

IADDA Annual Conference

September 7, 2011



Health Care Reform in
Massachusetts and the ACA:
Implications for the State,
Providers and Consumers

Overview of Uninsured in Massachusetts (2004)



- Estimated 460,000 uninsured adults -7.4%
- Highest rate among 19-24 year olds – 25.4% - similar to national data
- Rates highest among blacks, Hispanics
- 48.7% above 300% FPL
- Highest rates of uninsured among part-time workers at small employers

Key Elements of HCR

- Similar to elements of national HCR
- Passed in April 2006
- Individual mandate – tax penalty
- Employer mandate
- Government mandate – Medicaid expansion, subsidized plans
- Created “Wellness Fund”
- “Connector Authority” to oversee plans, cost, benefits
- Tension around overall financing and plan affordability v. benefits package

Expanded Coverage

- Medicaid expansion to children with family income less than 300% FPL
- Eliminated enrollment caps for long-term unemployed adults, HIV+ and disabled working adults
- Provides sliding-scale subsidies up to 300% FPL – Commonwealth Care
 <150% FPL - no premiums, no deductibles
- Offered by same MCOs as Mass Health (Medicaid) program
- “Affordable” plans for individual purchase above 300% - Commonwealth Choice

- Enrollment began in May 2007
- As of April 1, 2008, about 175,000 enrolled, exceeding estimates by more than 30,000
- As of Nov. 2010, 401,000 enrolled

Commonwealth Care SUD Coverage



- Advocacy by SUD/MH community led to improved SUD/MH benefits
- Different plans cover different services
 - All plans cover methadone maintenance, buprenorphine, inpatient and outpatient
 - no co-pay for methadone maintenance
 - Varying premiums, co-pays by plan and service
- All plans require prior authorization for SUD services
- **Coverage starting month after enrollment**

- MA Medicaid Plan – several options available
 - **Significant changes in PA/UR**
 - **Vary among plans**
- Presumptive eligibility only for pregnant women
- SUD/MH carve out in 1992
 - Expansion to non-categoricals in 1997
 - Further expansion in 2006
- Many services NOT covered
 - 50% of people in residential treatment facilities have Medicaid, but this is paid for by BSAS

