Massachusetts Health Care Reform:

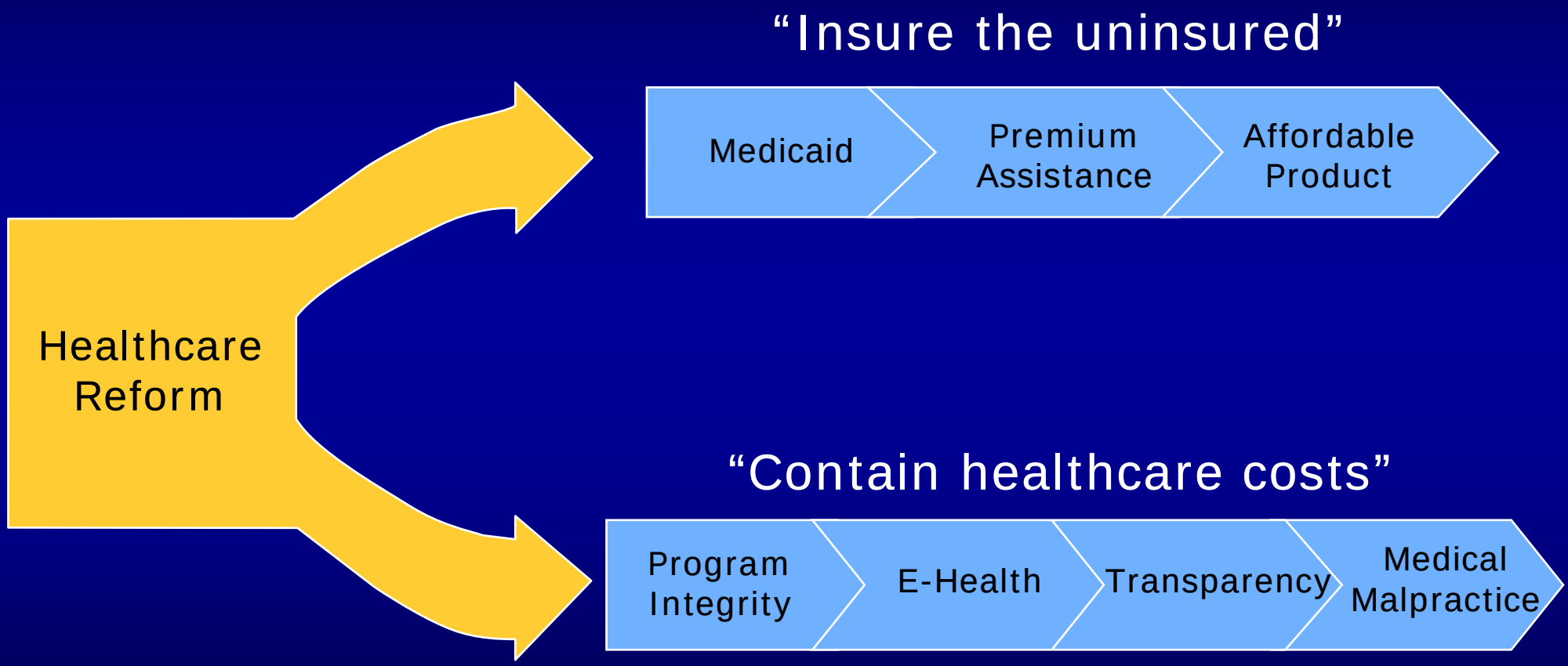
Using an 1115 Waiver to Provide Private Insurance to the Uninsured and to Contain Costs

