

Medicaid:

What are Other States Doing?

State Officials' Comments on Medicaid Reform

Comments of State Medicaid Officials on Cost Containment and Expansions:

"We don't have anything left to cut."

"We are going to be in a struggle. We are trying to put in some reasonable, logical controls, but there is still a push to cover more."

"Long term care is still the 800 pound gorilla."

"The legislature has looked at Medicaid seriously. For the most part, they have come to appreciate the value of Medicaid."

Cost Containment and Reform Strategies

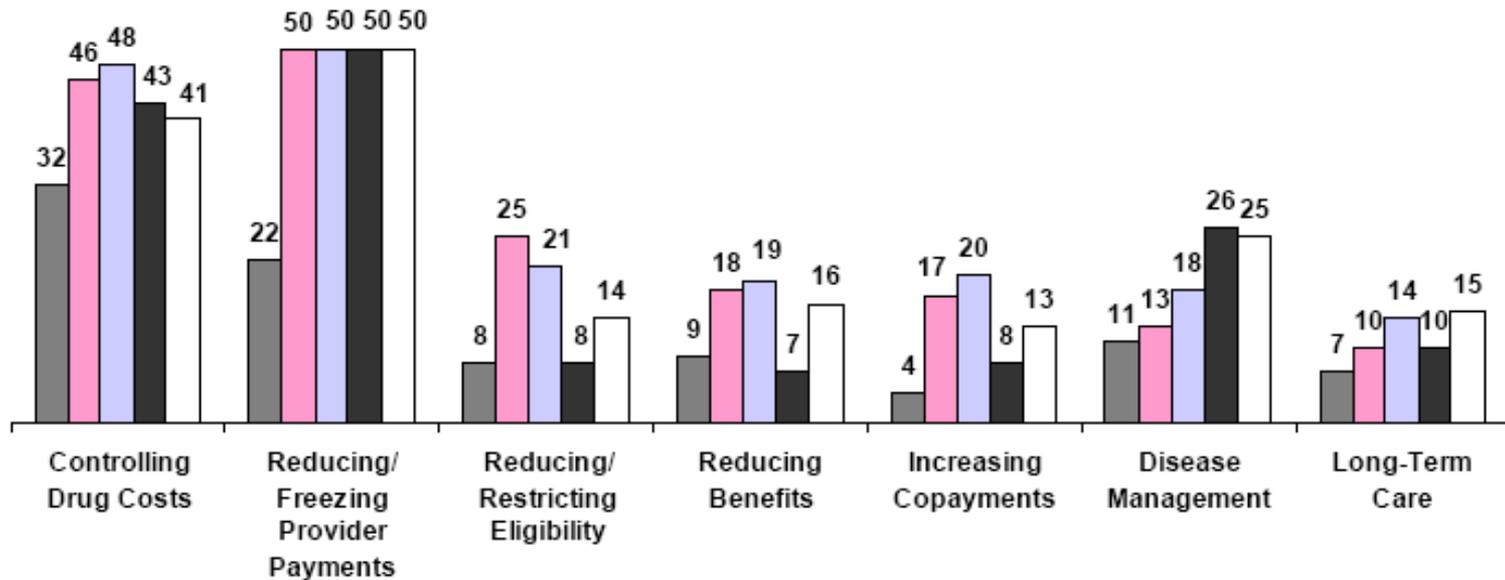
- Reduce/Freeze/Increase Provider Payments
- Control Drug Costs
- Reduce/Increase Eligibility
- Reduce/Increase Benefits
- Reduce/Increase Copayments
- Disease Management
- Case Management
- Tiered Grouping
- Long-Term Care
- Pay for Performance
- Price Transparency
- Share Insurance Risk
- Accountability