Health Care Reform in Massachusetts



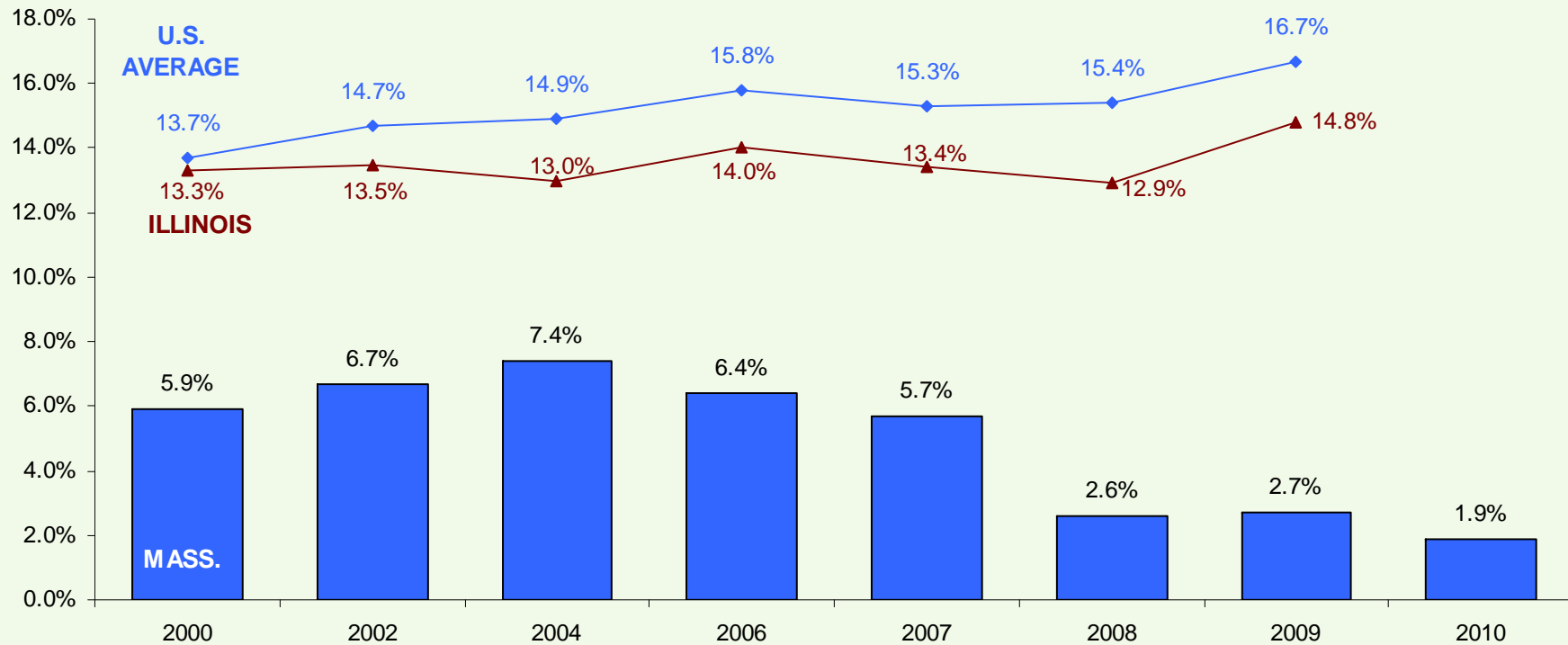
- As of Nov. 2010, 98.1% of non-elderly adults were insured
- 99.8% of children
- 41% Medicaid expansion
- 38% Commonwealth Care
- 21% Individual Purchase

Remaining uninsured likely to be young, single, male, have income less than 300% FPL and/or Hispanic



Massachusetts Now Has the Lowest Rate of Un-insurance in the Country

PERCENT UNINSURED, 2000–2010, ALL AGES



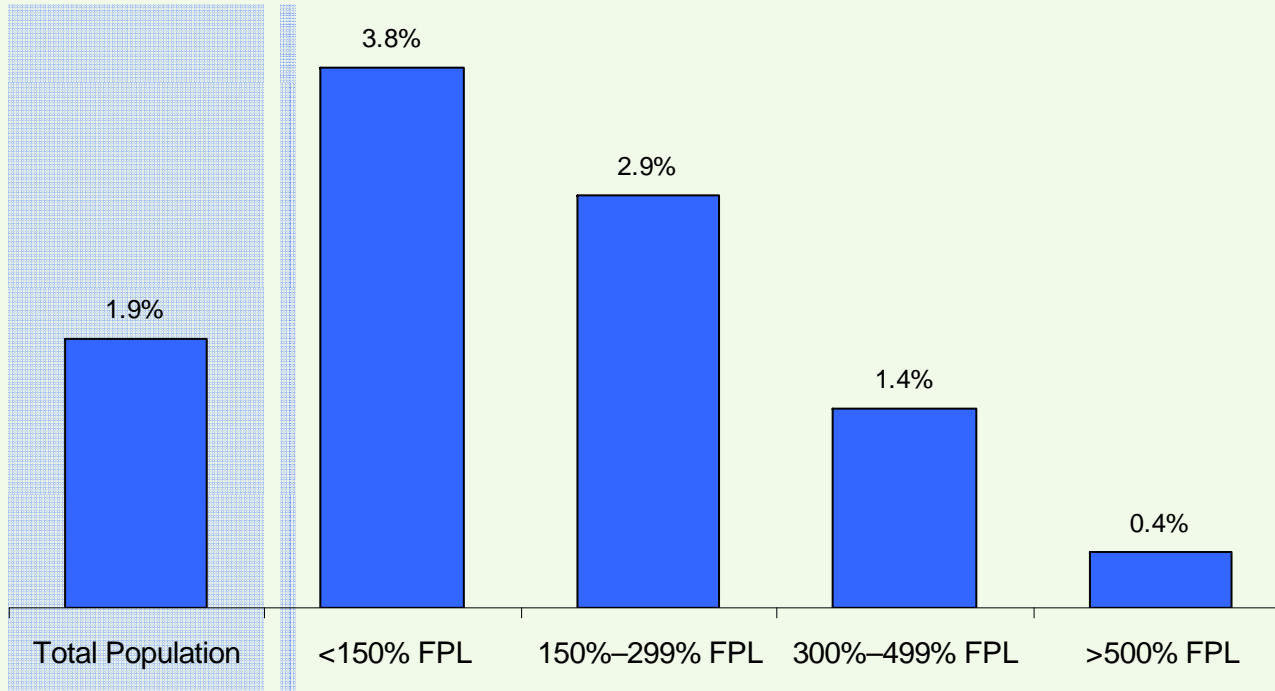
NOTE:As of 2008, the state contracted with a new vendor (Urban Institute) to track insurance coverage rates in Massachusetts. The Urban Institute implemented methodological changes to the tracking survey which may affect comparability of the 2008, 2009, and 2010 results to prior years.