Presentation to the Medicaid Commission

Governor Mitt Romney

January 26, 2006

Healthcare reform: Coverage and Cost Containment



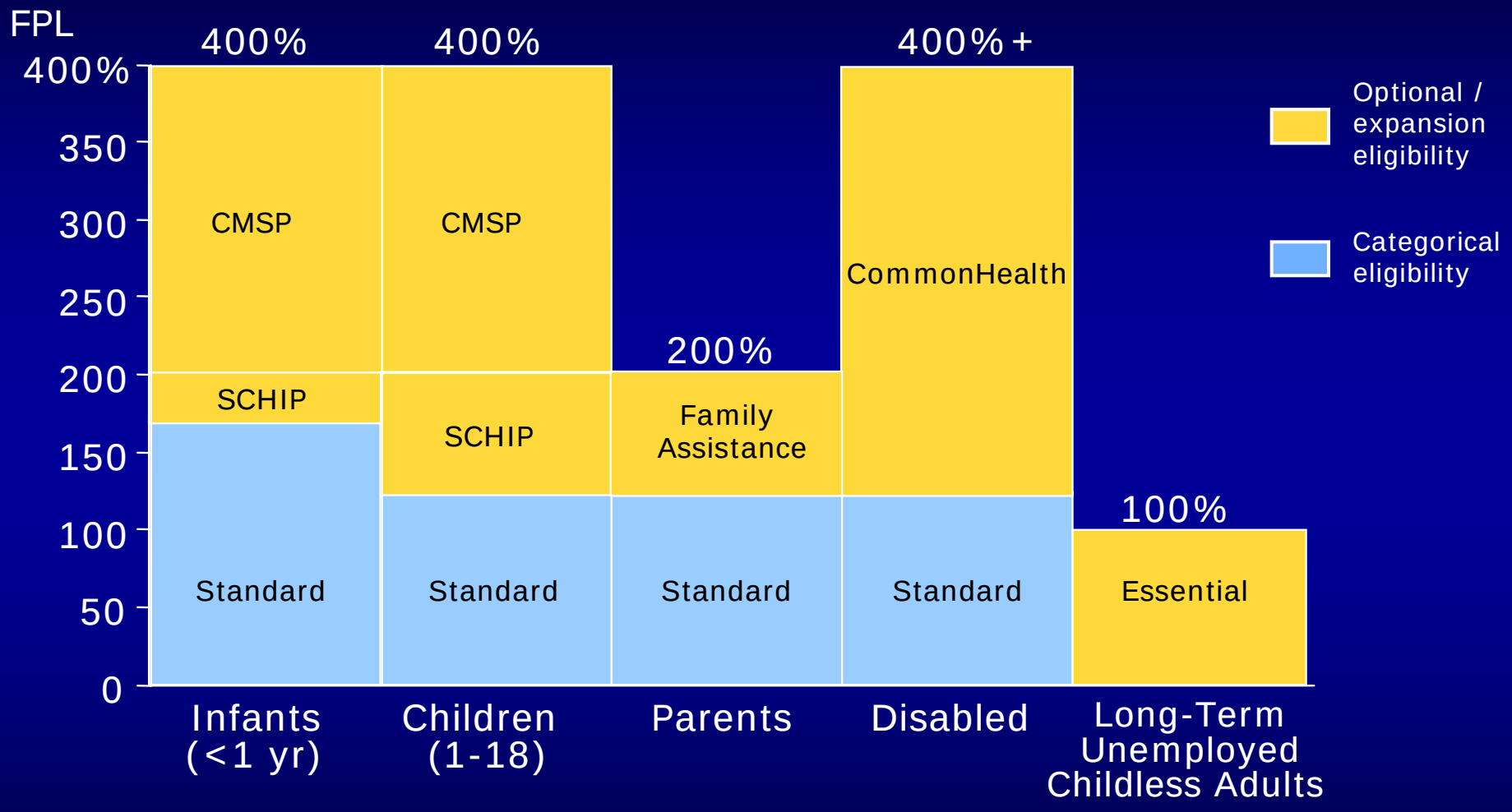
The Uninsured in Massachusetts

- Total Commonwealth Population: 6,400,000
- Currently insured (93%) 5,940,000
  - -Employer, individual, Medicare or Medicaid
- Currently uninsured (7%) 460,000

-≤100% FPL	Medicaid Eligible but unenrolled	106,000
-~100-300% FPL	Premium Assistance	150,000
->300 FPL	Affordable Private Insurance	204,000