Cost Containment Strategies

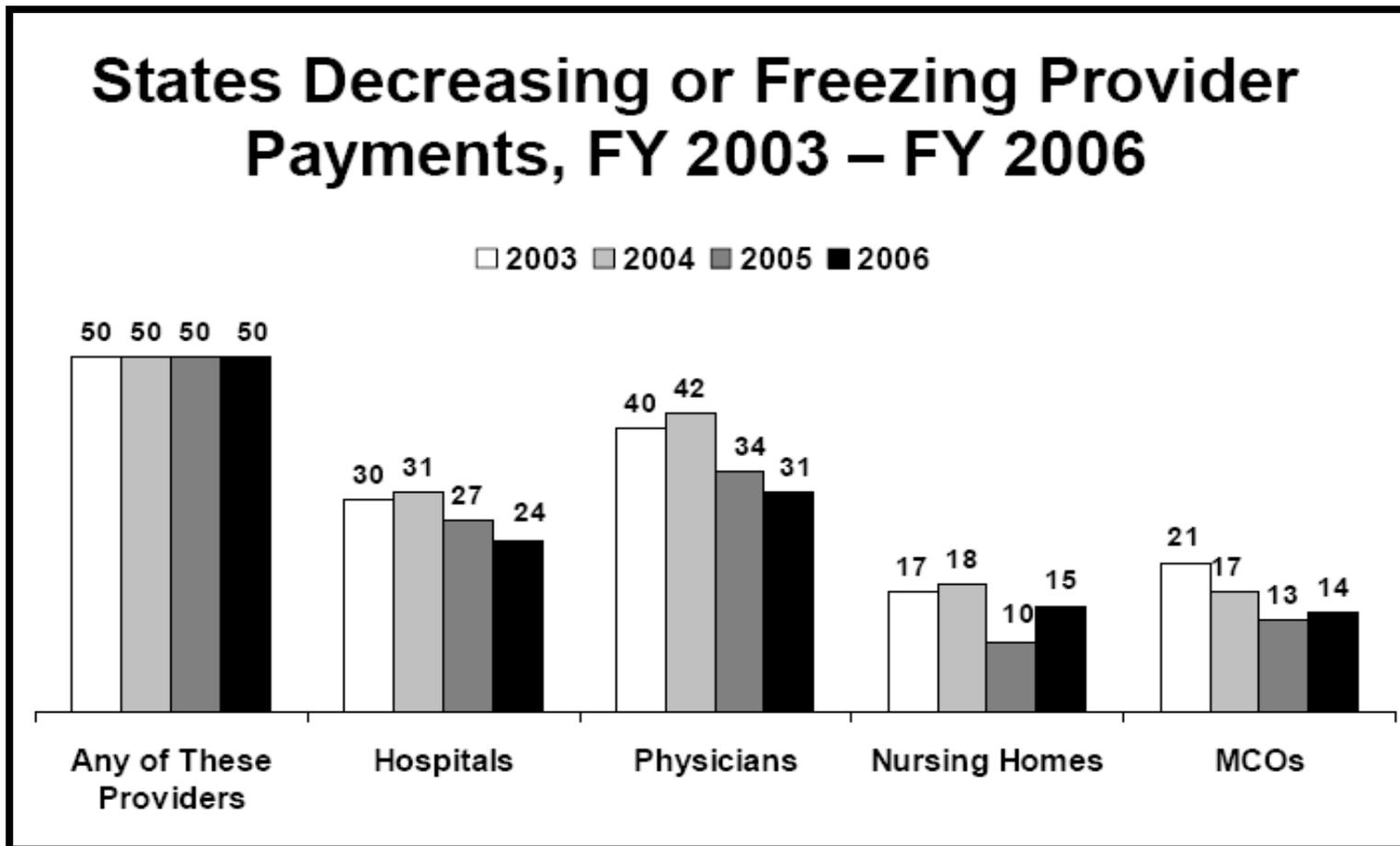
Kaiser 50 State Survey

States Undertaking New Medicaid Cost Containment Strategies FY 2002 – FY 2006

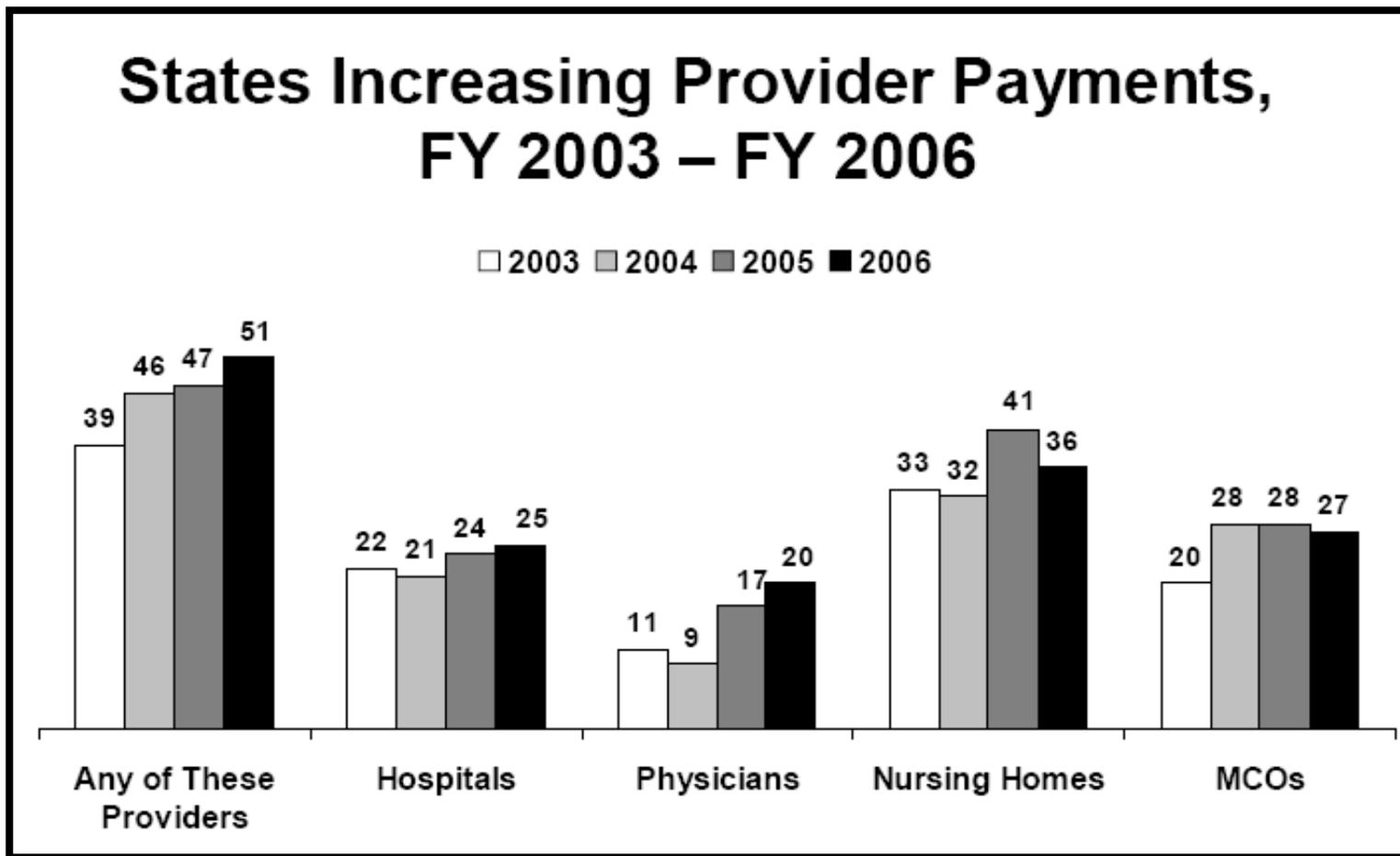
■ Implemented 2002 ■ Implemented 2003 ■ Implemented 2004 ■ Implemented 2005 □ *Adopted for 2006



