

# Health Insurance in Massachusetts: The Basics

*Transitions from Acute Care to  
Post Acute Care Task Force  
February 5, 2025*



*Liz Leahy, Massachusetts Association of Health Plans*

# CHAPTER 197 OF THE ACTS OF 2024

(a) There shall be a task force to study and propose recommendations to address acute care hospital throughput challenges and the impact of persistent delays in discharging patients from acute to post-acute care settings.

The task force shall examine:

- (i) hospital discharge planning and case management practices;
- (ii) payer administrative barriers to discharge;
- (iii) legal and regulatory barriers to discharge;
- (iv) efforts to increase public awareness of health care proxies and the importance of designating a health care agent;
- (v) post-acute care capacity constraints and additional opportunities to provide financial incentives to increase capacity;
- (vi) administrative day rates and the cost to hospitals of discharge delays;
- (vii) enhanced hospital case management practices and reimbursement for wraparound services;
- (viii) the adequacy of post-acute care facility insurance networks and the establishment of an out-of-network rate for post-acute care facilities;
- (ix) expanding MassHealth Limited coverage to include post-acute and long-term care services;
- (x) the effectiveness of interagency coordination to resolve complex case discharges;
- (xi) the adequacy of reimbursement rates of MassHealth and commercial carriers for nonemergency medical transportation;
- (xii) opportunities to expand coverage and reimbursement for services delivered by mobile integrated health programs certified by the department of public health and by participating providers in the federal Centers for Medicare and Medicaid Services acute hospital care at home program;
- (xiii) alternative transportation options for patients being discharged and transferred to post-acute care facilities or home health agencies; and
- (xiv) the adequacy of state resources and infrastructure to place complex case discharges in appropriate post-acute care settings, including, but not limited to, patients with dementia diagnoses, geriatric patients with psychiatric diagnoses, patients with behavioral health diagnoses, patients with substance use disorder diagnoses, justice-involved patients and patients who have been unable to find an appropriate placement for post-acute care for 6 months or longer.