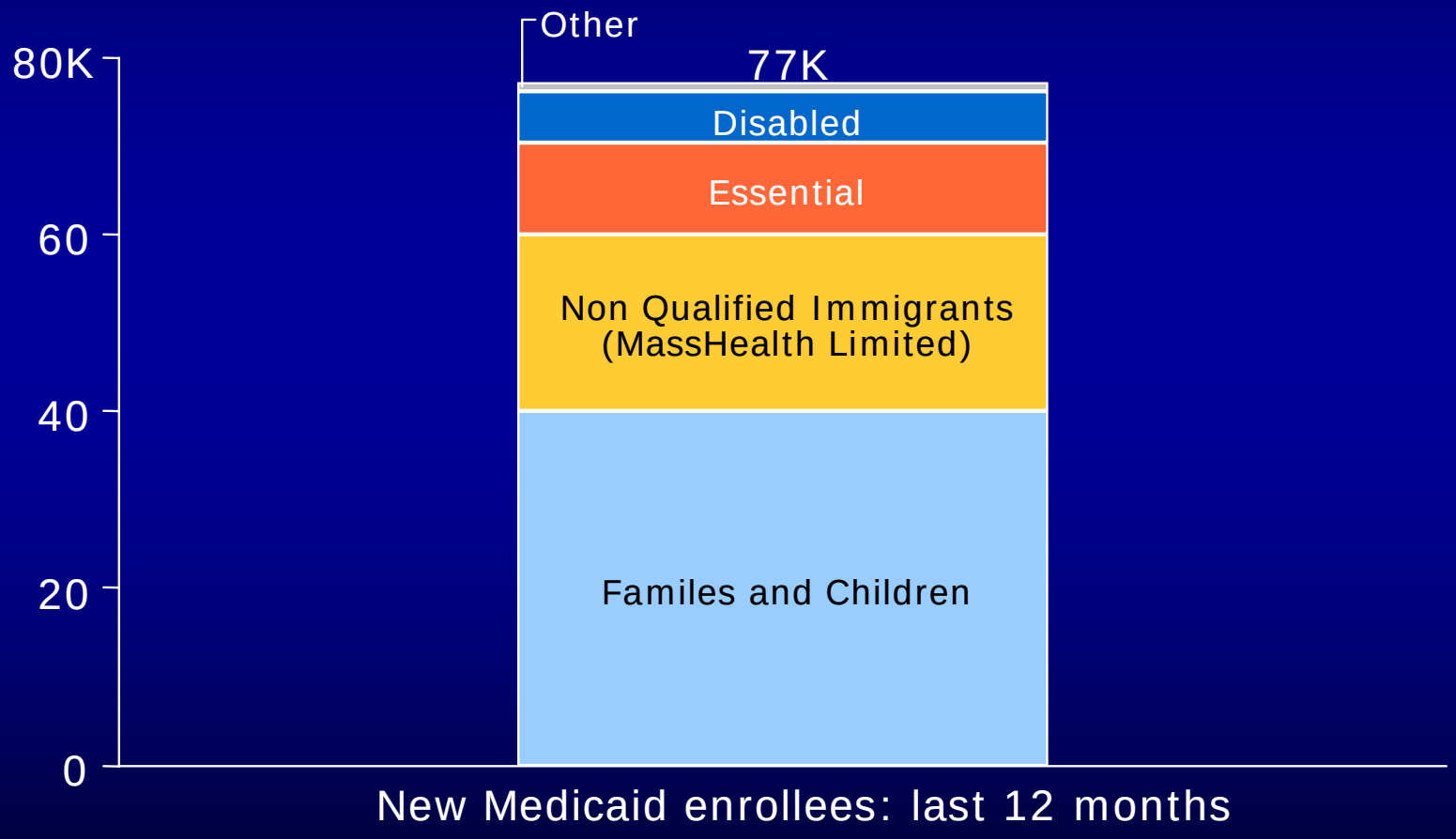
Note: Based on August 2004 Division of Health Care Finance statewide survey

Current MassHealth <65 eligibility: substantial optional and expansion populations



- **Standard:** Traditional Medicaid program and benefits
- **SCHIP**: Includes MassHealth buy-in to employee portion of employer sponsored insurance for parents of children covered under SCHIP
  CommonHealth: Sliding scale premium program for the working disabled
- **Children's Medical Security Plan (CMSP):** State-only funded preventive care program