Decreasing/Freezing Provider Payments



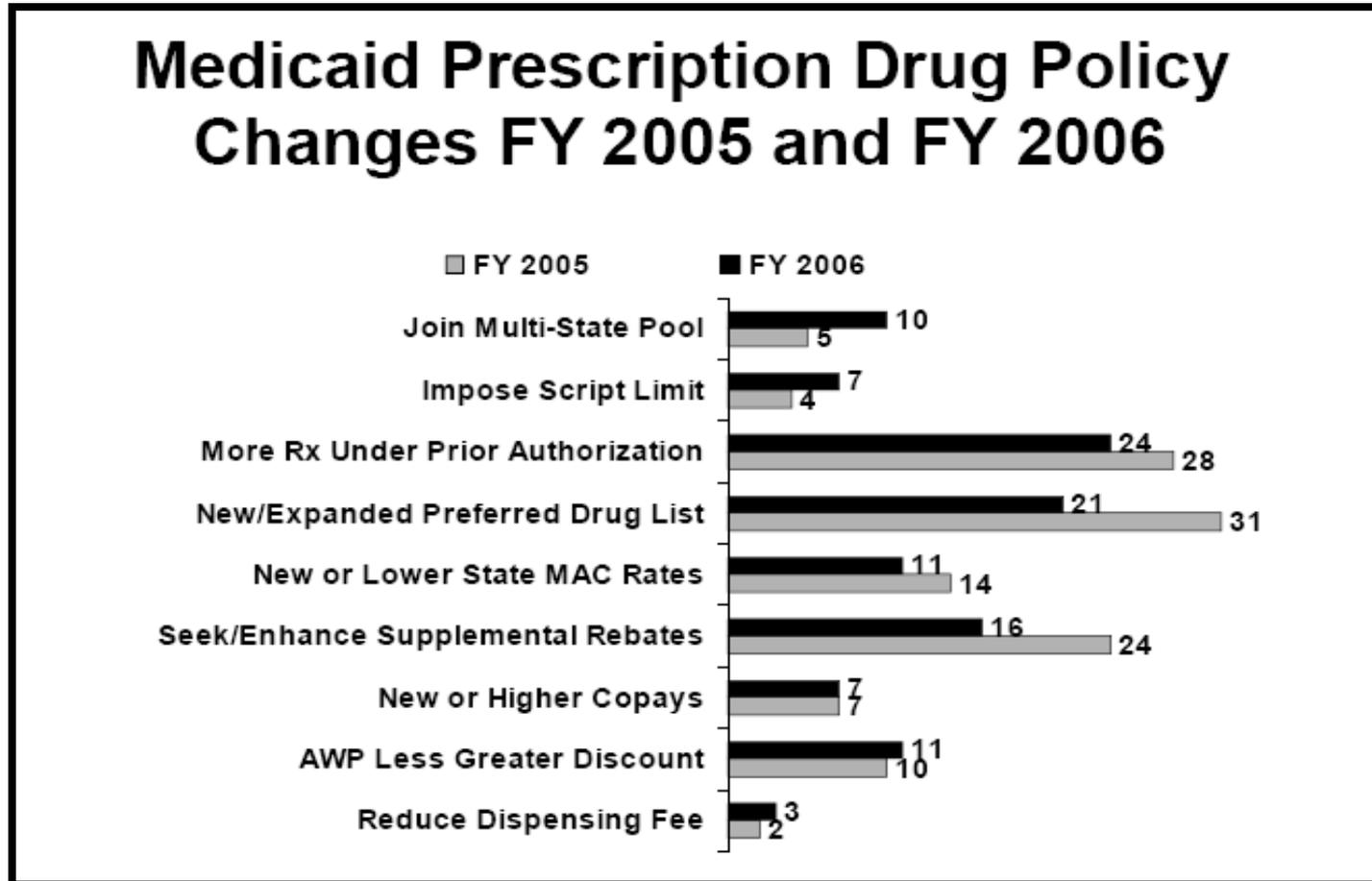
Increasing Provider Payments



Freezing Provider Payments

- **Kentucky**, in response to a projected budget shortfall, recently enacted a rate freeze for:
 - acute hospitals,
 - home health providers, and
 - local health departments.
- Rate Freeze is expected to save Kentucky \$20 million.

Prescription Drug Changes



Prescription Drug Changes

- **Maine** instituted prior authorization in its Medicaid program for the 100 most commonly used drug classes.
- Many states are strengthening their existing prior authorization programs to cover additional classes of drugs.
- Several are trying to join multi-state pools

Benefit Changes

- Reductions in 23 states focused primarily on reducing or eliminating optional Medicaid benefits for adults (ages 19-64)
- Reductions and Eliminations included the following:
 - Occupational, physical and speech therapies,
 - Chiropractic services,
 - Dental services,
 - Vision,
 - Mental health clinic services,
 - Acupuncture, and
 - Pharmacy benefits

Benefit Changes

- **Oregon** utilized a public prioritization process to rank a comprehensive set of primary and acute medical and mental illness conditions and services.
- Health care providers and consumers helped decide what services were most important.
- The Oregon legislature sets the funding level to cover a certain number of services on the list, but cannot rearrange the list.
- The final list included more than 700 conditions and treatments.
- The Legislature originally authorized funding for items 1 through 606 (1998).
- Effective April 1, 2005, Oregon provided coverage for lines 1 through 546.

Eligibility Changes

Reductions and Restrictions

- **Florida** eliminated coverage for 77,000 non-institutionalized beneficiaries in the optional aged and disabled program with incomes up to 88% FPL
- **Tennessee** eliminated coverage for adult expansion groups affecting 226,000 individuals
- **Missouri** eliminated coverage for employed disabled persons and increased frequency of eligibility reinvestigation efforts for adults
- **Vermont** increased the asset transfer look-back period from three to five years
- **Connecticut** imposed premium requirements on parents and Medicaid expansion adults

Expansions and Restorations

- **Colorado** removed its asset test for children and adults
- **Connecticut** restored eligibility for parents up to 150% of the FPL effective July 2005
- **Oklahoma** expanded eligibility to **children with disabilities through age 18** living at home regardless of parental income
- **Texas** restored coverage for pregnant women between 158% FPL and 185% FPL
- **Nevada** eliminated its asset test for pregnant women and children

Family Opportunity Act (FOA)

