



The Roadmap to Coverage – Preserving our Gains

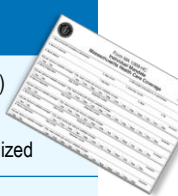

MLCHC – Community Health Institute
May 3, 2017

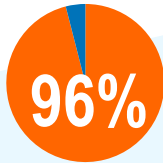
Audrey Shelto
President

Remember the Good Old Days?



A Quick Look Back: Comparing State and Federal Health Reform		FOUNDATION MASSACHUSETTS
	STATE (CHAPTER 58)	FEDERAL (ACA)
INDIVIDUAL RESPONSIBILITY	<ul style="list-style-type: none"> Affordability exemptions vary with income. MCC Penalties 	<ul style="list-style-type: none"> Affordability standard is set at 8%. MEC Penalties
GOVERNMENT SUBSIDIES	<ul style="list-style-type: none"> Medicaid Expansion for kids up to 300% FPL Subsidized insurance for adults up to 300% FPL 	<ul style="list-style-type: none"> Medicaid Expansion for adults up to 133% FPL Tax Credits up to 400% FPL (and Cost-Sharing Subsidies up to 250% FPL)
EMPLOYER RESPONSIBILITY	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> Small businesses with 11 FTEs RESERVED </div>	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> Small businesses with 50 FTEs DELAYED, NOT ENFORCED </div>
INSURANCE MARKET REFORMS*	<ul style="list-style-type: none"> Guarantee issue Prohibit pre-existing conditions that exclude coverage for 6 months beyond eligibility 2:1 age bands 	<ul style="list-style-type: none"> No discrimination based on health status/guarantee issue Prohibit pre-existing condition exclusions 3:1 age bands
<p>*The insurance market reforms in Massachusetts pre-dated Chapter 58 under separate legislation.</p>		
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Current MA Health Insurance Landscape		FOUNDATION MASSACHUSETTS
Massachusetts		
INDIVIDUAL RESPONSIBILITY	<ul style="list-style-type: none"> Coverage — maintained mandate to preserve coverage standards (MCC) Affordability — revised to maintain progressivity, while adopting 8% cap Penalty — “meshed” with federal to ensure residents are not dually penalized 	
MEDICAID EXPANSION AND GOVERNMENT SUBSIDIES	<ul style="list-style-type: none"> Expansion of Medicaid: transition from Commonwealth Care to MassHealth for individuals with income ≤133% FPL Tax Credits and Cost-Sharing Subsidies under ACA structured differently than Commonwealth Care program <ul style="list-style-type: none"> With federal support through the 1115 waiver, the state maintained existing premium subsidies and cost sharing levels up to 300% FPL New subsidy — in the form of federal tax credit — from 300–400% FPL 	
INSURANCE MARKET	<ul style="list-style-type: none"> Guarantee issue No pre-existing condition exclusions 2:1 age bands 	
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HIGHEST
COVERAGE
RATE IN THE
COUNTRY

ACA IMPLEMENTATION ISSUES RESOLVED



- Individuals in temporary MassHealth coverage moved to appropriate programs
- Annual eligibility redeterminations reinstated
- Connector website/ HIX functioning in real-time

CONTINUED OUTREACH TO THE REMAINING UNINSURED



FOCUS ON COST CONTAINMENT




- Chapter 224 passed in 2012

The Message in the Bottle:




Search ID: jstn251
"It says.... *desperately seeking someone to explain the difference between Obamacare and the Affordable Health Care Act...*"

<h2>Repeal and Replace Components under Discussion</h2>		 <small>FOUNDATION MASSACHUSETTS</small>
	CURRENT	POTENTIAL FEDERAL ACTION
Eligibility	<ul style="list-style-type: none"> ▪ MASSHEALTH: Most kids up to 300% FPL; most adults up to 133%; expansion – income-based (not categorical) ▪ CONNECTORCARE: Most adults up to 300% ▪ QHPs WITH TAX CREDITS: Some adults & kids between 300% & 400% 	<ul style="list-style-type: none"> ▪ No explicit changes ▪ States able to require able-bodied Medicaid recipients to work
INSURANCE MARKET REFORMS*	<ul style="list-style-type: none"> ▪ No discrimination based on health status/guarantee issue ▪ No pre-existing condition exclusions ▪ 2:1 age bands 	<ul style="list-style-type: none"> ▪ States can eliminate community rating ▪ States can decide EHB ▪ Allows higher premiums after lapse ▪ 3:1 – 5:1 age bands ▪ Eliminates individual mandate ▪ Eliminates employer mandate ▪ Keeps ACA parent coverage to 26
FINANCING	<ul style="list-style-type: none"> ▪ Cost sharing rebates (income sliding scale) ▪ Federal tax credits (income sliding scale) ▪ Waiver 	<ul style="list-style-type: none"> ▪ Eliminates federal support ▪ Age-based tax credits (\$2000-\$4000) ▪ ???

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7

<h2>Essential Health Benefits</h2>		 <small>FOUNDATION MASSACHUSETTS</small>
<ul style="list-style-type: none"> • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and SUD services • Prescription drugs 	<ul style="list-style-type: none"> • Rehab & habilitative care & devices • Lab services • Preventive & wellness services & chronic disease management • Pediatric services, including oral and vision care 	

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8

Medicaid's Current Financing Structure



States receive federal funding for all allowable program costs

- Federal dollars *guaranteed* as match to state spending
- In total, states are estimated to receive \$393 billion in federal Medicaid funds in FY2017 as a “match” to a projected \$230 billion in state funds
- Matching rates vary by state, population, and service. For example, MassHealth gets:
 - MassHealth Standard = 50%; CHIP = 88%; ACA expansion = 86%
 - Enrollment and eligibility systems = 75%; IT system upgrades = 90%
- Must follow federal rules (or waiver terms & conditions)

Massachusetts Key Facts

- \$13.7 B total spending FY15 (including federal and state funds)
- 50% federal match rate (avg.)

