

5 POINT PLAN FOR REAL REFORM OF THE MASSACHUSETTS HEALTH CARE SYSTEM

POINT 2 HEALTH CARE ACCESS & AFFORDABILITY

Developed in cooperation with Health Care for All

Section by Section Summary

Sections 1-4. Create an Office of Health Access and an Assistant Secretary for Health Access within the Executive Office of Health and Human Services. The Assistant Secretary supervises the Office of Medicaid, Division of Health Care Finance and Policy (DHCFP) and the access programs established by the bill.

Section 5. Authorizes MassHealth to cover all adults up to 200% of the federal poverty line, and removes the requirement in current law that only adults who are parents may be covered.

Sections 6-8. Authorize MassHealth to expand eligibility for children up to 300% of the federal poverty level.

Section 9. Directs the Secretary of Executive Office of Health and Human Services to seek a federal waiver to receive maximum federal reimbursements for all programs authorized by the bill.

Section 10. Restores cuts made to MassHealth benefits, such as adult dental care and eyeglasses, and requires MassHealth to cover smoking cessation and all hospital stays. The section also prevents MassHealth from imposing a more restrictive disability standard than that used by the federal government.

Section 11. Restores MassHealth coverage to legal immigrant adults.

Section 12. Repeals the requirement that carriers offering health plans to small businesses provide non-group coverage.

Section 13. Allows individuals to purchase small group insurance

Sections 14 and 15. Repeal the existing small group and nongroup reinsurance programs.

Section 16. Adds a new chapter 118H to the General Laws, titled Health Access and Affordability.

Section 1 of chapter 118H directs the Assistant Secretary for Health Access to certify as qualified all individual and small group health plans that provide reasonably adequate minimum standards of coverage. Only purchasers of qualified plans are eligible for subsidies under other provisions of the chapter.

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Section 2 of chapter 118H creates a sliding-scale subsidy program for workers with incomes between 200% and 400% of the federal poverty level who enroll in a qualified individual/small group plan or employer-provided coverage.

Section 3 of chapter 118H establishes an automatic health insurance assignment process for employees without access to employer-based health coverage. The assistant secretary will assign these employees into qualified health plans. The employees can accept, request a transfer to a different plan, or not participate in the coverage.

Section 4 of chapter 118H establishes a reinsurance program to lower premiums for individuals and small businesses. The reinsurance will cover 90% of medical expenses within the reinsurance corridor.

Section 5 of chapter 118H establishes a health access assessment for each employer subject to unemployment insurance. The assessment is calculated as a percent of payroll, which will be determined by the assistant secretary for health access. The assistant secretary will also set up a low-wage worker deduction to exclude some payroll from the assessment, and other reasonable exclusions.

Employers will receive a credit against their assessment for employee health insurance expenses. The assistant secretary is directed to set the assessment rate and low-wage worker deduction so that small, low-wage firms will not face a substantial burden in paying the assessment. Firms providing health benefits to their employees will not pay any assessment. Assessments paid will go to the Health Access and Affordability Fund.

Sections 17-19. Modify the insurance partnership program by increasing firm size to 75, increasing eligibility up to 250% of the federal poverty level, and increasing payments to participating firms by 50%.

Section 20. Directs the Office of Medicaid to streamline enrollment and participation in the Insurance Partnership program.

Section 21. Revises the method used to set MassHealth provider payment rates. The sections require MassHealth to adopt the Medicare payment systems, starting in fiscal year 2008. Rates are to be increased by the inflation level plus 10% until the Medicare rate levels are reached. Physician payments may reflect more than procedure for a single visit. Rates must also be sufficient to allow providers to cover the cost of providing health care to their employees. An advisory board will oversee and review changes and updates to MassHealth rates.

Section 22. Provides that the Division of Health Care Finance and Policy annually review and report on rates paid to MassHealth providers. It also directs the division to prepare an annual report on the extent to which private insurance coverage prices are higher than they would be otherwise due to inadequate payment by the Commonwealth.