- Provides federal Medicaid funds for children with disabilities whose family income does not exceed 300% FPL
- Parents may be required to pay a monthly premium on a sliding scale based on family income
- Requiring cost sharing is also an option
- Premiums and cost sharing shall not exceed 5% or 7.5% of income depending on income level

New or increased Copayments

- FY 2005 and 2006:
 - Prescription drug copayments (14 states)
 - Non-emergency use of the hospital emergency room (5 states)
 - Physician related services
 - Out-patient hospital services
 - Georgia increased copayments for “all services” to the maximum allowed

Cost Sharing and the DRA

- Before passage of Deficit Reduction act (DRA)
 - Limited to \$3 for most services
 - Barred providers from denying services to individuals who did not pay
 - Most Medicaid enrollees did not pay any cost sharing
- After passage of DRA
 - States may increase cost sharing beyond \$3
 - Providers may deny services for lack of payment
 - States may require premiums for beneficiaries whose income is at or above FPL
 - States may require beneficiaries whose income is at or above FPL to pay up to 20% of the cost of their services (may not exceed 5% of family's income)
 - States may increase co-payments over time at the rate of medical inflation

Disease and Case Management

- In FY 2005, 26 states developed new or expanded **disease and case management** programs
- In FY 2006, 25 states developed or expanded these types of programs
- Programs most commonly based on asthma, diabetes, hypertension or coronary heart disease
- Other disease/case management programs focus on:
 - Dual eligibles,
 - High cost individuals,
 - Pharmaceutical management,
 - Inappropriate emergency room usage, and
 - Comprehensive care management

Disease Management

- A disease management program may include the following principles:
 - Population identification processes;
 - Evidence-based practice guidelines;
 - Collaborative practice models to include physician and support-service providers;
 - Patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance);
 - Process and outcomes measurement, evaluation, and management;
 - Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).

Disease and Case Management

- **Florida** has an ambitious Medicaid disease management program.
- Includes six diseases (asthma, diabetes, hemophilia, HIV/AIDS, end-stage renal disease, congestive heart failure).
- Two of these diseases (diabetes and hemophilia) are statewide.
- Florida has had implementation problems with:
 - contracting with multiple disease management organizations and
 - failure to establish an explicit evaluation methodology.
- The Legislature has cut the Medicaid budget by \$113 million since 1997 in anticipation of cost savings.
- As of yet, there are no health outcome or cost saving data from Florida's disease management program
- Administrative costs for the program have exceeded \$24 million.

Disease and Case Management

- **Virginia** has run a disease management program since 1995 for Medicaid recipients with moderate to severe asthma.
- Emergency room visits have been reduced by 25 percent for this population.
- Program has achieved “substantial” cost savings over traditional Medicaid.

Disease and Case Management

- In **Mississippi**, pharmacists complete coursework and pass an examination on diabetes, asthma, hyperlipidemia, and coagulation disorders.
- Patients have 15- to 30-minute (or longer) sessions with their pharmacists up to 12 times per year.
- Using pharmacists [less expensive] and useful in states with a shortage of health care professionals.

Tiered Benefit Packages

- Enrollees are divided into different groups that are offered different benefit packages based on medical need.
- Steering away from the “one-size-fits-all” package.
- Beneficiaries in more healthy groups will be offered limited benefit packages compared to less healthy groups.
- If a beneficiary requires a service that is not covered under their benefit package, the state may or may not cover that service.
- Certain groups are exempt including pregnant women, blind and disabled individuals, and some kids.

Tiered Benefit Packages

- States with tiered benefit packages include:
 - Idaho
 - Kentucky
 - West Virginia

Tiered Benefit Packages

Idaho

- Idaho's goals:
 - Simplify eligibility to match identified needs
 - Establish policy goals relevant to specific populations
 - Modify benefits to meet identified needs and promote policy goals
 - Alter delivery systems to efficiently and effectively meet needs and policy goals
 - Match quality and performance improvement to population served

Tiered Benefit Packages

Idaho

- Three distinct health need categories:
 - Low-income children and working-age adults
 - Individuals with disabilities or special health needs
 - Elders (i.e. dually eligible for Medicare & Medicaid)
- Three distinct benefit packages:
 - Basic Benefits
 - Enhanced Benefits
 - Coordinated Benefits (for those dually eligible for Medicare & Medicaid)

Tiered Benefit Packages

Kentucky

- Kentucky has formed the following benefit packages:
 - **Global Choices** (235,000 members) will cover the general Medicaid population program including foster children and medically fragile children.
 - **Family Choices** (263,000 members) will cover most children including the SCHIP children.
 - **Optimum Choices** (3,500 members) covers individuals with mental retardation and developmental disabilities in need of long term care.
 - **Comprehensive Choices** (27,900 members) covers individuals who are elderly and in need of a nursing facility level of care and also individuals with acquired brain injuries.

Managed Care Initiatives

- Most common change was to expand the managed care service area.
- Moved new eligibility groups into managed care programs.
- Changed enrollment from voluntary to **mandatory** in either an area of the state or with a certain eligibility group.

Managed Care

Mandatory Enrollment

- **Mandatory enrollment is defined as follows:**
 - new Medicaid recipients have a certain time period after joining the Medicaid program in which to choose a plan;
 - If a recipient does not choose a plan in that time period, the state can assign the recipient to a managed care plan;
 - The recipient has a period of time in which to opt-out of the plan and into another, or into fee-for-service; and
 - Specific details related to time period, opt-out, etc. are determined and therefore vary by state.

Long Term Care (LTC)

- Represents over a third of total Medicaid spending in most states.
- Difficult to make cuts in this area due to the medical vulnerability of LTC recipients.
- Growing demand for home and community based service (HCBS) alternatives to institutional services.

Long Term Care (LTC)

- Nursing home cost controls
 - reduce the number of nursing home beds
 - tighten eligibility criteria
 - reduce payments for bed holds
 - Validate patient assessments (for purposes of **case mix reimbursement**)
 - reduce reimbursement for Medicare nursing home coinsurance costs

Case-Mix Reimbursement

- Case-mix reimbursement systems are intended to eliminate incentives that discourage nursing homes from admitting heavy-care Medicaid patients by varying the reimbursement rate with the patient's condition.