The national comparison presented here utilizes a different survey methodology, the Current Population Survey , which is known to undercount Medicaid enrollment in some states.

SOURCES:Massachusetts Division of Health Care Finance and Policy, *Massachusetts Health Insurance Survey*2000, 2002, 2004, 2006, 2007, 2008, 2009, 2010; U.S. Census Bureau, Current Population Survey 2000, 2002, 2004, 2006, 2007, 2008, 2009.



Low-income Residents Are More Likely To Be Uninsured Than Higher-income Residents



Low-income residents (family household income under 300 % of the FPL) comprise 72 percent of the remaining uninsured in Massachusetts, but only 40 percent of the insured population (data not shown).

While low-income residents are more likely to be uninsured, they have demonstrated the most dramatic income-related gains in coverage under health reform.

Total Uninsured	<150% FPL	150%–299% FPL	300%–499% FPL	>500% FPL
120,000	42.9%	29.2%	20.2%	7.7%



BSAS Services – Grade A Sausage?



Prevention Services:

Regional Centers for Health Communities (RCHC's)
Community-based Prevention Programs
Educational Materials
Media Campaigns
Overdose Prevention Services

Screening and Early Intervention Services

Community Health Center Screening, Intervention and Referral to Treatment Services (SBIRT)
Federal SBIRT Grant
Emergency Department SBIRT
Family Intervention Services

Acute Treatment Services

Acute Treatment Services (Level 3.7)
Clinical Support Services (Level 3.5)
Section 35 for Men and Women

Short Term Stabilization Services for Adults

Transitional Support Services
Tewksbury Stabilization Program

Youth Intervention and Treatment Services

Early Intervention (CASASStart)
Youth Stabilization
Youth Residential
Recovery High Schools
Youth Outpatient Services

Adult Residential Treatment

Recovery Homes
Therapeutic Communities
Social Model Recovery Homes
Specialized Residential Services for Women

Family Services

Outreach for Homeless families
Family Residential Treatment Programs
Supportive Housing Services For Homeless Families
Federal ACF Grant

Outpatient Services:

Outpatient Counseling
Opioid Treatment Services
Day Treatment/Enhanced Day Treatment/Intensive Outpatient
Acupuncture Services

Compulsive Gambling Treatment
Office-based Opioid Treatment (OBOT)

Housing and Homeless Services:

Substance Abuse Shelters for Individuals
Post Detox Pre-Recovery Programs (PDPR)
Supportive Case Management in Housing
Community-Based Case Management
Outreach to Homeless Youth and Adults