# TYPES OF INSURANCE COVERAGE IN MASSACHUSETTS

## Employer Sponsored

- Fully insured
- Self insured
  - GIC

## Health Connector

- ConnectorCare
- Individual, family, small business

## Medicaid

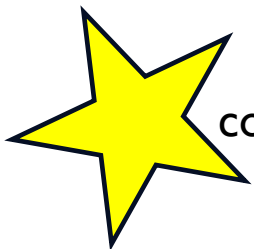
- FFS
- ACO/MCO
- ACO

## Medicare

- Original Medicare
- Medicare Advantage

## One Care & SCO

*Dual-eligible Medicare/Medicaid*

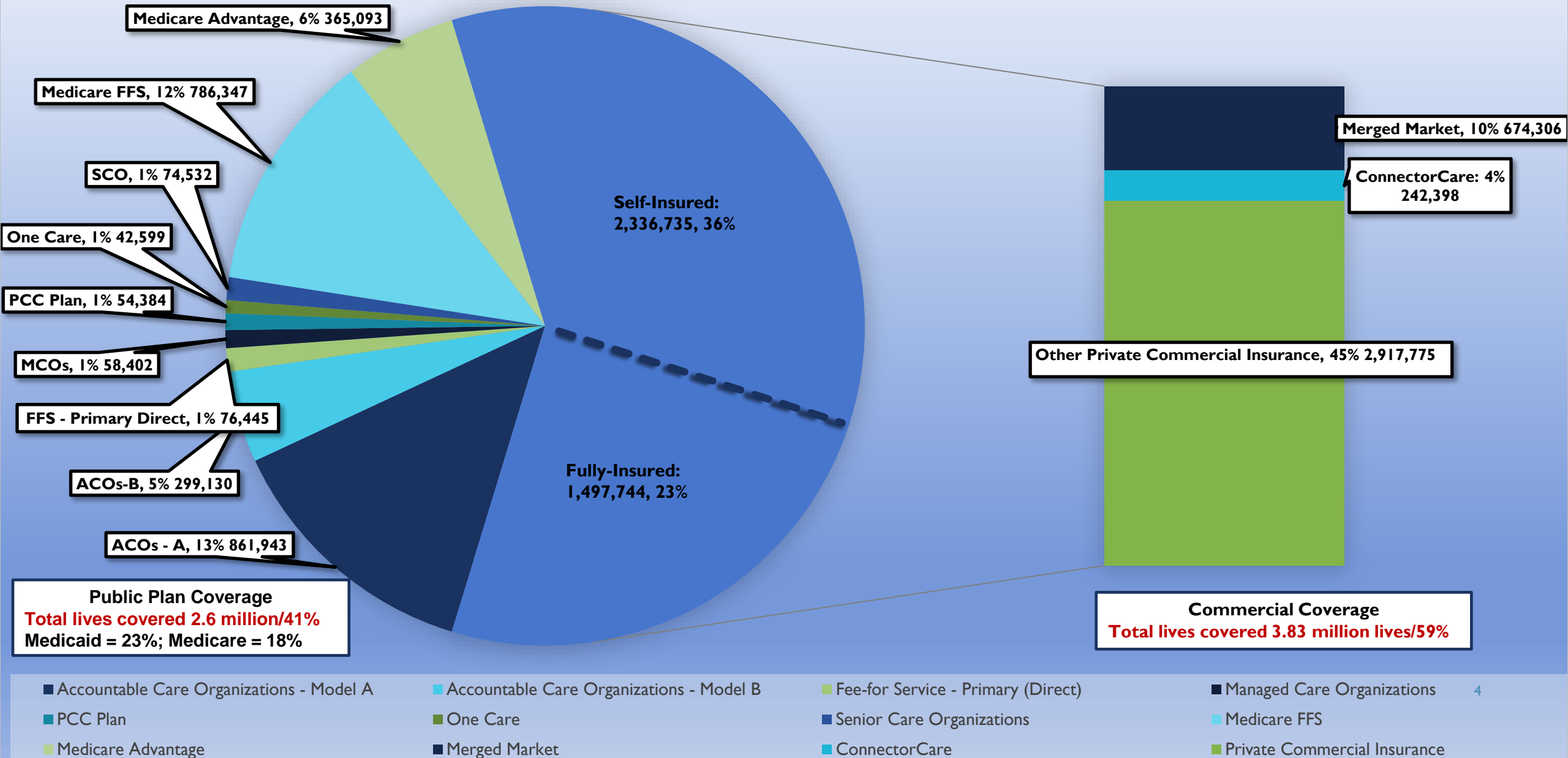


State legislative or regulatory action on commercial insurance can only impact the fully-insured market.



State legislative or regulatory action on public programs can only impact Medicaid.

# Massachusetts Health Insurance Coverage – March 15, 2024

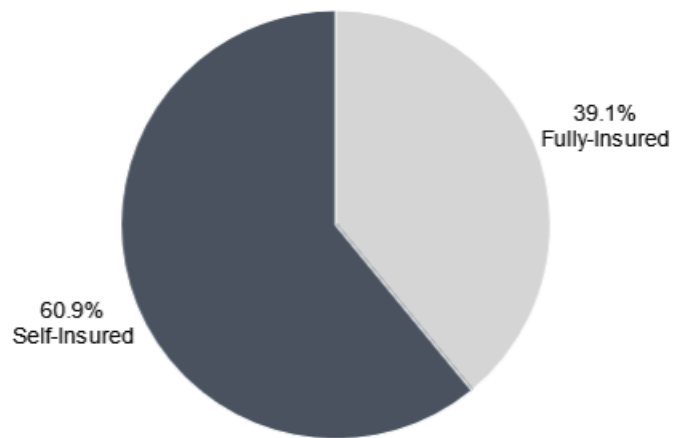


# STATE AND FEDERAL OVERSIGHT OF HEALTH INSURANCE

- Fully Insured Coverage – Subject to state regulation (see Chapter 175, 176)
- Self Insured Coverage – ERISA Preemption: Section 514, makes void all state laws to the extent that they “relate to” employer-sponsored health plans. This clause states that “the provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan....”
- Connector Coverage – Subject to ACA requirements, state law and regulation
- Medicaid Coverage – Subject to state law and CMS requirements, including waiver authorities
- Medicare Coverage – Subject to CMS requirements, federal pre-emption for state regulation.
  - 30.2 - Extent of Federal Preemption with Respect to State Regulation of MA Plans (Rev. 101, Issued: 08-19-11, Effective: 08-19-11, Implementation: 08-19-11) All State standards, including those established through case law, are preempted to the extent that they would specifically regulate health plans (including MA plans), with the exceptions of State licensing and solvency laws. Other State health and safety standards, or generally applicable standards, that are not specific to health plans are not preempted.