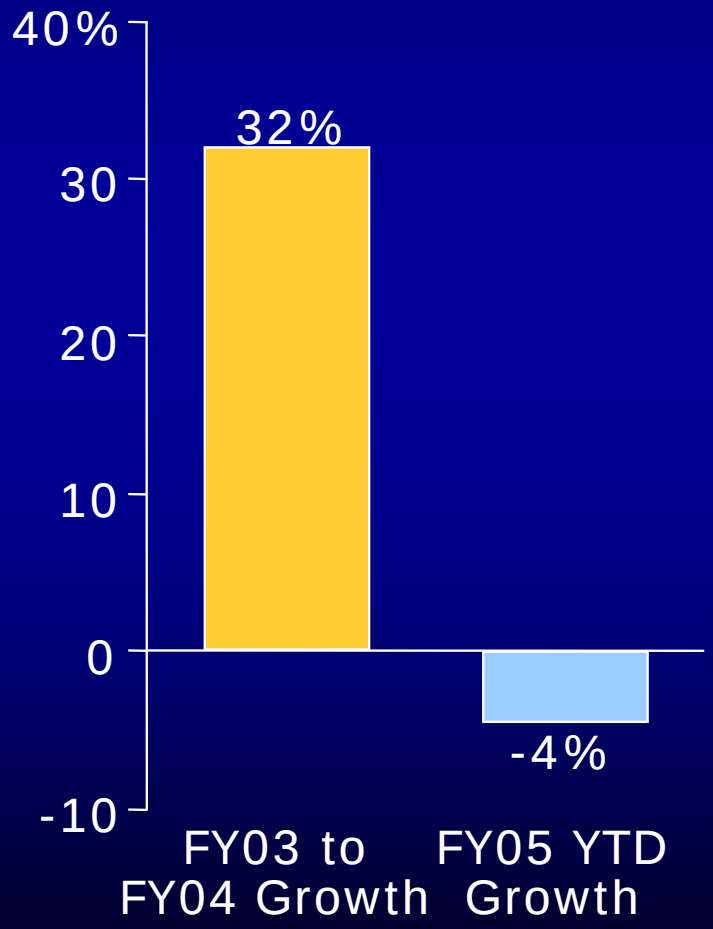
Through outreach and technology, MA has enrolled 77,000 Medicaid eligible “uninsured”



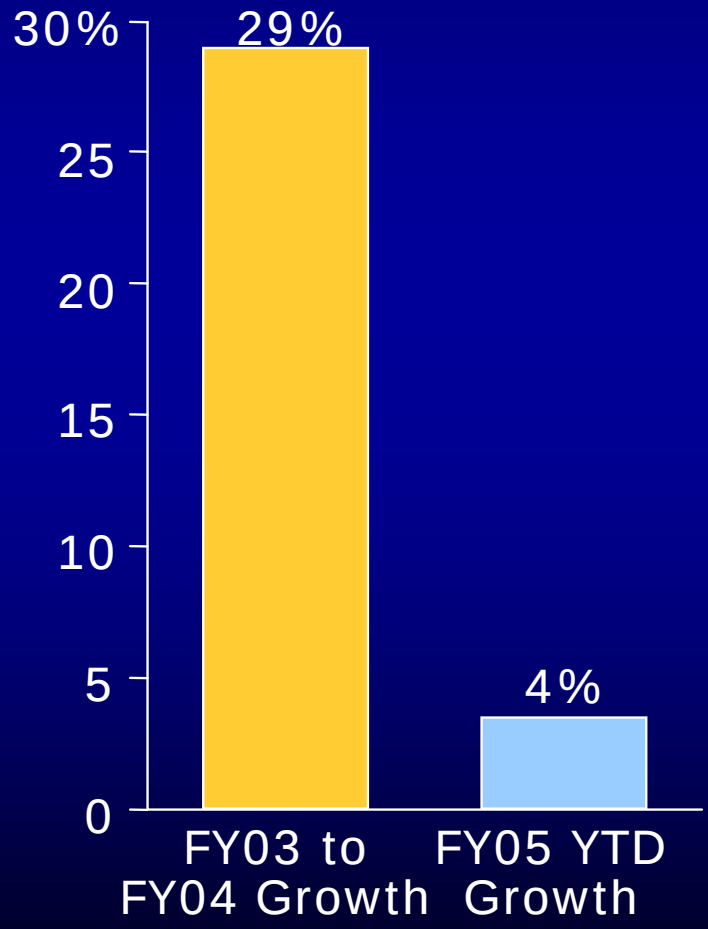
Note: Based on total MassHealth enrollment snapshot data through December 31, 2005.

Requiring enrollment of Medicaid eligibles is reversing free care utilization trends

"Free Care" visits and admissions



Growth in "Free Care" charges



Note: Based on Uncompensated Care Pool claims data through September 30, 2005.

