RE-FORMING REFORM

What the Patient Protection and Affordable Care Act Means for Massachusetts

Robert W. Seifert and Andrew P. Cohen
Center for Health Law and Economics, University of Massachusetts Medical School

FOUNDATION
BLUE CROSS BLUE SHIELD OF MASSACHUSETTS
EXPANDING ACCESS TO HEALTH CARE

Center for Health Law and Economics
UMASS MEDICAL SCHOOL
A Commonwealth Medicine Center of Distinction

The authors thank their colleagues at the Center for Health Law and Economics for their substantial contributions of research, analysis, and advice: Stephanie Anthony, Margaret Carey, Thomas Friedman, Katharine London, and Jean Sullivan.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In March, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA). This historic legislation, along with the Health Care and Education Reconciliation Act of 2010 signed a few days later, contains the most significant changes to America's health care system since the passage of Medicare and Medicaid. Major elements of the national reform are based on Massachusetts' pioneering health care reform law, Chapter 58 of the Acts of 2006; both have the central goal of ensuring access to affordable health care coverage for nearly all residents.

The PPACA is a complex law and states will play a key role in its implementation over the next several years. Paradoxically, Massachusetts policymakers may have to devote the bulk of their attention to the elements of federal reform that are directly modeled on Massachusetts, taking an active role in harmonizing differences between state and federal provisions and seizing opportunities to preserve and improve on the Chapter 58 reforms. While those reforms centered on expanding coverage, state policymakers are now focused on improving the health care delivery system to promote quality, contain costs, and increase transparency. This policy brief addresses the impact of federal reform on Massachusetts' previous reforms, discusses how the law is financed and its effect on businesses and individuals in the state, and highlights opportunities for further reform to the state's delivery system. It focuses on three broad areas:

- Financial Benefits and Coverage Gains: including large increases in federal financing for Massachusetts public coverage programs; expansions in public coverage to reach more Massachusetts residents; federal insurance subsidies for small businesses and people with low-to-moderate incomes; increased Medicaid primary care payments; additional health insurance protections; and new funding for pilot programs, demonstrations, and grants to test innovative ideas for improving quality and reducing costs.
- Taxes, Assessments, and Payment Adjustments: including taxes on some businesses, high-income earners, and high-cost health plans; reductions in the rate of Medicare payment increases for doctors, hospitals, and other providers; and penalties for some residents without insurance.
- Statutory Differences Requiring Policy Attention: including coverage requirements for individuals, families, and businesses; insurance subsidies for state residents; rules for health insurance exchanges; and insurance market reforms.

FINANCIAL BENEFITS AND COVERAGE GAINS

The PPACA will direct billions of new federal dollars into the Massachusetts health delivery system to expand coverage to new populations. The law also presents many opportunities for investments in pilot programs, demonstration projects, and grants to help the state reach its cost containment and quality of care goals. New insurance rules will further strengthen some aspects of the state's health insurance consumer protection laws.

ENHANCED FEDERAL MATCHING RATES FOR MEDICAID AND CHIP

The new national law includes additional financial assistance through increased federal contributions (matching rates) for spending on Medicaid and the Children's Health Insurance Program (CHIP), the components of MassHealth.

- The federal matching rate for Massachusetts state spending MassHealth childless adults below 133% of the federal poverty level (FPL) will increase progressively, from the 2010 rates of 50%[1] to 90% in 2020, bringing an additional $1.8 billion to the state from 2014 to 2019 and $347 million annually in 2020 and beyond.
- The federal matching rate for Massachusetts state spending on CHIP enrollees will increase from the current rate of 65% to 88% in 2016-2019, bringing an additional $100 million a year to the state over that period.

NEW FEDERAL DOLLARS FOR PREMIUM SUBSIDIES WILL COVER NEW POPULATIONS AND REPLACE EXISTING STATE DOLLARS

More Massachusetts residents will benefit from federal insurance subsidies than are currently eligible for Commonwealth Care (CommCare) and other state coverage programs. New federal premium subsidies for people earning between 133% and 300% FPL will free up state dollars now being used to subsidize CommCare members and will allow more flexible spending under the Massachusetts Medicaid Waiver. New premium subsidies targeted to legal immigrants and residents earning up to 400% FPL will help reduce the number of uninsured people in the state.

- Replacing Commonwealth Care premium subsidies with federal premium tax credits will save Massachusetts an estimated $125 million per year.
- Federal subsidies for people earning between 300% FPL and 400% FPL will expand public coverage options and make insurance more affordable for an estimated 23,000 to 50,000 Massachusetts residents.
- Replacing Commonwealth Care Bridge funds for legal immigrants (this program currently covers a subset of people earning less than 300% FPL) will save Massachusetts an additional $130 million per year. An estimated 32,000 to 58,000 legal immigrants in Massachusetts may qualify for new federal subsidies.

TAX CREDITS FOR SMALL BUSINESSES

Beginning in 2010, an estimated 109,000 small businesses in Massachusetts may be eligible to receive tax credits to help purchase insurance for their employees.

- Businesses with up to 25 low-wage full-time employees (FTEs) will be eligible for premium subsidies, based on number of employees and average wage, up to 35% of the employer contribution until 2013, and up to 50% for two years after 2013.

INCREASED MEDICAID PAYMENTS FOR PRIMARY CARE

Increased Medicaid payments for primary care services (equivalent to or exceeding Medicare Part B rates) will yield an additional $22 million per year for Massachusetts physicians in 2013 and 2014.

STRONGER INSURANCE PROTECTIONS

Although most of the insurance protections introduced by the PPACA already exist in Massachusetts, the PPACA extends some protections to include self-insured plans not under the purview of state regulators.

---

1 The Medicaid matching rate as of June 2010 is 61.6%, temporarily enhanced by federal stimulus spending.

In addition, the minimum loss ratio requirements and prohibitions on lifetime and annual limits will benefit some Massachusetts consumers, particularly within the state's student health insurance market. The PPACA will also improve access to coverage for dependents in Massachusetts, decreasing insurance gaps for some young adults.

NEW FUNDING OPPORTUNITIES FOR PILOT, DEMONSTRATION, AND GRANT PROGRAMS

The PPACA includes more than $22 billion in new funding for more than 100 categories of demonstration projects, pilot programs, and grants that seek to modernize and improve America's health care delivery system. Provisions in the law that are particularly relevant to ongoing efforts in Massachusetts include payment reform; delivery system redesign; care coordination; quality measurement and improvement; wellness and prevention; reduction in racial/ethnic disparities; and workforce development.

TAXES, ASSESSMENTS, AND PAYMENTS ADJUSTMENTS

To extend substantial benefits to the Commonwealth and many of its residents, the federal reform law raises revenue by creating some new taxes and assessments and recalibrating provider payments in selected areas.

NEW TAXES ON SOME BUSINESSES, RESIDENTS, AND HEALTH PLANS

Under the PPACA, some Massachusetts businesses and residents will face new financial obligations.

- Federal penalties for employers that do not offer insurance will be higher than the assessments they face under state law; these penalties will, however, affect only a very small percentage of Massachusetts firms.
- The federal Medicare payroll tax will increase by 0.9 percentage points for individuals who earn over $200,000 and couples who earn over $250,000 a year, starting in 2013. About 4% of Massachusetts tax filers are estimated to be liable for this tax, which will generate an estimated $139 million a year from Massachusetts residents. High-income earners will also face an additional tax on unearned income.
- A federal excise tax on high-cost health plans will be levied beginning in 2018. The tax threshold will be premiums of $10,200 for individuals and $27,500 for families, and will be indexed to inflation in subsequent years. The Commonwealth's high health care costs put its average premium levels among the highest in the country. For this reason, more health plans will likely be at risk for owing the excise tax in the Commonwealth than in other states.

MEDICARE PAYMENT CHANGES

The PPACA adjusts some of the payments that Medicare makes to health care providers.

- Payment rate adjustments to Medicare providers will reduce the rate of growth in Medicare fee-for-service payments, and thus Massachusetts provider revenues may be reduced by as much as $4.5 billion from 2010 to 2020.
- Reductions in Medicare DSH payments may reduce Medicare payments to Massachusetts hospitals by an estimated $494 million from 2010 to 2020.

STATUTORY DIFFERENCES REQUIRING POLICY ATTENTION

Despite major similarities between the PPACA and state health reform in Massachusetts, some details differ significantly. Many have been left up to further regulation, which Massachusetts must take an active role in shaping to maintain the reach and intent of state reforms. Examples include:

COVERAGE REQUIREMENTS AND PENALTIES FOR INDIVIDUALS AND EMPLOYERS

Since the PPACA does not preempt either the Commonwealth's individual insurance mandate or its requirement on larger employers to offer coverage or pay an assessment, some state residents and businesses may face both state and federal penalties unless the State acts to reconcile state law with the new federal provisions.

INSURANCE AFFORDABILITY UNDER INDIVIDUAL MANDATES

Under national health care reform's affordability standards, more low-income people in Massachusetts will be required to obtain insurance or face penalties than under current state law. In 2016 and beyond, uninsured people who earn enough to file a federal tax return but less than 250% FPL will face equal or higher penalties under federal law than they currently do in Massachusetts.

INSURANCE SUBSIDIES FOR INDIVIDUALS AND FAMILIES

While federal insurance subsidies will cover new populations and save state dollars that currently pay for coverage, some people with low-to-moderate incomes may face higher out-of-pocket spending because federal subsidies will be lower than those currently offered through Commonwealth Care. The Commonwealth could choose to spend some of its Medicaid savings to maintain Commonwealth Care subsidies at their current levels.

ROLE OF THE HEALTH CONNECTOR

Although the health insurance exchanges in the PPACA are modeled on Massachusetts' Health Connector, forthcoming federal rules will clarify the Connector's latitude in maintaining its current functions, including setting standards that exceed federally-mandated "minimum essential benefits."

INSURANCE MARKET CHANGES

While some of the new insurance rules introduced under the PPACA are already in effect in Massachusetts or will strengthen existing statutes, new federal modified community rating rules for age differences and tobacco use offer less protection than those in current state law. The Commonwealth will need to ensure that federal reforms set a minimum standard that states may exceed so these new rules do not weaken existing Massachusetts protections.

The process of implementing national reform is just beginning, with many details still to be determined. The Commonwealth's active and thoughtful participation in this effort is crucial, both to maximize the benefits of the new law and to prevent any erosion in the health care structures and laws that Massachusetts has worked so hard to develop. The Commonwealth's leadership in health reform up until now places Massachusetts in a good position to capitalize on the implementation of national reform in the years to come.

INTRODUCTION

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA), historic legislation that makes major changes to America's health care system. The following week, the Health Care and Education Reconciliation Act of 2010 amended parts of the PPACA to reflect points of compromise between the Senate and the House of Representatives. With passage of these two bills, the federal government enacted the most far-reaching health care reform since the passage of Medicare and Medicaid in 1965.

Major elements of the national reform are based on Massachusetts' pioneering health care reform law, Chapter 58 of the Acts of 2006. The PPACA follows the contours of Chapter 58 and earlier Massachusetts reforms, with emphasis on:

- shared financial responsibility for health care coverage among individuals, government, employers, and insurers;
- a mandate on individuals to obtain health insurance;
- public subsidies and expanded Medicaid coverage to help low- and moderate-income individuals and families afford coverage;
- consumer protections in the insurance market, such as guaranteed issue, guaranteed renewability, and prohibition on insurance underwriting based on pre-existing conditions; and
- establishment of health insurance exchanges, like Massachusetts' Health Insurance Connector Authority (Health Connector), where many Americans will shop for insurance.