# EMPLOYER SPONSORED COMMERCIAL COVERAGE: FULLY INSURED & SELF INSURED

Enrollment by Funding Type: 3/15/2024



Center for Health Information and Analysis. <https://www.chiamass.gov/enrollment-in-health-insurance>

## *What does “fully insured” mean?*

- The employer contracts with a health plan to cover a portion of medical costs for its employees and their dependents.
- Small to midsize businesses are typically fully-insured.

## *What does “self-insured” mean?*

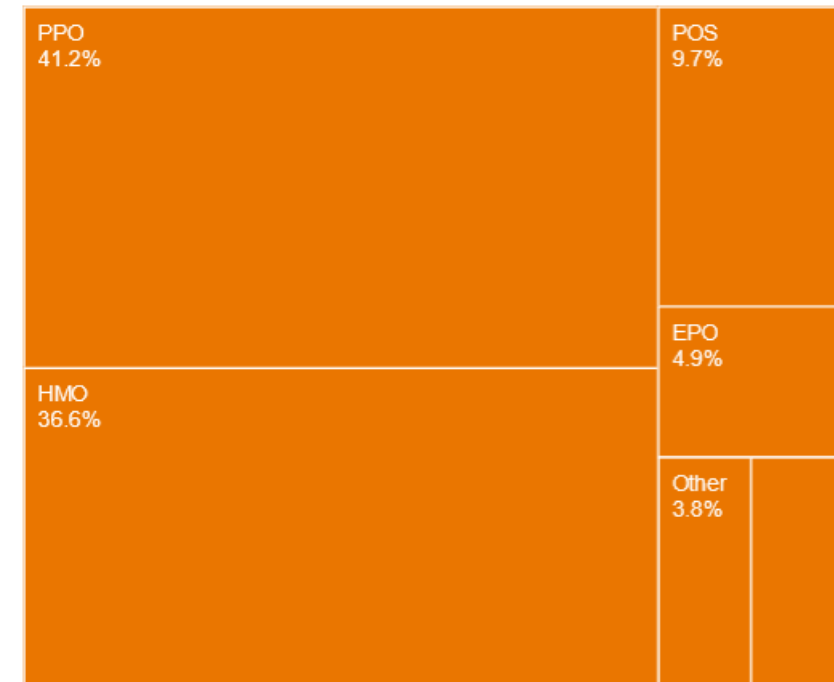
- The employer assumes financial responsibility and risk for its employees and their dependents’ medical claims.
- Larger companies and businesses are typically self-insured.

# PRODUCT DESIGN – EMPLOYER & CONSUMER CHOICE

***Employer and consumer choice of product design has an impact on a consumer's choice of providers, premium payments, and cost-sharing.***

- HMO – Health Maintenance Organization – lower premiums and cost sharing, coverage for in network care.
- POS – Point of Service – higher premiums, OON coverage often with referral.
- EPO – Exclusive Provider Organization – higher premiums, broader network.
- PPO – Preferred Provider Organization – higher premiums, more OON coverage without a referral.

Enrollment by Product Type: 3/15/2024



# COVERAGE THROUGH THE MA HEALTH CONNECTOR

## Overview of Small Group Qualified Health Plans

Carriers submitted 56 small group QHPs for consideration for 2025, no change from 2024.

