Health Care Access and Affordability
Conference Committee Report

Summary:

This Conference Committee Report contains a comprehensive plan for increasing health insurance coverage for all residents of Massachusetts. This bill is a bridge between principles in the House and Senate bills, H 4479 and S 2282. The bill would redeploy current public funds to more effectively cover currently uninsured low-income populations, and would make quality health coverage more affordable for *all* residents of the Commonwealth. The bill promotes individual responsibility by creating a requirement that everyone who can afford health insurance obtain it, while also responding to concerns about barriers to health care access. Provisions in the bill aim at achieving nearly universal health insurance coverage, but also maintain a strong safety net that has historically distinguished the state. Finally, the bill would ensure that the Massachusetts Medicaid program complies with the terms of the new federal waiver, maintaining continued receipt of annual payments from the federal Medicaid program.

A) Commonwealth Health Insurance Connector

The bill creates the Commonwealth Health Insurance Connector, to connect individuals and small businesses with health insurance products. The Connector certifies and offers products of high value and good quality. Individuals who are employed are able to purchase insurance using pre-tax dollars. The Connector allows for portability of insurance as individuals move from job to job, and permits more than one employer to contribute to an employee's health insurance premium. The Connector is to be operated as an authority under the Department of Administration and Finance and overseen by a separate, appointed Board of private and public representatives.

B) Insurance Market Reforms

The bill merges the non- and small-group markets in July 2007, a provision that will produce an estimated drop of 24% in non-group premium costs. An actuarial study of the merging of the two insurance markets will be completed before the merger to assist insurers in planning for the transition. The bill also enables HMOs to offer coverage plans that are linked to Health Savings Accounts, reducing costs for those who enroll in such plans. Young adults will be able to stay on their parents' insurance plans for two years past the loss of their dependent status, or until they turn 25 (whichever occurs first), and 19-26 year-olds will be eligible for lower-cost, specially designed products offered through the Connector.

Finally, the bill would impose a moratorium on the creation of new health insurance mandated benefits through 2008.

C) Subsidized Health Insurance

Commonwealth Care Health Insurance

The bill creates a subsidized insurance program called the Commonwealth Care Health Insurance Program. Individuals who earn less than 300% FPL and are ineligible for MassHealth will qualify for coverage. Premiums for the program will be set on a sliding scale based on household income, and no plans offered through this program will have deductibles. The program will be operated through the Connector, and retain any employer contribution to an employee's health insurance premium. The subsidized products must be certified by the Connector as being of high value and good quality.

For individuals who earn less than 100% of the Federal Poverty Level ($9,600/yr), special protections in this bill provide for subsidized insurance products with comprehensive benefits, and waive any premiums. Currently, most childless adults are not eligible for MassHealth at any income level, unless they are disabled or have very little history of employment.

Insurance Partnership Program

The bill expands eligibility for employee participation in the current Insurance Partnership program from 200% to 300% FPL, in order to provide another option for small businesses who want to offer health care to their employees.

D) The Medicaid Waiver

By shifting significant federal resources from supporting individual hospitals to funding health insurance coverage for uninsured individuals, and by living within a lifetime spending ceiling for waiver services, the bill meets the terms set by the Centers for Medicare and Medicaid for renewal of our 1115(a) MassHealth Demonstration Waiver.

E) Medicaid Expansions, Restorations, Enhancements

The bill expands Medicaid coverage of the uninsured by providing $3M for comprehensive community-based outreach programs to reach people who are eligible for Medicaid but not yet enrolled, and by expanding eligibility for children. Currently, children in families who earn up to 200% of the Federal Poverty Level (FPL) are eligible for MassHealth. The bill increases eligibility to children in families earning up to 300% FPL ($38,500/yr for a family of 2).

The bill also restores all MassHealth benefits that were cut in 2002, including dental and vision services, and creates a 2-year pilot program for smoking cessation treatment for MassHealth enrollees.

In response to concern that Medicaid has underpaid many of its providers in recent years, the bill includes $90 million in rate relief for Fiscal Years 2007, 2008 and 2009. It does this while keeping within the budget neutrality limits of federal financing under the Medicaid waiver. The bill also establishes, for the first time, a process of tying rate increases to specific performance goals related to quality, efficiency, the reduction of racial and ethnic disparities, and improved outcomes for patients.

F) Individual Responsibility for Health Care

The bill requires that, as of July 1, 2007, all residents of the Commonwealth must obtain health insurance coverage. Individuals for whom there are not affordable products available will not be penalized for not having insurance coverage. A sliding "affordability scale" will be set annually by the Board of the Connector.

The purpose of this "Individual Mandate" is to strengthen and stabilize the functioning of health insurance risk pools by making sure they include healthy people (who, if not offered employer-sponsored and -paid insurance, are more likely to take the risk of not having insurance) as well as people who know they need regular health care services (and therefore are more likely to go to great lengths, and expense, to obtain insurance.) The financing of the bill is based on redirecting some of the public funds we currently spend on "free care" provided through hospitals, to provide subsidized health insurance to the uninsured. The mandate is another way to make sure people do not rely on "free care" for their health care, but that they get comprehensive insurance.

Beginning in July 2007, Massachusetts residents will be required to have health insurance. Residents will confirm that they have health insurance coverage on their state income tax forms filed in 2008. Coverage will be verified through a database of insurance coverage for all individuals. The Department of Revenue will enforce this provision with financial penalties beginning with a loss of the personal exemption for tax year 2007 and then increasing to a portion of what an individual would have paid toward an affordable premium for subsequent years.