Long Term Care (LTC)

- **Vermont** provides pre-admission screening to potential nursing home residents (in addition to assessing current residents).
- Individuals who might otherwise be admitted for participation in HCBS or other programs are notified.
- People can choose between nursing care, HCBS, or other programs; state officials do not tell them which one to choose.
- As a result, nursing home bed days fell by 15,000 in the first three quarters of FY 2001, yielding savings of \$3.1 million.

Long Term Care (LTC)

- **Nebraska** received funding from HCFA to "buy back" nursing home beds.
- The beds were converted to assisted living units.
- This resulted in an increased supply of lower-cost residential service and a decreased supply of nursing home beds.
- Buy-back decreased overall Medicaid spending by reducing LTC spending on nursing homes.

Long Term Care (LTC)

- Home and Community Based Services (HCBS) programs
 - In FY 2005 and 2006, 26 states created new HCBS waivers or expanded existing waivers
 - 6 states added additional services to existing HCBS waivers
 - “Money Follows the Person” initiative

Long Term Care (LTC)

- **“Money Follows the Person” initiative**
 - Included in the Deficit Reduction Act of 2005
 - State proposes a new HCBS program for individuals who would otherwise receive institutional care.
 - The state continues to receive money for care of the individual, and
 - Qualified transition costs are eligible for an enhanced match rate.
 - In effect, 75 to 90 percent of transition costs will be covered by the Federal Government.
 - Higher matching rate is good for a one year period after the individual moves out of an institution and into the community.
 - Services must be provided as long as the person needs community services and is Medicaid eligible.

Pay-for-Performance

- **Simply put:** a contract whereby if an MCO (or provider) performs well on a set of **quality measures**, the MCO (or provider) receive a reward.

Pay for Performance

HEDIS Quality Measures

HEDIS® 2006 Summary Table of Measures and Product Lines

HEDIS 2006 Measures	Applicable to:			
	Medicaid	Commercial	Medicare	PPO
Effectiveness of Care				
Childhood Immunization Status	✓	✓		
Adolescent Immunization Status	✓	✓		
Appropriate Treatment for Children With Upper Respiratory Infection	✓	✓		
Appropriate Testing for Children With Pharyngitis	✓	✓		
Inappropriate Antibiotic Treatment for Adults With Acute Bronchitis	✓	✓		
Colorectal Cancer Screening		✓	✓	
Breast Cancer Screening	✓	✓	✓	
Cervical Cancer Screening	✓	✓		
Chlamydia Screening in Women	✓	✓		
Osteoporosis Management in Women Who Had a Fracture			✓	
Controlling High Blood Pressure	✓	✓	✓	
Beta-Blocker Treatment After a Heart Attack	✓	✓	✓	
Persistence of Beta-Blocker Treatment After a Heart Attack	✓	✓	✓	
Cholesterol Management for Patients With Cardiovascular Conditions	✓	✓	✓	
Comprehensive Diabetes Care	✓	✓	✓	
Use of Appropriate Medications for People With Asthma	✓	✓		
User of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	✓	✓	✓	
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓	
Antidepressant Medication Management	✓	✓	✓	
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	✓	✓	✓	
Glaucoma Screening in Older Adults	✓	✓	✓	
Use of Imaging Studies for Low Back Pain	✓	✓	✓	
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	✓	✓	✓	
Annual Monitoring for Patients on Persistent Medications	✓	✓	✓	
Drugs to Be Avoided in the Elderly	✓	✓	✓	

Pay-for-Performance

- Reward examples:
 - **New York** paid out \$13 million dollars in quality bonuses to health plans last year—up to 1 percent of each plan's monthly capitation premiums
 - **California** program will preferentially assign the 20 percent of Medicaid managed care enrollees who fail to select a health plan to plans that perform well on a number of quality measures
 - Public reporting of health plan performance

Price Transparency

"Americans know the price of almost everything they pay for, except for one of the most important things they pay for — their healthcare People deserve to know, indeed they have a right to know, what their healthcare costs and how good it is. Patients should also be able to see an estimate of the overall cost of the procedure, how much their insurer will pay and how much they will be expected to pay. That kind of information will allow patients to become informed consumers making informed choices about one of the most 'priceless' things in life — their health."

--Mike Leavitt

Price Transparency States

- States that have run legislation on price transparency for healthcare:
 - Arizona,
 - Arkansas
 - California
 - Colorado
 - Connecticut
 - Delaware
 - Florida
 - Georgia
 - Illinois
 - Indiana
 - Kentucky
 - Maine
 - Maryland
 - Massachusetts
 - Minnesota
 - Missouri
 - Nebraska
 - Nevada
 - New Hampshire
 - New Mexico
 - North Carolina
 - Ohio
 - Oregon
 - Pennsylvania
 - South Carolina
 - South Dakota
 - Tennessee
 - Texas
 - Utah
 - Vermont
 - Virginia
 - Washington
 - West Virginia
 - Wisconsin

Price Transparency

States

- **Arkansas** requires reporting of hospital charge information for inpatient services and outpatient emergency services.
- **California** requires that hospitals disclose prices for the top 25 most common outpatient services or procedures, and requires, upon request, estimates of expected bill if the person doesn't have health coverage.
- **Missouri** requires all hospitals and health care providers to provide charge data to the Department of Health and Senior Services.
- **Utah (HB 203, 2006)** would have required hospital and related medical billing to include plain English explanation of charges.

Health Opportunity Account

- South Carolina:
 - Allows enrollees to purchase comprehensive health coverage from state approved plans.
 - Recipients may “opt out” and use their account to purchase group insurance through their employer.
 - The remainder of account may be used to purchase additional benefits.