Small Group 2025*						
Issuers	Platinum	Gold	Silver	Bronze	Totals 2025	Totals 2024 for Comparison
Blue Cross Blue Shield	1	2	3	1	7	7
Fallon Health	1	2	2	1	6	6
Health New England	1	2	3	2	8	8
Harvard Pilgrim Health Care	1	2	3	2	8	8
Mass General Brigham Health Plan	1	2	3	1	7	7
Tufts Health Plan - Direct	1	2	2	1	6	6
United	1	3	2	1	7	7
WellSense Health Plan	1	2	3	1	7	7
<b>Totals 2025</b>	<b>8</b>	<b>17</b>	<b>21</b>	<b>10</b>	<b>56</b>	56
<i>Totals 2024 for Comparison</i>	8	17	21	10	56	

- The Massachusetts Health Connector offers a broad choice of plans for individuals, families and small businesses.
- Plan designs are prescribed under the Affordable Care Act with oversight through the state's Seal of Approval Process.
- ConnectorCare plans are also available for individuals up to 500% FPL through a pilot program.

# BENEFIT DESIGN AND CONSUMER CHOICE

## 2025 QHP Standardized Designs

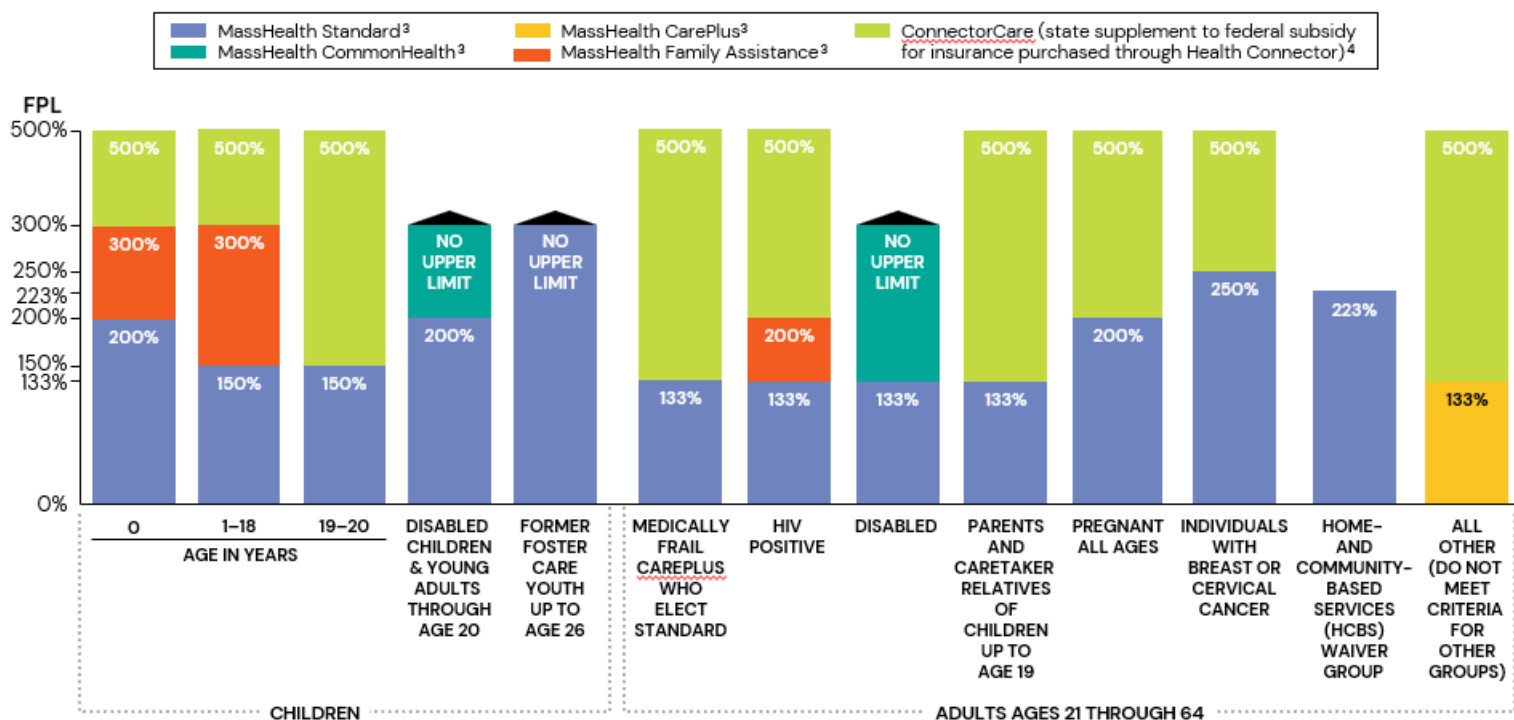
Plan Feature/Service <i>Note: "Deductible then..." means the member must first meet the plan's deductible; then, the member pays only the copay as listed for in-network services.</i>	2025 Platinum	2025 High Gold	2025 High Silver	2025 Low Silver (HSA compatible, Small Group Only)	2025 Bronze #1	2025 Bronze #2 (HSA compatible) Option 1
Annual Deductible – Combined	\$0	\$1,000	\$2,000	\$2,000	\$2,850	\$3,600
Annual Deductible – Medical	\$0	\$2,000	\$4,000	\$4,000	\$5,700	\$7,200
Annual Deductible – Prescription Drugs	N/A	N/A	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	\$3,000	\$6,000	\$9,200	\$7,050	\$9,200	\$8,000
Primary Care Provider (PCP) Office Visits and Mental/Behavioral Health Outpatient Services	\$20	\$20	\$25	Deductible then \$30	Deductible then \$30	Deductible then \$60
Specialist Office Visits	\$40	\$40	\$60	Deductible then \$60	Deductible then \$65	Deductible then \$90
Urgent Care	\$40	\$40	\$60	Deductible then \$60	Deductible then \$65	Deductible then \$90
Emergency Room	\$150	\$250	Deductible then \$350	Deductible then \$300	Deductible then \$400	Deductible then \$875
Emergency Transportation	\$0	\$0	Deductible then \$0	Deductible then \$0	Deductible then \$0	Deductible then \$0
Inpatient Hospitalization	\$500	Deductible then \$200	Deductible then \$1,000	Deductible then \$750	Deductible then \$1,000	Deductible then \$1,500