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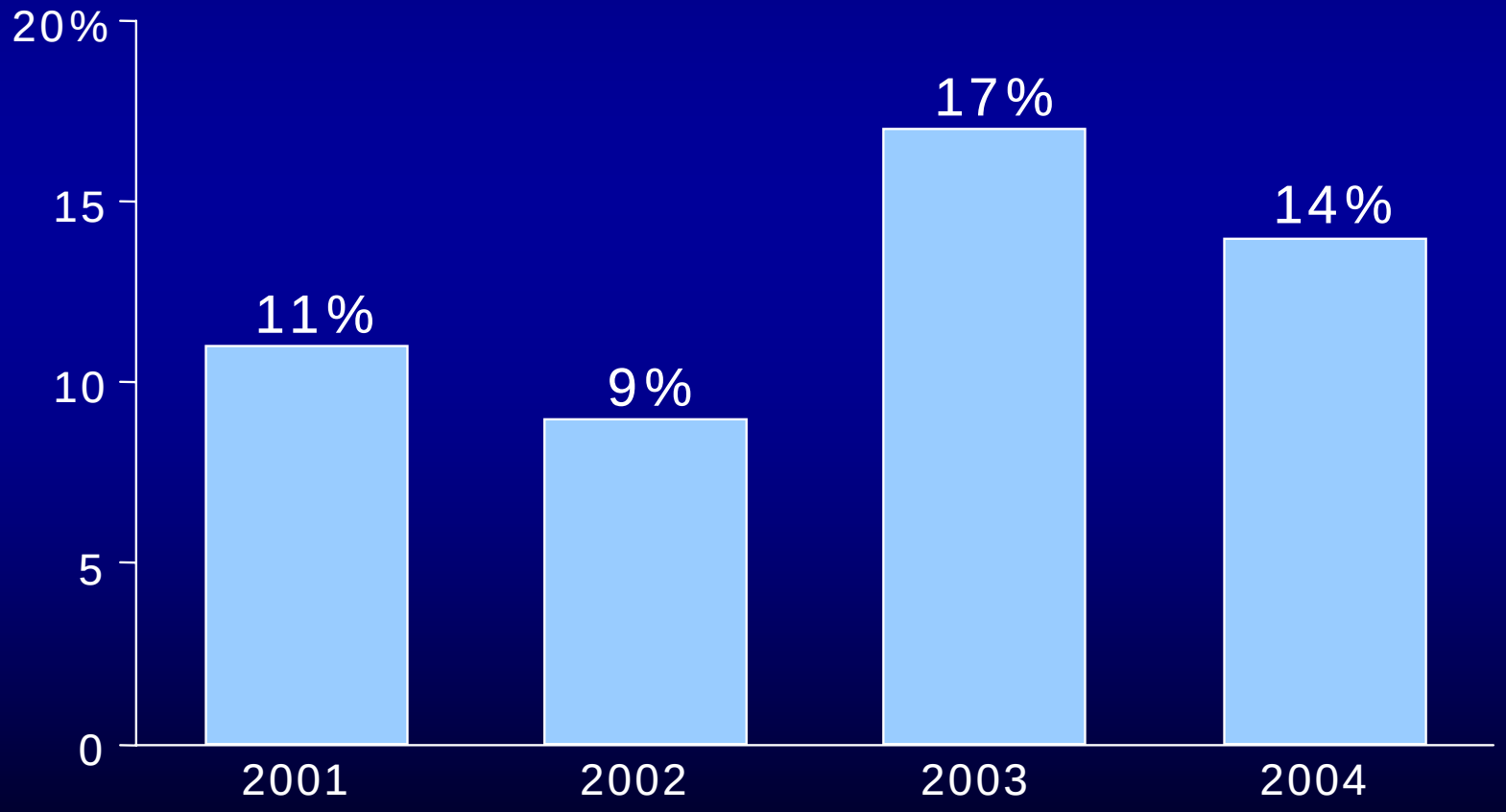
Premium increases are hurting small businesses and may lead some to drop insurance

