

Overview: Oversight of reform seeks to balance quality and cost

Reform remains the major health care theme in Massachusetts as lawmakers make adjustments in response to membership and cost. Membership in the Health Connector's plans now hovers at around 181,700, and the cost of delivering care remains a challenge. The state's top reform activities in recent months were finalizing minimum standards for health coverage and adopting new fair share contribution rules for businesses.

The Health Connector board recently left minimum creditable coverage regulations for this January virtually unchanged. However, for 2010, it added to the list of required medical benefits and expanded expectations for qualified High Deductible Health Plans. Meanwhile, the Health Connector has yet to launch its contributory Commonwealth Choice plans for small employers with 1 to 50 employees.

The continuation of the Commonwealth's reform initiatives was blessed by the federal government's vital Medicaid waiver—a three-year, \$21.2 billion agreement in principle that is even stronger than the state's current waiver.

Cost control, in the state budget and health care delivery, was the focus on Beacon Hill in recent months. A major new law promoting electronic medical record keeping and banning some pharmaceutical gifts to physicians seeks to promote efficiency and reform in the health care system. Gov. Patrick proposed emergency budget cuts in October that curb MassHealth and the Division of Insurance budgets and slash the Health Care Quality and Cost Council established under the health care reform law. On the federal level, long-awaited mental health parity became law while Massachusetts expanded the conditions covered under its own 2000 law.

On the Medicaid front, MassHealth, the state's program, initiated its first reprocurement of the program since 1997. In Washington, legislators passed major Medicare legislation, the "Medicare Improvements for Patients and Providers Act of 2008."

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MassHealth issued the first Request for Responses since 1997 for a full reprourement of its managed care program. FCHP is awaiting a decision about participation in the program.

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Health care reform update—

Health Connector activities ...

■ **Minimum creditable coverage regulations finalized**

The Health Connector board that oversees health care reform announced at its October meeting that it would add no new requirements to the minimum creditable coverage standards for the January 1, 2009, implementation date. The board changes were minor or added clarity and flexibility to pending requirements. Any plan that met the original January 1, 2009, MCC requirements should meet the revised requirements effective January 2009.

Fallon Community Health Plan has taken steps to ensure that our FCHP Direct Care, FCHP Select Care and Fallon Preferred Care plans meet minimum creditable coverage. As of January 1, we will discontinue for all small groups and most individuals any existing plans that don't have prescription drug coverage. Large groups may request them on a non-standard basis. To replace these plans, FCHP is introducing new plan design options with a prescription drug coverage benefit of \$25/\$100/\$100.

More significant changes for 2010

The Connector board did make, however, a few substantial changes that will become effective only on January 1, 2010, to give employers and insurers another yearly renewal cycle to make any necessary adjustments.

- The board added several new items to the **definition of “broad range of medical benefits”**— including diagnostic imaging and screening; maternity and newborn care; medical/surgical care; radiation therapy and chemotherapy. No items were added to the definition of “core services.”
- **High-deductible health plans** will be required to include this broad range of medical benefits and pre-deductible preventive care requirements. The board notes that the deductible and out-of-pocket limits can be consistent with federal requirements and exceed MCC levels. Also, the plan sponsor must facilitate access to a Health Services Account (HSA).

[To view the Health Connector's MCC Information Sheet, click here.](#)

■ **Contributory plans for small businesses still pending**

The Health Connector is still working on the rollout of its contributory Commonwealth Choice plans available for small employers with 1 to 50 employees. An employer would select a Commonwealth Choice coverage tier and a health plan as the benchmark plan and also determine the contribution level. Employees then choose the benchmark plan or another plan within the same coverage tier.

Broker training for this product has been in progress. At its October meeting, the Connector board viewed a demonstration of the contributory plan “shopping experience” from the point of view of a broker or employer.

In a mandated report to the legislature, the Health Connector's Executive Director Jon Kingsdale notes that **“the single largest piece of unfinished business in the Connector's start-up plan is bringing a value-added offering to the small group market.** An innovative ‘choice’ offering is now being rolled out for implementation in the late fall of 2008. It is designed to provide broad choice of health plans to the employees of small employers and to facilitate easy annual renewal for those employers. Using competition and transparency, this offering is intended to encourage more employees to enroll by allowing them to select the plan that best fits their preferences and pocketbook.”