G) Employer Responsibility for Health Care

Fair Share Contribution

The bill creates a "Fair Share Contribution" that will be paid by employers who do not provide health insurance for their employees and make a fair and reasonable contribution to its cost. The contribution, estimated to be approximately $295 per

full time employee (FTE) per year, will be calculated to reflect a portion of the cost paid by the state for free care used by workers whose employers do not provide insurance. Currently, a portion of the payments made by employers who do provide health coverage go towards free care costs, and this new contribution will help level the playing field. The Fair Share Contribution requirement will only apply to employers with 11 or more employees who do not provide health insurance or contribute to it, as defined by the Division of Health Care Finance and Policy, and will be pro-rated for employers with seasonal or part-time employees.

Free Rider Surcharge

The Free Rider surcharge will be imposed on employers who do not provide health insurance and whose employees use free care. Imposition of the surcharge will be triggered when an employee receives free care more than three times, or a company has five or more instances of employees receiving free care in a year. The surcharge will range from 10% to 100% of the state's costs of services provided to the employees, with the first $50,000 per employer exempted. Revenue gained from the surcharge will be deposited in the Commonwealth Care Trust Fund.

Mandatory Offer of Section 125 plans

Section 125 plans or "cafeteria plans" allow an employer to offer health insurance and other programs such as day care funding to employees on a pre-tax basis. Because of the significant savings which result from pre-tax insurance purchase, employers with more than 10 employees will be required to offer this pre-tax benefit to employees.

H) Reduction of Racial and Ethnic Health Disparities

The bill aims to reduce racial and ethnic health disparities by requiring hospitals to collect and report on health care data related to race, ethnicity and language. Medicaid rate increases in the bill are made contingent upon providers meeting performance benchmarks, including in the area of reducing racial and ethnic disparities. The bill creates a study of a sustainable Community Health Outreach Worker Program to target vulnerable populations in an effort to eliminate health disparities and remove linguistic barriers to health access. Finally, the bill creates a Health Disparities Council, to continue the work of the Special Commission on Racial and Ethic Health Disparities by recommending appropriate Legislative steps to reduce health disparities.

H) Health Safety Net Office and Fund

Many recommendations of the Inspector General's Office regarding the management of the Uncompensated Care Pool are included in the bill. Effective

October 1, 2007, the current Uncompensated Care Pool is eliminated, replaced by the Health Safety Net Fund. The Fund will be administered by a newly-created Health Safety Net Office located within the Office of Medicaid. The HSN Office will develop a new standard fee schedule for hospital reimbursements, replacing the current charges-based payment system. The plan anticipates the transfer of funds to the Commonwealth Care Health Insurance Program as free care use declines.

l) Funding

The plan leverages federal dollars to enhance and match state spending, and uses revenue generated by employer contributions to fund health insurance coverage.

Health Care Access and Affordability
Conference Committee Report

The Conference Committee on Health Care Access and Affordability began work in November 2005, following the passage of H 4479 in the House and S 2282 in the Senate. The report summarized below represents a bridge between principles of both the House and Senate bills.

Who are the Uninsured?

An estimated 550,000 people are uninsured in Massachusetts

- People with limited or no access to employer-sponsored coverage:
  - Low-income
  - Part-time, seasonal workers
  - Single, childless adults
  - Young adults
  - Children

- The number of uninsured individuals is growing, due to slow recovery from the economic downturn, erosion of employer-sponsored coverage, and reduced uptake by employees as the price of health insurance increases.

Why is Massachusetts addressing this problem now?

- Strong base of employer-sponsored insurance: 98% of employers with 100+ employees and 65% of smaller employers contribute to employees' health insurance
- Substantial existing funds are spent on the uninsured: over $600 million in the Uncompensated Care Pool
- Reauthorization of federal Medicaid waiver requires Massachusetts to redeploy funds to reduce the number of uninsured people
- Political leadership creates the opportunity to take a major step forward to substantially reduce uninsurance

Commonwealth Health Insurance Connector

What is the Connector?

- A central mechanism to connect individuals and small businesses with health insurance products
- The Connector certifies and offers products of high value and good quality.
- The Connector makes it easier for small businesses to give their employees the opportunity to buy health insurance with pre-tax dollars.

Who is eligible to "connect" to coverage?

- Individuals and businesses with 50 or fewer employees. Employed individuals may purchase health insurance with pre-tax dollars through the Connector.

Can small businesses participate in the Connector?

- Yes. In addition, employers can contribute any amount toward an employee's health insurance. Also, more than one employer may contribute to an employee's insurance premium, helping employees with more than one job.

What kinds of policies will be available through the Connector?

- This legislation protects the current range of benefits available through insurance in Massachusetts, including mental health and other mandated benefits. The Connector will review and certify products as being of good value and high quality.
- Plans offered through the Connector can choose to contract only with good value providers, rather than contracting with all providers in the state.
- The Connector will also offer a new range of products for Young Adults, ages 19-26, which will be tailored to meet their needs.
- Policies will have to meet current regulations on deductibles and co-pays except for those sold with a Health Savings Account (HSA) which will be able to have slightly higher deductibles but only when offered with the Account.

Who will oversee the Connector?

- The Connector operate as an Authority, similar to the School Building Assistance Authority under the Executive Office for Administration & Finance (A&F).
- A new, separate Board of the Connector will oversee the certification of products and the operations of the Connector.

MassHealth

What changes will be made to MassHealth?

- The bill increases eligibility to children in families earning up to 300% of the Federal Poverty Level (FPL) ($38,500/yr for a family of 2). Currently children in families up to 200% FPL are eligible for MassHealth. Massachusetts receives federal reimbursement of 65% reimbursement for most MassHealth programs for children.
- All MassHealth benefits that were cut in 2002, including dental and vision services, chiropractic and prosthetics, will be restored.

Commonwealth Care Health Insurance Program

What is the Commonwealth Care Health Insurance Program?

- Commonwealth Care will be operated through the Connector and will provide subsidies to people with incomes at or below 300% of the Federal Poverty Level (FPL), on a sliding scale, based on income.