Health Opportunity Account

- Florida and Kentucky:
 - Allows certain enrollees participating in health promoting practices
 - to earn credits to buy additional health care services, or
 - pay for copays

Additional Items

- **West Virginia:** Accountability and Member Agreements
- **Health Savings Accounts**
- **Vermont:** The State MCO and the 5 Year Block Grant
- **Florida:** Tiered Groups, Risk adjustment, and premiums
- **Massachusetts:** Healthcare for All

West Virginia Member Agreement

WEST VIRGINIA MEDICAID MEMBER AGREEMENT

I understand that it is my responsibility to select a primary care doctor. If you do not select a doctor in 45 days, one will be selected for you. I understand it is my responsibility to go to that doctor when I or my family members get sick. I understand that I should go to the doctor at least once a year for a check up, and to take my children more often when the doctor tells me to come. **I will listen to the doctor when I am or my children are sick, and do what the doctor tells me to do, including taking the medicines they give me. I will show up on time when I or my children have an appointment to see the doctor. If I cannot see the doctor when I have an appointment, I will call to tell my doctor I cannot come. I will only do this when there is a very good reason. If I miss three consecutive appointments, I understand I will be assessed a penalty.**

I will go the hospital emergency room only when I feel it is a medical emergency. Whenever, I am sick I will call my doctor first and go see him or her. If I cannot talk to my doctor or some one in the doctor's office and it is an emergency, then I will go to the hospital.

West Virginia Member Agreement

- West Virginia will offer enrollees a choice of two benefit packages:
 - a basic plan based on the current Medicaid service package and
 - an enhanced package that includes benefits not traditionally offered under Medicaid
- To enroll in the new advanced benefit package, enrollees will be asked to sign the member agreement
- Failure to comply with the agreement could result in the enrollees losing access to the enhanced package of benefits

Vermont

Global Commitment

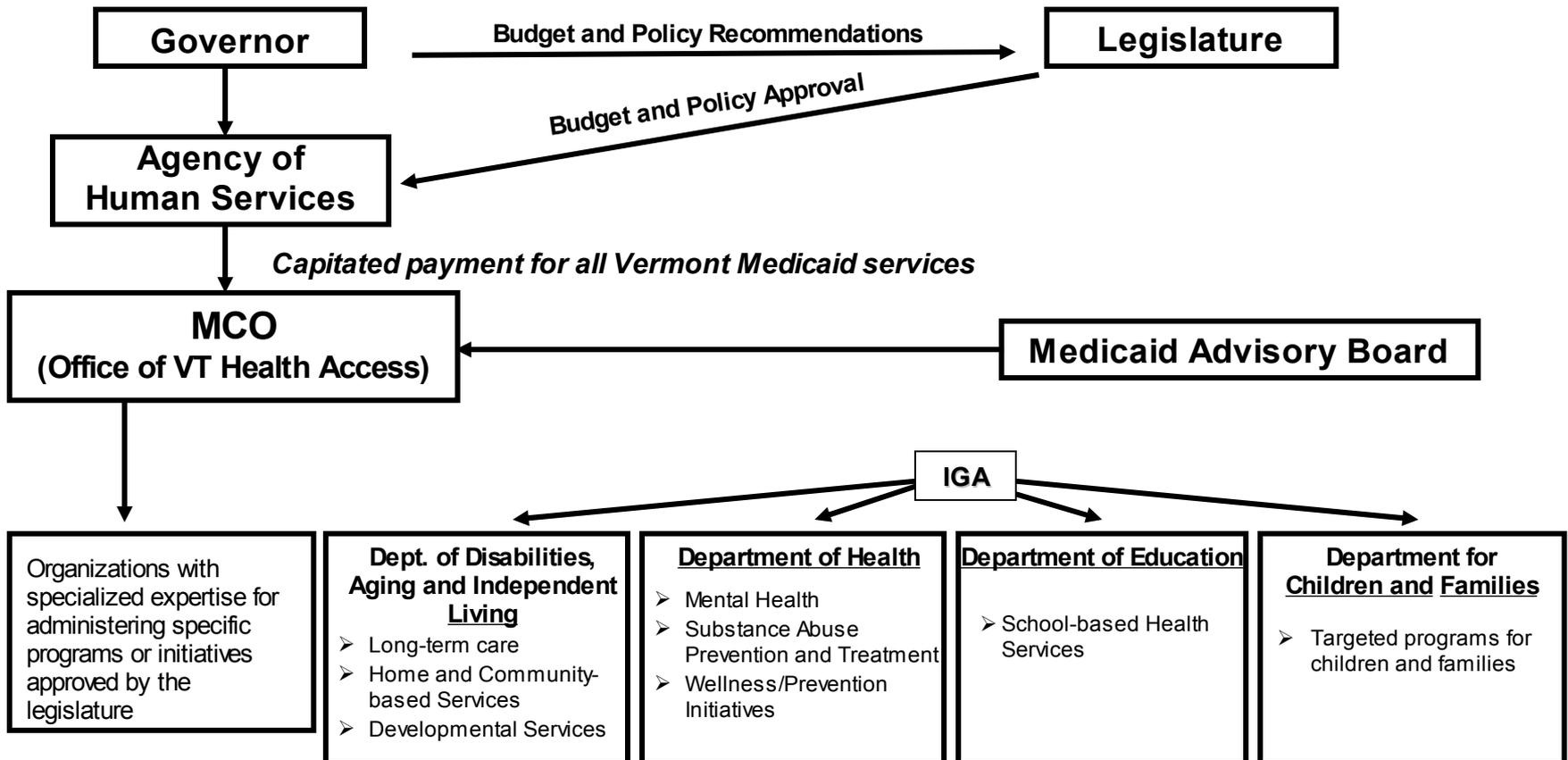
- Vermont Medicaid will operate under a 5-year budget neutrality ceiling
- Ceiling based on FY04 expenditures trended forward at 9% each year totaling \$4.7 billion cumulative over 5 years (gross state and federal dollars)
- Places the State at risk for caseload, inflation, and utilization
- Expenditure projections for the 5-year period are significantly below the 5-year ceiling , providing room for program growth

