CLIENT ALERT

ROPES & GRAY

HEALTH CARE April 17, 2006

Massachusetts Health Care Reform Legislation Chapter 58 of the Acts of 2006: An Act Promoting Access to Affordable, Quality, Accountable Health Care

On April 12, 2006, Governor Romney signed into law a sweeping reform of the way Massachusetts provides health care to uninsured and underinsured residents of the Commonwealth. This statute has been enacted as Ch. 58 of the Acts of 2006. The statute is intended to redistribute public funds to provide health insurance coverage to currently uninsured low-income populations as well as to provide affordable health insurance coverage options for all residents of the Commonwealth. The statute requires individuals to obtain health insurance, requires employers (who have more than ten employees) to offer insurance coverage to their employees or face the risk of substantial penalties, authorizes the creation of new health insurance products (and provides subsidies to low-income individuals to assist in their purchase of these products), makes changes to the Massachusetts Medicaid program, and reforms the free care pool.

Many of these new health care initiatives will be funded through the newly created Commonwealth Care Trust Fund, itself funded through several mechanisms, including:

- amounts paid by employer contributions and surcharges;
- Title XIX (Medicaid) financial federal participation revenue generated through hospital payments funded by the Health Safety Net Trust Fund (the newly created free care pool trust fund);
- other federal appropriations or monies made available under Section 1115 of the Social Security Act; and
- other payments made by and penalties collected from individuals and employers.

As with many new legislative initiatives, however, a great deal of information about the true impact of the statute remains unknown. The statute is subject to additional appropriations of over $30 million for FY06. The legislature is also likely to issue technical corrections to the statute. Also, virtually all of the key sections of the statute authorize the promulgation of regulations to address specific issues related to the new products and agencies created under the statute; these regulations are intended to provide additional guidance and will undoubtedly inform the implementation of the statute's requirements.

In addition, as with any legislation that seeks to regulate the provision of health insurance coverage in a broad-based way, it is possible that this statute could be challenged on the grounds that at least some of its provisions are pre-empted by ERISA because they relate to an employee benefit plan. Given the number of states that are enacting or seeking to enact "fair share" legislation, this is an issue that is being watched closely in many arenas.

1. Commonwealth Health Insurance Connector

The statute establishes a Commonwealth Health Insurance Connector (the "Connector"), governed by a board of eleven members, to connect individuals and eligible small groups with affordable health insurance products that have been certified with a "Seal of Approval" to be high-quality products. The Connector is structured to work as an independent Authority.

Individuals and businesses or other organizations or associations that on at least 50% of their working days during the previous year employed between 1 and 50 employees are eligible to purchase health insurance through the Connector ("eligible small groups") by entering into a binding agreement with the Connector. Employers can contribute to an employee's health insurance through the Connector, and according to the Conference Committee Report, for employees who work in more than one job, more than one employer may contribute to the employee's insurance. Insurance purchased through the Connector is portable if an employee leaves a job. Additionally, the Connector is authorized to administer the Commonwealth Care Health Insurance Program, providing subsidies for the purchase of health insurance through the Connector for lower-income individuals beginning October 1, 2006, as described further below.

The insurance plans offering health insurance coverage through the Connector may choose to contract only with providers that meet quality and value standards, thus earning the Connector Seal of Approval. The legislation states that plans offered through the Connector must meet all of the requirements for health benefit plans under the small group insurance licensure regulations in order to receive the Connector Seal of Approval. Plans must be authorized by the Commissioner of Insurance and underwritten by a carrier, defined as an insurer licensed or otherwise authorized to transact accident and health insurance under Chapter 175, 176A, 176B, or 176G. The statute provides for open enrollment for purchase of small group market insurance plans through the Connector from March 1, 2007 through May 31, 2007. The Connector will begin offering these Plans to small groups on April 1, 2007. The purchase of subsidized insurance under the Commonwealth Care Health Insurance Program will begin on an earlier date, October 1, 2006.