Despite the similarities between the new federal reforms and Massachusetts' reform, details of structure, operation, and implementation differ significantly in some areas. Many details remain unknown and have been left up to further regulation, which the state should take an active role in shaping to maintain the reach and intent of its reforms. The specific ways the federal legislation departs from the Massachusetts model will have implications and present opportunities, both large and small, for the future of Massachusetts health reform.

All states, including Massachusetts, will benefit from additional financial assistance through increased matching rates, new federal insurance subsidies, and coverage expansions to previously uninsured populations. The law provides for new revenue for the federal government in the form of fees and taxes on businesses in the health care industry and high-income individuals. For providers, there will be increased payments for primary care, slowed growth in Medicare and Medicaid rates, and reductions in Medicaid and Medicare Disproportionate Share Hospital (DSH) payments. States, municipalities, and various health care organizations will have the opportunity to take advantage of some of the numerous demonstration programs, pilot projects, and grants to test innovative ideas for improving quality and containing costs.

This policy brief addresses the impact of federal reform on Massachusetts' previous reforms, discusses how the law is financed and its effect on businesses and individuals in the state, and highlights opportunities for further reform to the state's delivery system. It focuses on the following areas:

SHARED RESPONSIBILITY

- The shared responsibility provisions in the PPACA include an individual mandate, insurance affordability standards, insurance subsidies for families and small businesses, and employer coverage requirements that both reflect Massachusetts reform and depart from it, raising the possibility that differing standards may result in parallel but not identical requirements and consequences.
- The PPACA's financing provisions should transform the state's Section 1115 MassHealth Demonstration Waiver after 2014, but the Waiver will still be needed for Massachusetts to maintain the structure and scope of its safety net health programs.
- Maintenance of effort (MOE) rules under the PPACA require Massachusetts (and other states) to maintain eligibility for programs at the levels that were in place when the PPACA passed, possibly creating financial constraints. States are already under an MOE requirement to qualify for enhanced funding under the federal stimulus law (ARRA), so they must maintain these levels even after enhanced ARRA funding expires.

FINANCING

- Federal financial assistance for implementation will bring billions of new federal dollars to Massachusetts government and small businesses.
- Some of the revenue provisions that help finance federal reform will affect some Massachusetts manufacturers, insurers, and high-income families.

HEALTH INSURANCE EXCHANGE

- New rules for insurance exchanges may affect the structure of the Health Connector; specific details are still to be determined.

INSURANCE MARKET RULES

- New insurance rules may alter the benefits offered in health insurance policies and how they are priced and sold in the Commonwealth.

PROVIDER PAYMENTS

- Provider payment changes will reduce the payments that some Massachusetts medical providers can anticipate in the years to come, particularly in the Medicare program, while increasing Medicaid primary care payments and quality improvement initiatives.

DEMONSTRATION PROJECTS, PILOT PROGRAMS, AND GRANTS

Demonstration projects, pilot programs, and grant opportunities may benefit Massachusetts' health care delivery system and can be tapped to support current efforts, such as reforming the provider payment system and coordinating care for chronically ill populations.

1. SHARED RESPONSIBILITY

As in Massachusetts, federal reform is built around the concept of shared responsibility: continued reliance on the employer-sponsored insurance (ESI) system, with requirements for larger employers either to provide coverage or pay an assessment; an expectation that individuals will provide for their own coverage to the extent they are able; and expansions of government programs and subsidies to help people with low and moderate incomes pay for coverage that otherwise would be unaffordable.

Although the Massachusetts health care system already features each of these elements, the federal legislation contains new rules and details that differ from the state's. Some of these differences may necessitate changes in state law and regulations to harmonize the two systems. Others will raise choices for Massachusetts policy makers about how to shift the state's reform to better complement and comply with the federal law.

CONSUMER RESPONSIBILITY: INDIVIDUAL MANDATE

Beginning in 2014, the PPACA requires everyone in the country, with a few exceptions, to have health insurance. This federal mandate will be enforced using financial penalties levied through the federal income tax system.

MORE LOW-INCOME MASSACHUSETTS RESIDENTS WILL BE REQUIRED TO HAVE INSURANCE, BUT THE FEDERAL MANDATE WILL APPLY TO FEWER HIGHER INCOME PEOPLE

Under both the state and federal mandates, people may be exempted from the individual mandate if affordable insurance is not available to them. Affordability is defined differently in Massachusetts and in the federal law. Massachusetts extends an exemption to everyone who earns less than 150% of the Federal Poverty Level (FPL) and to people for whom the lowest cost plan in a region exceeds the affordability threshold at their income level. In contrast, the PPACA exempts people earning under the federal income tax filing threshold[2] and those for whom the lowest cost plan exceeds 8% of income.

Unless state action reconciles the differing affordability standards, the PPACA will require more Massachusetts residents who earn less than 300% FPL to obtain insurance or face penalties. The affordability standard–the level below which premiums are considered affordable and thus the individual mandate applies–is higher in the PPACA than in Massachusetts for this income range. As demonstrated by table 1, individuals who earn just over $30,000 per year (300% FPL) are exempt from the Massachusetts insurance mandate if their share of premiums totals more than $175 per month, whereas they are only exempt from the federal mandate if premiums total more than 8% of their income, about $217 per month. However, families who earn more than 300% FPL and some individuals who earn above 500% FPL are more likely to owe a Massachusetts penalty than a federal penalty. For example, a family of three earning about 400% FPL will be exempt from the Massachusetts penalty if premiums total more than $586 per month, as compared to the flat affordability threshold of 8% of income (about $490 per month) under the PPACA (see table 1).

2 The income tax filers' threshold is roughly equivalent to 86% FPL for individuals and 79% FPL for a family of three.

TABLE 1: COMPARISON OF INDIVIDUAL MANDATE AFFORDABILITY STANDARDS IN MASSACHUSETTS AND THE PPACA

	MONTHLY PREMIUM ABOVE WHICH INSURANCE IS CONSIDERED UNAFFORDABLE			
	CURRENT MASSACHUSETTS STANDARD (2010)		FEDERAL STANDARD UNDER PPACA (2014, AS IF APPLIED IN 2010)	
ANNUAL INCOME (FPL)	INDIVIDUAL	FAMILY OF 3	INDIVIDUAL	FAMILY OF 3
Up to single tax filing threshold ($9,350)	$0	$0	$0	
Up to joint tax filing threshold ($18,700)	$0	$0		$0
100 - 133%	$0	$0	$72-96	$122-162
133.1 - 150%	$0	$0	$96-108	$162-183
150.1 - 200%	$39	$78	$108-144	$183-244
200.1 - 250%	$77	$154	$144-181	$244-305
250.1 - 300%	$116	$232	$181-217	$305-366
300.1 - 360%	$175		$217-260	
300.1 - 398%		$373		$366-486
360.1 - 408%	$235		$260-295	
398.1 - 511%		$586		$486-624
408.1 - 504%	$354		$295-364	
511.1 - 625%	Affordable	$849		$624-763
Above 625%	Affordable	Affordable	8% of income	

The state standard would consider more people at these income levels to have affordable coverage available, relative to the federal standard.

Included in another range.

UNINSURED RESIDENTS MAY FACE BOTH STATE AND NATIONAL PENALTIES

Since 2007, Massachusetts adults have been subject to an individual insurance mandate under the state's health care reform law.[3] Since the new federal insurance mandate has somewhat different provisions and does not preempt the state mandate, state action would be required to prevent uninsured Massachusetts residents from facing both state and federal penalties.

When the federal penalties take full effect in 2016 and beyond (penalties phase in at lower levels in 2014 and 2015), uninsured people who earn less than 250% of the Federal Poverty Level (FPL) will face equal or higher penalties under the PPACA than they currently do in Massachusetts. For example, an individual who is uninsured for an entire year and earns just under 200% FPL (nearly $22,000 per year) will owe a projected Massachusetts penalty of about $310 and a federal penalty of $695 (see table 2).

In contrast, some uninsured people with moderate incomes (and who have affordable coverage available to them) will face lower penalties under the federal mandate than under the state's mandate. For instance, an individual who is uninsured for an entire year, is older than age 26, and earns more than 300% FPL (about $32,500) will owe a projected penalty of $1,530 in Massachusetts compared with $695 for the federal penalty (see table 2). Less than 3 percent of the Massachusetts population with incomes over 300% FPL reported

3 The Massachusetts Department of Revenue collected $16.4 million in penalties from 44,935 people – less than 1% of the state's population – who were uninsured for all or part of 2008. Individual mandate: 2008 Preliminary Data Analysis, Massachusetts Division of Insurance, December 2009.

being uninsured in 2009.[4] Also notable is that the federal mandate includes half the adult penalty for uninsured children under age 18, whereas the Massachusetts mandate exempts children altogether.

TABLE 2: INDIVIDUAL MANDATE PENALTIES, MASSACHUSETTS COMPARED TO THE PPACA (FOR INDIVIDUALS WHO ARE UNINSURED FOR AN ENTIRE YEAR)

ANNUAL INCOME (% OF FEDERAL POVERTY LEVEL)	ANNUAL INCOME FOR AN INDIVIDUAL ($) (2016 PROJECTION)*		PENALTY IN MA (PROJECTED FOR 2016)†	PPACA PENALTIES (2016)	
	BOTTOM	TOP		BOTTOM	TOP
0 – tax filer's threshold	$0	$10,700	$0	$0	$0
Tax filer's threshold - 133%	$10,701	$16,450	$0	$695	$695
133.1 - 150%	$16,451	$18,550	$0	$695	$695
150.1 - 200%	$18,551	$24,750	$310	$695	$695
200.1 - 250%	$24,751	$30,900	$630	$695	$695
250.1 - 300%	$30,901	$37,100	$950	$695	$695
Above 300% FPL (age 18-26)	>$37,100	n/a	$1,090	$695	$695+
Above 300% FPL (age 27 and above)	>$37,100	n/a	$1,530	$695	$695+

Note: Example penalties are for individuals, not families.
Individual mandate penalties under the PPACA are the greater of $695 (half for children up to 18), up to 3 times that amount for a family; or 2.5% of taxable household income in excess of the income tax filing threshold.
* 2016 tax filing threshold and poverty levels use 2010 figures inflated by the US Consumer Price Index for Urban Consumers (CPI-U) (The Puget Sound Economic Forecaster, prepared by Conway Pedersen Economics, Inc., updated 4-21-10: http://www.seattle.gov/financedepartment/cpi/forecast.htm).
† 2016 Massachusetts penalties estimated using the projected increase in per capita national health expenditures (CMS Office of the Actuary, National Health Expenditure Projections 2004-2019, Table 1: National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2004-2019. http://www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf, accessed May 27, 2010.). Historically, Massachusetts premium prices have grown faster than national per capita health expenditures; if this trend continues, actual penalties in 2016 may be higher than shown.
+ Penalty amount is the greater of $695 or .025 x the amount that exceeds the tax filer's threshold.

MASSACHUSETTS' MINIMUM CREDITABLE COVERAGE STANDARDS WILL CONTINUE TO ENSURE COMPREHENSIVE COVERAGE

All adult residents of Massachusetts are required to have insurance that meets comprehensive Minimum Creditable Coverage (MCC) standards set by the Board of Directors of the Health Connector. Insurance products that do not conform to MCC are not allowed to be sold through the Connector; furthermore, individuals enrolled in insurance plans that do not meet MCC standards are not considered insured for purposes of the state mandate.