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Section 23. Establishes a Health Quality and Cost Council. The Council will develop goals to lower health care costs and improve quality of care. The recommendations are designed to promote high-quality, safe, effective, timely, efficient, equitable, and patient-centered health care. In addition, the Council will establish an advisory committee with members representing a broad cross-section of the health care industry.

Section 24. Establishes a community health worker outreach program. This program will create an outreach plan that identifies barriers to health care, particularly in ethnic and racial minority communities, and develop strategies to reduce these barriers and improve public health.

Section 25. Amends the Public Health Council statute to make the Council more independent. Appointments will reflect public health, medical education, providers, nurses, physicians, and consumers

Sections 26-28. Replace the Children's and Senior's Health Care Assistance Fund created in 1996 with a new Health Access and Affordability Fund. All revenue to support the current MassHealth waiver and programs created by the bill will be appropriated from the new Fund.

Sections 29-31. Increase the cigarette tax by 50 cents per pack, and direct the revenue to the Health Access and Affordability Fund.

Frequently Asked Questions

Part 1. The Coalition

Who are the members of the Coalition?

The coalition is growing every day. As of December 1, 2004, it has 22 members:

- American Cancer Society
- Boston Center for Independent Living
- Boston Medical Center
- Cambridge Health Alliance
- Coalition for Social Justice
- Families USA
- Health Care For All
- Home and Health Care Association of Massachusetts
- Massachusetts Academy of Family Physicians
- Massachusetts AFL-CIO
- Massachusetts Business Leaders for Quality Health Care
- Massachusetts Council of Community Hospitals
- MIRA Coalition
- Massachusetts Health Council
- Massachusetts Hospital Association
- Massachusetts League of Community Health Centers
- Massachusetts Medical Society
- Neighbor to Neighbor
- SEIU 615
- SEIU 2020
- UMass Memorial Healthcare
- Western Mass Health Access Coalition

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Part 2: The Basic Concept

What are the main goals of the coalition's proposal?

The bill makes substantial improvements in Massachusetts health care in three interrelated areas:

- expanded access to health care coverage
- reduce growth rate in health care costs
- improve quality of health care

The bill builds on the current Massachusetts health care system, and requires minimal disruption of existing arrangements. Passage of the bill would lead to affordable access to quality coverage for most residents of the Commonwealth. It approaches universal coverage, but we do not claim everyone would get covered.

According to the researchers working with the Blue Cross Blue Shield Foundation Roadmap Project, the benefits of covering the uninsured would exceed the cost by a ratio of 3 to 1.

These are our principles:

- MassHealth coverage must expand to cover more low-income people
- Employers have a responsibility to contribute to the health care needs of their employees
- Through intelligent targeting of assistance to small businesses and individuals, government can make health coverage affordable
- Hospitals, doctors and other providers deserve fair payments from the state
- The state can play a key role in coordinating and encouraging quality improvements

The problems of access, quality and cost are interlinked. The uninsured are a factor in the high cost of our system. Lack of quality raises costs, too. High costs contribute to the weakening coverage by the private sector. This bill takes a systemic view of these concerns.

Why cover the uninsured?

The BCBS Roadmap project research by the Urban Institute summarized the economic impact of covering the uninsured:

Expanding coverage to the uninsured in Massachusetts would result in economic and social benefits due to improved health of \$1.2 billion to \$1.7 billion. These benefits are based on estimates of the effect of the lack of health insurance on health, including lower mortality and morbidity and lower wages and productivity.

These estimates of economic and social benefits, i.e., the value of better health, including the higher wages and productivity that the newly insured would experience if fully insured, exceed the incremental cost of expanding coverage by a ratio of about 3:1. The many other

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benefits that would come from universal coverage are difficult to quantify. They include reduced financial uncertainty and depletion of assets such as bankruptcy; improved workplace productivity and higher tax payments; improvement in the quality and availability of personal health services, particularly emergency room care; reduced pressure on the public health system; and lower costs of other public programs such as Medicare and state and federal disability programs.

Others make arguments from *social justice* perspectives.

What is the health impact of being uninsured?

