individual mandate	Connector to recommend a schedule of a percentage of income for each 50 per cent increment of FPL that an individual could be expected to contribute towards purchase of coverage. Affordable contribution amounts to take into account all out of pocket costs, including, but not limited to, deductibles, costs for medically necessary non-covered services, co-insurance, co-pays and premiums. Connector to consider contribution schedules such as for government benefits programs, and may consider Massachusetts-specific cost of living. Schedule to be approved only following a public notice and hearing. Bill provides for open enrollment for eligible individuals and dependents, as defined in c. 176J, from 9/1/06 through 11/30/06, with no pre-existing limitations or waiting periods for anyone who enrolls in this period	
A "voluntarily uninsured patient" is an uninsured patient whose gross family income exceeds 300% of FPL and who has declined employer's offer to pay for or arrange for health insurance coverage A municipal employee who declines coverage offered through employer and receives care through the UCP or Medicaid is considered a "voluntarily uninsured employee"	All residents of Commonwealth 18 years of age without coverage as of 1/1/07 within a broadly defined category of "creditable coverage"	

Senate Bill	House Bill	Comments
DHCFP assesses a "free rider" surcharge or "voluntarily uninsured patient," who accesses health care services	Individuals covered by mandate must have creditable coverage, provided the coverage is deemed "affordable" according to a schedule set by the Connector Board (see above) Creditable coverage can be through a high deductible plan or the new young adult plan described in # above, but coverage must have an annual hospital benefit of at least $100K An individual may dispute the determination of "affordability" through a review panel at the Dept. of Revenue. The Commissioner of Revenue is authorized to issue regs relating to this review An individual subject to the mandate may seek an exemption if imposition of penalty (see #6D below) would create extreme hardship, based on criteria to be determined by Commissioner of Revenue	
The "free rider" surcharge is equal to 30%-100% of the free care cost of the "voluntarily uninsured individual," plus an administrative surcharge for DHCFP	Effective 1/1/07, failure to comply with mandate gives rise to a penalty equal to 50% of the "minimum insurance premium amount which meets the definitions of creditable coverage for which the individual would have qualified" during the months he did not have coverage. Connector is to establish this level Dept. of Revenue may retain refunds to fund penalty, but this offset has lowest priority of any other offset use of refunds in current law	

Senate Bill	House Bill	Comments
	If refunds not sufficient to pay full amount of penalty, Commissioner may assess individual directly. Effective 1/1/09, if penalty not paid within 60 days of notification, RMV may refuse to renew individual's driver's license until penalty paid Carriers and Medicaid are to report monthly to GIC on individuals to whom they provide creditable coverage	
Up to $50 million of the surcharges from employers and employees to go into the Reinsurance Trust Fund, to be applied to reinsurance support for plans covering groups of up to 5 employees under 176J and covering individuals under 176M; balance of surcharges to the General Fund	Penalty proceeds deposited in Commonwealth Care Fund	
Individuals to file "Health Insurance Responsibility Disclosure" form with DHCFP, to include acknowledgement by "voluntarily uninsured person" of financial responsibility for care Entities providing UCP services are to provide any uninsured patient with written notice of criminal penalties for committing fraud in connection with receiving such services. DHCFP to promulgate a standard written notice form, to be made available to providers in English and other languages, that includes	All persons filing individual tax returns as residents are to indicate status of health care coverage on return. Failure to indicate, or failure to have coverage in force, gives rise to penalties described above Penalties for any willful misuse of "personal information for personal gain" under the chapter establishing personal responsibility	

Senate Bill	House Bill	Comments
written notice of every employee's protection from employment discrimination and a list of health insurance options available to voluntarily uninsured employees		
Companion appropriations bill to accompany reform bill creates a Health Care Access and Investments Trust Fund, to be administered by Secretary of EOHHS with input from MassHealth Payment Policy Advisory Board (see #2H below). Health Care Access and Investments Trust Fund expires on 10/30/09, with funds remaining to be transferred to General Fund Companion appropriations bill authorizes transfer of $162,575,000 from Stabilization Fund to Health Care Access and Investments Trust Fund $116 million to be transferred to new fund from Stabilization Fund by 6/30/2005 and every year thereafter Reinsurance Trust Fund, which is funded by "free rider" assessments on "non-providing employers" and "voluntarily uninsured persons" Note: no changes to current Uncompensated Care Pool funding provisions	Commonwealth Care Fund, established effective 7/1/06, which is funded by: • employer assessments (see ##5A and 5B above); • penalties under individual mandate (see ##6D and 6E above); • "any federal reimbursement received for benefits and payments provided pursuant to" c. 118E and the new c. 118H Commonwealth Care program; • appropriations to support the waiver program • Distressed Hospital Fund, which is terminated and transferred to Commonwealth Care Fund, excerpt for amounts needed to complete current fiscal year commitments • 50% of earning of Health Security trust Fund during FY 2007 also to be transferred to Commonwealth Care Fund	
Purpose of Health Care Access and Investments Trust Fund is "to maintain a world class health care system" by making targeted investments to certain participating Medicaid providers and to:	Commonwealth Care Fund to be used for programs designed to increase health coverage, including Commonwealth Care and to support services to 19-64 adults under Medicaid without dependents (covered up to	