The Health Connector's report on the [implementation of the health care reform law from 2006 to 2008](#) is largely narrative, but does evaluate some elements of the law's implementation. Kingsdale notes, “There are many more challenges to come. The most pressing issue for the success of health reform is reducing the rate of growth in the cost of health care. ... Fundamental reform of provider

reimbursement and financial incentives in health care will be necessary to sustain near-universal coverage.”

■ Latest membership figures for Health Connector plans

The Connector board recently released its latest progress reports on membership in the Commonwealth Choice and Commonwealth Care products, which now totals 181,708.

As of November 1, 2008, the **Commonwealth Choice program continues to increase slowly**, showing a total of 18,987 members. (FCHP has approximately a 13% share of these members.)

Commonwealth Care membership continues to decrease. As of November 1, membership was down to 162,721 members from a peak of over 177,000 last February. The Health Connector is hopeful that the trend will eventually reverse, noting that enrollment activity continues to be high, just not high enough to outweigh disenrollment losses driven in part by the redetermination process. [that is, when information that impacts a member’s eligibility, such as income and employment, is updated and no longer qualifies that individual for the program.] FCHP’s Commonwealth Care membership totals have risen to nearly 8,700 members.

Massachusetts has the highest rate of residents with health insurance in the nation, according to a US Census Bureau study released in August. The study, which averaged data from 2006 and 2007, showed 92.1% of Bay Staters had health insurance. Nationally, nearly 86% of Americans were insured in that period.

Other reform activities ...

■ Rule changes for “fair share contribution”

The Massachusetts Division of Health Care Finance and Policy (DHCFP) announced October 1 that it adopted [revised Employer Fair Share regulations](#) that require employers to make “a fair and reasonable contribution” toward their employees’ health insurance coverage or pay a fee (\$295 annually per employee) to the state.

The original regulations exempted employers from the assessment if they either (1) had at least 25% of their full-time employees enrolled the employer’s group health plan, **or** (2) offered to contribute at least 33% toward the premium cost for a group health plan for full-time employees that had worked at least 90 days.

What’s new

The revised regulations—which take effect on January 1, 2009—maintain the existing “or” test for small firms with 50 or fewer full-time equivalent employees. **Companies with more than 50 full-time equivalent employees will be required to meet both tests.** However, firms with more than 75% of their full-time employees participating in their group health plan will automatically be exempt from the assessment.

The regulation also **shifted the assessment from an annual to a quarterly basis for all employers**, a change mandated by a provision of the supplemental budget bill passed last summer. The period from October 1, 2008, to December 31, 2008, will be the first quarterly filing period. For this quarter, the old requirements (33% contribution or 25% enrollment) continue to apply to all employers. For details, see the [“Fair Share Employer Contribution” regulations](#) (430 CMR 15:00) on the Web site of the Division of Unemployment Assistance, Executive Office of Labor and Workforce Development.

Businesses and insurance groups across the state had expressed strong opposition to imposing additional assessments and taxes to fund the health reform effort. The final regulation made a number of adjustments to the original proposal, based on the public comments.

The Division of Health Care Finance and Policy projects that these new regulations will generate \$30 million in revenue annually, compared to \$7.5 million under the former regulations. The funds will support government-funded health insurance programs, including Commonwealth Care, MassHealth and the Health Safety Net. The state estimates that approximately 1,100 firms will be liable for the fair share contribution under the new regulations.

■ **Individual coverage mandate is more complicated for 2008**

The state's Department of Revenue has developed the health care 1099 forms for tax year 2008. The 2008 process adds an additional layer of complexity in that **the individual mandate will apply for the entire year, with any gap in coverage of greater than 63 days subject to a penalty.** For 2008, therefore, forms will need to specify the time period a member was covered. (For 2007, individuals were only required to have coverage on the final day of the year.) For more details about the individual penalty, see the [Department of Revenue's Technical Information Release 07-18](#).

Fallon Community Health Plan will mail its commercial plan subscribers who are Massachusetts residents a 1099-HC form (proof of coverage) in January 2009, in time for tax filings. (This does not apply to our Fallon Senior Plan™, MassHealth or Commonwealth Care members.) The form shows coverage by each month in the year. Then, in turn, the subscriber (and dependents over the age of 18) will use the information on this form to complete state form Schedule HC when filing 2008 state income taxes.