From the Kaiser Foundation's *The Uninsured: A Primer*: "There is a strong relationship between health insurance coverage and access to medical services. Health insurance makes a substantial difference in the amount and kind of health care people are able to afford, as well as where they obtain care. Research has repeatedly shown that the lack of insurance ultimately compromises persons' health because they are less likely to receive preventive care, are more likely to be hospitalized for avoidable health problems, and are more likely to be diagnosed in the late-stages of disease. Having insurance improves health overall and could reduce mortality rates for the uninsured by 10 to 15%."

Part 3: The Problem

How many uninsured people live in Massachusetts?

The best source is the DHCFP survey. They do a comprehensive survey of insurance status every two years. Their latest survey was done in 2004, but only the basic results have been released (the administration has used the detailed results in developing its plan).

Here are the results:

Number of uninsured:	2004	454,000
Previous years' uninsured:	2002	418,000
	2000	365,000
Percent of population uninsured:	2004	7.4% (adults – 10.6%)
	2002	6.7% (adults – 9.2%)
	2000	5.9% (adults – 8.0%)

Another source of data is the Current Population Survey, done by the Census Bureau. This report, which cannot be directly compared to the DHCFP survey, shows 650,000 uninsured.

How fast are health care costs growing?

Health care is becoming increasingly unaffordable for many in Massachusetts. The DHCFP 2003 employer survey found premiums increased by 39% from 2000 to 2003. Employers responded by reducing their contributions (dropped 6% on average from 2001 to 2003). Employee contributions increased on average by 53% from 2001 to 2003, and copayments increased 50%.

Of companies that don't offer coverage, 94% said it was because the premiums were too high.

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What is currently being done by state government to improve health quality?

Massachusetts providers deliver high quality care. Our health plans and providers are generally rated highly. Yet state government has done little to lead the system to pursue innovative quality improvement strategies. The Department of Public Health has several programs, and the Group Insurance Commission and MassHealth are exploring using the reimbursement system to encourage quality. There no coordinated, public, state leadership on health quality and costs. In other parts of the country, (for example, the Pittsburgh Regional Healthcare Initiative) strong leadership has resulted in a healthcare system that is accountable to the public for making quality improvements.

Part 4: The Bill

What is the cost of the bill?

The Blue Cross Roadmap project estimates the incremental cost of covering all the uninsured at between \$374 and \$539 million. Not all of this cost will be borne by taxpayers. A substantial portion of this cost will come from federal funds and employers who do not now cover their workers. We expect this proposal to cover most, but not all, of the uninsured. Covering the uninsured will benefit the economy by some \$1.2 – \$1.7 billion, increasing prosperity and tax receipts. Other provisions, such as reinsurance and rate reform, will cost additional funds. There are substantial savings to Massachusetts businesses and the health care system.

Because of these and other factors, we will not be able to project a total cost for the legislation until the spring of 2005. For example, the state's uninsurance statistics for 2004 have not yet been released. Estimating the cost requires a detailed analysis of the interplay of the various inter-related components of the proposal. The Blue Cross Foundation's Roadmap is performing this level of analysis that will provide the necessary information. Their analysis will be ready by the spring of 2005.

The coalition is committed to paying fully for the initiatives in the legislation with new and identifiable revenues. We do not support expanding health care in ways that crowd out spending for education and other programs.

Provisions of the Bill

Who administers the programs in the bill?

A new Assistant Secretary for Health Access will be responsible for overseeing all of the various access programs set up by this legislation. Additionally, he or she will supervise the Office of Medicaid, the Division of Health Care Finance and Policy (DHCFP).

How does MassHealth expand?

MassHealth will expand to cover all low income adults (19-64) under 200% of the federal poverty line (less than \$38,000 for a family of four). Currently MassHealth covers only parents up to 133% of poverty (up to 200% if employer coverage is available).

MassHealth will also cover all children under 19 years old in households making less than 300% of the federal poverty level (\$56,000 for a family of four).

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The Commonwealth will seek federal matching funds for the newly covered people under MassHealth. A worker with access to employer coverage will be required to enroll in his or her firm's plan. MassHealth will pay part of the employee's premium. This is current law.