2. Commonwealth Care Health Insurance Program

The Commonwealth Care Health Insurance Program, a program within the Connector, will provide subsidies to assist the purchase of health insurance through the Connector to eligible individuals with incomes at or below 300% of the Federal Poverty Level (the "FPL"), on a sliding-scale basis, beginning on October 1, 2006. According to the Conference Committee Report, the goal of the Commonwealth Care Health Insurance Program is to redirect funds currently spent on providing free care in hospitals toward subsidizing the purchase of health insurance through the Connector for uninsured who qualify.

To be eligible for subsidies, in addition to having an individual or family income at or below 300% of the FPL, an individual:

- must have been a resident of Massachusetts for the previous six months;
- must not be eligible for MassHealth, Medicare, or CHIP;
- or family member's employer must not have provided health insurance coverage in the last six months for which (1) the individual is eligible, and (2) the employer covers at least 20 per cent of the annual premium cost of a family health insurance plan or at least 33 per cent of an individual health insurance plan (which condition may be waived in certain circumstances); and
- must not have accepted a financial incentive from an employer to decline the employer's subsidized health insurance plan.

No premium will be charged to individuals who earn below 100% FPL.

Plans offered through this premium assistance program will not include a deductible. They will be offered exclusively by managed care organizations that currently contract to provide Medicaid managed care insurance for MassHealth enrollees (i.e. Neighborhood Health Plan, Boston Medical Center Health Net, Network Health, and Fallon Community Health Plan) through July 2009, provided these plans meet enrollment targets. The legislation provides that such organizations will be deemed to be carriers and the contracts offered by them will be considered health benefit plans. After 2009, enrollment for the premium assistance program beneficiaries will be opened to other plans.

3. Low-Income Benefits: Medicaid, MassHealth

The statute also affects the Massachusetts Medicaid program (called MassHealth) by increasing rates payable to hospitals and physicians for providing care to MassHealth patients, expanding eligibility for MassHealth enrollment, and restoring certain previously eliminated MassHealth benefits.

The legislation provides stable funding for certain publicly operated or public service hospitals that have historically provided the majority of the uncompensated care in the Commonwealth. The Boston Medical Center Corporation and the Cambridge Public Health Commission are provided with funding for FY 2007 at levels consistent with their net supplemental payments from the Commonwealth for FY 2006. Payments for FY 2008 and 2009 will depend on these entities' success in transitioning individuals from the free care pool into insurance plans and also in minimizing the number of individuals seeking care from the free care pool.

Medicaid

This statute provides for Medicaid rate increases for hospitals and physicians of $90 million each year in fiscal years 2007, 2008, and 2009. In fiscal years 2008 and 2009, these increases will be contingent on quality and performance measures, including the reduction of racial and ethnic disparities in the provision of health care, as discussed below.

MassHealth

MassHealth eligibility is extended to children in families earning up to 300% of the Federal Poverty Level (FPL) (up to $38,000/year for a family of two), effective July 1, 2006, from the current eligibility level of 200% FPL. In addition, the statute restores all MassHealth benefits cut in 2006, effective July 1, 2006. The Conference Committee Report says such services include dental, vision, chiropractic and prosthetics. The legislation also provides that the Executive Office of Health and Human Services will seek federal approval to raise enrollment caps in MassHealth CommonHealth program, MassHealth HIV+ program, and MassHealth Essential.

4. Individual and Employer Mandates

Individuals

The statute imposes an individual mandate, requiring Massachusetts residents ages 18 and older to carry health insurance coverage with the goal of maintaining a diversified risk pool and stabilizing premium payments, according to the Conference Committee Report. Residents are required to obtain and maintain "creditable coverage," which includes certain group health plans, student health insurance programs, Medicare Part A or B, Medicaid, and certain other plans or coverage, as specified. For new Massachusetts residents or those terminating prior coverage, the statute provides for 63 days to obtain creditable coverage.

The State will assess compliance with this mandate by requiring residents to report on their state income tax forms, beginning in 2008, whether they have maintained health insurance that qualifies as "creditable coverage" over the prior year or, alternatively, are claiming a religious exemption. This mandate will be enforced by financial penalties. For tax year 2007, the penalty will be the loss of the state personal tax exemption or one-half of the personal exemption for an individual filing

jointly with a spouse. For subsequent years, the penalty will increase to a portion, not to exceed 50%, of what the individual would have paid for an affordable premium. Penalties will be deposited in the Commonwealth Care Trust Fund.

