



FEDERAL AND STATE HEALTH REFORM HIGHLIGHTS – 2014

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MARGE HOUY, SENIOR CONSULTANT
BAILIT HEALTH PURCHASING, NEEDHAM, MA

ATTORNEY PAUL V. MULKERN, JR.
MILTON, MA

Topics

- Massachusetts Health Care Reform Update
 - High Cost of Care in Massachusetts
 - Responses
 - Action Steps for Municipalities
- ACA Update
 - Employer Mandate
 - Minimum Value Standard
 - Affordable Coverage
 - Employee Eligibility for Subsidized Coverage
 - Implications for Municipalities
 - Individual Shared Responsibility Mandate
 - ACA Cadillac Tax

Setting the Context

- Massachusetts Health care reform legislation enacted in 2012, Chapter 224, promotes cost containment in part by:
 - Reporting on cost trends, provider price variation and payment methodologies
 - Conduct Cost and Market Impact (CMIR) reviews of material changes in provider operations or governance structure, such as mergers and acquisitions, that may negatively impact costs
- Review key findings of two key reports
 - 2013 Annual Report on MA Health Care Market, August 2013; Center for Health Information and Analysis (CHIA)
 - 2013 Cost Trends Report, January 2014, Health Policy Commission
- Discuss implications for municipalities

High Cost of Care in Massachusetts

- MA's per capita spending is highest of any state in US
- Per capita personal health care expenditures* are 36% higher than US average
 - Almost half can be explained by older population, high provider costs, broad insurance coverage
 - MA residents use significantly more hospital services and LTC services compared to national average. Compared to US averages, MA residents
 - Were admitted to hospital 10% more often after adjusting for age
 - Visited ED 13% more often
 - Used hospital-based OP services 72% more often

*includes spending on activities related to maintaining and improving both physical and behavioral health and includes spending on services not covered by health insurance.

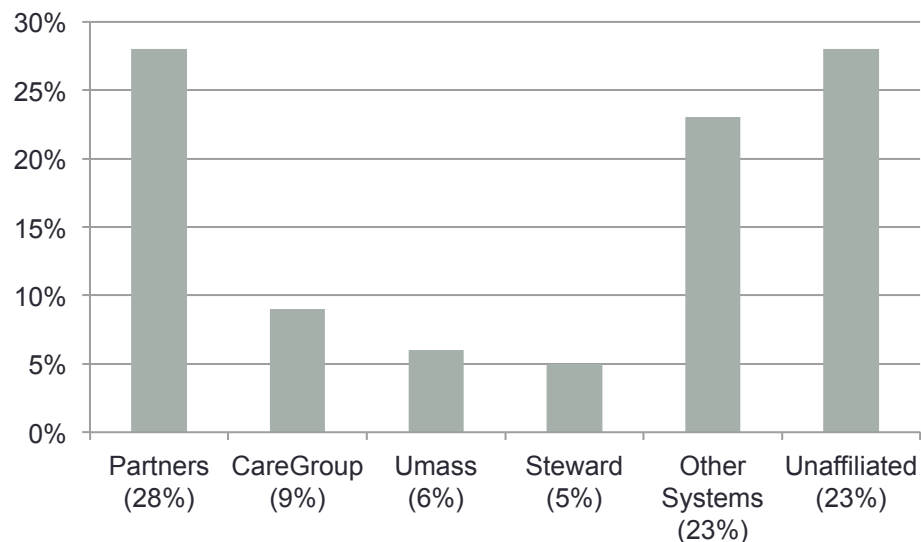
Prices are Driving Cost Increases

- Increases in spending by commercial payers between 2001 and 2011 was primarily driven by price
 - Impact of higher unit prices
 - Use of higher-priced providers



Payments to Higher Cost Providers

- Most payments are going to high cost providers
 - 80% of total hospital and provider payments were paid to providers with prices above the network median
 - Top 25% highest paid providers received 51% of total payments
- Systems received over 2/3rds of commercial payment in 2011



Largest Hospital & Physician Systems

System	Hospitals	Affiliated Doctors	Other
Partners	8; 3 more pending	1165	Considering own insurance product; SSH merger challenged
Steward	10	559	
Atrius	0	518	
BI Deaconess	3	369	BID+Lahey+Atrius = 1054 physicians
NE Quality Alliance	0	365	
UMass	5	347	
BMC	0	347	
BayState	3	301	
Lahey	0	167	

High Costs Tied to Market Leverage

- Provider organization size and market leverage are correlated with higher prices
- Prices among hospitals differ significantly and cannot be explained by differences in quality of care or types of patients treated
 - Partners had acute hospital prices above network median price across all payers' networks
 - Steward HealthCare and Circle Health (Lowell Gen Hosp) had acute hospital prices below median price among most payers
- Partners and Atrius physicians had relative price levels significantly higher than network median across most payers in 2011

Total Relative Costs

- Health Risk Adjusted Total Medical Expense (TME)
 - Partners was the only group with TME above network average for BCBS, HPHC and Tufts
 - Health Alliance with Physicians (UMass) was only group with TME below network average for BCBS, HPHC and Tufts