■ **Fed's Medicaid waiver renewed for reform initiatives**

The federal government announced September 30 that it will renew the Commonwealth's health care reform waiver. The three-year, \$21.2 billion agreement in principle, which is expected to be formalized with the Centers for Medicare & Medicaid Services in the coming weeks, represents a stronger commitment to the principles of health care reform than the state's current waiver.

The new agreement, a \$4.3 billion increase over the current waiver, fully preserves existing eligibility and benefit levels as well as federal matching funds for all programs, including Commonwealth Care at 300% of the federal poverty level. The agreement protects federal matching funds for MassHealth waiver programs for the long-term unemployed, the disabled, and people living with HIV. It also allows the state to meet all of its health care obligations for the current fiscal year.

■ **DHCFP study reveals impact of mandated benefits**

The Division of Health Care Finance and Policy, pursuant to the health care law, completed last July its [Comprehensive Review of Mandated Benefits in Massachusetts](#). The report estimates that approximately 12% of health care premium dollars goes to mandated benefits. It claimed that this may be a high-end estimate, as some mandated benefits would likely be covered even in the absence of a mandate. However, the insurance industry has suggested that 12% may be an accurate estimate, arguing that some aspects of DHCFP's study tended to downplay the role of mandates.

Stateside—

■ **Flurry of bills ends July session**

In the weeks leading up to the conclusion of its 2008 formal session at the end of July, the state legislature passed several major bills affecting health insurance. Most bills that failed to pass at that time were deferred until the next formal session, which begins after January 1.

- **State budget**

Beacon Hill passed both a fiscal year 2009 budget bill and a supplemental budget bill. The supplemental appropriations bill, signed by Gov. Patrick in August, contained several provisions intended to raise additional funds for health care reform initiatives, most notably a \$33 million assessment on health insurers' reserves.

Update: On October 15, citing the downturn in the economy, **Governor Patrick proposed a number of emergency budget cuts.** Some of the cuts, in departments that report up to the Governor's office, are automatic, while others require the action of other elected officials or of the legislature. Some key items are:

- **Cuts in MassHealth** spending and in the Division of Insurance's budget.
- **A substantial cut of more than 40% in the Health Care Quality and Cost Council's budget.** The cuts quickly resulted in the layoff of all of the Council's permanent staff, including Executive Director Katharine London. The Division of Health Care Finance and Policy will assume staffing responsibility for the Council's day-to-day operations. The effect of this development on the future of the Council's data collection and its quality and cost Web site, one of its major initiatives, remains unclear. Data collection is continuing, and an October 23 Patrick Administration memo noted that the Web site "is expected to debut later this fall and will represent a significant first-step in transparency initiatives."
- **Changes to the Group Insurance Commission's** contribution structure, requiring high-salaried employees to make larger contributions to their health insurance coverage. Another GIC-related change would extend the time period each year in which municipalities can elect to join the GIC. On October 30, the legislature approved the municipality change, but has yet to approve the contribution change.

• **Cost control**

The legislature passed a final version of its much-anticipated cost control bill, originally proposed by Senate President Therese Murray. Signed by Gov. Patrick, the law seeks to promote efficiency and reform in the health care system, improve access to health care services, promote transparency of cost and quality data and encourage the adoption of health technology improvements.

The new law provides \$25 million to promote **electronic medical record-keeping** in doctors' offices and requires the state university to graduate **more primary care doctors**. The heavily publicized provision to **ban gifts by pharmaceutical manufacturers to physicians** was watered down in the final legislation. Rather than an outright ban, the law bans only certain types of gifts such as sports tickets and free travel, and requires that pharmaceutical and medical device-making firms publicly disclose gifts worth more than \$50. The Department of Public Health is required to develop a code of conduct for pharmaceutical manufacturers, who must publicly disclose certain information about their activities in this area.

The final bill also **includes several components that affect health insurers**, among them provisions establishing annual rate filings and hearings, setting statewide standards for uniform coding and billing, and requiring health insurers to recognize nurse practitioners as providers.

• **Benefit mandates**

Lawmakers passed two bills in July increasing the scope of existing benefit mandates. One new law ([Chapter 256 of the Acts of 2008](#)) **extends the state's current mental health parity law** ([Chapter 80 of the Acts of 2000](#)) to include a greater range of conditions than those currently covered, including substance abuse. (FCHP's current mental health benefit already has full parity for all mental health conditions. The current law, however, allows caps to be imposed in limited situations.) The new requirements go into effect at a group's first renewal on or after July 1, 2009.