Annual premium growth – small group family plans



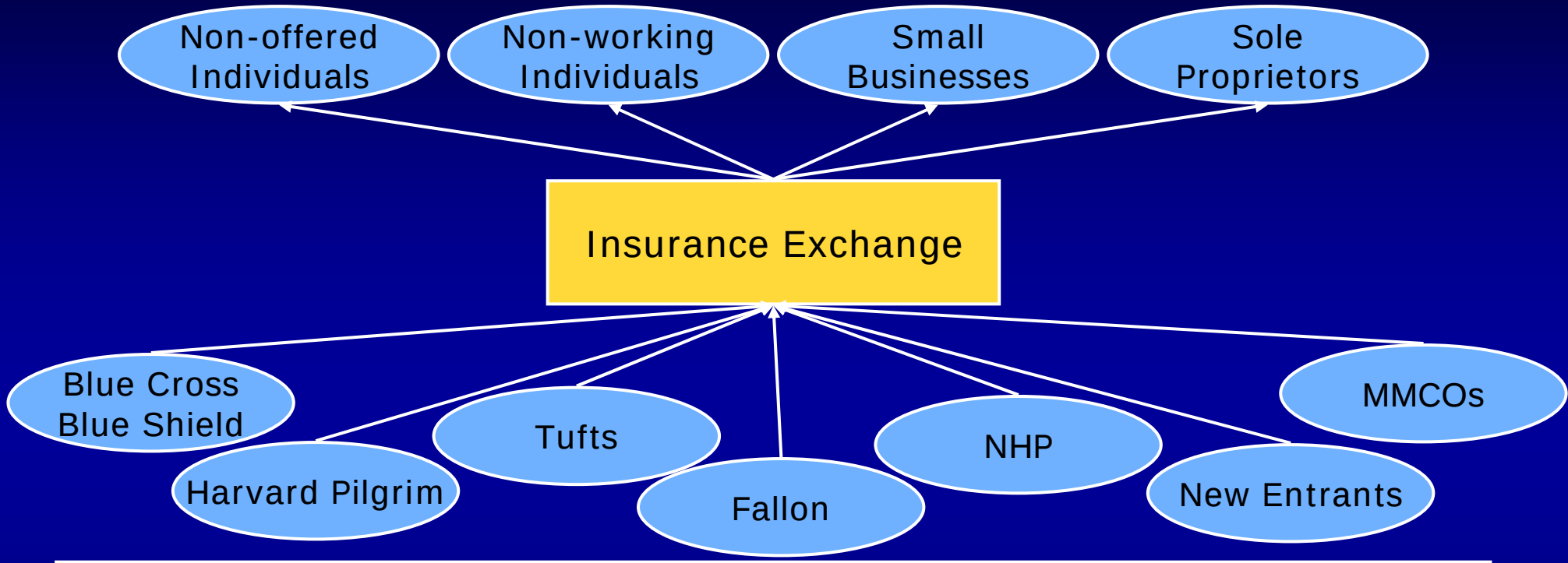
MA reforms address the crisis for small businesses and individuals

- Permits private insurers to offer new, affordable policies to small businesses and individuals
- Reduces cost through pre-tax treatment of premium payments
- Makes it easier for all businesses to offer insurance to their contractors and part-time workers
- Levels the playing field for small businesses and individuals who don't work for large companies
- Enables individuals to purchase health insurance that is portable

Commonwealth Care affordable products represent good value, and are comprehensive

	Standard Small Group	"Affordable Products"
Primary care	Yes	Yes
Hospitalization	Yes	Yes
Mental Health	Yes	Yes
Prescription Drugs	Yes	Yes
Provider network	"Open Access"	Defined
Annual deductible	"First Dollar Coverage"	$250-$1,000
Co-pays	Low ($0,10,20)	Moderate ($0,20,40)
"Mandated benefits"	Included	Exclusions permitted w/ board approval
Monthly premium	**$350+**	**Less than $200**

The Exchange/Connector makes it work



- Enables tax deductibility for working individuals
- Mechanism to reach part-time workers and individuals with multiple jobs
- Eliminates minimum contribution and minimum participation rules that make it difficult for small businesses to offer insurance
- Insurance portability from job to job

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Contrary to the common perception, this population is eminently insurable

- Substantially younger than the average population
- Predominantly male and single
- Representative of statewide mix of race and ethnicity
- 82% are high school graduates, of which 15% have college degrees
- 78% are working, with the majority working full-time
- Like others, these individuals respond very well to insurance-like features