Medicaid Financing Structure: Alternative Options



	Current	Block Grants	Per Capita Cap
Federal Funding	Open ended	Aggregate amount	Per enrollee amount
Risk	Federal and state government share enrollment and spending risk	State bears enrollment and spending risk	States bears spending risk
Annual Trend	Determined by costs and individual state spending decisions	National benchmark trend rate (likely below medical inflation)	National benchmark trend rate (latest proposal is medical inflation)
Responsiveness to Medical Advances or Public Health Crises	Responsive	Not responsive	Not responsive
Spending Outside of Cap	N/A	Proposals to date would put most or all spending in the cap	Latest proposal would exclude admin, DSH and spending for certain limited-benefit populations
State Flexibility	State flexibility subject to federal minimum standards; Section 1115 waivers provide additional flexibility	Increased flexibility, but likely with some minimal benefit and accountability standards (e.g. mandatory service coverage for elderly and disabled populations)	Increased flexibility, but likely some minimal benefit and accountability standards
State Spending Requirements	State spending required; Match rates vary by population, services	Uncertain	State match likely but not certain

Medicaid Financing Structure and State Flexibility



Capped funding proposals may be coupled with new state “flexibility”, including the ability to:

- Make changes in coverage for mandatory and optional populations – beyond the “expansion” population:
 - Capped enrollment
 - Waiting lists
- Add new restrictions on eligibility and enrollment:
 - Open/closed enrollment periods
 - Monthly reporting and other paperwork requirements
- Modify benefits or require premiums and/or copayments
- Impose fewer federal rules on managed care and scope of benefits

Federal Vehicles for Changing ACA



- **Legislative**
 - Discussion on a repeal/replace bill ongoing; specific components unclear
 - Cost Sharing Reductions (de-funding or by dropping lawsuit)
- **Regulatory Processes**
 - Essential Health Benefits
 - Section 1115 Waivers
 - Section 1332 Waivers
 - Open Enrollment Periods and Premium Payment Grace Periods
- **Executive Order - Enforcement**
 - Individual Mandate
 - Employer Mandate

Confusion. Bigly.

“Pre-existing conditions are in the bill. And I just watched another network than yours, and they were saying, ‘Pre-existing is not covered.’ Pre-existing conditions are in the bill. And I mandate it. I said, ‘Has to be.’”



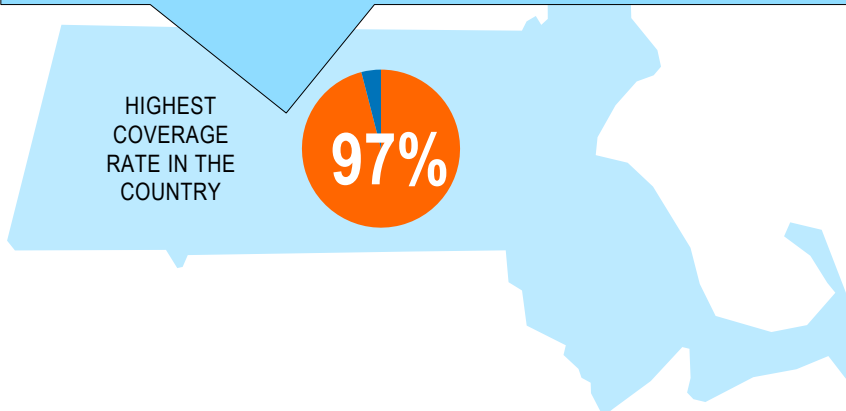
“Most importantly, we’re going to drive down premiums. We’re going to drive down deductibles because right now, deductibles are so high, you never – unless you’re going to die a long, hard death, you never can get to use your health care.”

POTUS: “We’re taking across all of the borders or the lines so that insurance companies can compete --”
Dickerson: “But that’s not in --”
POTUS: “—nationwide.”
Dickerson: “—this bill. The borders are not in—”
POTUS: “Of course, it’s in.”

Governor Remains Committed to Coverage

“I’m not going to speculate on what the terms or conditions or the nature of whatever it is might happen in Washington will look like, but we’ll obviously work to make sure that the people of Massachusetts continue to have access to a system that virtually covers everybody.”

-Governor Baker



Delegation Remains Committed to Coverage



Joe Kennedy III attacks GOP health plan for its 'malice'

The current system isn't perfect — not by a long shot. But the GOP's strategy for Obamacare? Repeal and Run.



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15

Local Activities to Preserve Coverage



- **MA Coalition for Coverage and Care** co-convened by Foundation & Health Care for All
 - Over 70 organizations and 9 individuals: consumers, business, insurers, labor, hospitals, doctors, community health centers, religious groups and many others
 - Guiding Principles:
 - **Preserve and improve access to, and the affordability of, health insurance coverage in Massachusetts**
 - **Protect the gains in access to care, health, and health equity that have resulted from near universal coverage in the state**
- Educational resources describing impact of federal changes on Massachusetts
 - Manatt Health – Proposals to Cap State Medicaid Funding: Massachusetts Considerations
 - Urban Institute – Health Insurance Policy Simulation Model (HIPSM) calibrated to MA to assess health insurance coverage and cost implications of potential changes

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16



Thank you !