In contrast, the federal law requires only individual and small group policies issued through state exchanges to offer a comprehensive set of "essential benefits," including coverage for preventive care, ambulatory and emergency services, mental health services, maternity care, prescription drugs, and other services. Unlike the Massachusetts MCC standards, compliance with the federal individual mandate is determined by a

4 Sharon Long et al. Health Insurance Coverage and Access to Care in Massachusetts: Detailed Tabulations Based on the 2009 Massachusetts Health Insurance Survey. Division of Health Care Finance and Policy, November 2009.

separate standard of "minimum essential coverage," which considers virtually any public, individual, or employer-sponsored coverage acceptable for this purpose. There may be instances where an insured individual in Massachusetts has coverage that complies with the federal mandate but does not meet Massachusetts MCC standards. How such situations are resolved will depend on federal regulations, yet to be issued, and possibly require state action to reconcile the rules.

SPOTLIGHT: INDIVIDUAL MANDATE

ISSUE	IMPACT ON MASSACHUSETTS
Exemption for premium affordability	Under the PPACA, more people who earn less than 300% FPL will be required to obtain insurance or face penalties.
Requirement to purchase insurance coverage	The federal mandate to purchase insurance does not preempt the Massachusetts mandate; without legislative action individuals will be subject to both.
Penalties for not having insurance coverage	In 2016 and beyond, individual mandate penalties under the PPACA will be greater than those under the state mandate for people earning less than 250% FPL. State penalties for remaining uninsured will be higher than the federal penalties for some moderate-income people.
Minimum insurance standards	State MCC standards promote comprehensive coverage; new policies that meet federal but not state standards could challenge MCC.

GOVERNMENT RESPONSIBILITY: MEDICAID EXPANSION, INSURANCE SUBSIDIES, AND THE MASSHEALTH WAIVER

The PPACA balances the requirement for individuals to maintain health insurance with a commitment by the government to make coverage available and affordable for low- and moderate-income people who otherwise could not afford it. The government will offer assistance through a Medicaid expansion and introduction of health insurance subsidies for individuals earning up to 400% FPL ($43,320 for an individual and $88,200 for a family of four in 2010). The federal government will assume most of the fiscal responsibility for these coverage expansions. In Massachusetts, federal dollars will replace some existing state subsidies.

This approach largely parallels the system Massachusetts established under its 2006 health care reform law. Chapter 58 extended coverage through the new Commonwealth Care program to all adults (ages 19 and older) who earned up to 300% FPL, were not eligible for MassHealth or employer-sponsored coverage, and met other eligibility criteria. The reform also included coverage expansions under MassHealth, such as an extension of CHIP up to 300% FPL and several smaller expansions of eligibility under the Medicaid program (MassHealth includes both Medicaid and CHIP). Today, most people in Massachusetts with incomes up to 300% FPL have access to coverage, through either an employer or a public program.

Federal funds, matched by state dollars, were critical to the state's ability to move forward with its 2006 health reform law. Massachusetts' Section 1115 Medicaid Demonstration Waiver provided the financial underpinning for the insurance coverage expansions.[5] The Waiver operates through an agreement with the federal

5 Massachusetts' 1115 Waiver, as renegotiated in 2005, required the state to redirect money that it had used to pay for uncompensated care into new subsidies for private health insurance, paving the way for the creation of Commonwealth Care under Chapter 58. The Waiver, which has been in place since 1997, is an agreement between the State's Executive Office of Health and Human Services (EOHHS) and the federal Centers for Medicare and Medicaid Services (CMS) that waives certain federal rules that govern the way Massachusetts operates its Medicaid program.

government and typically is extended every three years. The next extension will begin in July 2011 and go through June 2014 (state fiscal years 2012-14), so major changes in response to the PPACA are unlikely in that iteration (with one possible exception, as explained below). Beyond 2014, implementation of national reform is likely to transform the Waiver, but even in the era of national reform, Massachusetts will still need many elements of its Waiver to maintain the character and reach of the MassHealth program.

HOW NATIONAL REFORM AFFECTS THE MASSHEALTH WAIVER

The MassHealth Waiver is a comprehensive approach to coverage expansion, program innovation, and financing. While several PPACA provisions appear to lessen the need for the Waiver, it still contains essential components of the Massachusetts system of public coverage. For example, the Waiver provides the authority to require MassHealth members to enroll in managed care plans, and to offer streamlined eligibility criteria. The Waiver also authorizes innovative programs such as CommonHealth and Diversionary Behavioral Health Services, and expanded eligibility for pregnant women, people with HIV/AIDS, and women with breast or cervical cancer. In addition, the Waiver is an important source of federal funds, not only for benefit payments, but also for support to state and safety net hospitals, and to providers and low-income patients who need assistance with hospital bills through the Health Safety Net. Massachusetts will continue to rely on its MassHealth waiver to maintain the structure of its safety net health programs.

The PPACA changes Medicaid eligibility rules and introduces federal subsidies that will have direct implications for the MassHealth Waiver. While many details will remain uncertain until the federal government issues regulations and guidance in the coming months, some general observations are now possible.

MEDICAID: CHANGES WILL NOT AFFECT PROGRAM ELIGIBILITY, BUT WILL AFFECT OTHER ASPECTS OF THE WAIVER

The PPACA extends eligibility for Medicaid up to 133% FPL for all non-Medicare eligible parents, children, and childless adults under 65, which considerably broadens the program's reach in most states. Since Massachusetts already covers this entire population in either MassHealth or Commonwealth Care, eligibility for coverage will not be affected.

The Medicaid expansions will affect how the MassHealth Waiver is used to provide coverage for low-income residents, however. Commonwealth Care members earning below 133% FPL will become eligible for coverage under regular Medicaid rules (known as the Medicaid State Plan), rather than as a group whose eligibility is granted under the Waiver agreement (an "expansion population"). Similarly, many of the childless adults now enrolled in MassHealth Basic and MassHealth Essential will be covered under the State Plan, whereas now they are considered expansion populations. Medicaid and Commonwealth Care coverage is very similar for this population.

The transition of these low-income groups has important financial implications for Massachusetts. First, the state will receive enhanced federal match for this group beginning in 2014 (see section 2). In addition, reclassifying spending for these groups as "without-waiver" increases the budget neutrality cushion in the Waiver by reducing spending on expansion populations. This change will strengthen the likelihood that the

Waiver's current scope can be maintained and possibly fund improvements in the future.[6] The PPACA allows states to expand eligibility for Medicaid up to 133% FPL prior to 2014 (albeit without enhanced match); Massachusetts may want to exercise this option as part of the FY2012 Waiver extension to take advantage of the budget neutrality benefit.

FEDERAL INSURANCE SUBSIDIES WILL BRING FINANCIAL BENEFITS AND COVERAGE EXPANSIONS; STATE ACTION MAY BE REQUIRED TO MAINTAIN HIGHER COMMCARE SUBSIDY LEVELS

Beginning in 2014, the federal government will offer premium tax credits and cost-sharing tax credits to help individuals and families afford health insurance coverage. People who earn between 133% and 400% FPL will be eligible for assistance.

Currently in Massachusetts, eligibility for Commonwealth Care ends at 300% FPL; an estimated 23,000 to 50,000 state residents who earn between 300% and 400% FPL may become newly eligible for insurance subsidies.[7] Some of these people now are uninsured or may purchase expensive—often unaffordable (under the state's definition of affordability)—insurance in the individual market. The PPACA also allows legal immigrants to qualify for federal insurance subsidies but retains the prohibition on Medicaid eligibility for those who have been in the U.S. for less than five years. Between 32,000 and 58,000 legal immigrants in Massachusetts may qualify for new federal subsidies.[8] Massachusetts now uses state-only dollars ($40 million for most of state fiscal year 2010) to subsidize coverage for a group of legal immigrants through the Commonwealth Care Bridge Program, which has more limited benefits than regular Commonwealth Care. Federal funds will now be available for this group.

The federal tax credits for insurance will replace the combined federal/state subsidies under Commonwealth Care for people earning more than 133% FPL. This displacement of the state's share of the subsidy for this population will save Massachusetts an estimated $125 million per year in current dollars[9] and create additional spending flexibility under the State's MassHealth Waivers. The federal premium credits will be lower than current Commonwealth Care subsidies, however, meaning that low-income people will likely owe a larger share of income toward their premiums unless state subsidies continue at some level. The credits will be tied to the second-lowest cost "silver" plan (one of the standard benefit packages to be offered through the exchange; (see section 3), with an actuarial value of 70%.[10] The federal government will also offer cost-sharing tax credits to individuals who earn less than 250% FPL, which will, in effect, raise the actuarial value of these plans. Even with the cost-sharing subsidies, federal subsidy levels will require greater contributions

6 For CMS to approve a waiver, it must meet the criterion of "budget neutrality," i.e. the federal share of Medicaid spending under a waiver may not exceed what Medicaid spending would have been absent the waiver.

7 The lower bound estimate is the number of uninsured people with income between 300% and 399% FPL from the Massachusetts Health Insurance Survey ("Health Insurance Coverage and Access to Care in Massachusetts: Detailed Tabulations Based on the 2009 Massachusetts Health Insurance Survey," Mass. Division of Healthcare Finance and Policy, November 2009). The upper bound is the number of uninsured plus the number reporting having non-group coverage.

8 Authors' estimates based on data from the 2008 American Community Survey.

9 MassHealth estimate.

10 For health insurance, actuarial value is the total value of a health plan's benefits based on the amount of out-of-pocket costs an individual will face when seeking care. For instance, a plan with an actuarial value of 70% could have 30% co-insurance, where the plan pays for 70% of every service and the individual owes 30% of the costs. Insurers can vary plan design to reach a specific actuarial value by including co-payments, deductibles, and other cost-sharing mechanisms, as well as co-insurance.

from people under 300% FPL than currently under Commonwealth Care. For instance, an individual in Commonwealth Care who earns between 201% and 250% FPL currently pays about $1,933 per year in premiums and out-of-pocket costs; the same individual would owe an estimated $2,210 per year in premiums and out-of-pocket costs under federally subsidized coverage (see table 3).

TABLE 3: POTENTIAL ENROLLEE COST EXPOSURE: NATIONAL REFORM VERSUS CURRENT MASSACHUSETTS PROGRAM (INDIVIDUAL COVERAGE, 2010 DOLLARS)

		NATIONAL REFORM	MASSACHUSETTS[1]
	PERCENTAGE SHARE	**ESTIMATE AT MIDPOINT OF INCOME RANGE**	**ESTIMATE AT MIDPOINT OF INCOME RANGE**
0-133% FPL			
Average Annual Premium Contribution	2% of income	$144	$17
Average Annual Out-of-Pocket (OOP) Costs[2]	0-6% of OOP cost	$25	$97
Average Annual Spend		$169	$114
134 - 150% FPL			
Average Annual Premium Contribution	3-4% of income	$525	$70
Average Annual OOP Costs[2]	6% of OOP cost	$102	$225
Average Annual Spend		$626	$295
151 - 200% FPL			
Average Annual Premium Contribution	4-6.3% of income	$979	$605
Average Annual OOP Costs[2]	13% of OOP cost	$220	$450
Average Annual Spend		$1,199	$1,056
201 - 250% FPL			
Average Annual Premium Contribution	6.3-8.05% of income	$1,753	$1,145
Average Annual OOP Costs[2]	27% of OOP cost	$457	$788
Average Annual Spend		$2,210	$1,933
251 - 300% FPL			
Average Annual Premium Contribution	8.05-9.5% of income	$2,620	$1,731
Average Annual OOP Costs[2]	30% of OOP cost	$508	$788
Average Annual Spend		$3,127	$2,519
301 - 399% FPL			
Average Annual Premium Contribution	9.5% of income	$3,603	No subsidized coverage
Average Annual OOP Costs[2]	30% of OOP cost	$508	No subsidized coverage
Average Annual Spend		$4,111	No subsidized coverage

Note: Chart assumes categorical or financial ineligibility for Medicaid.

Denotes lower cost.