Safety Net Care: Using premium assistance to make private insurance more affordable

- **Private health insurance** with the same benefits as affordable insurance products, but with **lower co-pays** and **no deductibles**
- Monthly premiums set according to a **sliding scale** based on individual income, as with SCHIP
- **Federal Waiver** requires that a Safety Net Care program begin by July 1, 2006 in order to maintain Federal Medicaid funding

Safety Net Care example

FPL	Single Person Income	Weekly Premium*	% of Income	Weekly State Subsidy*
<100%	$9,570	$2.30	1.3%	$66.93
150%	$14,355	$6.92	2.5%	$62.31
200%	$19,140	$11.54	3.2%	$57.69
250%	$23,925	$18.46	4.0%	$50.77
300%	$28,710	$32.31	5.8%	$36.92

*All numbers pre-tax; Assumes no employer contribution

Employers will remain the cornerstone for the provision of health insurance

- Existing IRS/ERISA provisions
- Existing and new state non-discrimination provisions
- Prohibition of indirect measures that circumvent the purpose of the law
- Competition for workers

The Personal Responsibility Principle

- Given Medicaid, premium assistance and affordable insurance products will be available, all citizens will have access to health insurance they can afford
- In this new environment, people who remain uninsured would be unnecessarily and unfairly passing their healthcare costs to everyone else
- Personal responsibility means that everyone should be insured or have the means to pay for their own healthcare

Personal Responsibility Principle Provisions

- A minimum level of insurance or proof of financial means will be required

- For those who do not comply:
  - -Loss of personal tax exemption
  - -Withholding of a portion or all of income tax refund for deposit in a state personal healthcare expenditure account
  - -Other penalties are under consideration

- For those without coverage that use medical services:
  - -Self-pay will be required
  - -If unable to pay, provider may request payment from the state personal healthcare expenditure account
  - -If the bill exceeds the account balance, an appropriate wage withholding plan will be established
  - -Other “free-rider” provisions are under consideration

Organizing principles for a “fully insured” population

- Stabilize the small group insurance market and keep small businesses from dropping insurance
- Introduce lower-priced, comprehensive health insurance products
- Bring younger, healthier people into the risk pool
- Create an Exchange to permit pre-tax premium payments
- Facilitate the purchase of insurance by part-time employees and employees with multiple employers
- Promote a culture of insurance and personal responsibility

Successful passage of healthcare reform legislation relies upon the MA 1115 waiver

- The Waiver commits new funding to MA predicated on three key conditions:
  - -MA must achieve benchmarks to lower the uninsured rate
  - -Funding follows the individual, not the institution
  - -Elimination of intergovernmental transfers
- Federal reimbursement can now be used for premium assistance for the purchase of private insurance by low-income individuals
- Premium assistance payments are paid with demonstration project and allowable DSH diversion funding
  - -First of its kind waiver allows DSH funds to be spent on non-hospital, non-CHC providers

CMS and the Commonwealth both benefit from this proposal

- Ensures program integrity
- Provides predictability in financial exposure
- Money follows the person, not the institution
- Improves transparency and accountability
- Emphasizes preventive care and appropriate care in an appropriate setting
- CMS maintains final approval of how money gets spent