Skilled Nursing Facility	\$500	Deductible then \$200	Deductible then \$1,000	Deductible then \$750	Deductible then \$1,000	Deductible then \$1,500
Durable Medical Equipment	20 percent	20 percent	Deductible then 20 percent	Deductible then 20 percent	Deductible then 20 percent	Deductible then 20 percent
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$40	\$40	\$60	Deductible then \$60	Deductible then \$65	Deductible then \$90
Laboratory Outpatient and Professional Services	\$0	Deductible then \$25	Deductible then \$25	Deductible then \$60	Deductible then \$50	Deductible then \$55
X-rays and Diagnostic Imaging	\$0	Deductible then \$35	Deductible then \$50	Deductible then \$75	Deductible then \$100	Deductible then \$135
High-Cost Imaging	\$150	Deductible then \$150	Deductible then \$350	Deductible then \$500	Deductible then \$350	Deductible then \$750
Outpatient Surgery: Ambulatory Surgery Center	\$250	Deductible then \$100	Deductible then \$500	Deductible then \$500	Deductible then \$500	Deductible then \$500
Outpatient Surgery: Physician/Surgical Services	\$0	Deductible then \$0	Deductible then \$0	Deductible then \$0	Deductible then \$0	Deductible then \$0
Prescription Drug	Retail Tier 1 \$10	\$25	\$30	Deductible then \$30	\$30	Deductible then \$30
	Retail Tier 2 \$25	\$45	\$55	Deductible then \$60	Deductible then \$65	Deductible then \$120
	Retail Tier 3 \$50	Deductible then \$75	Deductible then \$75	Deductible then \$105	Deductible then \$100	Deductible then \$200
	Mail Tier 1 \$20	\$50	\$60	Deductible then \$60	\$60	Deductible then \$60
	Mail Tier 2 \$50	\$90	\$110	Deductible then \$120	Deductible then \$130	Deductible then \$240
	Mail Tier 3 \$150	Deductible then \$225	Deductible then \$225	Deductible then \$315	Deductible then \$300	Deductible then \$600
Federal Actuarial Value Calculator	90.51 percent	81.56 percent	71.34 percent	71.66 percent	64.64 percent	64.41 percent

- The Affordable Care Act sets strict requirements for QHPs, including Out Of Pocket (OOP) maximums set annually for all out of pocket expenses, including prescriptions, deductibles, copayments, and coinsurance, as well as a maximum deductible amount.
- Health plans offer products that fit into four metallic tiers based on narrow actuarial value ranges set by the ACA.
- Tiers determine the cost sharing ratio between what a Plan Member pays and the Health Plan pays.