1. Premium contributions are based on individual premiums for BMC HealthNet, the most popular Commonwealth Care plan.

2. OOP costs are averages for individual coverage based on the projected value of the Commonwealth Care Plan (1, 2A, 2B, 3A) associated with the specific income level, and projected average medical spending (from 2010 Towers Watson Healthcare Cost Survey).

Subsidies for people who earn between 250% and 400% FPL will require them to pay between 8.05% and 9.5% of their income. These people technically will be exempt from the federal mandate because they will need to spend more than 8 percent of their income for insurance premiums, which is the federal affordability standard.

The State might choose to spend some of its Medicaid and CHIP savings to maintain Commonwealth Care subsidies at their current level. Specifics of how much of the $125 million savings such a "wrap" would cost (as well as consideration of including the group from 300-400% FPL in the wrap), exactly how it would be done, and whether federal match would be available, will depend upon discussions with and formal guidance from federal officials and may require action by the state legislature.[11]

TABLE 4: NEW FEDERAL RULES AND SUBSIDIES WILL CHANGE MASSACHUSETTS' COMMONWEALTH CARE PROGRAM AND BRING MORE FEDERAL MONEY INTO THE STATE

INCOME LEVEL	NEW RULES CAUSING THE CHANGES	IMPLICATIONS FOR THE STATE	AMOUNT OF FEDERAL $ COMING TO MASSACHUSETTS	IMPLICATIONS FOR PEOPLE IN THIS CATEGORY
<133% FPL Childless adults	This group shifts from Commonwealth Care (Waiver category) into Medicaid (non-Waiver).	State receives enhanced FMAP for coverage of this population beginning in 2014.	$2 billion in new federal funds between 2014 and 2019.	Improved benefits
133%-300% FPL	People in this income range currently have Commonwealth Care and will receive new federal subsidies, in the form of premium and cost-sharing credits.	Federal government pays 100% of subsidies for this population, freeing up state dollars, though federal subsidy is less generous for enrollees.	$125 million new federal funds per year.	Potential increase in out-of-pocket costs, unless state contributes to maintain current subsidy levels.
300%-400% FPL	People who are currently unsubsidized will receive premium subsidies from the federal government.	Many people in this income range for whom insurance is now unattainable will be able to afford it.	$600 per individual, $4,000 per family of 4.*	Fewer uninsured.
Legal immigrants up to 400% FPL	Legal immigrants are eligible for federal subsidies.	Federal subsidies will support current Commonwealth Care Bridge enrollees and others not currently eligible for the program.	$130 million per year.†	Fewer uninsured.

Estimates from the Massachusetts Executive Office of Health and Human Services, 2010, unless otherwise noted.
* Kaiser Family Foundation, Health Reform Subsidy Calculator (http://healthreform.kff.org/SubsidyCalculator.aspx, accessed May 28, 2010). Estimates based on 40-year-old policyholder at 350% FPL using "higher cost area" premium.
† Estimate is for group up to 300% FPL only.

SMALL EMPLOYER TAX CREDITS WILL HELP BUSINESSES PURCHASE COVERAGE

Beginning in the 2010 tax year, the PPACA extends tax credits to small businesses to help them purchase health insurance for their employees. These subsidies will be available to small businesses with 25 or fewer full time-equivalent (FTE) employees with average wages per employee below $50,000 per year. Businesses with 10 or fewer FTEs and annual average wages of $25,000 or less will be eligible for full tax credits.

11 The degree to which Congress intended to preempt the authority of state or local governments to further regulate or subsidize the individual mandate is not clear. If no preemption is intended, no federal approval of any additional state-funded assistance to individuals in meeting their mandate would be required. However, Massachusetts would presumably want to receive federal reimbursement to the extent allowable on any such assistance, which would likely require federal approval.

Sole proprietors are not eligible to receive small business tax credits, though they will be eligible for the individual premium subsidies beginning in 2014. From 2010 to 2013, small businesses with 11 to 25 FTEs will be eligible for premium credits of up to 35% of the employer's contribution. In 2014 and beyond, small businesses will be eligible to receive the tax credits for only two years, but the maximum credits will rise to 50% of employers' premium contributions. An estimated 109,000 small businesses in Massachusetts may be eligible to receive these new tax credits.[12]

TABLE 5: SMALL BUSINESS TAX CREDITS IN THE PPACA

	PHASE I	PHASE II
YEARS	2010-2013	2014 and beyond
LENGTH OF AVAILABILITY FOR BUSINESS	4 Years	2 years
ELIGIBLE EMPLOYERS	25 or fewer employees (excluding sole proprietors) and average annual wages less than $50,000 per year.	25 or fewer employees (excluding sole proprietors) and average annual wages less than $50,000 per year. Must purchase insurance through the Exchange.
BENEFIT	Up to 35% (25% for tax-exempt businesses) of an employer's contribution towards employees' insurance premiums. Businesses with 10 or fewer employees and average annual wages less than $25,000 per year will be eligible for the full credit, which phases out as firm size and average wage increases.	Up to 50% (35% for tax-exempt businesses) of employers' contributions towards employees' insurance premiums. Businesses with 10 or fewer employees and average annual wages less than $25,000 per year will be eligible for the full credit.

MAINTENANCE OF EFFORT REQUIREMENTS

Federal health care reform initiates new maintenance of effort (MOE) requirements for state Medicaid programs and CHIP. These new requirements take effect immediately and extend the previous MOE requirements for Medicaid that had been in effect under the American Reinvestment and Recovery Act (ARRA).

Maintenance of effort requires Massachusetts to maintain funding and eligibility levels for MassHealth and Commonwealth Care and prevent increases in premiums and enrollment fees in these programs. States still have latitude to adjust some benefits and provider rates. Cuts enacted but not yet part of a state's Medicaid or CHIP plan cannot be implemented, although states are allowed to expand programs or implement more generous enrollment practices at any time. States that violate the MOE requirements can lose all of the federal matching funds that support their state programs.

The PPACA requires MOE for adults in Medicaid until a state exchange is fully operational (by 2014). The law requires MOE for children in Medicaid and CHIP through September 10, 2019. States that experience or anticipate a budget crisis during 2011 to 2013 can apply to be excused from certain MOE requirements.

12 CHLE estimate based on data from the U.S. Small Business Administration, Office of Advocacy.

MOE requirements limit states' authority to manage their Medicaid and CHIP programs. Since states are currently under an MOE requirement for ARRA (for which the enhanced FMAP expires in 2011), the new MOE requirements will extend the timeframe during which states have limited authority to 2014.

Massachusetts could potentially waive some of the new MOE requirements for adults after ARRA sunsets, because the PPACA would allow the HHS Secretary to presume the Health Connector to be an exchange prior to 2014. Additionally, the MOE exception for a budget crisis may provide Massachusetts with some leeway if the state continues to experience such fiscal problems that it needs to change eligibility or premium levels before then.

SPOTLIGHT: GOVERNMENT RESPONSIBILITY

ISSUE	IMPACT ON MASSACHUSETTS
Medicaid expansion and Massachusetts programs	The federal Medicaid expansion will not affect eligibility for public programs in Massachusetts, but will shift some people currently covered under the Waiver into the State Plan.
Federal insurance subsidies and the state's role	Federal tax credits will offset about $125 million in state funds that currently pay for Commonwealth Care coverage for individuals earning more than 133% FPL. Massachusetts could consider using the state dollars that are replaced by the federal subsidies to wrap around the new plans and maintain the same level of assistance for Commonwealth Care enrollees.
Insurance subsidies for newly eligible populations	Approximately 23,000-50,000 state residents who earn between 300 and 400% FPL will become eligible for insurance subsidies. Approximately 32,000-58,000 legal immigrants in Massachusetts with incomes up to 400% FPL may qualify for new federal subsidies. Some of these people are currently covered under the Commonwealth Care Bridge Program.
Small business tax credits	An estimated 109,000 small businesses in Massachusetts may be eligible to receive these new tax credits.
Maintaining the Waiver	Massachusetts will continue to rely on its MassHealth Waiver to maintain the structure of its safety net health programs.
Maintaining coverage and eligibility levels	Since Massachusetts is currently under an MOE requirement under ARRA, the PPACA extends the timeframe during which the state has limited flexibility to change eligibility or premium levels. Some benefits may still be adjusted.

EMPLOYER RESPONSIBILITY

As in Massachusetts, the federal reform law presumes that most people will continue to obtain health insurance through employment, through either their own or a spouse's or parent's job. To encourage employers to continue to provide employer-sponsored insurance (ESI), the PPACA requires businesses above a certain size to offer coverage that meets minimum standards or pay a penalty. Key differences with Massachusetts' employer requirements will oblige policy makers to ensure the state system is consistent with new the federal rules.

The Massachusetts insurance mandate applies to individuals, so businesses are not required to provide coverage that conforms to minimum coverage standards. Individuals who buy ESI that does not meet the state's minimum creditable coverage (MCC) requirements still face individual mandate penalties, however. Anyone

who has an offer of ESI, regardless of whether it meets MCC or is affordable, is not eligible for insurance premium subsidies in Commonwealth Care.

In contrast, the federal law allows employees to be eligible for premium and cost sharing tax credits—even if the employee has an offer of ESI—if an employer-sponsored plan has an actuarial value of less than 60%, or if the employee's share of the premium is more than 9.5% of the employee's income. The PPACA will impose assessments both on businesses with more than 50 employees that do not offer coverage and on those that do offer insurance but still have employees who receive premium tax credits.

Employers are required to offer "free choice vouchers" to their employees who earn less than 400% FPL and whose share of insurance premiums is between 8% and 9.8% of income. The employee can use a voucher—which is equal to the amount that the employer would have paid for ESI coverage—to buy a plan in the state exchange. Employers that provide Free Choice Vouchers will not be subject to penalties, and individuals who receive them will not be eligible to receive insurance tax credits.[13]

HIGHER FEDERAL PENALTIES, BUT MORE FIRMS WILL BE EXEMPT

The federal law exempts small employers with 50 or fewer employees from the employer penalty. In 2009, 98% of Massachusetts businesses with 51 or more employees offered coverage.[14] The Massachusetts employer assessment applies to businesses with 11 or more full-time equivalent (FTE) employees. Just 824 businesses were liable for state assessments in 2008, of which only 116 employed more than 50 FTEs.[15] Assessments are higher in the PPACA than they are in the Massachusetts law. The federal rules also depart from Massachusetts rules in that employers offering insurance may still be penalized if their employees are receiving public subsidies.

Since the federal requirements do not replace the existing state requirements, some businesses will likely owe both a state and a federal penalty unless the state legislature amends existing Massachusetts law.

13 The amount of these vouchers is deductible by the employer and will not be considered as income for the employee. If the cost of the exchange plan is less than the amount of the voucher, then the employee can keep the remainder of the premium as additional income.

14 Results from the 2009 Massachusetts Employer Survey. The Massachusetts Division of Health Care Finance and Policy, January 2010.

15 Division of Health Care Finance and Policy. Data as of May 27, 2010.

TABLE 6: COMPARISON OF EMPLOYER RESPONSIBILITY REQUIREMENTS

ISSUE	MA EMPLOYER REQUIREMENTS	PPACA EMPLOYER REQUIREMENTS
EMPLOYER RESPONSIBILITY	Small businesses with at least 11 FTEs are subject to employer responsibility requirements.	Small businesses with at least 50 employees are subject to employer responsibility requirements.
PENALTIES	$295 per employee for employers that do not meet the "fair and reasonable contribution": • At least 25% of full-time employees are enrolled in the health insurance plan, and the employer makes a financial contribution to the plan. • The employer pays at least 33% of the premium cost for the employees' health insurance plan. Businesses with 50 or fewer FTEs must meet at least one of the two criteria; businesses with 51+ FTEs must meet both.	Two assessments: For employers that offer coverage but have workers who cannot afford the employee share (premiums cost more than 9.5% of income) and who receive a public subsidy: • $3,000 per employee per year receiving the subsidy or $2,000 multiplied by the total number of employees in the firm, whichever is less. For employers that do not offer coverage: • $2,000 per FTE, disregarding the first 30 employees.
NUMBER OF FIRMS CURRENTLY SUBJECT TO REQUIREMENTS	2008: among 23,128 firms with 11+ employees, 824 were liable for assessment, 96.7% met criteria. Penalty raised $7.1m.* Since 2008, the criteria have been tightened; In 2008, the rules that applied to businesses with fewer than 50 employees have applied to all businesses regardless of size.	2% of Massachusetts businesses with 51 or more employees do not currently offer coverage.