Who will be eligible for the Commonwealth Care Health Insurance Program?

- People who earn up to 300% FPL ($48,000/yr for a family of 3), and are not eligible for other public insurance. People who have employer-sponsored insurance may be eligible, but the employer must pay a portion of the premium cost.
- People who earn below 100% FPL ($9,600/yr for an individual) will not be subject to any premium.

What benefits will be provided through the Commonwealth Care Health Insurance Program?

- Enrollees in the Commonwealth Care Insurance program will have a portion of their health insurance subsidized by the state.
- Plans offered through the premium assistance program will not include a deductible. There will be special protections for enrollees with incomes below 100% FPL.
- Managed care organizations that contract to provide health care for MassHealth enrollees will be the sole providers of subsidized health insurance for the initial years of the program (through July 2009), provided that they meet certain enrollment targets. After that, participants in the subsidized program will be able to enroll in other plans.
- Plans will be offered through the Commonwealth Care Health Insurance Connector, and must be approved by the Connector and meet other standards set by the Connector board.

Insurance Products

What types of insurance products will this legislation authorize to be available on the market?

- Merging the small- and non- group markets will stabilize the non-group market, and lower rates by 24% for individuals.
- New, targeted products will be offered to 19 to 26 year olds at low cost. These plans will offer "first dollar" coverage for primary care visits and comprehensive benefits
- Health Savings Accounts (HSAs) will be given favorable state tax treatment and authorized to be sold by HMOs.

Will this legislation affect mandated benefits?

- The bill places a moratorium on new mandated insurance benefits until January 1, 2008 at which time the state will have completed a review about the costs and necessity of all current mandates.
- *All* current mandated benefits are protected. New plans offered on the market will continue to provide high-quality benefits.

Individual Investment

Why is an individual investment necessary?

- Currently, every taxpayer pays for the care of those who are uninsured and need emergency care. Requiring those who can afford health insurance to purchase coverage is fair.
- Projections of the individual mandate show that the vast majority of the uninsured will take coverage.
- Experience and research has shown that voluntary measures aren't enough. Regardless of the price of insurance, some people choose to hedge their bets on health insurance by going without.
- By requiring everyone to have coverage, those who are healthy and currently uninsured will enter the insurance risk pool and thus help to stabilize the cost of premiums for the currently insured.
- No health care reform proposal without an individual mandate has ever been projected to enroll more than half of the uninsured.

Why is the "affordability" clause included in the bill?

- It is fair to require individuals to have insurance when an affordable product is available to them, based on a graduated affordability scale.

What will penalties be for not having health insurance?

- Beginning in July 2007, Massachusetts residents will confirm health insurance coverage by reporting whether or not they had insurance on state income tax forms in 2008.
- The Department of Revenue will enforce this provision with financial penalties. For tax year 2007, the penalty for not having health insurance coverage will amount to a loss of the personal exemption. For tax year 2008 and later, the penalty will increase to a portion of what an individual would have paid toward an affordable premium.

Employer Contribution

Why does the bill require a financial contribution by employers?

- Currently, a portion of the health insurance payments made by employers who do provide coverage for their employees go towards reimbursing hospitals and other providers for the cost of caring for the uninsured. Employers who DO NOT provide health insurance don't pay this premium. It seems fair to ask employers who don't contribute to pay a portion of the cost of providing health care to the uninsured.

How will the employer contribution work?

- Employers who don't make a "fair and reasonable" contribution toward employee health insurance premiums will be required to make a per-worker "fair share contribution." The contribution will be calculated to represent the cost of free care used by the employees of non-contributing employers, but will be capped at $295 per employee.

- Businesses with 10 or fewer employees will not be subject to the contribution. The amount of the contribution will be pro-rated for temporary or seasonal employees.

Other Frequently Asked Questions:

How will this bill affect small businesses?

- Connector will take away the administrative burden of offering insurance with pre-tax dollars.
- Connector will help small businesses choose high value, good quality products.
- Connector will allow for multiple employers' paying into one person's insurance premium and allow for portability – excellent benefit for part-time employees.
- Individuals who leave a small business that offered coverage through the Connector will be able to maintain the same health plan on their own – a valuable benefit for seasonal employees.
- The bill expands eligibility for the current Insurance Partnership Program. Employees with incomes up to 300% FPL (instead of 200%) will be able to participate, and their employer will receive a subsidy towards his or her share of the premium cost

How will this health reform legislation impact the large safety net hospitals?

- Boston Medical Center and Cambridge Health Alliance will continue to be supported for providing care to the uninsured

How will this legislation impact Community Hospitals?

- Community hospitals will benefit from additional funds available for Medicaid provider payments.
- Expanded Medicaid eligibility and assistance with purchasing private insurance will result in more people with insurance coverage, reducing the burden of free care and bad debt that hospitals bear now.
- A more rational system for reimbursing hospitals for the cost of providing uncompensated care will help community hospitals receive their fair share of available reimbursement funds.

Will the bill provide rate increases for providers?

- Hospitals and physicians will receive Medicaid rate increases of $90 million each year in FY07, FY08 and FY09.
- In FY08 and FY09, these increases will be tied to quality and other performance measures.

What will happen to the Free Care Pool under this legislation?

- The current Uncompensated Care Pool is eliminated by this legislation.
- A new, reformed Health Safety Net Fund, overseen by the Office of Medicaid, will reimburse hospitals and community health centers more fairly for uncompensated care.
- Reforms will make the Health Safety Net Fund efficient—reimbursements will be made using a new standard fee schedule, instead of the current charge-based payment system
- Less money will be needed for the Health Safety Net Fund as more people in Massachusetts acquire coverage.
- Some funds used for the Health Safety Net Fund now will be transferred to provide subsidized Commonwealth Care Health Insurance to individuals in the future, as the number of uninsured declines.