Employers

Employers of 11 or more employees will be required to contribute toward health insurance or health care costs in the Commonwealth, either prospectively or through fines. Employers and their employees will have to complete "Health Insurance Responsibility Disclosure" forms, indicating whether the employer has offered to pay for or arrange for the purchase of health care insurance for its employees and whether the employee has accepted or declined such coverage.

- Fair Share Contribution. Employers who employ 11 or more full-time equivalent employees and are not a "contributing employer" (i.e. do not offer employees health insurance coverage through a group health plan to which the employer makes a "fair and reasonable" premium contribution) will be required to pay a per-employee fair share contribution, which may not exceed $295 per employee, pro-rated for part-time or seasonal employees.
  - Please note that the statute does not define the "fair and reasonable" contribution, and leaves this issue open to further regulation by the Division of Health Care Finance and Policy. Doing so leaves unanswered questions employers might have regarding the sufficiency of the health care coverage they currently offer to their employees.
  - This "fair share" contribution is capped at $295 per employee per year. The actual contribution amount will be determined based on a number of factors, including a portion of the cost paid by the state for free care. Governor Romney vetoed this section of the legislation, stating that "it is not necessary to implement or finance health care reform," but it has been widely reported that the legislature is likely to override this veto.
- Free Rider Surcharge. A surcharge will be imposed on "non-providing employers," defined as those who employ 11 or more employees but do not contribute toward or arrange for the purchase of health insurance for employees *and* whose employees use a certain amount of free care over a year (referred to as a "state-funded employee").[1] An employer is not considered a "non-providing employer", and would not be subject to the surcharge, with respect to employees (1) who are covered through a bona fide collective bargaining agreement, (2) who participate in the Insurance Participation Program, or (3) for whom the employer contributes to employees' insurance through the Connector. The surcharge can be significant, ranging from 10% to 100% of the costs to the Commonwealth of free-care services provided to the state-funded employees, or dependents of such employees, (first $50,000 exempted), and will be deposited into the Commonwealth Care Trust Fund.
- Mandatory Offer of Section 125 "Cafeteria Plans." Effective January 1, 2007, employers with 11 or more employees in the Commonwealth are required by the statute to offer Section 125 "cafeteria plans" to employees so that employees may purchase health insurance products and other benefits on a pre-tax basis. Employers will need to review their benefits and consider whether any changes need to be made to their existing benefits plans in light of this requirement.

Employers will also be directly affected by several changes imposed in the form of policy requirements for insurers, as discussed in the next section.

5. Insurance Licensure Reform

The statute implements several changes to the insurance licensure statutes, the most notable of which is the merger of the non- and small-group markets in July 2007. The statute rewrites the licensure statutes for the small group market by modifying virtually all of the definitions, changing the factors health benefit plans may use to adjust premiums and establish rates,

[1] Please note that the statutory definition of "employees" is ambiguous. The statute generally defines employees as full-time equivalent employees ("FTE's"). The definition of "non-providing employers" (§ 32) for the purpose of free charge surcharge, however, simply references an "employer that employs not more than 10." We have been told that the legislature recognizes that the statute contains drafting errors; this ambiguity may be such an error.

and placing limits on waiting periods and exclusions on coverage for pre-existing conditions for eligible individuals who request coverage within certain time limits. No waiting period may be imposed on plans offered to individuals who have been without coverage for 18 months prior to application. Please note that — as is true with many other sections of the statute — the statute requires the Commissioner of Insurance to promulgate regulations relating to these requirements, leaving important issues such as permissible pre-existing condition exclusions and waiting periods to be fleshed out at a later date. The legislative conference committee reports that these changes are projected to produce an estimated drop of 24% in non-group premium costs. An actuarial study of the merging of the two insurance markets will be completed before the merger to assist insurers in planning for the transition.