Response: Increase Hospital Efficiency

- Hospitals with higher expense structures could reduce operating expenses, while maintaining equal or better quality of care
- Inpatient operating expenses across all MA hospitals varies greatly
 - Differences among operating expenses per discharge of 23% between 25th (\$8,157) and 75th (\$10,032) percentiles
- Even among major teaching hospitals, there is a wide range of operating expense levels
 - Differences among operating expenses per discharge of 35% between 25th (\$8,626) and 75th (\$11,933) percentiles
- Some hospitals achieve high quality with lower operating expenses

Response: Reduce Wasteful Spending

- In MA between 21% and 39% of all spending is wasteful
 - Overtreatment: unnecessary or use of setting more intensive than necessary. MA service intensity is approximately 3.5% higher than US average
 - Poorly delivered care: hospital acquired infections, ineffective preventive care. \$300 - \$450 million
 - Failures of care coordination: avoidable readmissions. \$700 million
 - Higher prices: significant variation in relative prices not tied to quality or patient characteristics
 - Administrative complexity: physicians report spending >10% of income on administrative costs.

Response: New Payment Methodologies Promote Value

- Current fee-for-service payment (FFS) methodology promotes high utilization and fragmented care, which is costly
- Payers/providers moving to Alternative Payment Methodologies that reward pay for better integrated care, improved quality and reduced costs

FFS → partial global payment → full global payments

Alternative Payment Methodology

- Alternative Payment Methods by commercial insurers in 2012 (APM)
 - FFS: 64% of commercial payer payments to providers
 - APM: 35% of commercial payer payments and only within HMO insurance products
 - BCBSMA: 49% under APM
 - Tufts: 38% under APM
 - HPHC: 30% under APM
- Medicaid and Medicare also moving to APMs
- State moving towards tipping point to create major shift in how care is delivered

Action Steps for Municipalities

- Understand your group's cost drivers
 - Ask your plan for its assessment of your group compared to plan, regional and industry benchmarks
 - Understand how the changing market will impact your group
- Use your purchasing power to establish performance standards for payers and providers. For example:
 - Require a certain percentage of your claims payments be subject to alternative payment methodologies
 - Require that quality incentives address key sources of wasteful spending
 - Penalties for avoidable inpatient readmissions
 - Tie hospital payments to implementation of IHI programs to reduce hospital-acquired infections

Involve Your Enrollees

- Structure plan designs to encourage appropriate use of services. For example:
 - Tiered or limited network to incent use of efficient hospital/providers
 - Increase co-pay for ED services to incent use of PCP
 - Incentives to select providers who practice in Patient-Centered Medical Homes
 - Provide incentives to make lifestyle changes (e.g., smoking) that directly impact health care costs
 - Provide incentives that encourage members with chronic conditions to obtain all recommended care (e.g., zero co-pay for specific diabetes-related drugs and services)

Questions and Discussion

Employer Mandate

- Perhaps the most significant change scheduled to be implemented in 2014 – but now deferred until 2015

Effective in 2015, employers with at least 50 full-time employees (or 50 full-time equivalents) must offer their full-time employees (average 30 hours of service per week) health insurance coverage that meets shared responsibility standards:

- Plan covers at least 60% of covered health care expenses for a typical population (minimum value standard)
- Plan is affordable

Minimum Value Standard

- The plan must cover at least 60% of total health care costs under the plan. If out-of-pocket costs such as co-pays/co-insurance/deductibles represent 40% or more of total health care costs under the plan, the plan does not satisfy standard
- It is our understanding that most, if not all, plans offered to municipalities by the State's non-profit insurers satisfy this standard.

Affordable Coverage

- Coverage is affordable if the employee's share of the premium expense:
 - For the lowest cost individual coverage offered by the employer
 - Does not exceed 9.5% of the employee's household income
- Since employers will not know total household income, Federal Regulations create 3 Safe Harbors
 - W-2 wages
 - Rate of Pay
 - Federal Poverty Line

Eligibility for Subsidized Coverage

If	If
the employee is not eligible for coverage through employment	the employer's plan does not meet affordability requirements or minimum value standards
Then	And
Employee may obtain coverage through the Connector	If the employee's household income is less than four times the Federal Poverty Level (\$94,200 for family of 4),
	Then,
	the employee will be eligible for premium tax credits

Implications for Employees

- Because the affordability test is based on household income compared to the cost of individual coverage.
 - Lower paid Employees with families may not qualify for premium subsidies despite the fact that their share of Family plan premium is very expensive.

Individual Shared Responsibility Mandate

Unlike Employer Mandate, the Individual Shared Responsibility Mandate and the individual penalties that attach have not been deferred and are effective in 2014.

- Individual must either:
 - Be enrolled in minimum essential coverage, or
 - qualify for an exemption, or
 - pay a shared responsibility payment
- The penalty in 2014 will generally be the greater of:
 - \$95. (\$47.50 for dependents under 18) for each person for whom the taxpayer is liable (up to a \$285. maximum) or
 - 1% of the employee's household income for the year

Most Significant Issue For MA Public Employers?