Recovery Support Services

Recovery Engagement Centers
Consumer Education
Federal Access to Recovery Grant

Criminal Justice Programs

Services in County Houses of Correction
Court Diversion Programs
First Offender Driver Alcohol Education (DAE)
Second Offender 14-Day Residential Program for Driving Under the Influence of Liquor (DUIL)
Second Offender Aftercare (SOA)

Training, Technical Assistance and Support Services

Substance Abuse Information and Referral Helpline
Problem Gambling Information and Referral Helpline
Tobacco Training and Technical Assistance
Women's Services Capacity Building
HIV/HEP C Training and technical Assistance

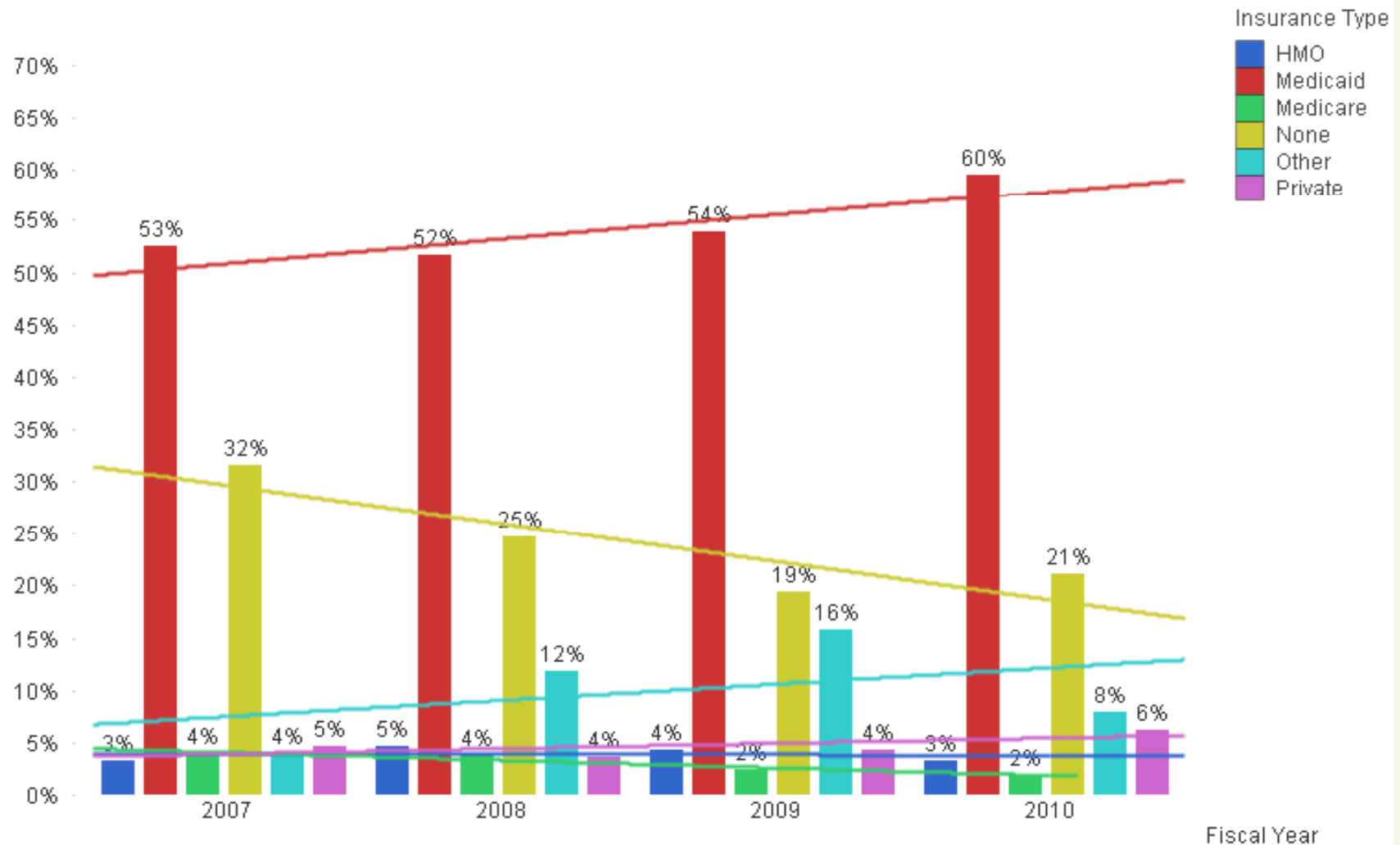
Financial Model of the Potential Impact of HCR on Funded Services