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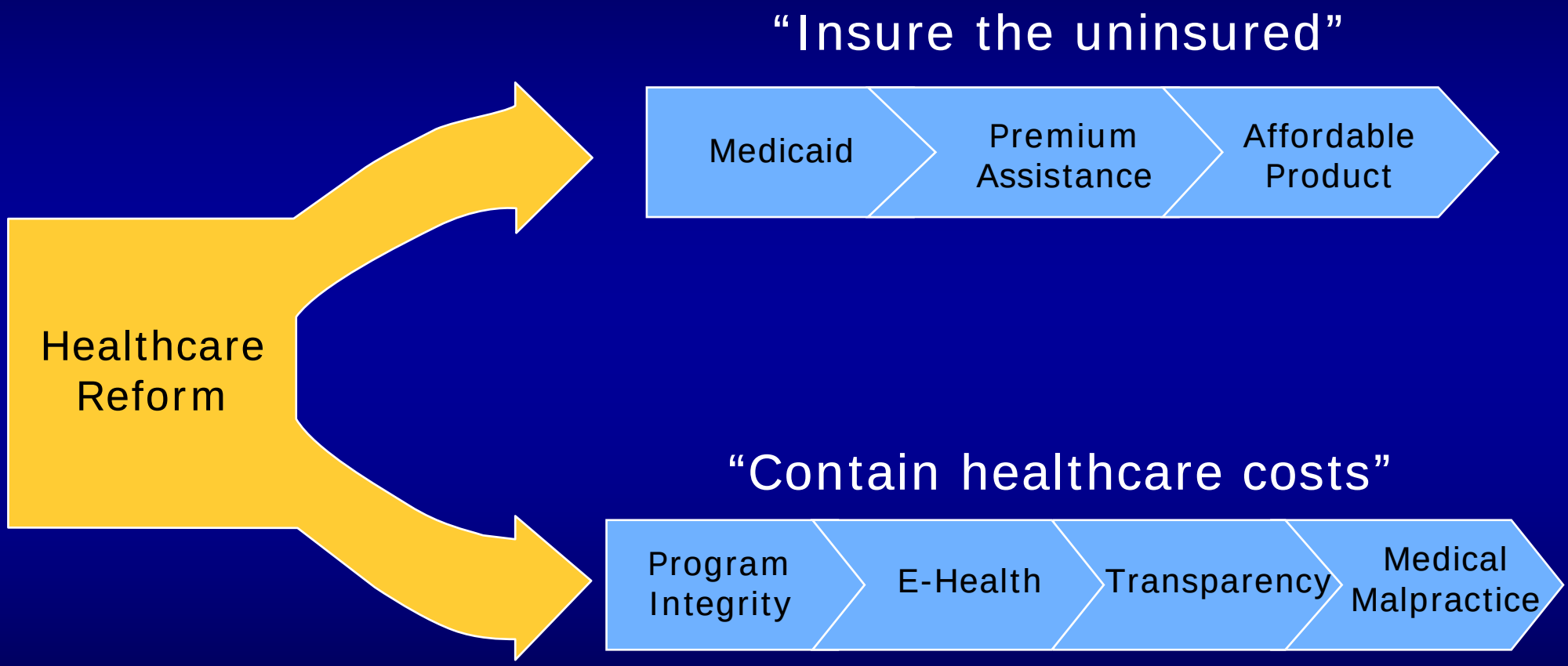

Consumer engagement is necessary to control healthcare cost

- Transparency – Patient Right to Know
  - Improve the understanding of price and quality
  - Reward efficient, high-quality providers
  - Website launched in October
- Electronic Medical Records
  - Massachusetts E-Health Collaborative pilot to implement electronic medical record systems in three regions
  - $50 million seed investment by Blue Cross/Blue Shield of MA Foundation
- Program integrity
  - Enhanced DOR income matching capability
  - Recent reorganization to strengthen program integrity function
  - Deployment of technology for improved provider and utilization review
- Medical Malpractice
  - Major patient safety legislation to be filed next month

“Patient right to know” – CABG example

Massachusetts Health Care Quality and Cost Information, by Hospital

Coronary Artery Bypass Graft Surgery (CABG) Mortality

Legend

★	Mortality significantly higher than state average	$	Hospitals with lowest 25% of costs
★★	Mortality as expected	$$	Hospitals in middle 50% of costs
★★★	Mortality significantly lower than state average	$$$	Hospitals with highest 25% of costs

Hospital Name	Quality	Cost	Total Cases	Days in Hospital
			4,604	
Hospital A	★★	$$	454	7
Hospital B	★★	$$	381	8
Hospital C	★★	$$$	623	9
Hospital D	★★	$$	296	7
Hospital E	★★	$	393	7
Hospital F	★★	$$	718	9
Hospital G	★★	$$	149	10
Hospital H	★★	$$	365	7
Hospital I	★★	$$$	191	8
Hospital J	★★	$$$	419	8
Hospital K	★★	$$	26	8
Hospital L	★★	$	80	7
Hospital M	★★	$	508	9

Notes:

Cost and Days data from FY02; Quality, Cases, from CY02 Mass-DAC, MDPH

Sources: DHCFP Hospital Discharge Data, DHCFP 403 Hospital Cost Report, Mass-DAC CABG report

For CABG methodology, refer to Mass-DAC report, October, 2004