Vermont

Global Commitment

- FY06 Budget Bill approved the creation of Office of Vermont Health Access (OVHA) as a Public MCO
 - Manages all Vermont Medicaid expenditures under capitated agreement
 - Administers the public health insurance programs and pharmacy benefits
 - Oversees implementation of all approved policy and program changes
 - Adheres to all federal MCO requirements
 - Through formal agreements, funds other organizations to provide specialty benefits
 - Agency of Human Services will provide capitated payment to OVHA for all Vermont Medicaid Services

Vermont Global Commitment

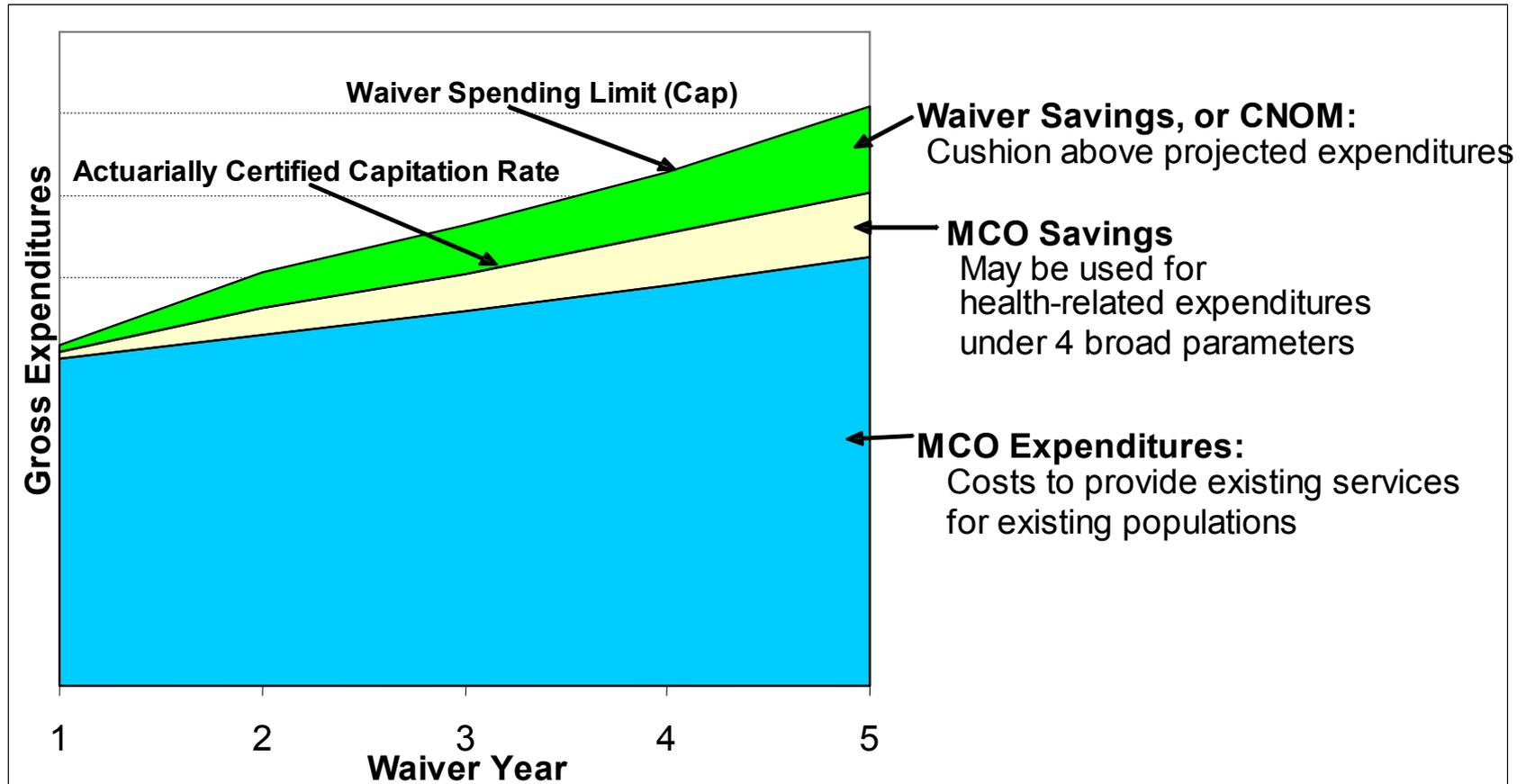


Vermont

Global Commitment

- Provides Vermont with greater flexibility with regard to program design and operations
 - Cover health services not available under Title XIX of the Social Security Act
 - Explore alternative reimbursement approaches (e.g., case rates)
 - Invest saved funds in programs designed to improve health outcomes such as:
 - Respite programs,
 - Tobacco Cessation,
 - Emergency Mental Health Services, and
 - Newborn Screening
 - Substance Abuse Services
 - Encourage inter-departmental collaboration and consistency across programs
 - Changes must be approved by the Vermont Legislature
 - Does not authorize Vermont to change benefits for mandatory populations and mandatory benefits
 - There is a 5% corridor for Vermont to make changes to the benefits provided to optional and expansion populations, if authorized by the Vermont Legislature
 - Program reforms approved by the Vermont Legislature that significantly increase or decrease program benefits or eligibility would require federal approval

Vermont Global Commitment



Health Savings Accounts

There are two main components to a Health Savings Account (HSA):

- Catastrophic Insurance Coverage
 - Low premium due to high deductible
 - Minimum annual deductible of \$1,000 (\$2,000 for family)
 - Maximum annual deductible of \$5,000 (\$10,000 for family)

Health Savings Accounts

Component 2

1. HSA Trustee or Custodian

- Account must be established with a qualified trustee or custodian (established similarly to IRA or 401(k) account)
- Both the employee and employer may contribute to the account
- Maximum annual contribution is 100% of HDHP deductible or \$2,600 (\$5,150 for family)
- Eligible employer and employee contributions to an HSA are excludable from their respective gross incomes
- Distributions are also excludable from gross income if used for a qualified medical expense
- Distributions or portions of distributions not used for medical expenses are included as gross income and is subject to an additional 10% tax