* Division of Health Care Finance and Policy, May 2010.

SPOTLIGHT: EMPLOYER RESPONSIBILITY

ISSUE	IMPACT ON MASSACHUSETTS
Requirement to offer coverage	New federal requirement does not preempt current state law. Unless the state legislature amends current law, some businesses may face both a state and federal penalty for not offering coverage.
Penalties	Penalties are higher in the federal legislation, but will apply to a smaller set of businesses than the state's employer requirement.

2. FINANCING

Federal health care reform will bring billions of dollars to Massachusetts through insurance subsidies for families and businesses and an increase in the state's Medicaid matching rate for some expansion populations. From a state budget perspective, Massachusetts will benefit financially from federal reform because the insurance subsidies will supplant state funds that currently subsidize coverage for Commonwealth Care and Commonwealth Care Bridge enrollees. Also, the increase in the federal matching rate for Medicaid will allow fewer state dollars to cover the same number of people. The PPACA also contains several revenue provisions that will levy new taxes and fees on some Massachusetts residents and businesses.

FEDERAL MATCH: INCREASED FEDERAL FUNDING FOR COVERAGE OF LOW-INCOME POPULATIONS

The federal government will support states' expansion of their Medicaid programs by providing enhanced federal matching funds for newly eligible populations. Some states, including Massachusetts, already have expanded coverage to groups such as childless adults and to traditional Medicaid populations at higher income levels. Under its MassHealth Waiver, Massachusetts offers subsidized insurance coverage to people who earn up to 300% FPL through MassHealth or Commonwealth Care. The federal legislation allows Massachusetts and other "expansion states" to receive an increased federal match beginning in 2014 to help fund coverage for eligible populations, in particular childless adults who earn 133% FPL or less. In 2020 and beyond, Massachusetts will receive a 90% match for this lowest income group of childless adults (see table 7). The enhanced FMAP will yield $1.8 billion for 2014-2019 and $347 million per year in 2020 and beyond.[16]

The federal government will provide a 23 percentage point increase in the CHIP matching rate from federal fiscal year 2016 (beginning October 1, 2015) to 2019, which will bring an additional $100 million of federal funds into Massachusetts each year.

TABLE 7: FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) INCREASES FOR MASSACHUSETTS UNDER THE PPACA

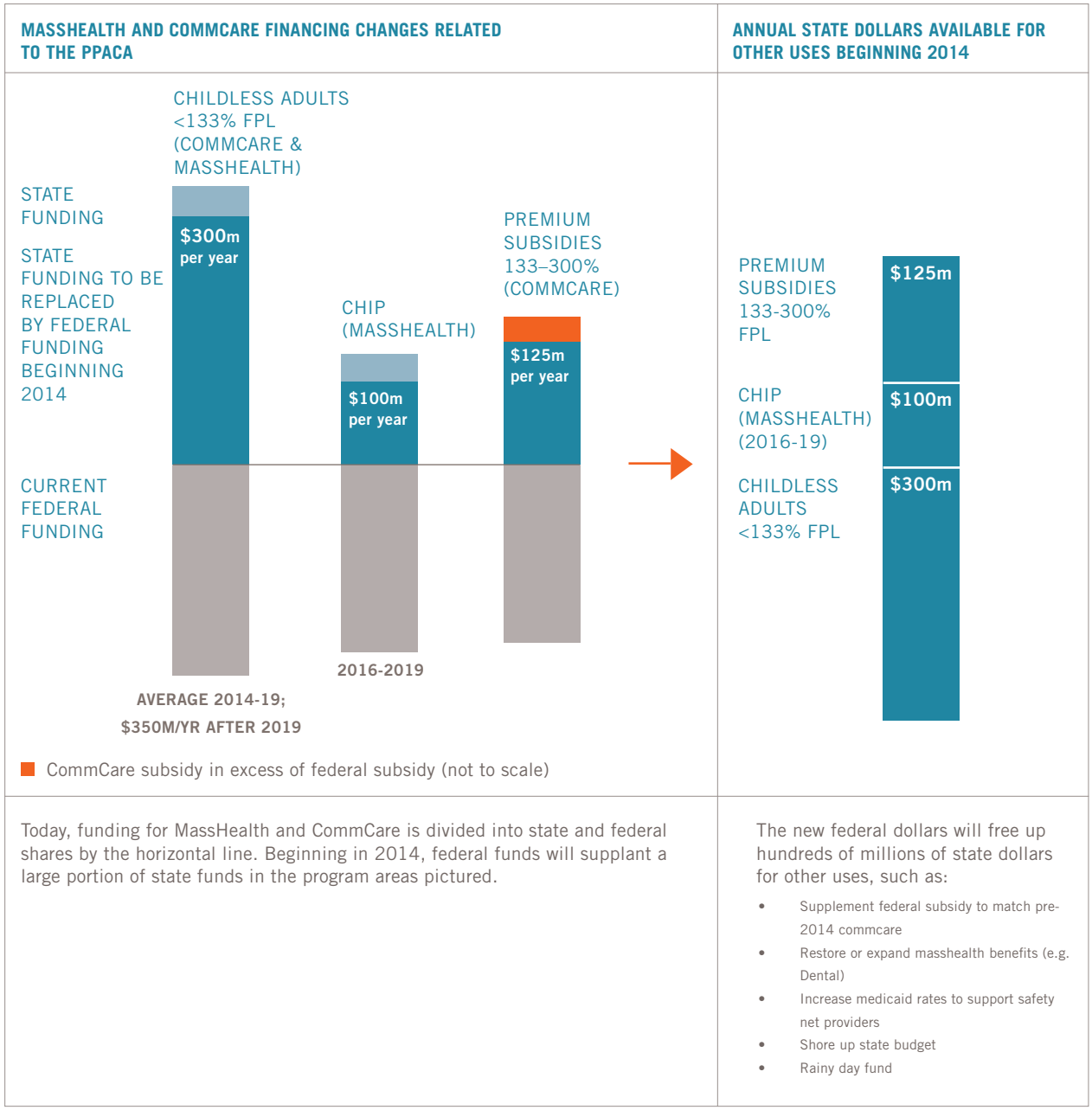
FEDERAL FISCAL YEAR (BEGINS 10/1 OF PRIOR CALENDAR YEAR)	MEDICAID FMAP <= 133%FPL	MEDICAID FMAP >133% FPL	CHIP FMAP
2010*	61.6%	61.6%	65%
2011* (thru 6/30/11)	61.6%	61.6%	65%
2012	50%	50%	65%
2013	50%	50%	65%
2014	75%	50%	65%
2015	80%	50%	65%
2016	85%	50%	88%
2017	86%	50%	88%
2018	90%	50%	88%
2019	93%	50%	88%
2020	90%	50%	†

* Enhanced Medicaid FMAP in 2010-11 due to ARRA. ARRA FMAP expires 12/31/10 but Congress is now considering an extension.
† CHIP program authorization expires in 2019.

16 MassHealth estimate.

Figure 1 illustrates the additional federal funds that will be available to Massachusetts in the coming years, from enhanced federal match and from the new federal premium subsidies (described in Section 1) that will make it possible to save or redeploy state dollars.

FIGURE 1. STATE DOLLARS REPLACED BY INCREASED FEDERAL MATCH OR FEDERAL SUBSIDIES IN THE PPACA



Today, funding for MassHealth and CommCare is divided into state and federal shares by the horizontal line. Beginning in 2014, federal funds will supplant a large portion of state funds in the program areas pictured.

The new federal dollars will free up hundreds of millions of state dollars for other uses, such as:

- Supplement federal subsidy to match pre-2014 commcare
- Restore or expand masshealth benefits (e.g. Dental)
- Increase medicaid rates to support safety net providers
- Shore up state budget
- Rainy day fund

EXCISE TAX ON HIGH-COST HEALTH PLANS: MASSACHUSETTS PLANS WITH HIGHER PREMIUMS ARE MORE AT RISK OF OWING THE EXCISE TAX

The PPACA institutes an excise tax on high cost health plans beginning in 2018. The tax is equal to 40% of the amount that a premium for a given policy exceeds a set threshold. The threshold will be $10,200 for

individual policies and $27,500 for family policies in the first year of the tax and will be indexed to inflation in subsequent years. While the tax technically is levied on health insurance companies, most observers assume that insurers will pass on these costs to employers and consumers through premium increases. Massachusetts has among the highest average premiums of any state and high premiums put health plans more at risk of facing the excise tax.

If current trends in insurance premiums continue, median individual and family premiums in Massachusetts may be subject to the tax in 2024; individual premiums 10% above the median may exceed the threshold in 2022, and family premiums 20% above the median could be taxed in 2019 (see table 8).[17] Several municipalities across the state now provide coverage to their employees at a premium level that already exceeds the 2018 thresholds.[18]

TABLE 8: ESTIMATED EFFECT OF EXCISE TAX ON PREMIUMS IN MASSACHUSETTS, 2018-2024

	2018	2019	2020	2021	2022	2023	2024
PROJECTED MEDIAN PREMIUM IN MA							
Individual	$8,335	$8,819	$9,330	$9,871	$10,444	$11,050	$11,691
Family	$22,423	$23,723	$25,099	$26,555	$28,095	$29,724	$31,448
PROJECTED TAX ON PLAN COSTING THE MEDIAN MA PREMIUM							
Individual	$0	$0	$0	$0	$0	$0	$256
Family	$0	$0	$0	$0	$0	$0	$639
PROJECTED TAX ON PLAN COSTING 10% MORE THAN MEDIAN MA PREMIUM							
Individual	$0	$0	$0	$0	$175	$442	$724
Family	$0	$0	$0	$0	$422	$1,139	$1,897
PROJECTED TAX ON PLAN COSTING 20% MORE THAN MEDIAN MA PREMIUM							
Individual	$0	$13	$159	$318	$593	$884	$1,192
Family	$0	$7	$388	$806	$1,546	$2,328	$3,155

Sources: Median premium data from 2009 DHCFP Employer Survey, as reported in DHCFP Health Care in Massachusetts: Key Indicators, February, 2010 (http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/key_indicators_feb_10.pdf). Premium data include both the employer and employee contributions. The 2009 premiums are inflated by projected growth in per capita health care spending (CMS Office of the Actuary, National Health Expenditure Projections 2004-2019, Table 1: National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2004-2019. http://www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf, accessed May 27, 2010.) Historically, Massachusetts premiums have grown faster than national health expenditures, so estimates of excise tax liability may be conservative.

Excise tax thresholds are indexed by the US Consumer Price Index for Urban Consumers (CPI-U) +1% before 2020, then CPI-U (The Puget Sound Economic Forecaster, prepared by Conway Pedersen Economics, Inc., updated 4-21-10: http://www.seattle.gov/financedepartment/cpi/forecast.htm).