A second law ([Chapter 214 of the Acts of 2008](#), *An Act Increasing Coverage of Nonprescription Enteral Formulas*) increased the cap on the mandate for **low-protein food products** from \$2,500 to \$5,000, effective in October 2008.

After the formal session ended, the legislature passed and the Governor signed the “**Children’s Mental Health**” bill. The new law ([Chapter 321 of the Acts of 2008](#)) doesn’t include any new benefit mandates. It requires pediatricians to routinely screen children for behavioral health problems, with parental consent. It creates a system for school personnel to receive consultation and guidance to recognize and better understand children’s’ mental health needs. Its main impact on insurers is a requirement that behavioral health vendors be identified by name on member identification cards.

The feds—

■ Medicaid

- **MassHealth, the state’s Medicaid program, issued an RFR for a full reprocurement of its managed care program**—the first reprocurement of the program since 1997. Fallon Community Health Plan submitted a proposal to continue its participation in the program. As part of this process, MassHealth is making a number of changes to program requirements. Examples include new requirements for complex case management, an expansion of eligibility, changes in MassHealth’s service area definition, changes in financial requirements and the addition of provisions related to the Children’s Behavioral Health Initiative. MassHealth’s response to health plans is pending. The reprocurement is for a January 1, 2009, renewal date, but due to the tight timeline, full implementation of new requirements will not occur until July 1, 2009.

■ Medicare

- A major piece of Medicare legislation, the “**Medicare Improvements for Patients and Providers Act of 2008**,” was enacted in July following a congressional override of President Bush’s veto. This legislation addresses several items, including scheduled cuts to physician reimbursement (which Congress had previously deferred to June 30, 2008), funding for the Medicare Advantage program and concerns about aggressive Medicare Advantage marketing practices. Key provisions of the law are as follows:
 - **There will be a phase-out reduction in the indirect medical education reimbursement to Medicare Advantage health plans.** This will cost insurers \$14 billion over five years. The savings to Medicare allows the scheduled pay cut to physicians to be postponed further for 18 months.
 - **Special Needs Plans (SNPs) received extended authorization** through calendar year 2010, but with a moratorium preventing new SNPs from entering the program.
 - Beginning with plan year 2010, **Private Fee for Service plans** will no longer be exempt from meeting Medicare Advantage provider network and access standards.
 - **Medicare Part D plans will be required to provide prompt payment of claims** within 14 days of receipt of clean claims submitted electronically and 30 days of receipt of clean claims submitted otherwise.

■ Federal legislative activity

New players in Washington

In an historic presidential election, the Democrats took control of the White House and extended their majorities in both the House and the Senate. With some races too close to call, the latest tally at print time has the Democrats with a 255-174 majority in the House of Representatives and a 57-40 majority in the Senate. The final headcount won’t tip the scales dramatically. Health care reform is likely to be a hot topic in the new administration, but may take a back seat in the short-term to other immediate-priority issues, such as the economy.

Mental health parity passes

The U.S. Congress recently passed the long-awaited federal mental health parity legislation as an attachment to the "financial bailout" bill (Emergency Economic Stabilization Act) that was passed and signed into law in early October (Public Law 110-343, Division C, Section 512, page 117, [Mental Health Parity and Addiction Equity Act of 2008.](#))

The legislation requires full parity for both mental health and substance abuse by including deductibles, copayments, out-of-pocket expenses, coinsurance, covered hospital days and covered outpatient visits. The measure also includes a small business exemption for companies with fewer than 50 employees, as well as a cost exemption for all businesses. For most groups, it becomes effective with the first renewal on or after October 3, 2009.

Fallon Community Health Plan either meets most of the law's requirements already or soon will under similar legislation recently passed at the state level enhancing the mental health parity law of 2000. Unlike the state law, which only covers fully-insured business, **the new federal requirements are applicable to most self-funded groups.**

Coming soon—

- Contributory Commonwealth Choice plans for small employers with 1 to 50 employees
- The Health Care Quality and Cost Council's "quality and cost" Web site

For more information

For more details on health care reform and FCHP products, turn to employer or broker section of our Web site, fchp.org. You'll also find past issues of [Eye on Government in Health Care](#) for easy reference.

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