MassHealth will also cover services cut in 2002, such as dental care and eyeglasses. MassHealth will also cover smoking cessation programs. Additionally, it will also cover legal immigrants who were cut in 2003.

What is the cost of the MassHealth expansion?

Governor Romney estimates that 106,000 people of the 460,000 uninsured are currently eligible but not enrolled in MassHealth (the DHCFP previously said the number was 70,000). The cost for covering these people is already accounted for in the budget, according to the Governor.

The 2002 DHCFP survey found that 30% of the uninsured were below 200% of the poverty line. Applying this percentage to the 2004 total number of uninsured leads to 138,000 uninsured below 200% fpl. Subtracting the 105,000 already eligible leads to an additional 33,000 people covered by the MassHealth expansion for adults.

Assuming no other changes in coverage, the cost of fully covering this population would be about \$104 million per year. Half of the cost would be reimbursed by the federal government. However, a substantial percentage would be newly eligible for employer-provided coverage, because of the employer responsibility provisions. Additionally, many already-insured people below 200% would join MassHealth. Under the bill, these people would be required to remain in their employers' plan. MassHealth would subsidize only part of the employee's share of the premium, again with 50% federal reimbursement.

Because of the complex interaction of the employer responsibility provisions and the MassHealth expansion, we are not yet able to estimate the total cost to the state of this expansion. We expect the Roadmap analysis to provide much of the cost data.

What support is provided for middle income families and small businesses?

Middle income subsidy: Middle income families (\$25,000 - \$50,000 for a family of 2) will receive subsidies from the state to help them pay for health insurance. The subsidies will be on a sliding scale, phasing out at the top end of the scale.

This prevents assistance from ending abruptly as income rises above the Medicaid level. The cost of this provision depends on the amount of the subsidies, and the number of eligible people. We do not have the data that allows us to estimate a cost for this provision.

Reinsurance: Under the reinsurance program, the Commonwealth will pay part of the catastrophic claims for small businesses and individuals. This program is modeled on the Healthy New York program that has lowered premiums by about 30% in New York. In that program, the state pays 90% of claims between \$5,000 and 75,000. In 2003, New York spent about \$12 million for the reinsurance program that covered around 60,000 people. Enrollment has continued to grow and now exceeds 100,000 people.

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By absorbing the expense of high-cost cases, health plans can lower premiums and pass on the savings to small employers and individuals. The bill gives authority to the Assistant Secretary to set the reinsurance levels. The cost will depend on how the reinsurance program is set up.

Automatic assignment: Companies that do not cover their workers are required to provide demographic information to the state, which then facilitates the enrollment of these workers into a coverage plan. The program is voluntary for the worker, but would make it easier for uninsured workers to get into coverage.

How does the employer responsibility provision work?

Large employers who do not provide health insurance need to be held responsible for their employees' health care. Under the bill, all employers will pay an assessment, set as a percentage of their payroll. There will be a "standard deduction," (in the bill, called the low-wage worker deduction) exempting from the assessment a set amount of payroll for the first few employees. Companies will also be able to take a credit against the assessment for their health care costs. Below is a model for illustrative purposes. However, we must stress that the level of the tax and the exemption is not yet set. The bill allows the administrators to set the levels. The directive in the bill is as follows:

"The assistant secretary shall set the assessment rate and low-wage worker deduction so that small, low-wage firms will not face a substantial burden in paying the assessment, as determined by the assistant secretary. The assessment rate shall be set so that firms providing reasonably substantial health benefits to their employees will not pay any net assessment."

Here's the example, based on round numbers for illustration purposes

The Jones Company has 25 employees. The wage levels vary, but the total payroll is \$750,000 a year (based on an average wage of \$30,000).

For illustration purposes, suppose the "standard deduction" allows employers to deduct the first \$15,000 of payroll for their first 10 workers from the amount subject to assessment. This would let Jones Company deduct \$150,000 (10 x 15,000) from their payroll. Thus their assessment would be based on only \$600,000 of their payroll (750,000 – 150,000).

For illustration purposes, if the assessment rate is set at 5% of payroll, the company would owe 5% of \$600,000, or \$30,000.