Some proponents of the excise tax argue that in addition to generating significant revenue—$32 billion nationally in 2018 and 2019—the tax will help contain health care cost inflation by discouraging plans with excessively rich benefits. The scope of benefits is only one of many factors that contribute to the high cost of health plans, however. Costs also are affected by the health mix of the workforce, local medical and insurance

17 Analysis by CHLE using average premium data from the Massachusetts Division of Health Care Finance and Policy employer survey (2009), increased by projected growth in per capita health care spending (CMS, Office of the Actuary).

18 Murphy, Sean. "Health tax may wallop towns: Levies to be steep if high-end plans aren't scaled back." The Boston Globe, April 5, 2010.

markets, medical prices and practice patterns, employer's industry, as well as other, more diffuse factors. A 2010 study of health plans across the country found that a plan's benefit design (actuarial value) determined only 3.7% of variation in the cost of family coverage, whereas a combined variable including benefit design, industry type, local insurance market, and plan type accounted for 15.5% of variation in health plan premiums.[19] Success in efforts now underway in Massachusetts to moderate rates of increase in premiums would benefit insurers and employers, and would enable people to maintain the broad coverage that many now have without facing the new tax.

SPOTLIGHT: THE EXCISE TAX ON HIGH COST HEALTH PLANS

ISSUE	IMPACT ON MASSACHUSETTS
Excise tax	With current trends, median individual and family premiums in Massachusetts will be subject to the tax beginning in 2024. This provides additional financial incentive to moderate premium growth.

OTHER REVENUE PROVISIONS: MASSACHUSETTS BUSINESSES AND HIGH-INCOME EARNERS WILL CONTRIBUTE TO FUNDING NATIONAL REFORM.

In addition to the excise tax on high cost health plans, the PPACA raises revenue from several other new taxes, fees, and assessments on individuals and businesses.

MEDICARE TAXES ON HIGH INCOME EARNERS

The health care law increases the Medicare payroll tax by 0.9 percentage points for individuals who earn over $200,000 per year and for couples who earn more than $250,000 per year. Based on 2008 income data, about 4% of tax filers would face this tax in Massachusetts, which would raise an estimated $139 million per year (in 2008 dollars) from state residents.

TABLE 9: INCREASE IN THE MEDICARE PAYROLL TAX ON HIGH-INCOME EARNERS

	NUMBER OF HOUSEHOLDS OVER TAX THRESHOLD	PERCENTAGE OF MA FILERS	MEAN NEW TAX LIABILITY (BASED ON 0.9% TAX RATE)	ADDED TAX LIABILITY (MILLIONS)
SINGLE FILERS WITH INCOME OVER $200K	21,800	1.7%	$1,197	$26.1
JOINT FILERS WITH INCOME OVER $250K	76,100	6.5%	$1,485	$113.0
TOTAL	97,900	4.0%	$1,421	$139.1

Source: CHLE estimates based on 2008 American Community Survey.

19 Gabel, Jon, Jeremy Pickreign, Roland McDevitt, and Thomas Briggs. "Taxing Cadillac Health Plans May Produce Chevy Results." Health Affairs 29, No. 1 (2010): 174-181.

The PPACA also includes a 3.8% assessment on unearned income from investments, rents, dividends, annuities, and other sources. This assessment applies to the same cohort of high-income earners as the increased Medicare payroll tax. The Congressional Budget Office (CBO) estimates that these two taxes together will generate $210 billion nationally over 10 years.[20] Both taxes take effect on January 1, 2013.

TAXES AND INCENTIVES FOR MASSACHUSETTS BUSINESSES

Several other new taxes and tax incentives in the federal health care legislation will affect businesses that are prevalent in the Massachusetts economy, including medical device manufacturers, health insurance companies, and pharmaceutical manufacturers. The CBO projects that these taxes and assessments will collectively raise $107 billion over ten years.[21]

Beginning in 2013, medical device manufacturers will face a 2.3% excise tax on the first sale or use of a medical device. The law exempts certain medical devices from the tax including eyeglasses, contact lenses, hearing aids, and any medical device that is generally purchased by the public at retail for individual use. An analysis by a medical device trade publication estimated that 86% of the tax would be borne by the 10 largest manufacturers in the US. The effect could be more pronounced among smaller companies, but the impact will not truly be known until the tax goes into effect.[22]

In addition to the excise tax on high cost health plans described above, a $6.7 billion annual assessment on insurance companies will begin in 2014 and be apportioned across the country based on market share. As with the excise tax, this levy would likely be passed along to consumers in their premiums. The law provides limited exemptions for non-profit insurers that target vulnerable populations, including those with 80% or more income from government programs and voluntary employees' beneficiary associations. The fee will be reduced to 50% of net premiums for non-profit insurers, so the dominant health plans in Massachusetts, all of which are non-profit, will only be subject to half of this fee. In 2011, the tax on pharmaceutical manufacturers will generate $2.8 billion per year nationally.

The law also contains tax incentives to spur economic development, such as 12-year patent protection for companies that produce biologics – medicines created through biological (as opposed to chemical) processes. In 2009 and 2010, there is a therapeutic discovery tax credit for drug development by life sciences companies with 250 or fewer employees.

20 Congressional Budget Office. Letter to Speaker of the House Nancy Pelosi, March 20, 2010.

21 Congressional Budget Office, Letter to Speaker of the House Nancy Pelosi, March 20, 2010.

22 MassDevice, "Analysis: Big players bear the brunt of medical device tax." http://www.massdevice.com/blogs/massdevice/analysis-big-players-bear-brunt-medical-device-tax, accessed May 28, 2010.

SPOTLIGHT: OTHER REVENUE PROVISIONS

ISSUE	IMPACT ON MASSACHUSETTS
Medicare taxes	High income earners in Massachusetts will face Medicare payroll tax increases and an income tax surcharge.
Taxes on businesses	The medical device industry, pharmaceutical manufacturers, and insurance companies will face new taxes.
Tax credits for businesses	Companies that produce biologics will enjoy 12 year patent protection and small-to-medium life sciences companies receive a therapeutic discovery tax credit for drug development in 2009 and 2010.

3. HEALTH INSURANCE EXCHANGE: IMPLICATIONS FOR THE HEALTH CONNECTOR

The PPACA requires each state to establish an American Health Benefits Exchange for non-group health insurance plans and a Small Business Health Options Program (SHOP). Both may operate under a single body. Policymakers modeled the concept of the health benefits exchange on Massachusetts' Health Insurance Connector Authority, which the Commonwealth established under its 2006 health reform law. The PPACA allows the federal Secretary of Health and Human Services (HHS) to presume, using a process that is yet to be defined, that state exchanges in operation prior to 2010, such as the Health Connector, qualify as an exchange under the new law. Depending on how the law is interpreted and applied, the new federal rules for exchanges may require the state's Health Connector to change in several ways.

INSURANCE SUBSIDIES

Under the PPACA, eligible individuals and families will receive tax credits to help them afford health insurance premiums and cost-sharing. The Internal Revenue Service will oversee the allocation of insurance subsidies. Currently, the Health Connector serves as the conduit for insurance subsidies, collects premium contributions directly from individuals covered by Commonwealth Care, and pays premiums to the Managed Care Organizations (MCOs) that administer the state-subsidized health plans.

Since federal insurance subsidies will at least partially replace state expenditures under Commonwealth Care, the Health Connector's future role depends, in part, on how federal subsidies will flow to beneficiaries–directly from the U.S. Treasury or through an intermediary like the Health Connector, for example. The law does not specify exactly how the subsidies will be allocated to eligible individuals and families, so this issue will most likely be resolved through regulation. Importantly, the PPACA does not appear to close off the possibility for subsidies to go through the Health Connector. It is also unclear whether the managed care organizations (MCOs) that currently offer Commonwealth Care plans will have an exclusive role offering the subsidized plans, or if other plans will also be available to people who receive premium subsidies. This decision will have important implications for those MCOs for which Commonwealth Care constitutes a significant portion of their membership.

MINIMUM COVERAGE STANDARDS AND NEGOTIATING WITH HEALTH PLANS

The PPACA calls for the federal HHS Secretary to set standards for qualified plans regarding marketing, provider network, quality, and enrollee satisfaction. The Secretary is charged with establishing a method for rating plans on cost and quality and with setting pay-for-performance guidelines, which will be implemented by state exchanges. The PPACA gives state commissioners of insurance the responsibility to review premiums, make recommendations about which plans should be excluded from participation in exchanges, and report premium trends to the federal HHS Secretary.

In Massachusetts, the Health Connector Board establishes Minimum Creditable Coverage (MCC) standards and affordability guidelines. The Health Connector also plays an active role in negotiating premium rates with the Commonwealth Care MCOs and certifying plans for participation in Commonwealth Choice based on quality and coverage standards. Although the PPACA does not explicitly give exchanges the power to negotiate rates with plans, it does not preempt such a role.

It is not yet clear whether the federal standards will serve as a baseline that states will be allowed to exceed. The federal law gives state exchanges the role of certifying that health plans meet the federal standards and also allows them to determine whether health plans are in the interest of "qualified individuals and employers in the state." Forthcoming rules and guidance will determine the latitude the Health Connector will have to maintain its current functions.

PLAN DESIGNS AND OTHER NEW RULES FOR EXCHANGES

The federal law introduces standard benefit categories for plans sold through insurance exchanges, which are similar to those offered through the Health Connector. Plans will be offered in standard benefit categories: Bronze, Silver, and Gold–similar to Massachusetts–and Platinum (unique to the PPACA). The PPACA's categories correlate with actuarial value, whereas the Massachusetts versions are defined by standard benefits. While the overall range is similar, it is uncertain whether Massachusetts will be able to continue its standard benefits approach. The federal law also specifies a catastrophic plan targeted to young adults (under age 30) and people who are exempt from the insurance mandate because an affordable option is not available. The Health Connector currently offers Young Adult Plans for people ages 18 to 26, but most of these plans do not constitute catastrophic coverage because they feature annual caps. All plans introduced by the PPACA include an out-of-pocket maximum at the current Health Savings Account limit ($5,950 for an individual, $11,900 for a family in 2010). Further federal guidance will be needed to determine whether states will be permitted to set lower limits, as Massachusetts now does.

The federal law allows states to create an optional Basic Health Program for people earning between 133% and 200% FPL where subsidies flow through the state. This is similar to Commonwealth Care as currently structured (though Commonwealth Care includes people up to 300%, which might make adoption of a Basic Health Program in Massachusetts difficult in practice). Beginning in 2017, state exchanges also have the option to offer large group plans, which is not allowed under the Health Connector. The PPACA gives exchanges the responsibility to verify whether individuals covered under employer-sponsored plans are accessing subsidies. Exchanges will also oversee the use of free choice vouchers that businesses offer to employees who face unaffordable premiums. Federal regulation should help to clarify how the Health Connector will assimilate and operationalize these new functions.

SPOTLIGHT: HEALTH INSURANCE EXCHANGES

ISSUE	IMPACT ON MASSACHUSETTS
Insurance subsidies	Federal subsidies will at least partially replace state expenditures under Commonwealth Care. The Health Connector currently collects member premiums and pays MCOs, which may change depending on federal regulations and whether state subsidies continue.
Minimum coverage standards, affordability and rate negotiation	The Health Connector negotiates rates with Commonwealth Care MCOs and sets MCC and affordability levels, which may change due to federal regulations about the roles of exchanges.
Plan designs	The federal law introduces standard benefit categories for plans sold through insurance exchanges, which are similar to those offered through the Health Connector (though the Massachusetts plans are defined by benefits, not specific actuarial values).