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

Conference Committee Report

Section-by-Section Summary

Bill Section	MGL Chp	MGL Sec	Description
0			Emergency Preamble
1			Appropriation language
2			Contains FY06 supplemental spending of $15.45 million related to bill.
2A			Contains FY06 supplemental spending of $14.55 million related to bill.
3	6A	16J-L	Creates a Health Care Quality and Cost Council that will promote health care quality improvement and cost containment.
	6A	16M	Creates a MassHealth Payment Policy Advisory Board to review and evaluate Medicaid rates and rate methodologies, especially rates paid to Community Health Centers.
	6A	16N	Creates a special commission to study the feasibility of reducing or eliminating the surcharge payor assessment paid by insurers and self-insured employers into the Free Care Pool.
	6A	16*O*	Creates a Health Disparities Council within EOHHS to make recommendations to reduce racial and ethnic health disparities in the Commonwealth
4	10	35M	Allows Board of Registration in Medicine Trust funds to carry over into the next fiscal year.
5	17	3	Changes composition of Public Health Council to include members from public health schools, providers, and health advocates, none of whom will be appointed by the Governor.
6	26	7A	Creates a new Health Access Bureau within the Division of Insurance with responsibility for oversight of the small group and individual health insurance market and affordable health plans.
6A	26	7B	Establishes a database within the Bureau to track insurance coverage for purposes of complying with the individual mandate. All insurers must report monthly coverage to the Bureau for this database and the information will be shared with DOR.
7	26	8H	Directs the Division of Insurance, in consultation with the Connector, to establish and publish annually minimum standards for health insurance products.
8	29	2*OOO*	Creates a Commonwealth Care Trust Fund that will receive revenue generated from the Fair Share Contribution, the Free Rider Surcharge, and other revenue that will be used to pay for subsidized health insurance and Medicaid rate increases.
	29	2PPP	Creates an Essential Community Provider Trust Fund that will replace the current Distressed Provider Fund. Funds will be used to make grant payments to hospitals and community health centers in accordance with criteria established by the new Health Safety Net Office.
	29	2QQQ	Technical change that reestablishes an existing fund used to maximize federal reimbursements.
	29	2RRR	Technical change that reestablishes an existing fund used to make payments to DMR facilities.
9	32	1	Allows board members of the Connector to receive pension benefits

Bill Section	MGL Chp	MGL Sec	Description
10	62	1	Changes current tax law definition of "Code" so that it includes section 223 of the Internal Revenue Code, which creates a deduction for health savings accounts.
11	111	24K	Establishes a pediatric palliative care program, administered by Public Health, to serve children with life-threatening illness, and their families.
12	111M*		Individual Mandate. Adds a new chapter 111M, establishing a requirement that residents for whom an affordable health insurance product is available must have "creditable coverage."
		1	Defines "creditable coverage" as a qualifying health plan type as listed in section and to be further defined by the board of the Connector. Also defines "resident" for purposes of the individual mandate.
		2	Establishes the procedure for implementation of the individual mandate. Effective July 1, 2007, qualifying individuals for whom "creditable coverage" is deemed affordable must have "creditable coverage" in place. Individuals must include information about health insurance status on their tax forms. Failure to meet the insurance requirement will result in a penalty, assessed by the department of revenue, which will be the loss of the personal exemption for tax year 2007. All penalties will be deposited in the Commonwealth Care Trust Fund.
		3	Establishes an exemption for individuals whose religious beliefs prevent them from using medical health care.
		4	Establishes a hardship exemption process.
		5	Authorizes the commissioner of revenue to promulgate regulations to carry out the individual mandate.
13	111M	2b	Creates a penalty for non-compliance with the individual mandate as equal to 50% of an available premium cost for each month the individual was not adequately covered beginning January 1, 2008.
14	118E	6	Requires Office of Medicaid to report on the previous year's activities of the Medical Care Advisory Committee.
15	118E	9A	Raises eligibility for children receiving MassHealth from 200% FPL to 300% FPL. Effective July 1, 2006
16	118E	9A	Prevents MassHealth from establishing disability criteria for determining eligibility that is more restrictive than the federal Social Security standard
17	118E	9A	Places in statute MassHealth eligibility standards for people with HIV at 200% FPL
18	118E	9A	Adds a new clause to require the Office of Medicaid to provide a monthly list of MassHealth-enrolled individuals for whom they provided "creditable coverage" to the DOI
19	118E	9C	Expands employee eligiblity for participation in Insurance Partnership Program to 300% FPL.
20	118E	9C	Ensures that Insurance Partnership subsidies are consistent with those provided under Commonwealth Care subsidy program.
21	118E	9C	Ensures that Insurance Partnership subsidies are consistent with those provided under Commonwealth Care subsidy program.
22	118E	9C	Specifies that self-employed individuals enrolled in the Insurance Partnership Program are eligible for employee subsidy only.

