AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

December 7, 2011

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Guidance

12/7/11 CMS/CCIIO issued final regulations regarding medical loss ratios (MLR), rules created under §10101 of the ACA which establish the minimum dollar percentage that health insurance companies must spend of consumers' health insurance premiums on medical care, not on income, overhead or marketing.

Beginning in 2011, the ACA required insurance companies in the individual and small group markets to spend at least 80% of collected premium dollars on medical care and quality improvement activities; insurance companies in the large group market are required to spend at least 85%. Insurance companies must report their MLR data to HHS on an annual basis so that residents of every state will have information on the value of the health plans offered by insurance companies in their state. Insurance companies that do not meet the MLR standard are required to provide rebates to their consumers. Insurers will make the first round of rebates to consumers in 2012. Rebates must be paid by August 1st each year. Under the final rules, plans must send their customers a notice about the MLR even if they meet the requirements and don't have to offer rebates. The notice will state what the insurer's MLR means and how the insurer's MLR has improved under the ACA. In addition, data on special types of plans, including mini-med plans, will be publicly posted in spring 2012. The final rules also make any rebates tax-free.

According to CMS, estimates from 2011 indicate that, starting in 2012, up to nine million Americans could receive rebates worth from $0.6 to $1.4 billion. However, early reports suggest insurers lowered premium growth rather than confront the possibility of providing rebates, either a win for consumers.

Other modifications made in the final rules include a phase-down of the special circumstances

adjustment for health plans with limited coverage known as "mini-med" plans. The final rules gradually tighten those standards and by 2014, mini-med plans will be banned by the prohibition on annual limits in the ACA. In addition, the rules state that HHS will post the mini-med MLR data that has been collected from the issuers in the spring of 2012.

The MLR requirements will take effect next year for most plans, but states can request a more gradual process if they believe the MLR would hurt consumers. The ACA allows the Secretary to adjust the medical loss ratio (MLR) standard for a state that meets certain criteria. In order to qualify for this adjustment, a state must demonstrate that requiring insurers in its individual market to meet the 80% MLR has a likelihood of destabilizing the individual market and result in fewer choices for consumers. HHS has approved adjustments to the MLR levels in six states and denied requests from four states. Seven more state requests are still pending.

Read the final rule regarding Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act at: http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/pdf/2011-31289.pdf

Comments on selected sections of this final rule are due January 6, 2012.

Read the final rule regarding Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans at: http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/pdf/2011-31291.pdf

Comments on selected sections of this final rule are due February 6, 2012.
For more information on the final rules, visit:
http://cciio.cms.gov/resources/factsheets/mlrfinalrule.html

12/6/11 DOL announced proposed rules which implement §6606, §6605 of the ACA, and target fraud in certain employer-based healthcare plans known as MEWAs, or multiple-employer welfare arrangements. Designed to give small employers access to low cost health coverage on terms similar to those available to large employers, MEWAs are arrangements that provide health and welfare benefits to two or more unrelated employers. However, DOL says that MEWAs have been rife with fraud and the policies have been able to circumvent state laws that require plans to keep enough funds readily available to pay claims.

Under the proposed rules, the Secretary of Labor is given a new set of enforcement tools to protect employers, health care providers and workers from mismanaged multiple-employer welfare arrangements (MEWAs) that fail to pay legitimate claims or embezzle premium dollars. Furthermore, the Secretary of Labor would be authorized to issue cease-and-desist orders to multiple employer health plans suspected of committing fraud and to seize assets of those appearing to be financially unstable. The new regulations require MEWAs to register with the Labor Department before establishing operations in a new state and authorize DOL to shut down MEWAs it believes are fraudulent.

Through September 2011, the department initiated 821 civil and 314 criminal investigations involving MEWAs. It also indicted 184 individuals with 133 convictions or guilty pleas. Charges involve millions in lost or stolen funds. The Labor Department has previously needed a court order when it identified possible fraud which allowed potential delinquents additional time to further drain their plans' reserves. While states have some enforcement options now, the process often takes too long to protect enrollees' assets. The new rules would allow enforcement without prior notice or hearing so that regulators to stop operations and freeze any remaining funds before administrators can lose or disappear with them

Read the proposed rule regarding Filings Required of Multiple Employer Welfare Arrangements and Certain Other Related Entities at: http://www.gpo.gov/fdsys/pkg/FR-2011-12-06/pdf/2011-30918.pdf

Comments are due March 5, 2012.