Eligibility of “Temporary” Employees Including Substitute Teachers

- ACA requires that Large Employer offer coverage to employees who average at least 30 hours per week
- NEW HIRES – must be offered coverage no later than 90th day of employment if the Employer reasonably knows that a new employee will average at least 30 hours per week

e.g. substitute teacher hired to fill-in for teacher on year-long child rearing leave

VARIABLE HOUR EMPLOYEES

If Employer does not reasonably know how many hours the employee will work employee considered variable hour employee

SEASONAL EMPLOYEES

Regulations don't provide a definition – “good faith”
determination by employer

But regulations clear that substitute teachers are not
seasonal employees

Ongoing Variable Hour Employees

- Employer adopts standard measurement period of 3 to 12 months
- At conclusion of period, Employer determines whether employee has averaged 30 hours per week
- N.B. In determining whether the employee has averaged 30 hours per week, paid leave is counted as hours worked. Unpaid leave is generally not included. However, unpaid leave for
 - a.) the FMLA
 - b.) USERRA (military leave)
 - c.) jury duty

must be excluded from the calculation

School Employees

- Summer school break must be excluded from the calculation
- e.g. If Employer elects a standard measurement period of 12 months, substitute teacher who is off for 12 weeks during the Summer, will have her/his annual hours divided by 40 (rather than 52) in determining whether s/he averaged 30 hours per week over that 12 month Standard Measurement Period

At the end of the Standard Measurement Period

The Employer determines whether the employee has averaged at least 30 service hours per week

Standard Stability Period

- Follows the Standard Measurement Period (although an Employer may elect to separate the Measurement Period and the Stability Period with the Standard Administrative Period of up to 90 days' duration.)
- The employee will either be eligible or ineligible for coverage during this stability period – depending on average hours during Measurement Period

Duration of Stability Period

- 6 months or the same length as the Measurement Period, whichever is greater
- Change in hours worked during Stability Period does not effect eligibility during that period

New Variable – Hour Employees

- If Employer reasonably knows at time of hire that employee will average 30 hours per week, it must provide coverage within 90 days – no measurement period
- If Employer does not know at time of hire whether the employee will average 30 hours:
 - Initial Measurement Period
 - Initial Administrative Period
 - Initial Stability Period

Initial Measurement Period

Begins on employee's start date or the 1st day of the succeeding month and lasts for a minimum of 3 months and a maximum of 12 months (Employer Choice)

Initial Administrative Period

- Up to 90 days except that the Initial Measurement Period and the Initial Administrative Period combined may not exceed 13 months (plus fraction)

Initial Stability Period

May last up to one month longer than Initial Measurement Period but in no event longer than 12 months.

- Regulations allow Employers to transition new employees onto the Standard Measurement/Administrative/Stability Period cycle once a determination regarding eligibility has been made under the initial process

Penalty Considerations

- If coverage offered to less than 95% of eligible full-time:
 - PENALTY: \$166.67 per month (\$2,000 per year) x total employees (but not including first 30 employees)
- If coverage offered to 95% or more of full-timers:
 - PENALTY: \$250. per month (\$3,000 per year) x number of employees who purchase subsidized coverage through the Massachusetts Connector

M.G.L. c. 32B, Section 2(d)

Bases eligibility on whether employee's duties require "not less than 20 hours, regularly, in the service of the governmental unit during the regular work week of permanent or temporary employment" (emphasis supplied)

- Thus, Chapter 32B does not deny eligibility to an employee because her/his employment is temporary.
- Quite possible that an individual who is hired to substitute for a teacher who will be absent for 3 months or longer is eligible for coverage under c.32B

Temporary Employees

- By the same token, it is arithmetically difficult to envision many situations where a day-by-day substitute who “averages” 30 hours per week over an extended period does not work more than “20 hours, regularly, in the service of the governmental unit during the regular work week of permanent or temporary employment.”

Bottom Line Analysis

- In short, if Employers deny coverage to employees who qualify as full-time under the ACA (and elect to pay the penalty, instead) it is quite conceivable that those employees take legal action to secure coverage under c. 32B.

ACA CADILLAC TAX

Effective January 1, 2018

ACA Cadillac Tax — Imposes a 40% excise tax upon the amount by which employment-based health insurance premiums exceed statutory thresholds

- **General Thresholds**

- \$10,200 – Individual
- \$27,500 – 2 person or Family coverage

- **Higher Thresholds for plans that cover:**

- a.) pre-Medicare retirees, and/or
- b.) have the majority of workers employed in high-risk jobs (e.g. fire, police, construction or mining)
- \$11,800 – Individual
\$30,950 – 2 person or Family

Thresholds linked to inflation –

But to the extent that medical inflation exceeds the general rate of inflation, more and more plans will exceed the thresholds.

Estimates of the impact of the tax vary widely

Some consultants estimating that, by 2029, 75% of health plans will be effected by the tax.

Employers taking action to avoid the tax:

1.) increasing co-pays, deductibles and other cost-sharing devices

2.) reducing benefits

Particular challenges to MA employers as:

1. high cost medical care
2. statute doesn't currently index thresholds by geographic area

Questions and Discussion