Bill Section	MGL Chp	MGL Sec	Description
23	118E	9C	Specifies that self-employed individuals enrolled in the Insurance Partnership Program are eligible for employee subsidy only.
24	118E	12	States that MassHealth must provide public hearing and notice before restricting eligibility or benefits.
25	118E	13B	Makes Medicaid rate increases for hospitals contingent on hospitals' meeting certain quality standards and performance benchmarks.
26	118E	16C	Expands S-CHIP eligibility for children from 200% FPL to 300% FPL.
27	118E	16D	Places in statute MassHealth Essential eligibility for elderly and disabled special status immigrants, and prohibits sponsor deeming.
28	118E	23	Technical language change.
29	118E	53	Restores all MassHealth benefits cut in 2002, including dental, vision, chiropractic, and prosthetics, effective July 1, 2006.
	118E	54	Creates a Wellness Program for MassHealth recipients to encourage healthy outcomes by reducing premiums as goals are met
30	118E	55	Health Safety Net Office definitions
	118E	56	Creates Health Safety Net Office to replace current Uncompensated Care Pool administration.
	118E	57	Creates a Health Safety Net Trust Fund, to replace the current Uncompensated Care Trust Fund and Pool.
	118E	58	Sets out provisions concerning hospital liability to fund (similar to current provisions in MGL 118G:18).
	118E	59	Sets out provisions concerning surcharge payor liablity to fund (similar to current MGL 118G:18A).
	118E	60	Sets out provisions concerning remibursements to hospitals and community health centers from Health Safety Net Trust Fund.
31	118G	1	Technical language change.
32	118G	1	Adds definition of "non-providing employer" for purpose of Free Rider surcharge.
33	118G	1	Adds definition of "payments from non-providing employers" for purpose of Free Rider surcharge.
34	118G	1	Technical language change.
35	118G	1	Adds definition of "state-funded employee" for purpose of Free Rider surcharge.
36	118G	1	Technical language change.
37	118G	2	Technical language change.
38	118G	2	Technical language change.
39	118G	3	Technical language change.
40	118G	5	Technical language change.
41	118G	6	Requires hospitals' uniform reporting to Division of Health Care Finance and Policy to include names and addresses of employers whose employees receive free care.
42	118G	6B	Requires applicants for free care to be enrolled in other publicly-funded health programs, if eligible; applicants deemed ineligible for such programs are required to provide the name and address of their employer and their own identifying information, including social security number.

Bill Section	MGL Chp	MGL Sec	Description
		6C	Requires every employer and employee doing business in Massachusetts to sign, under oath, a Health Insurance Responsibility Disclosure form indicating whether the employer has offered insurance and whether the employee has accepted or declined it.
43	118G	18-18A	Technical language change.
44	118G	18B	Sets out provisions governing assessment of Free Rider surcharge on non-providing employers.
45	118H		Creates the Commonwealth Care Health Insurance program, which will provide subsidized insurance to people with incomes under 300% FPL who are not eligible for other publicly-funded programs. Subsidies will be paid based on a sliding scale for eligible plans that are procured by the Commonwealth Health Insurance Connector. The new chapter provides that enrolles with incomes under 100% FPL will not pay premiums or deductibles, and also contains other language protections for all enrollees.
46	149	6D 1/2	Prohibits employers from penalizing employees who use free care.
47	149	188	Creates the Fair Share Contribution, to be paid by employers who do not provide or make a reasonable contribution to health insurance for their employees. The contribution requirement will apply to employers with 11 or more employees, will be pro-rated for part-time employees, and will be capped at $295 per employee.
48	151F		Establishes the requirement that all employers with more than 10 employees must maintain a Section 125 plan to give employees access to pre-tax health insurance payments. Employers who do not comply will be faced with a fine.
49	175	108	Require family policies to maintain children up to age 25 or for 2 years past "loss of dependent status", whichever occurs first.
50	175	110	Insurers offering blanket or group insurance policies may only sell to employers if the insurance is offered to all full-time employees and the employer must offer to cover the same premium contribution percentage for each employee, allowing, however greater contribution percentages to lower paid employees and separate percentages for employees with collective bargaining agreements. This policy is intended to prevent employers from offering different health plans to different classes of workers or dropping coverage for certain workers.
51	175	110M	Requires commercial insurers to provide a monthly list to DOI of residents for whom they provided "creditable coverage" for the previous month.
52	176A	8 1/2	A corporation organized under this chapter may only contract to sell a group non-profit hospital service contract to an employer if the group non-profit hospital service contract is offered to all full-time employees and the employer must offer to cover the same premium contribution percentage for each employee, allowing, however greater contribution percentages to lower paid employees and separate percentages for employees with collective bargaining agreements. This policy is intended to prevent employers from offering different health plans to different classes of workers or dropping coverage for certain workers.

Bill Section	MGL Chp	MGL Sec	Description
53	176A	8Z	Require family policies to maintain children up to age 25 or for 2 years past "loss of dependent status", whichever occurs first.
54	176A	34	Requires non-profit hospital services to provide a monthly list to the Group Insurance Commission of residents for whom they provided "creditable coverage" for the previous month.
55	176B	3B	A medical service corp can offer a group medical service agreement sell to employers if the insurance is offered to all full-time employees and the employer must offer to cover the same premium contribution percentage for each employee, allowing, however greater contribution percentages to lower paid employees and separate percentages for employees with collective bargaining agreements. This policy is intended to prevent employers from offering different health plans to different classes of workers or dropping coverage for certain workers.
56	176B	4Z	Require family policies to maintain children up to age 25 or for 2 years past "loss of dependent status", whichever occurs first.
57	176B	22	Requires medical service corps to provide a monthly list to the Group Insurance Commission of residents for whom they provided "creditable coverage" for the previous month.
58	176G	4R	Require family policies to maintain children up to age 25 or for 2 years past "loss of dependent status", whichever occurs first.
59	176G	6A	An HMO may only sell to employers if the insurance is offered to all full-time employees and the employer must offer to cover the same premium contribution percentage for each employee, allowing, however greater contribution percentages to lower paid employees and separate percentages for employees with collective bargaining agreements. This policy is intended to prevent employers from offering different health plans to different classes of workers or dropping coverage for certain workers.
60	176G	16A	An HMO can include a maximum deductible consistent with the maximum contribution requirements allowed for a federally-established Health Savings Account (HSA)
60A		16B	Allows HMOs to offer Coverage for Young Adult plans as long as the provisions are consistent with those established for those plans.
61	176G	30	Requires HMOs to provide a monthly list to the Group Insurance Commission of residents for whom they provided "creditable coverage" for the previous month.
62	176J	1	Eliminates "case characteristics" from the determination of "Adjusted average market premium rates" and uses "rate basis type" in its place. (In compliance with HIPAA)
63	176J	1	Establishes a "Base premium rate" as a midpoint rate for each rate basis type for each health benefit plan offered by a carrier.
64	176J	1	Modifies "benefit level" to include the service delivery and network of a health benefit plan
65	176J	1	Eliminates preferred provider arrangements (176I) from being considered carriers for the non-group and small group market.