But if the company provided health care benefits to 15 of their employees, and spent on average \$3000 per worker, they would receive a credit of \$45,000 (15 x 3000). They would owe nothing, since the credit of \$45,000 is larger than the assessment owed of \$30,000. If they did not cover their workers, they would owe the \$30,000.

Why this model? Unlike the 1988 Universal Coverage bill, which required a set per-worker assessment from most employers, this percent-of-payroll assessment increases as ability to pay increases. Large firms with highly-paid workers would face a

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substantial incentive to provide coverage, while small, low-wage firms would be exempt.

What changes are made to the Insurance Partnership program?

The Insurance Partnership program provides subsidies to low-income workers with employer-based coverage, and helps their employers afford the coverage. The bill simplifies enrollment procedures, and expands the eligibility and benefits. Small businesses with as many as 75 employees (up from 50) can get reimbursed as much as \$1,500 (up from \$1,000) per eligible employee. Eligibility for employees is increased from 200% of poverty to 250% of poverty.

What are the bill's provisions for provider reimbursement reforms?

Currently, MassHealth routinely pays providers far below the cost of care. Depending on the service, payments range from 60% to 80% of cost, or less. This underpayment discourages physicians and other providers from accepting MassHealth patients, and leads to cost-shifting, where providers are forced to raise rates charged to private patients to make up for underpayments from MassHealth.

The bill proposes moving to a system where MassHealth pays providers using the federal government's Medicare fee schedule. In addition to more closely approximating cost (Medicare is still somewhat below cost for many services), using Medicare will reduce the administrative burden on physicians, hospitals and other providers who will not have to use unique codes and billing forms for MassHealth. Instead they will use the Medicare methods which are standard among health care providers.

What is the role of the Quality and Cost Council in the bill?

Under the bill, an independent, 5-person board, chaired by the Governor, will set quality improvement standards as well as the cost reduction goals. Appointments will be made by the Gov, AG, Auditor, Senate President, and Speaker. Persons appointed must be independent of health industry and be chosen for their expertise.

With input from an advisory panel and the public, the board will set annual quality improvement targets. Recommendations for improvements will be issued annually to key stakeholders, the Legislative and Executive Branches, and various state agencies for action and/or enactment. In addition, the board will issue an annual report on how well prior year targets are being met.

What is the Community Health Worker Program in the bill?

The community health worker outreach program will create an outreach plan that identifies barriers to health care, particularly in minority and underserved communities, and develop strategies to reduce these barriers and improve public health.

What changes does the bill make to the Public Health Council?

The Public Health Council exercises oversight authority over DPH. The bill makes the council more independent, by providing for representation of provider and public health interests. Currently, Public Health Council members are all appointees of the governor. The intent is to allow the council to be more independent in its actions related to public health.

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How is the bill funded?

A new Health Access and Affordability Fund will be established, which will support all of the programs established by this legislation. Funds would come from existing funds going to the uninsured, federal matching funds, assessments and premiums, and new state revenues. The bill enacts a tobacco tax increase; however, additional funding may be needed. We are committed to paying for the full cost of the final legislation. The bill will not require cutbacks in education or other programs.

Why increase the cigarette tax?

The cigarette tax is increased by \$0.50 per pack. Our current tax is \$1.51/pack. This puts us 6th highest in the country, behind Rhode Island (\$2.46), New Jersey (\$2.40), Michigan (\$2.00) Montana (\$1.70), Alaska (\$1.60), and tied with Connecticut and a penny ahead of New York (\$1.50). A \$1.50 New York City tax puts the combined tax there at \$3.00/pack; while in Chicago the combined rate is \$2.14 per pack.

Our tax was last raised in 2002, and experts agree it should be increased periodically to keep up with inflation. A 50-cent tax increase would raise over \$100 million (which could be matched by federal Medicaid funds), would lead to 23,000 fewer teen smokers, saving 7,300 kids from premature death. The long-term health savings would be \$400 million.

Polling in Massachusetts and other states has demonstrated that the public strongly supports cigarette tax increases.