# MASSHEALTH: MEDICAID COVERAGE FOR INDIVIDUALS

Standard	CommonHealth	Medicare Savings Program (formally MassHealth Senior Buy-In)	Family Assistance	CarePlus	MassHealth Limited
<ul style="list-style-type: none"><li>• Provides a full range of health care benefits.</li><li>• Subject to income, age, and disability requirements.</li></ul>	<ul style="list-style-type: none"><li>• Provides benefits similar to MassHealth Standard for disabled adults and children who cannot get MassHealth standard.</li></ul>	<ul style="list-style-type: none"><li>• Programs that pay for some or all of Medicare beneficiaries' premiums, deductibles, copays, and co-insurance.</li></ul>	<ul style="list-style-type: none"><li>• Available to residents of Massachusetts who meet the income and asset rules for MassHealth Standard, but have an immigration status that keeps them from getting MassHealth Standard.</li></ul>	<ul style="list-style-type: none"><li>• Broad range of benefits available to adults who are not otherwise eligible for MassHealth standard.</li><li>• Available up to 133% FPL</li></ul>	<ul style="list-style-type: none"><li>• Available to people 65 and older who meet the income and asset rules for MassHealth Standard or MassHealth Family Assistance, but have an immigration status that keeps them from getting MassHealth Standard or Family Assistance.</li><li>• MassHealth Limited doesn't pay for long-term-care services. MassHealth Limited coverage is for emergency medical services only.</li></ul>

## MASSHEALTH INCOME LIMITS VARY FOR DIFFERENT AGES AND ELIGIBILITY GROUPS<sup>1,2</sup>



<sup>1</sup> MassHealth eligibility includes nuances not included in this chart; MassHealth staff can help determine eligibility. Additional information can be found at <https://www.mass.gov/service-details/masshealth-coverage-types-for-individuals-and-families-including-people-with>.

<sup>2</sup> MassHealth Limited, not shown in this chart, provides emergency health services to people who, under federal law, have an immigration status that keeps them from receiving coverage financed with federal funding. Income eligibility for this population is similar to MassHealth Standard: 200% FPL for pregnant women and children up to age 1; 150% FPL for children ages 1-20 years; 133% FPL for adults ages 21-64.

<sup>3</sup> For more information on these coverage types, see slide 19.

<sup>4</sup> ConnectorCare eligibility was extended to people earning between 300% and 500% FPL as a two-year pilot, effective January 1, 2024.

## ELIGIBILITY FOR SENIORS AGED 65 AND OLDER GENERALLY INCLUDES AN ASSET TEST AND LOWER INCOME THRESHOLDS; MOST SENIORS ALSO HAVE MEDICARE<sup>1</sup>

POPULATION	INCOME/ASSETS <sup>2</sup>	COVERAGE <sup>4</sup>
Living in community, with or without Medicare eligibility, citizen or lawfully present immigrant	≤100% Federal Poverty Level (FPL) ≤\$2,000 Assets (for an individual)	Comprehensive coverage through MassHealth Standard or Family Assistance (based on immigration status). For those with MassHealth Standard, MassHealth also pays their Medicare cost-sharing and premiums.
Living in community, certain noncitizens	≤100% FPL ≤\$2,000 Assets (for an individual)	MassHealth Limited — Emergency services only.
Living in community, eligible for Medicare, citizen or lawfully present immigrant	≤190% FPL <sup>3</sup>	Medicare Savings Program— Covers Medicare Part A and B premiums, co-pays, coinsurance, and deductibles. Members also receive Medicare Part D Extra Help. <sup>5</sup>
Living in community, eligible for Medicare, citizen or lawfully present immigrant	>190% and <225% FPL <sup>3,6</sup>	Medicare Savings Program – Covers Medicare Part B premiums. Members also receive Medicare Part D Extra Help.
Living in or waiting for facility-based long-term care, citizen or lawfully present immigrant	No specific income limit ≤\$2,000 Assets (for an individual)	MassHealth Standard — Including LTSS. Member must pay income (minus monthly personal need and spousal maintenance allowances) toward nursing facility care.