Bill Section	MGL Chp	MGL Sec	Description
66	176J	1	Eliminates "case characteristics" from being used in determination of pricing of health benefit plans leaving "rate basis type" as the primary price differentiation method.
67	176J	1	Adds definitions for "Connector Seal of Approval" regarding approval of the value of benefit plans by the Connector. Also defines "creditable coverage" for individuals as any one of eleven types of health coverage including group health plans, federal employee and military plans, Medicare and Medicaid plans, and any other plans that meet HIPAA requirements.
68	176J	1	Defines an "eligible individual" for health insurance as a resident of the Commonwealth
69	176J	1	Extends the definition of "eligible small business" to include as one affiliated companies with the "same corporate parent".
70	176J	1	Includes small businesses within a MEWA (multiple employer welfare agreement) in the definition of "eligible small business"
71	176J	1	Clarifies "emergency services" to include mental medical conditions and assistance to pregnant women.
72	176J	1	Adds consideration for rates of "eligible individuals and their dependents" (residents of MA) in setting "Group average premium rates"
73	176J	1	Adds tobacco usage as a factor for consideration in setting group base premium rates.
74	176J	1	Defines "group health plan" as "an employee welfare benefit plan" with specification given to defining medical care.
75	176J	1	Redefines "health benefit plan" to exclude MEWA (multiple employer welfare agreements) from being included in this definition. The definition further excludes hospital indemnity insurance polities if offered separately from a coordinated benefit plan, specific disease insurance purchased to supplement a health plan, and also excludes student health plans from this definition. The commissioner is given the authority to modify this definition.
76	176J	1	Adds a definition for "modified community rate" defining how carriers must offer the same premiums to members within a particular rate basis type and can only vary premiums on age, group size, industry, participation rate, geographic area, wellness program usage, tobacco usage, or benefit level. Specifically, this section adds wellness program usage and tobacco usage as rating categories.
77	176J	1	Specifies that genetic information in the absence of a related condition cannot be used against an individual as a preexisting condition. Eliminates prototype plans as it pertains to HMOs.
78	176J	1	Adds tobacco usage as insurance "rating factors"
79	176J	1	Provides a definition for "resident" as a "natural person living in the commonwealth" but providing exclusions for individuals to qualify as residents based upon their confinement to a MA nursing home or hospital. Also defines "Trade Act/Health Coverage Tax Credit" to allow affected individuals to qualify for federal funds.
80	176J	1	Requires providers to pay for emergency services during an insured's "waiting period" if a waiting period exists within the health benefit plan.

Bill Section	MGL Chp	MGL Sec	Description
81	176J	2	Opens the small group market to accept nongroup members as "eligible individuals" as of July 1, 2007.
82	176J	3	Changes requirements health benefit plans must meet with regard to premium setting and rate basis types. This section establishes a maximum rate band range from .66 to 1.32 for the following factors: age, industry, participation-rate, wellness program rate, and tobacco use rate. Additionally, carriers can apply only the following factors outside of the rating band in establishing premiums: benefit level, geographic region, adjustment for eligible individual rather than small group, and group size adjustment. Additionally, requirements are laid out for which carriers with 5,000 or more members will be required to file a plan with the Connector to be considered for the "Connector Seal of Approval."
83	176J	4	Modifies the current requirement of carriers to make health benefit plans available in the following ways: Requires carriers to offer coverage effective within 30 days to any eligible individuals if they request coverage within 63 days of prior creditable coverage. If the 63 day period has lapsed, carriers must offer coverage to eligible individuals but may impose a 6 month exclusion of coverage for pre-existing conditions and a 4 month waiting period for receipt of services with the exception of emergency services which must be covered. However, plans offered to individuals without coverage for 18 months prior to application may not be subjected to a waiting period. Additionally, a carrier can deny enrollment in any plan if the carrier files proof of intent to stop selling that plan with the Commissioner. Carriers can require individuals or groups of 1-5 to enroll in plans via the Connector or an intermediary.
84	176J	5	Specifies that plans offered to Trade Act/ Health Coverage Tax Credit eligible persons may not include a waiting period of more than 3 months or a pre-existing condition exclusion. This brings these plans in line with federal regulations for federal reimbursement for qualifying individuals. Increases the period in which an eligible individual, employee, or dependent may go without coverage from thirty days to 63 days before a pre-existing condition may be excluded from coverage. Decreases the waiting period in which a newly insured member must wait for coverage from six months to four months. Eliminates waiting periods entirely for eligible individuals who have had no creditable coverage for the past 18 months. Specifies defined "creditable coverage" rather than general "coverage".
85	176J	6	Incorporates "eligible individuals" into those eligible for plans in the merged market
86	176J	6	Allows plans to offer restricted networks that differ from the overall carrier's network.
87	176J	7	Requires electronic filing of rates and notification to DOI of actuarial methodology and any relevant changes prior to filing.
88	176J	8	Requires the governing committee of the carrier-funded small-group reinsurance plan to establish a plan to phase out the program by June 2007.