Florida Overview

- New Options/Choices:
 - Premium based customized plans
 - Opt-out
 - Enhanced Benefits
- Financing:
 - Based on predicted future costs
 - Individuals assigned a risk-adjusted premium
- Coverage:
 - Comprehensive component
 - Catastrophic component

Florida

Customized Plans

- Benefits for Medicaid eligible individuals:
 - Fixed premium
 - Variety of plan choices from a variety of providers
 - Increased access to specialized care
 - Ability to select a plan that best meets their needs
 - Must provide all federally mandated services for a given population
 - May vary in scope, amount and duration for some benefits
 - May cover services not traditionally covered by Medicaid
- All medically necessary services for children and pregnant women will be provided
- Customized plans are evaluated in two ways:
 - How the value of proposed benefits compares historically
 - If medical services meet needs of target population

Florida

Opt-Out

- Recipient can choose to enroll in employer sponsored health insurance instead of Medicaid certified plan.
- Self-employed individuals may purchase private insurance.
- Medicaid will pay the employee share of the employer-sponsored premium on behalf of the recipient.
- Individuals with access to employer-sponsored insurance may opt out at any time.

Florida

Enhanced Benefits

- A pool of funds is set aside to encourage recipients to engage in “Healthy Behaviors.”
- Individual Medicaid recipients earn access to “credit” dollars from the pool by completing defined healthy practices and/or behaviors.
- Once credits are earned, they may be used to purchase health-related services and products.
- Earned credits may be used during or within three years following cessation of Medicaid eligibility.

Florida

Risk-Adjusted Rates

- Certain conditions (AIDS, asthma, diabetes, etc.) and use of particular pharmaceuticals have strong link to future health care costs.
- Statistical models correlate historical diagnoses and pharmaceutical utilization to likelihood of future health care cost.
- Individuals assigned a “risk score.”
- Individual risk scores generate premium, based on recipient’s predicted needs.
- Health plans credited with risk score/premium of each individual enrolled.
- Collective risk scores/premiums of members generate health plan revenues/capitation tied to expected health costs.

Massachusetts

Reform Highlights

- Covers 95% of the uninsured in 3 years
- Preserves federal Medicaid funding
- Simplifies health insurance for small businesses
- Reforms Uncompensated Care
- Promotes financial stability of health care system
- Rewards cost-effective, high quality care
- Encourages shared responsibility: government, individuals, employers, health care providers

Massachusetts Strategies

1. Commonwealth Health Insurance Connector:
 - New State Authority
 - Makes it easier to find affordable policies
 - Reduces administrative burden for small business
 - Allows more people to buy insurance with pre-tax dollars
 - Allows part-time and seasonal employees to combine employer contributions in the Connector
 - Allows for portability for policies

Massachusetts

Strategies Continued . . .

1. Market Reforms:

- Merger of the non-group and small-group markets
- Prior to merger, state will commission study of merger in context of the law's provisions

3. New Products:

- Existing high-deductible plans can now be tied to Health Savings Accounts
- Family plans to allow young adults to stay on the policy for two years beyond loss of dependent status, or until age 25, whichever occurs first
- Industry can develop special products for 19-26 year olds, offered through the Connector

Massachusetts

Strategies Continued . . .

1. Subsidies:

- Commonwealth Care Health Insurance Program (CCHIP):
 - Sliding-scale subsidies to individuals with incomes below 300% of the Federal Poverty Level (FPL) (\$48,000 for a family of 3)

2. Medicaid:

- Coverage of children up to 300% FPL – parents can buy cheaper individual or couples' policies
- Raise enrollment caps on certain programs (i.e. HIV)
- On site internet portal created to determine Medicaid eligibility and automatically sign up those who are eligible before they receive care

Massachusetts

Strategies Continued . . .

1. Current Uncompensated Care Pool Eliminated:
 - Replaces Uncompensated Care Pool with Safety Net Care (SNC) Fund
 - Administered by SNC Office, in Medicaid
 - SNC Office develops standard fee schedule to reimburse uncompensated care
 - Medicaid providers receive rate increases over next three years at level of \$540M for hospitals & physicians across the state

Massachusetts

Responsibility

- Individuals:
 - As of July 1, 2007, individuals must have health insurance
 - Individuals who cannot afford insurance, as determined by the Connector, are not penalized
 - Income tax forms will include a question about insurance status for the tax year and Department of Revenue will verify coverage through an insurance industry database
 - Penalties for not having insurance:
 - Tax year 2007: loss of the personal exemption
 - Subsequent tax years: A fine equivalent to 50% of the monthly cost of health insurance for each month without insurance

Massachusetts

Responsibility

- **Businesses:**
 - Employers who don't make a "fair and reasonable" contribution to employee healthcare will be required to make a per-worker "fair share" contribution
 - Contribution capped at \$295 per full-time-equivalent employee, per year
 - Businesses with 10 or fewer employees will be exempt from the contribution
 - Pro-rated for temporary or seasonal employees who work for at least 30 days in a year
 - All employers with 11 or more workers must offer a "cafeteria plan," as defined in Section 125 of the I.R.S. code
 - Allows workers to purchase health insurance with pre-tax dollars
 - The plan must be filed with the Connector

Massachusetts Uninsured

Helps provide care to the following groups:

Uninsured Group 1:
Medicaid Eligible
(106,000)

Solution

- On site Internet portal created for hospitals and clinics.
- Data for uninsured individuals seeking treatment is entered into the Internet portal.
- Qualified individuals are automatically enrolled in Medicaid.

Uninsured Group 2:
**Moderate Income
and Small Businesses**
(204,000)

Solution

- Healthcare cafeteria plan mandated for employers with more than 10 employees.
- Established a healthcare entity which "connects" small businesses (50 or fewer employees) with healthcare products.
- Individuals may purchase directly from entity.

Uninsured Group 1:
**Income up to 300% of
Federal Poverty Level**
(150,000)

Solution

- Created a subsidized insurance program for uninsured individuals who are not eligible for a government insurance program.
- Premiums are set on a sliding scale based on household income and there are no deductibles.
- Co-payments are assessed in some instances.