4. INSURANCE MARKET RULES: MOSTLY ALIGNED WITH CURRENT STATE LAWS, BUT THE EFFECT OF RATING RULES HAS YET TO BE DETERMINED

Federal health care reform introduces several new consumer protections into the health insurance market. Some become effective six months after passage of reform while others take effect in subsequent years, particularly 2014. Most only affect the individual and small group markets, but several also apply to large group and self-insured plans. Massachusetts already has implemented most of the rules contained in the federal legislation, such as guaranteed issue and guaranteed renewability of health plans, community rating restrictions, and protection against medical underwriting for people with pre-existing conditions. Slight differences between new federal rules and those in Massachusetts may require some changes in state laws.

EFFECTIVE 6 MONTHS FOLLOWING ENACTMENT: PROHIBITING RESCISSIONS, ELIMINATING COVERAGE CAPS, AND EXPANDING CHILDREN'S ELIGIBILITY FOR PARENTS' INSURANCE

The PPACA prohibits insurance companies from canceling peoples' insurance coverage after they seek care, except in cases of outright fraud. This practice, called rescission, had been allowed in the majority of states, but the Massachusetts Division of Insurance has discouraged it and insurers in the state do not appear to use it.

Federal reform also prohibits lifetime caps on insurance coverage and "unreasonable" annual benefit limits for plans in the individual and group markets, including self-funded plans (annual limits will be completely prohibited in 2014). None of the plans offered through the Health Connector contain lifetime caps. The Young Adult Plans offered through the Health Connector are allowed to contain annual benefit maximums, as are student health insurance plans. Some group plans offered outside the Health Connector contain lifetime or annual benefit limits; these plans will also need to comply with the federal rules.

The PPACA allows children to stay on their parents' plans, including self-funded plans, up to age 26. The new federal rule is slightly more generous than Massachusetts' current system, so it would potentially decrease insurance gaps for some young adults.[23] The law also changes the tax treatment of these benefits by allowing deductibility of insurance premiums for dependents up to age 27, which could save money for some Massachusetts parents whose children are covered under their plans.

EFFECTIVE BEGINNING 2011 AND 2014: MEDICAL LOSS RATIOS, UNIFORM DISCLOSURE, AND MODIFIED COMMUNITY RATING

In 2011, the federal law will implement minimum requirements for health insurers' medical loss ratios. A medical loss ratio (MLR) is the portion of an insurance premium dollar that pays for health care expenses; the remaining amount covers an insurer's administrative expenses, marketing, profits, and other non-medical costs. Large group plans (offered by employers with more than 100 employees) will need to maintain MLRs of at least 85%; small group and individual market policies must maintain MLRs of 80%. Insurers that do not meet the thresholds must rebate a portion of the premium to subscribers. Self-insured plans are excluded from these requirements.

The majority of insurance plans in the Massachusetts group and individual markets have MLRs that exceed these limits.[24] It is possible that these new requirements will improve coverage in the state's student health insurance market, however, where the average MLR is 69%.[25] Federal regulations should determine whether each separate product will have to meet these levels or if the requirements apply to an insurer's entire book of business.

Also in 2011, the federal HHS Secretary is required to develop uniform explanation of coverage documents that all insurers—individual, small group, large group and self-insured plans—will have to implement in 2012. These standards will determine the appearance of the insurance disclosure forms, the language plans use in their materials, and information that plan summaries must include. The Health Connector's website currently displays standard information for all Commonwealth Choice plans; other health plans in Massachusetts will need to incorporate these changes as well.

In 2014, the PPACA introduces new modified community rating restrictions for insurance plans. Community rating compels insurers to offer equivalent premiums to potential enrollees regardless of differences in health histories and demographic characteristics. In an exception to the federal community rating restrictions, rates can vary based on age by a factor of 3 (i.e., older people can be charged premiums up to three times higher than their younger counterparts). The law also allows insurers to vary premiums for tobacco users within a 1.5:1 rate band and permits different premiums based on family size and geographic location. These rate bands are additive, so the variation can be as much as 4.5:1. The bands apply to individual and small group plans as well as fully-insured large group plans offered through an exchange. Massachusetts currently maintains a 2:1 rate band for age, industry, participation rate, wellness programs, and tobacco use (in addition to other allowable adjustments such as geographic location and family size). The wider rate band for age will particularly affect older state residents unless the federal government allows Massachusetts to continue its more protective rating rules.

23 Massachusetts law only allows children to maintain their parents' insurance as dependents up to age 26 if they have not been removed from dependent status on their parents' taxes for two or more years.

24 In 2008, private insurers in Massachusetts had an average MLR of 88%.

25 Student health program baseline report, the Massachusetts Division of Health Care Finance and Policy, November 2009.

Other aspects of the federal insurance market reforms – concerning risk pooling and merging of markets, for example – are less restrictive than the current law in Massachusetts and would, if adopted in the state, undo effective state reforms and result in higher premiums for some Massachusetts residents. It would be in the state's interest to engage actively in the federal rulemaking process to ensure that the new federal standards are established as a minimum that states can exceed.

Currently in Massachusetts, employers with fully insured plans can impose a waiting period of up to six months for people who do not have continuous coverage. (Employers who self-insure are not bound by any waiting period restrictions.) The PPACA places a 90 day cap on the waiting period for employer-sponsored insurance, so some state residents may be able to more readily access coverage under the new rules. Also, when the PPACA eliminates pre-existing exclusions for everyone—including those in self-insured plans—in 2014, some Massachusetts residents may benefit (the exclusions are removed for children in the first six month of implementation).[26]

SPOTLIGHT: INSURANCE MARKET REFORMS

ISSUE	IMPACT ON MASSACHUSETTS
Pre-existing conditions, guaranteed issue and renewability, prohibition of rescissions, dependent coverage through age 26, uniform disclosure of benefits.	Similar to current state rules; small impact.
Prohibition on annual and lifetime caps	These coverage restrictions will be eliminated in Student Health Plans, Young Adult Plans, and some employer-sponsored plans where they now exist.
Medical loss ratios	New limits will mainly affect the student health insurance market, possibly improving coverage.
Rating rules	Federal provisions are less restrictive than current Massachusetts rules, resulting in less protection and higher premiums if the state had to adopt them.

5. PROVIDER PAYMENTS

The coverage expansions under national reform will bring new patients with health insurance to doctors, hospitals, and other medical providers. But many providers will also face payment reductions for uncompensated care and other services. An important lesson from Massachusetts is that uncompensated care may decline, but will not disappear, under federal reform. The PPACA makes several changes to the Medicaid and Medicare programs that will affect payments to Massachusetts health care providers through decreases in Medicaid and Medicare Disproportionate Share Hospital (DSH) payments and increases in compensation for primary care providers under Medicaid. The law also achieves significant savings in the Medicare program through a reduced rate of growth in Medicare fee-for-service payments.

26 Massachusetts law allows insurers to impose pre-existing conditions exclusions for six months or less for people without continuous coverage, though the "look back" period is limited to the previous six months. These exclusions are not permitted for people who have continuous coverage.

MEDICARE: REDUCTIONS IN PROVIDER PAYMENTS

PAYMENT ADJUSTMENTS FOR MEDICARE PROVIDERS

The federal health reform law reduces the "market basket" payment rate adjustments that Medicare makes to health care providers. From 2010 to 2020, this change will reduce the rate of growth in Medicare fee-for-service payments nationally by $136 billion. The Massachusetts Hospital Association (MHA) estimates that medical providers[27] in the state may receive up to $4.5 billion less in Medicare payments than expected over 10 years.[28]

MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

Hospitals that treat a disproportionate number of low-income Medicare beneficiaries receive supplemental payments from Medicare. The PPACA anticipates that the need for these payments will decrease as coverage expands. Thus, the law reduces the payment rate adjustments that Medicare makes to DSH hospitals by 75% in 2014 and subsequently increases payments to particular providers based on the amount of uncompensated care they provide. Nationally, between 2014 and 2019 these reductions will total $22 billion. The MHA estimates that Massachusetts providers will receive up to $494 million less in Medicare DSH payments over 10 years because of these rate reductions.[29]

MEDICARE AREA WAGE INDEX

Medicare pays different rates to medical providers in different areas of the country based on geographic variation in labor and benefit costs. For instance, providers in Boston, Massachusetts receive more money for the same service than their counterparts in Missoula, Montana. The Medicare wage area adjustment generally results in higher payments to Massachusetts providers because they practice in a higher-cost locale than providers in most of the country. The PPACA requires the federal HHS Secretary to provide a plan to Congress by 2011 on how to comprehensively reform the Medicare wage index system. It is not clear what effect such a change would have on payments to Massachusetts providers. Other PPACA provisions, related to the method for making Medicare wage area adjustments, could bring significant financial benefits to Massachusetts hospitals.

MOTIVATING QUALITY IMPROVEMENT

In fiscal year 2013, the Medicare program will begin monitoring risk-adjusted readmission rates for several common medical conditions: heart failure, heart attacks, and pneumonia. After two years, the program will expand to include readmissions for additional medical conditions. The goal is to reduce the number of expensive hospital readmissions by motivating improved patient care. Hospitals that do not reduce their readmission rates may experience payment reductions, while those that do better on these measures may benefit. Massachusetts ranked 37th among states in 2009 on Medicare readmissions within 30 days, so this could have an impact on hospitals in the state.[30] Efforts are already under way in Massachusetts to reduce readmissions, particularly for people with chronic illnesses, through initiatives such as Patient-Centered Medical Homes and proactive care coordination.

27 Inpatient and outpatient hospital services, inpatient psychiatric facilities, inpatient rehabilitation facilities, home health agencies and long term care hospitals.

28 "The Impact of the Federal Healthcare Reform Law on Massachusetts Hospitals and Healthcare Providers," the Massachusetts Hospital Association, April 26, 2010.

29 Ibid.

30 Medicare 30-Day Hospital Readmissions as a Percent of Admissions, 2009. The Commonwealth Fund State Scorecard (http://www.commonwealthfund.org/Maps-and-Data/State-Scorecard-2009/DataByDimension/Table.aspx?ind=28&tf=1), accessed May 28, 2010.

MEDICAID: LOSS OF SOME DSH, REWARDS FOR PRIMARY CARE

MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

The federal health care law directs the federal HHS Secretary to reduce DSH nationally by a total of $18.1 billion from 2014 through 2020 and to apply these reductions to quarterly federal financial participation (FFP) payments.[31] The law directs the Secretary to impose the largest reductions on states with the lowest percentages of uninsured residents. The method will take into consideration instances where DSH payments support coverage expansions under Medicaid Section 1115 waivers, as is the case in Massachusetts. The degree of protection is not specified in the law, however, leaving it to future federal regulation. The Secretary will also impose larger DSH reductions on states that do not target DSH payments to hospitals with high inpatient percentages of Medicaid recipients and high uncompensated costs. Although the law sets mandatory annual aggregate reduction targets for each of these years, the HHS Secretary is given broad regulatory discretion in allocating reductions to each state.

Massachusetts will likely lose some DSH funding because of its low uninsured rate, though the loss may be mitigated by the protection for states that use their DSH allotments under a Section 1115 waiver. Since Massachusetts has the lowest uninsured rate in the nation, the rules that define how the DSH reductions will be allocated across states will be of great importance here.

PRIMARY CARE PAYMENTS

The PPACA increases Medicaid payments for primary care services in 2013 and 2014 to no less than 100% of Medicare Part B rates (MassHealth currently pays roughly 80% of Medicare rates for primary care). These payments will not increase state expenditures because states will receive 100% FMAP on the rate increases. Massachusetts primary care physicians will gain about $22 million per year in 2013 and 2014, after which the payment increases sunset.[32] One possible use of the state Medicaid dollars freed up by increased federal assistance would be to continue to support primary care payment increases beyond the initial two years.