Read the proposed rule regarding Ex Parte Cease and Desist and Summary Seizure Orders-Multiple Employer Welfare Arrangements at:
http://www.gpo.gov/fdsys/pkg/FR-2011-12-06/pdf/2011-30921.pdf

Comments are due March 5, 2012.

Read the DOL Fact Sheet at: http://www.dol.gov/ebsa/newsroom/fsproposedm1revisions.html

12/5/11 CMS announced a **final rule on the Availability of Medicare Data for Performance Measurement** that will make more information available to the public about the performance of providers and suppliers, while protecting patient privacy. The final rule explains how organizations can become qualified by CMS to receive standardized extracts of Medicare claims data under Parts A, B, and D for the purpose of measuring provider and supplier performance. The regulations are effective January 6, 2012.

The rule gives qualified organizations, like employers and consumer groups, access to data that can help them identify high quality health care providers or create online tools to help consumers make educated health care choices. Information that could identify specific patients, however, will not be publicly released and strong penalties will be in place for any misuse of data.

This final rule implements §10332 of the ACA regarding the release and use of standardized extracts of Medicare claims data for qualified entities to measure the performance of providers of services (referred to as providers) and suppliers. The rule explains how entities can become qualified by CMS to receive standardized extracts of claims data under Medicare Parts A, B, and D for the purpose of evaluation of the performance of providers and suppliers. The rule also lays out the criteria qualified entities must follow to protect the privacy of Medicare beneficiaries.

The final rule is required by the ACA as part of an initiative to promote transparency in the provision of health care services, giving beneficiaries access to information that will help them make more informed decisions about their health care. The final rule makes the data cost-effective for qualified entities to access, gives qualified organizations more flexibility in their use of Medicare data to create performance reports for consumers, and extends the time period for health care providers to confidentially review and appeal performance reports before they become public.

Read the final rule at: http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/pdf/2011-31232.pdf
Prior guidance can be viewed at www.healthcare.gov

News

12/5/11 CMS announced the **initial launch of http://medicaid.gov/**, the first Federal government website devoted to the policies of Medicaid and the Children's Health Insurance Program (CHIP). The new site design provides information about the Medicaid and CHIP programs that is organized and updated to reflect current policy issues and priorities. CMS designed the site with consumer friendly and easily-accessibly answers to the most commonly asked questions and requests for information. Medicaid.gov prominently features Federal policy guidance; lists of pending and approved waivers; highlights ACA implementation efforts; State-specific program information and data; and improved search capabilities. The site also includes a section for consumers to help them get information about the Medicaid or CHIP program in

their State and links to http://www.healthcare.gov/ and www.insurekidsnow.gov where broader information about health coverage options is available.

11/30/11 CMS announced the **operational details for the next phase of the Medicare Competitive Bidding Program** for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) which was expanded under §6410 of the ACA. Under the program, suppliers can compete to become Medicare suppliers by submitting bids to provide certain items in competitive bidding areas. Already in 2011, the first phase of the program has saved Medicare 35% compared to the traditional fee schedule. In addition, CMS monitoring data have shown a successful implementation with no changes in beneficiary health status. The second phase will expand into 91 additional metropolitan areas. A National Mail Order Competition for diabetic supplies will also coincide this phase. The program is estimated to save Medicare, seniors, and taxpayers $28 billion over a 10 year period.

More information can be found at: CMS

Upcoming Events

Quarterly Affordable Care Act Implementation Stakeholder Meeting
Wednesday, December 21, 2011 from 10 AM- 11 AM
1 Ashburton Place, 21st Floor
Boston, MA

MFP Waiver Topical Discussion Group
Friday, December 16, 2011 from 10:30 AM - 12 PM
France Conference Room, UMass Medical School
333 South Street
Shrewsbury, MA

Money Follows the Person Working Group
Thursday, February 2, 2012 from 2 PM - 3:30 PM
Saxe Conference Room
Worcester Public Library
3 Salem Square
Worcester, MA

Please contact MFP@state.ma.us to attend the MFP meeting and to request reasonable accommodations.

More information on MFP can be found at: Money Follows the Person

Bookmark the **Massachusetts National Health Care Reform website** at:
National Health Care Reform to read updates on ACA implementation in Massachusetts.

Remember to check the Mass.Gov website at: Dual Eligibles for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.