- Reported client income at time of admission tracked to plan type
- Medically reimbursable SUD treatment services offered by the plan(s)
- Current utilization and expenditures for these reimbursable services (Detox, step down, methadone, day treatment and outpatient services) by newly eligible clients
- Assumption that 50% of eligible clients will enroll in year one; 90% in year two
- Anticipated off-set of \$5.8m in year one and \$10.5m in year two

Insurance Status of Clients Entering Detox

Trend in Insurance Type by Fiscal Year



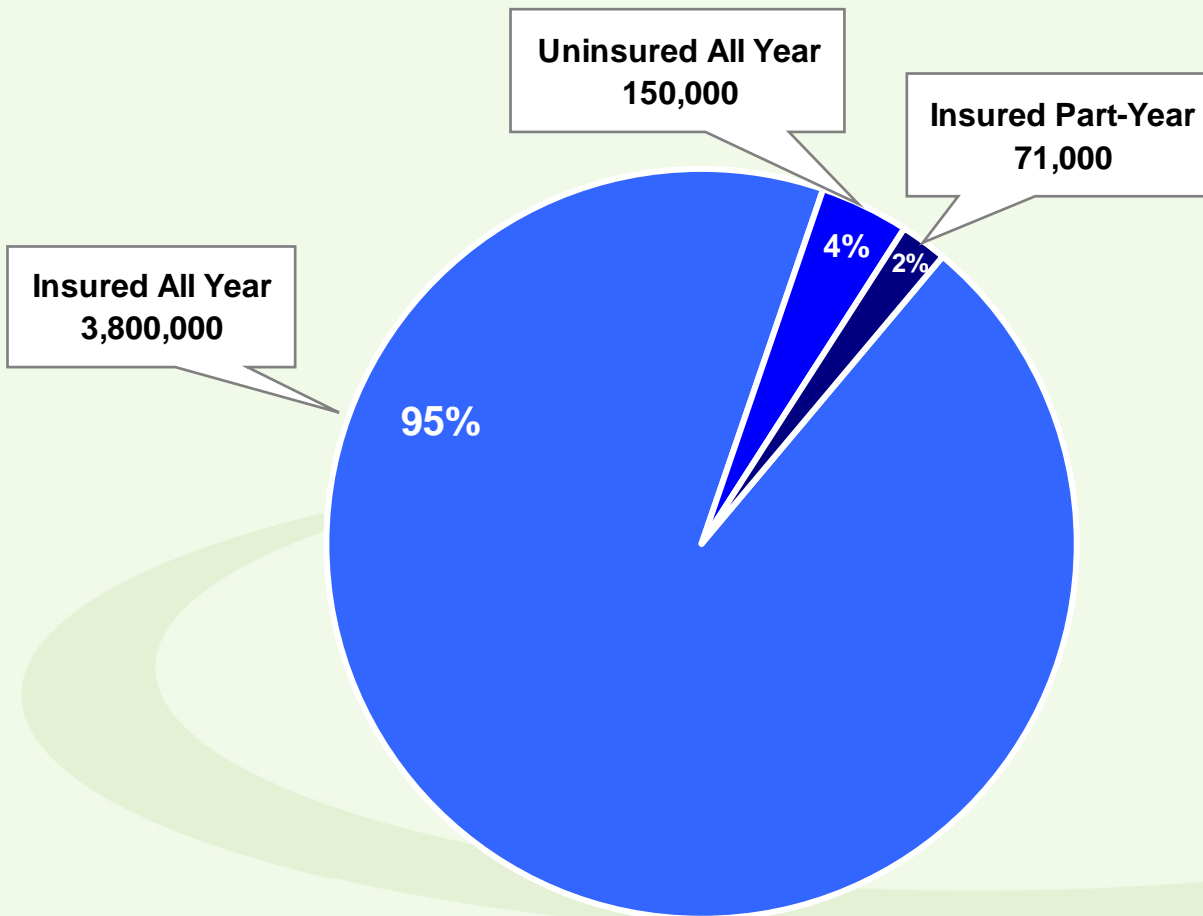
254 TSS/CSS clients surveyed in June 2009