Senate Bill	House Bill	Comments
• invest in hospitals, CHCs, licensed clinics and physicians that participate in Medicaid • encourage Medicaid providers to increase enrollment in Medicaid • provide incentive to Medicaid providers to deliver care and encourage use of low-cost settings • encourage hospitals to implement safe staffing models, reduce medical errors and invest in technologically advanced capital equipment • address practice of cost-shifting to providers and consumers Reinsurance Trust Fund used to provide reinsurance for carriers with plan covering groups of up to 5 employees under 176J and covering individuals under 176M	100% of FPL - see #1B above) Funds for program subject to appropriation from the Commonwealth Care Fund (see #7 below). If director of Connector determines that amounts in the Fund are insufficient to meet projected costs of enrolling new eligible individuals, secretary is to impose a cap on enrollment In FY 2007, $40 million of Fund to be used to support Medicaid rate increases for hospitals and physicians Funds may be transferred from Commonwealth Care Fund to Health Safety Net Trust Fund	
Continuation of UCP	Replacement of UCP with Health Safety Net Fund administered by director of Health Safety Net Office at Medicaid Office to define eligibility criteria for reimbursable health services, scope of services eligible for reimbursement, standards for medical hardship, and standards for reasonable efforts to collect payments for the costs of emergency care HSNF to be fund of last resort for uninsured	

Senate Bill	House Bill	Comments
	HSNF funded by hospital liabilities, FFP, appropriations and draws on Commonwealth Care Fund Hospital liability to fund determined as is current liability to UCP Surcharge payor liability eliminated, except as provided, on a contingency basis, in #5D above. If reinstated, surcharge percentage based on generating $300 million (text actually says $300,000 but obviously means $300 million), with office authorized to adjust percentage mid-year if it projects that surcharge percentage will yield less than $280 million or more than $320 million in the fiscal year Health Safety Net Office is mandated to administer a demonstration program of health care coverage for fishermen	
No provisions	Use of HSNF to pay hospitals and CHCs for reimbursable health services provided to uninsured $6 million to be used annually to support case management and other demonstration projects that would reduce liability of the fund to acute hospitals Payment rates to acute hospitals and CHCs set by office, in consultation with DHCFP, on a fee-for-service basis:	

Senate Bill	House Bill	Comments
	For acute hospitals, use of Medicare system, including all of Medicare's adjustments for direct and indirect graduate medical education, disproportionate share, outliers, organ acquisition, bad debt, new technology and capital and the full annual market basket index increase, with system modified only to account for: the differences between Medicare and the program funded by the HSNF, including the services and benefits covered, use of a grouper and DRG relative weights determined by the HSN office in consultation with DHCFP and the MHA to reimburse acute hospitals at rates no less than they receive from Medicare; the extent and duration of such coverage; the population served; and the assurance that providers will be held harmless at current reimbursement levels. After implementing the new methodology, the office is to ensure that rates are not then less than rates for comparable services under Medicare, taking into account the adjustments described above For CHCs, rates to derive from a base rate no less than the then current Medicare Federally Qualified Health Center rate, adjusted for wage differences, increased for payment for additional services not included in the base rate, such as EPSDT, 340B pharmacy, urgent care, and emergency room diversion Payment to acute hospitals and CHCs for bad debt to be made upon submission of evidence that reasonable efforts have been made to collect the debt. Hospitals and CHCs to determine eligibility of patients for other sources of coverage and are subject to audit by office to assure compliance	

Senate Bill	**House Bill**	**Comments**
Entities providing UCP services are to provide any uninsured patient with written notice of criminal penalties for committing fraud in connection with receiving such services. DHCFP to promulgate a standard written notice form, to be made available to providers in English and other languages, that includes written notice of every employee's protection from employment discrimination and a list of health insurance options available to voluntarily uninsured employees	Reimbursable health services for the uninsured are broader than current allowable free care. Non-emergency and urgent services are to be provided at CHCs unless no community hospital or hospital licensed CHC is within 5 miles of a hospital campus Note: The definition of reimbursable services includes services to the underinsured as well as the uninsured, but there is no authority to make payments for services to the underinsured An "underinsured" person is a resident whose health insurance plan or self-insurance health plan does not pay for health services that are eligible for reimbursement from the HSNF, or who is enrolled in a publicly funded health care program that does not provide coverage for services eligible for reimbursement from the HSNF if such person meets income eligibility standards set by the HSN office.	