<sup>1</sup> MassHealth eligibility includes nuances not included in this chart; for example, the higher income thresholds and other eligibility requirements that are part of Frail Elder or HCBS waivers are not described here.

<sup>2</sup> Certain assets are excluded from the asset test; see 130 CMR 520.007 – 520.008 for details. Asset limits are listed for individuals; the amounts for couples are higher.

<sup>3</sup> MassHealth eliminated an asset test that had previously applied to both Medicare Savings Programs, effective March 1, 2024.

<sup>4</sup> For more information on these coverage types (i.e. MassHealth Standard and Family Assistance), see slide 19.

<sup>5</sup> Part D Extra Help is a Medicare program which helps pay Medicare drug coverage (Part D) premiums, deductibles, coinsurance, and other costs.

<sup>6</sup> For seniors with income above 210% of FPL, support from the Medicare Savings Program is capped by an annual federal allocation to states.

# TYPES OF MANAGED CARE IN MASSHEALTH

## ACOs

- Accountable Care Partnership Plans - groups of primary care providers (PCPs) who work with just one managed care organization to create a full *network* that includes PCPs, specialists, behavioral health providers, and hospitals.
- Primary Care Accountable Care Organizations - groups of primary care providers or PCPs who, together, form an ACO that is responsible for your care and the coordination of your care. The ACO works directly with MassHealth to provide primary care and to coordinate the full range of services for you, along with its other members. Primary Care ACO Plans work with the MassHealth network of specialists and hospitals and may have certain providers in their “referral circle.” The “referral circle” gives you direct access to certain other providers or specialists without the need for a referral from your primary care provider (PCP).

## SCO

- A comprehensive health plan that covers all of the services normally paid for through Medicare and MassHealth. This plan provides services to members through a senior care organization and its network of providers. It combines health services with social support services by coordinating care and specialized geriatric support services, along with respite care for families and caregivers. SCO offers an important advantage for eligible members over traditional fee-for-service care. There are no copays for enrolled members enrolled.

## One Care

- A comprehensive health plan that covers all of the services normally paid for through Medicare and MassHealth. This plan provides services for individuals who are between the ages of 21 and 64, have a disability, have Medicare Parts A and B, qualify for Part D, have MassHealth Standard or MassHealth CommonHealth, and do not take part in a Home and Community Based Services Waiver.

## PACE

- Provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. An interdisciplinary team of health professionals provides PACE participants with coordinated care.

# MEDICARE COVERAGE

## Original Medicare

- Includes Part A (inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care) and Part B (services from doctors and other health care providers, outpatient care, home health care, durable medical equipment, and preventive visits).
- May join a separate Medicare Drug Plan (Part D) to get Medicare drug coverage.

## Medicare Advantage

- Medicare-approved plan from a private company that offers an alternative to Original Medicare for health and drug coverage. These “bundled” plans include Part A, Part B, and usually Part D.
- Plans develop networks to manage costs and offer extra benefits that Original Medicare does not.



# THE ROLE OF MANAGED CARE

*ADMINISTRATIVE REQUIREMENTS TO ENSURE RIGHT CARE, RIGHT PLACE, RIGHT TIME*

# REQUIREMENTS GOVERNING PRIOR AUTHORIZATION

## **Mandated Turnaround Times – Prior Authorization**

- Fully-insured commercial – 2 business days
- Medicare – 10 business days/14 calendar days. In 2026, this will shorten to 72 hours for expedited requests and 7 calendar days for standard requests for Medicare, Medicaid, CHIP.
- MassHealth – pharmacy within 24 hours, transportation within 7 days, independent nursing within 14 days, other services within 21 days.