Bill Section	MGL Chp	MGL Sec	Description
89	176J	9	Adds "eligible individuals" to those who do not qualify for "continuous coverage"
90	176J	10	Establishes "Coverage for Young Adults" as a health plan with exact specifications to be set by DOI. Only individuals between 19 & 26 who do not have employer -sponsored coverage are eligible for these products.
91	176M	1	Ends enrollment opportunities for non-group.
92	176M	1	Provides a definition for "Trade Act/Health Coverage Tax Credit Eligible Persons" to allow those who qualify to receive the federal benefit.
93	176M	3	Ends enrollment opportunities for non-group.
94	176M	3	Ends enrollment in non-group products aside from dependents of current enrollees. Requires nongroup insurers to notify members at least annually of all products and premiums for which they are eligible in the merged market.
95	176M	6	Phase-out proposal for non-group health reinsurance plan
96	176N	1	Defines "emergency services" and "health plan"
97	176N	2	Excludes pregnancy as a pre-existing condition.
98	176N	2	Extends the time an individual can be without coverage from 30 days to 63 days.
99	176N	2	Changes the maximum waiting period on an individual from 6 to 4 months.
100	176N	2	Allows an individual who has been without coverage for 18 months to have no waiting period or pre-existing conditions exclusionary period.
101	176Q		Establishes the Commonwealth Health Insurance Connector Authority (the Connector)
		1	Definitions.
		2	Establishes the Connector as an Authority within the Exec Office of Administration and Finance. Establishes the governance of the Connector with the Secretary of A&F as the director of the 11 member Connector board.
		3	Authorizes actions of the Board including taking actions necessary to offer insurance products to individuals and small businesses, publishing a schedule for premiums at which individuals of varying ages are eligible, establishing a schedule for affordability to be used in enforcing the individual mandate (ch 111M) based upon percentage of income eligible to be spent on health care.
		4	Specifies that the Connector will offer products to eligible individuals and small groups
		5	Establishes the criteria products must meet to receive the Seal of Approval and be offered through the Connector.
		6	Outlines requirements of small businesses who participate in the Connector
		7	Authorizes the Connector to administer Commonwealth Care health insurance program beginning October 1, 2006.
		8	Directs an interagency agreement with the department of revenue for purposes of determining eligibility for commonwealth care.
		9	Allows the GIC to allow employees and contractors into the Connector mechanism.

Bill Section	MGL Chp	MGL Sec	Description
		10	Establishes further criteria for Connector Seal of Approval product specifications
		11	Allows for intermediaries and producers to earn commission on individuals enrolled through the Connector
		12	Connector operations will be financed through surcharge on all Connector health plans
		13	Establishes financial liability of Connector
		14	Reporting requirements for Connector.
		15	Establishes requirements for a study to report on the operations of the Connector
		16	Implementation language
102	Ch 47, Acts of 1997		Extends Fisherman Health Care Demonstration program through 2012.
103	Ch 241 of the Acts of 2004		Repeals Distressed Provider Expendable Trust Fund
104	Acts of 2005	45	Adds language to 4000-0352 item in FY06 budget, regarding MassHealth outreach, to ensure community organizations receive the majority of funds
105			Raises enrollment cap on MassHealth CommonHealth program by 1,600 people
106			Raises enrollment cap on MassHealth HIV+ program by 250 people
107			Raises enrollment cap on MassHealth Essential by 16,000 people, effective July 1, 2006
108			Directs EOHHS to create a 2-year pilot program for smoking cessation benefits for MassHealth enrollees. This program will be funded by the Tobacco Trust Fund.
109			Directs EOHHS to study the creation of selective provider networks
110			Directs DPH to study the role of Community Health Workers, and to develop a sustainable Community Health Worker program
111			Directs EOHHS to seek maximum federal match of State Children's Health Insurance (S-CHIP) funds
112			Directs EOHHS to seek an amendment to the Medicaid 1115 federal wavier, and to seek maximum federal matching funds. Mandates that all negotiations with CMS would necessarily involve members of the House and Senate.
113			Establishes a moratorium on changes to Medicaid behavioral health services, pending a report outlining and justifying proposed changes.
114			Creates a commission to study the merger of the non-group and small-group insurance markets. Report will be filed with legislature by December 2006 with any legislative recommendations which would be useful in implementing the merger.

Bill Section	MGL Chp	MGL Sec	Description
115			Provides for an open enrollment period for purchase of health insurance through the Connector.
116			Authorizes transfer of funds to the Massachusetts Technology Park Corporation for implementation of a computerized physician order entry system initiative.
117			Authorizes transfer of balance in Uncompensated Care Trust Fund to Health Safety Net Trust Fund.
118			Authorizes transfer of funds remaining in Distressed Provider Expendable Trust Fund to the Essential Community Provider Trust Fund.
119			Authorizes funding transfer for partial funding reform implementation.
120			Authorizes transfer of funds from Commonwealth Care Fund to Uncompensated Care Trust Fund in FY07.
121			Authorizes transfer of funds for start-up costs for Commonwealth Health Insurance Connector.
122			Authorized continued payments of supplemental funding to Medicaid Managed Care Organizations operated by Cambridge Health Alliance and Boston Medical Center.
123			Provides exclusive rights to Medicaid Managed Care Organizations that are contracting with the state as of July 1, 2006 to offer plans under the Commonwealth Care subsidized insurance program, provided that they meet certain enrollment targets.
124			Sets out hospital and surcharge payor liability; Uncompensated Care Pool distributions for FY07.
125			Continues a moratorium on changes to Uncompensated Care Pool regulations.
126			Repeals above moratorium on Pool regulations, effective October 2007.
127			Establishes a legislative moratorium on new mandated health benefit legislation until the Division of Health Care Finance and Policy completes a comprehensive review of such benefits or until January 1, 2008, whichever is later.
128			Authorized funding for rate increases of $90 million in each of the fiscal years 2007-2009.
129			Directs Secretary of the Executive Office of Health and Human Services to conduct a study determining the cost of allowing primary care family caregivers to obtain MassHealth benefits.
130			Authorizes transfer of revenues from the University of Massachusetts to the state, related to hospital funding.
131			Authorizes transfer of revenues from the University of Massachusetts to the state, related to hospital funding.
132			Directs EOHHS to develop a plan and timeline for implementing health care reform legislation.
133			Directs the Executive Director of the Connector to submit a plan of operation and recommendations for amendments to Chapter 176Q to the Board of the Connector by August, 2006.
134			Directs the Department of Labor and the Division of Health Care Finance and Policy to report on the implementation and impact of the Fair Share Contribution.