6. DEMONSTRATION PROJECTS, PILOT PROGRAMS, AND GRANTS

The federal health reform law provides for more than $22 billion in new funding for more than 100 demonstration projects, pilot programs, and grants that seek to modernize and improve America's health care delivery system. Many of these projects aim to foster greater collaboration and communication among providers, consumers, government, and payers. These investments reveal the federal government's interest in supporting a broad array of experimentation, study, and evaluation to promote quality improvement, cost containment, transparency, strategic workforce development, reduction in racial and ethnic disparities, and effective coordination of care. Although these projects have been largely overlooked in the public discourse about the law, they represent significant federal investment in and commitment to improving evidence-based policymaking and practice.

31 Medicaid DSH allotments totaled about $11.3 billion in federal fiscal year 2009. (Kaiser Family Foundation, statehealthfacts.org, accessed May 27, 2010).

32 Division of Health Care Finance and Policy estimate.

The PPACA takes a decentralized approach to encourage delivery system innovation at the state and local levels. Many of the projects and grants are targeted to state and local governments, particularly those concerning individual wellness, payment reform in the Medicaid program, workforce development, malpractice reform, and service delivery reforms to better coordinate care for chronically ill populations. Other initiatives seek to empower doctors, nurses, hospitals, medical schools, and other local health care organizations to develop initiatives that promote workforce training, primary care, more effective health information technology, and better coordination between doctors. A few of the grants and programs are intended for employers, such as grants to support businesses, both large and small, to develop wellness programs that keep their workforces healthy and productive (table 10 lists some examples of opportunities for Massachusetts).

Decades of health systems research has provided scores of good ideas for what needs to be done to promote quality and curb costs, but large scale funding to test these ideas has been lacking. The dedication of $22 billion in federal support under the PPACA begins to fill this gap. Gaps also remain in the data about which kinds of projects would work best to meet the goals of higher quality, more transparency, and lower costs. The new federal law promotes research and evidenced-based reform by requiring the federal government to track the progress and outcomes of these initiatives. The hope is that projects that are successful in containing costs and promoting quality and efficiency locally can be spread across the country.

A number of demonstrations in the law are particularly relevant to ongoing efforts in Massachusetts. These include projects in the areas of payment reform, delivery system redesign, care coordination, quality measurement and improvement, wellness, reduction in racial and ethnic disparities, and workforce development. Many of the significant health policy efforts currently under way in Massachusetts, such as the work of the Health Care Quality and Cost Council, will find potential support in a demonstration, grant, or pilot project funded through the PPACA. In particular, the PPACA establishes a Center for Innovation within the Center for Medicare and Medicaid Services (CMS) that will likely issue grants to support initiatives involving global payments, care for individuals eligible for both Medicaid and Medicare, and many other issues that particularly concern Massachusetts stakeholders and policymakers.

CONCLUSION

In its early stages of implementation, national health care reform clearly reinforces the shared responsibility model on which Massachusetts reforms are built: the expectation that individuals will provide for their own families' coverage to the extent they are able, reaffirmation of the central role of employers in providing coverage, and an enhanced role for the participation of government in helping to make health insurance available and affordable.

The PPACA will bring important benefits to the state. Its coverage expansion and subsidy provisions make it possible to reduce Massachusetts' lowest-in-the-nation uninsured rate even further, primarily by making coverage attainable for people with moderate incomes (between 300% and 400% FPL) and legally residing immigrants. Billions of additional federal dollars in increased matching payments and subsidies to individuals and small businesses will help the state budget, give the state flexibility to supplement coverage or subsidies, and most likely stimulate the economy. Insurance market changes will close a few gaps in consumer protection in Massachusetts, particularly for young adults. Providers of primary care to MassHealth mem-

TABLE 10: EXAMPLES OF DEMONSTRATIONS, GRANTS, AND PILOTS IN THE PPACA RELEVANT TO MASSACHUSETTS

PAYMENT REFORM	Global payment demonstration program (Sec. 2705)
	Demonstration project to evaluate integrated care around a hospitalization (sec. 2704)
	Pediatric ACO demonstration (Sec. 2706)
	National pilot program on Medicare payment bundling (Sec. 3023)
WELLNESS	Wellness Demonstration (Sec. 1201, 4206)
	Education to promote personal responsibility regarding sex and healthy relationships for youth (ages 10-20) populations (Sec. 2953)
	Preventive benefits outreach campaign (Sec. 4004)
	Incentives to prevent chronic diseases in Medicaid (Sec. 4108)
QUALITY	
Providers	AHRQ's Center for Quality Improvement and Patient Safety grants and contracts for institutions to adapt and implement models and practices that promote evidence-based quality (sec. 3501)
	Grants to develop quality measures (Sec. 3013)
	Grants or contracts to implement medication management services in treatment of chronic diseases (Sec. 3503)
State government	Establishment of a Medicaid quality measurement program (Sec. 2701)
	Establishment of community health teams to support patient-centered medical homes (Sec. 3502)
WORKFORCE DEVELOPMENT	
Providers	Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals (Sec. 3508)
	Grants for training of mid-career public and allied professionals (sec. 5206)
	Support and development of primary care training programs (Sec. 5301)
	Training opportunities for direct care workers (Sec. 5302)
	Geriatric workforce development (Sec. 5305)
State government	State health care workforce development grants (Sec 5102)
	Workforce diversity grants (Sec. 5404)
	Demonstration projects to address health professions workforce needs (Sec. 5507)
SERVICE DELIVERY AND CARE COORDINATION	
Providers	Independence at home Medicare demonstration (Sec. 3024)
	Medicare Hospice concurrent care demonstration project (Sec. 3140)
	Community-based collaborative care network program (Sec. 10333)
State government	Planning grants to provide health homes for chronically ill patients (Sec. 2703)
	Grants for early childhood home visitation programs (Sec. 2951)
	State grant program for providers that serve underserved populations (Sec. 10501)
	Establishment or support of emergency care response pilot program (Sec. 3504)

SPOTLIGHT: DEMONSTRATIONS, PILOTS, AND GRANTS

ISSUE	IMPACT ON MASSACHUSETTS
Delivery system reform	The law dedicates $22 billion to support more than one hundred pilots, demonstrations, and grants. These projects support innovation at the state and local levels regarding health care quality, cost-containment, transparency, workforce development, care coordination, and other issues.

bers will be paid more generously for two years. Billions of dollars worth of grants, demonstrations, and pilot programs create opportunities for innovation in delivery and payment systems, workforce development strategies, quality improvement, reduction in racial and ethnic disparities, and prevention and wellness.

These benefits come at some cost, of course. The PPACA levies new taxes on high-income earners and on businesses in the insurance, pharmaceutical and medical device industries. Some people with low and moderate incomes may owe more in terms of penalties, premiums and cost sharing. Some provider payments will decline or grow more slowly over time, which could have a substantial effect on doctors, hospitals and other facilities that serve large numbers of Medicare beneficiaries. Yet there are also potentially positive incentives for businesses that develop effective new pharmaceuticals and providers that deliver efficient, high quality care.

Paradoxically, policy makers in Massachusetts may have to devote much of their attention to the elements of the federal law that are directly modeled on Massachusetts' reform. State policy makers may need to act to preserve the features of state reform that are stronger than the federal provisions. Details of the individual mandate and associated penalties differ, for example, so questions of how to align state and federal requirements and whether to maintain dual penalties will need to be considered. Similarly, different affordability standards raise the question of whether it should be policy to avoid situations in which someone may be subject to the federal requirements on individuals or employers but not to the state's (or vice-versa). Federal premium subsidies extend further up the income scale than the state's, but subsidy levels differ; the state will want to consider whether to supplement the federal subsidies with some of the savings it will gain through enhanced federal matching rates. Operationally, the Health Connector differs in some ways from the role the PPACA envisions for state exchanges. There are few details at this point, however, so the extent to which the Health Connector will have to adapt to federal specifications is yet to be determined. Some federal insurance market reforms offer weaker protections than those currently in place in Massachusetts, and it is not yet clear whether the state will be allowed to maintain its standards.

Though passage of the PPACA was itself an odyssey, the implementation journey is just beginning. Federal reform is very much a work in progress, with details to be revealed and changes to be made along the way. States will participate in the process and respond as the law is further developed through regulations and other guidance. Massachusetts is well situated for this journey. Participating fully will enable the Commonwealth to maximize the benefits of the new law, while guarding against erosion of the strong system that is currently in place.

APPENDIX: KEY PPACA IMPLEMENTATION DATES FOR MASSACHUSETTS

2010	
	March: President Barack Obama signs into law the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010.
Shared responsibility	Tax credits to purchase coverage extended to small businesses with fewer than 25 employees and annual wages less than $50,000 per year.
Insurance market reforms	Prohibition on rescissions by insurance companies.
	Prohibition of lifetime insurance caps.
	Dependent coverage extended to children up to age 26.
	Elimination of pre-existing conditions exclusions for children.
Provider payments	First phase of reduction in the rate of increase of some Medicare physician payments.
2011	
Shared responsibility	July: Next extension of Massachusetts' Medicaid Waiver for MassHealth and Commonwealth Care (SFY 2012-2014).
	Consider expanding Medicaid State Plan coverage to childless adults earning < 133% FPL prior to 2014 (no enhanced federal match until 2014).
	Enhanced federal Medicaid match under federal stimulus law expires.
Provider payments	Federal HHS Secretary will report to Congress about how to reform the Area Wage Index system for Medicare.
Financing	New annual assessment on pharmaceutical manufacturers takes effect.
Insurance market reforms	Implement minimum requirements for health insurers' medical loss ratios (85% large group market, 80% individual and small group markets).
	Federal HHS Secretary must develop uniform explanation of coverage documents for health insurance.
Demos, pilots and grants	Creation of an Innovation Center within the Centers for Medicare and Medicaid Services.
2012	
Provider payments	July 1: The Medicare program will begin monitoring risk-adjusted readmission rates for several common medical conditions: heart failure, heart attacks, and pneumonia.
2013	
Provider payments	Increase Medicaid payments for primary care physicians up to at least Medicare Part B rates (2013 and 2014).
Financing	Medicare taxes on high income taxpayers take effect (0.9% increase in Medicare payroll tax and surtax on unearned income).
	New tax on medical device manufacturers takes effect.
Insurance market reforms	Implement uniform explanation of coverage for all health insurers.
2014	
Shared responsibility	Federal individual mandate takes effect (penalties phased in at lower levels in 2014 and 2015).
	Employer mandate takes effect, requiring employers with 50 or more employees to offer coverage meeting minimum standards or pay an assessment.
	Massachusetts will begin to receive enhanced federal matching payments for covering childless adults (FMAP peaks in 2019 at 93% and levels off at 90% for 2020 and beyond).
	Federal premium and cost sharing subsidies become available to families and individuals earning up to 400% FPL.
	Small business tax credits will be available for only two years in 2014 onward.
Exchange	States must have established a health insurance exchange or the federal government will administer an exchange in states that have not taken action.
Financing	$6.7b assessment on insurance companies takes effect.
Insurance market reforms	Prohibition of annual benefit limits for insurance.
	Implement community rating restrictions for individual and small group plans, and for all fully insured plans offered through an exchange.
	Eliminate pre-existing conditions exclusions for everyone.
	Limit waiting periods for health insurance coverage to 90 days.
Provider payments	Begin to reduce DSH payments to hospitals (make reductions over six years, through 2019).
	Introduce additional medical conditions to monitor for risk-adjusted readmission rates.
2015	
Shared responsibility	October: CHIP matching rate increases 23 percentage points to 88% in Massachusetts.
2016	
Shared responsibility	Penalties for the federal individual mandate attain their full, authorized level (the greater of $695 per person, up to a family maximum, or 2.5% of income).
2018	
Financing	Excise tax on high cost health plans takes effect.