- 174 men
- 79 female
- **16% were uninsured**
- Highest uninsured among 18-25 year olds living with parents

Insurance status of Civilly-committed

- 50% are less than 30 years old
- 71% of women v 48% men are insured.

Most Massachusetts Tax Filers Comply With the Individual Mandate by Having Insurance Year-round



During calendar year 2008, 2 percent of tax filers were uninsured for part of the year and 4 percent were uninsured for the entire year.

NOTE: Numbers do not add to 100 percent due to rounding.

SOURCE: Massachusetts Health Connector and Department of Revenue; *Data on the Individual Mandate Tax Year 2008*, December 2010.

What Has Massachusetts Achieved Relative To Its Health Coverage Goals?



- 401,000 more Massachusetts residents have gained health insurance coverage than had it before reform.
- Massachusetts now has the highest rate of health insurance coverage in the nation.
 - 98.1 percent of Massachusetts residents are insured.
 - 99.8 percent of Massachusetts children are insured.
- Since reform, insurance coverage has increased most significantly for non-elderly adults, particularly for low-income adults.
- The remaining uninsured are more likely to be young, single, male, non-elderly low-income adults, and/or of Hispanic ethnicity.

Observations/Questions



- Significant uninsureds (20%) still presenting for tx – primarily young adult men
- Premiums, co-pays/deductibles may be a barrier –
Appeal to Connector to drop co-pays for detox denied
- Considerable enrollment criteria – IDs, Home address, time
- Considerable churning/dis-enrollment among plans
- **No major cost shifting, except OP**
- Varying administrative capacity to handle claims among providers – Burdensome and costly
- SSA share of purchase shrinking

Observations/Questions

- Are more people getting treatment? Appears to be NO. Need for All-payer database
- Federal Block Grant still critical for unenrolled/uninsured, capacity development
- Revised payer of last resort policy
- Who remains uninsured? Why?
- Where are they coming from? CJ referrals?
- Does greater consumer choice require enhanced program marketing? Early evidence suggests YES!
- What is our capacity/competencies to play in a managed care world?
- What are provider competencies relative to network development. PA, UR, billing and talking the language of managed care
- Revised RFR requirements related to these competencies
- Role and authority of state agencies? Insurance Purchaser? Developer of Services?
- Relationship with state Medicaid Office

What Challenges Remain For Massachusetts Health Reform?



- The remaining uninsured include some who may be more difficult to persuade to obtain coverage and many who do not qualify for government-subsidized or employer-sponsored coverage.
- Barriers to care persist for some populations.
- Rising health care costs, independent of reform, threaten the sustainability of the entire health care system.

State Implications

Financial Modeling

System Capacity

Enhance Contracting Standards to Optimize Third-party Reimbursement

Shifting purchased services

Explore other Purchasing Strategies

Role of SSA – QA. Capacity Development, etc

Role and Expertise with Medicaid, Exchange and other insurers

Shaping Construction of Provider Community

Engagement and Retention Strategies, particularly with young adults

Provider Implications

- Strategic planning
- Competencies relative to dealing with insurers

Network Criteria

Administrative Functions

EHRs

- Marketing Strategies
- Merger? Strategic partnerships?

Consumer Implications



- Increased Access ??
- Expanded Services
- Enrollment Criteria
- Affordability
- Greater Choice
- More Integrated Care