Bill Section	MGL Chp	MGL Sec	Description
135			Allows hospitals to appeal to receive rate increases before meeting quality standards.
136			Requires website with cost and quality information to be operational by July, 2006.
137			Includes provisions governing the length of terms for the initial members of the Public Health Council.
138			Includes provisions governing the terms of the initial members of the Board of the Commonwealth Health Insurance Connector.
139			Allows individuals to enter into the merged insurance market on and after July 1, 2007.
140			Effective Dates
141			Effective Dates
142			Effective Dates
143			Effective Dates
144			Effective Dates
145			Effective Dates
146			Effective Dates
147			Effective Dates

Health Care Reform
Conference Committee Bill

April 3, 2006

Joint Caucus for House Members

HIGHLIGHTS:

- 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
- Promotes cost-effective, high quality care
- Everyone "plays their part": individuals, government, health care providers, employers

Health Care Coverage – Today:

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

Strategies to improve coverage:

- Commonwealth Health Insurance Connector:
  - Reduces administrative burden for small business
  - Makes it easier to find affordable policies
  - Allows more people to buy insurance with pre-tax dollars, reducing price by 25% or more
  - Allows part-time and seasonal employees to combine employer contributions in the Connector
  - Individuals can keep policy, even if job changes

More Strategies to improve coverage

- Market Reforms:
  - Merger of the non-group and small group markets, reducing premiums for individuals by 25%.
  - Prior to merger, state will commission a study of merger in context of the bill'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 past loss of dependency, or until 25, whichever occurs first
  - Industry can develop special products for 19-26 year olds, offered through the Connector

A special note on insurance products:

- The Commonwealth's regulatory framework for health insurance is strongly pro-consumer.
- This bill maintains comprehensive health insurance plans. No changes are made to limits on deductibles, co-payments, or co-insurance.
- New products on the market can take advantage of better value hospitals, doctors, and other providers to create more affordable products.
- The bill gives favorable state tax treatment to Health Savings Accounts – high-deductible plans are currently available, but without this financially advantageous tool.

More Strategies to improve coverage

- Subsidies:
  - Commonwealth Care Health Insurance Program:
    - Sliding-scale subsidies to individuals with incomes below 300% of the Federal Poverty Level (FPL)($48,000 for a family of 3)
    - NO PREMIUMS for people with incomes below 100% FPL ($9,700 for an individual)
    - NO DEDUCTIBLES
  - 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
  - Raise enrollment caps on Essential, CommonHealth, HIV program
  - Restore all benefits cut in 2002- including dental and vision services

Plan meets terms of Medicaid waiver renewal:

- Spending on Medicaid for FY07 and 08 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
- Expect plan to be approved by the federal Centers for Medicare and Medicaid (CMS)

Reforms Uncompensated Care:

- Eliminates current pool as of Oct.1, 2007
- Replaces it with Safety Net Care (SNC) Fund
- Administered by SNC Office, in Medicaid
  - (resources moved from current pool administrator, Division of Health Care Finance and Policy)
- 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 Boston Medical Center and Cambridge Health Alliance as they adjust to change from "Free Care" reimbursements to subsidized insurance premiums
- Medicaid providers receive overdue rate increases over next three years
  - total of $230M for hospitals across the state; $40.4M for physicians
- Move to Safety Net Care standard fee schedule will help community hospitals
- Creates an Essential Community Provider grant program to provide targeted support to safety net hospitals and community health centers

Promotes 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

EVERYONE "plays their part"!

- 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 your 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 equaling 50% of the monthly cost of health insurance for each month without insurance

Why is an Individual Mandate Necessary?

- Every taxpayer pays for uninsured who need emergency care.
  - Requiring those who can afford it to purchase coverage is fair.
- Research has shown voluntary measures aren't enough.
  - Regardless of the price of insurance, some people will hedge their bets and go without.
- No health care reform proposal without an individual mandate has ever been projected to enroll more than half of the uninsured.
- Through a mandate, those who are healthy and currently uninsured will enter the insurance risk pool and help stabilize the cost for everyone.

The Employer Contribution Today

- 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 premium.
- It's time to ask ALL employers to contribute to the cost of providing health care to the uninsured.

The 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 not be subject to the contribution.
- The amount will be pro-rated for temporary or seasonal employees who work for at least 30 days in a year.
- "Mandatory Offer of Section 125 Plan"
  - This provision requires that, as of Jan.1, 2007, all employers with 11 or more workers must adopt a "cafeteria plan" as defined in federal law, which permits workers' purchase of health care with pre-tax dollars. The plan must be filed with the Connector.

Employers "Free Rider"

- 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.
  - Division of Health Care Finance and Policy assesses the surcharge: which "shall be greater than 10%, but no greater than 100% of the cost to the state" of the free care, with the first $50,000 of costs exempted.

Funding

- Plan leverages federal matching $$ to enhance some state spending
- Uncompensated Care $$ redeployed
- Employer contributions
- $125M from the General Fund

Additional Provisions:

- 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.
  - A study to develop 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 Ethic Health Disparities.

Additional Provisions:

- $20M in funding for public health and prevention programs
- $5M for Massachusetts Technology Collaborative's Computerized Physician Order Entry (CPOE) initiative

Additional Provisions:

- Wellness Program participation and smoking cessation can reduce MassHealth premiums for expansion population
- Insurers may offer discounted premiums to non-smokers
- Disability standards for MassHealth not more restrictive than for Social Security