# WHAT WE HEARD

- **Bed Shortages.** Since the start of the pandemic, more than 25 nursing facilities have closed in Massachusetts, creating bed shortages which impact placement at skilled nursing facilities, which then impacts placement at institutional rehab facilities and long-term acute care hospitals.
- **Staffing Shortages.** Staffing shortages at post-acute care facilities continue to be the primary and often sole issue in finding post-acute care placement for members. Staffing impacts are not just about keeping all beds in use, but since many health plan members have complex medical and BH needs, they often require more assistance. This makes finding a bed in a post-acute setting challenging because many facilities are not able to staff at the level needed to provide additional supervision and support.
- **Level of Care.** As bed shortages limit patient options for appropriate levels of care, case managers responsible for discharge planning are, understandably, frustrated by PA denials for inappropriate placement when they've found a bed at a higher level of care than needed or the need for plans to enter into a single case agreement with an out of network facility that the plan didn't have a prior relationship with.
- **Medicare Reimbursement.** Pressures on hospital case managers to move patients quickly are exacerbated by Medicare payment policies – Medicare patients no longer needing an acute hospital level of care, but who remain in the hospital awaiting placement (not hooked up to anything, just getting meals and a bed) are reimbursed for Administrative Days only, not for acute hospital level of care.

# WHAT WE'VE TRIED: PA WAIVERS

## December 2022-March 2023

- During the 90 day waiver, the number of patients awaiting discharge to SNF decreased by only 3%, while the number of patients awaiting discharge to LTACH/IRF increased by 52%, indicating that a waiver of prior authorization did not address the system-wide capacity challenges.
- Plan Experience. Rather, waiving prior authorization has created care coordination challenges, raising concerns about patients being placed in inappropriate or ill-equipped post-acute care facilities. Data from one MAHP member plan found that the waiver:
  - Increased overall admission to post-acute facilities by 14%
  - Increased use of non-participating providers by 50%
  - Resulted in 102 members identified as not meeting clinical criteria to admit to a post-acute facility, but who were admitted inappropriately due to the waiver in place

## January 2024-April 2024

- Hundreds of members inappropriately placed (defined as placed at the wrong level of care based on medical necessity guidelines)
- Dozens of members placed in OON sites of care
- Estimated over \$1M in excess costs to members/state for OON placement.
- Significant impact on case management and member satisfaction
  - Members reported being discharged from the hospital to early, limiting their ability to develop alternative discharge plans
  - Members reported having limited choice in facilities they were discharged to, requesting SNF transfer upon admission
  - Largest impact on members with BH, SUD, homelessness, dementia and end of life patients.
- Increase in administrative burden for patients, providers, and plans
  - Waiver of these authorizations resulted in multiple unnecessary concurrent reviews, phone calls for clinical documents, issuing Notice of Medicare Non-Coverage letters, and other regulatory termination of coverage/no longer meeting skilled care letters, and appeals.

# WHAT WE'RE TRYING NEXT

## 24-hr TaT pilot

- Insured health benefit plans issued or renewed in Massachusetts are required to “prove or deny a request for prior authorization for admission to a post-acute care facility or transition to a post-acute care agency for any inpatient of an acute care hospital requiring covered post-acute care services by the next business day following receipt by the payer of all necessary information to establish medical necessity of the requested service; provided, however, that no new admission may occur until the applicable pre-admission screening and resident review required pursuant to 42 CFR 483 is complete.”
- “[i]f the calendar day immediately following the date of submission of the completed request is not a payer’s business day, and the payer cannot otherwise make a determination by the next calendar day, and the receiving post-acute care facility or agency is both open to new admissions and has indicated that said facility or agency will accept the enrollee, then prior authorization shall be waived; provided, that the payer shall provide coverage and may begin its concurrent review of the admission on the next business day; provided further, that the payer shall not retrospectively deny coverage for services to an enrollee admitted to a post-acute care facility or transitioned to a post-acute care agency after a waiver of prior authorization pursuant to this section unless the claim was a result of fraud, waste or abuse.”
- “[a]n adverse determination of a prior authorization request pursuant to this section may be appealed by an enrollee or the enrollee’s provider and such appeal, in the case of an enrollee of a commercial payer, shall be subject to the expedited grievance process pursuant to clause (iv) of subsection (b) of section 13 of chapter 176O of the General Laws....Nothing in this section shall be construed to require a payer to reimburse for services that are not a covered benefit.”

## Standard Form

- The division shall develop and implement a uniform prior authorization form for the admission of patients from an acute care hospital to a post-acute care facility or transitioned to a home health agency certified by the federal Centers for Medicare and Medicaid Services for covered post-acute care services.