In addition, the statute implements requirements whereby insurers, group non-profit hospital service corporations, medical service corporations, and HMOs are only permitted to contract with employers if the employer offers the insurance to all full-time employees who live in the Commonwealth. The statute also requires the employer to make the same premium contribution percentage for each employee, although greater percentage contribution amounts are permitted for lower-paid employees, with certain limitations.[2] Also, the employer is permitted to enter into agreements that provide a different premium contribution percentage for employees who are covered by collective bargaining agreements.

The legislation also provides for extended coverage for young adults. It requires family policies to be written to maintain coverage for children up to age 25, or for two years past the child's loss of dependent status, whichever occurs first. It also allows health maintenance organizations, licensed under Chapter 176G, to provide coverage for young adults between ages of 19 and 26 through young adult health benefit plans with "first-dollar" coverage for primary care visits and comprehensive benefits, as long as coverage is consistent with minimum standards established in Chapter 176J, § 10.

The statute permits HMOs to offer contracts that include a decuctible consistent with the requirements for high deductible health plans ("HDHPs") (as defined in Section 223 of the Internal Revenue Code), so long as those HDHPs are offered in conjunction with a Health Savings Account ("HSA"). While this provision should allow employers to offer a wider array of plans with significant premium savings for their employees, it does raise questions about the status of existing high deductible products, approved by the Massachusetts Division of Insurance and currently being provided by HMOs, that are not offered in conjuction with HSAs. Presumbly this incongruity will be addressed through the technical amendment process.

6. Reforms to Free Care

Effective October 1, 2007, the current Uncompensated Care Pool is eliminated, replaced by the Health Safety Net Fund. The purpose of the Fund remains, however, to maintain a health care safety net by reimbursing hospitals and community health centers for a portion of the cost of reimbursable services provided to low-income, uninsured or underinsured residents of the Commonwealth. The Fund will be administered by a newly-created Health Safety Net Office located within the Office of Medicaid. The Health Safety Net Office will develop a new standard fee schedule for hospital reimbursements, including a fee-for-service reimbursement system for acute care hospitals, replacing the current charges-based payment system. Acute care hospitals and other payors are required to pay into the Fund, with their liability to the Fund dependent on the ratio of the hospital private sector charges as compared to all hospitals' private sector charges, and will also be required to make surcharge payments (similar to the requirements currently imposed by M.G.L. c. 118G, §§ 18, 18A). The plan anticipates the transfer of funds to the Commonwealth Care Health Insurance Program as free care use declines.

[2] The statute appears to limit the application of this section only to full-time employees, although the statutory language is ambiguous and it could be suggested that the statute requires employers to make the same percentage of premium contribution to all employees, whether or not they are employed on a part-time or full-time basis.

7. Quality Programs

The statute establishes a Health Care Quality and Cost Council to promote high-quality, safe, effective, equitable health care. The Council is responsible for developing and implementing health care quality improvement goals intended to lower or contain growth in health care costs and to improve quality of care, including reductions in racial and ethnic health disparities in care. The statute authorizes the Council to contract with an independent health care organization for technical assistance in developing health care quality goals; cost containment goals; performance measurement benchmarks; design and implementation of health quality interventions; and a consumer health information website and reports to provide consumers comparative quality data on select services. The statute calls for the Council to develop performance benchmarks for its goals (and to publish them annually) in a way that advances a common national framework for quality measurement and reporting, including but not limited to measures approved by the National Quality Forum and adopted by the Hospitals Quality Alliance.

The statute requires that the Council maintain a consumer health information website containing information comparing the cost and quality of health care services and general information as appropriate to help consumers make informed decisions regarding medical care and to provide updated information on this website at least annually. The website should include, if possible:

- comparative information by facility, clinician or physician group practice for each service or category of service for which comparative information is provided;
- general information related to each service or category of service; and
- comparative quality information by facility, clinician or physician practice that is not service-specific, such as patient-safety and satisfaction information.

Insurers and health care providers will be required to submit data to the Council, as required by regulations to be promulgated, and financial penalties will be assessed, up to a $50,000 maximum, for failure to report data in a timely manner. The Council will monitor and report on the progress of its initiatives through conducting annual public hearings, reporting to the legislature at least annually, and establishing an advisory committee comprised of members of health care industry and other stakeholders.

Contact Information

Questions about these issues and about services that our firm provides in this area should be directed to:

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