Report to the Massachusetts Legislature

Implementation of Health Care Reform

Fiscal Year 2010

November 2010

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1.0 Preface

Support for health care reform in Massachusetts remains strong more than four years after the passage of Chapter 58 of the Acts of 2006. Many elements of Massachusetts' health care reform are reflected in the historic national health reform legislation, the Patient Protection and Affordable Care Act (PPACA), which was signed into law in March 2010. Similar to the guiding principle of Chapter 58, the national law relies upon shared responsibility by government, businesses, and individuals in order to improve access to health insurance coverage. Health insurance Exchanges that facilitate the purchase of individual and small business health insurance coverage, subsidies designed to help low and moderate income individuals afford health insurance, potential penalties for employers that do not provide a sufficient level of health insurance coverage, and penalties for individuals who fail to comply with the coverage mandate are all examples of successful aspects of the Massachusetts health care reform model that will be implemented across the nation in coming years.

Recognizing the similarities between national health reform proposals and the Massachusetts model, the Commonwealth Health Insurance Connector Authority (Health Connector) used the grant money it was awarded as a recipient of the John F. Kennedy School of Government at Harvard University's 2009 Innovations in American Government Award to educate state leaders throughout the country about the challenges and opportunities associated with implementation of health reform. In collaboration with AcademyHealth, the Health Connector organized a conference attended by policymakers and state leaders from 42 states and the District of Columbia in January 2010. Attendees learned how to set up Exchanges and discussed other lessons from Massachusetts' experience in implementing the initial stages of health care reform. As states begin implementing PPACA, the Health Connector and all of the agencies and stakeholders that have contributed to carrying out health reform in the Commonwealth will be looked to for guidance.

The ongoing implementation and continued success of health reform in Massachusetts would not be possible without the cooperation and efforts of many state agencies. The Health Connector expresses gratitude to the Executive Office for Administration and Finance (ANF), the Executive Office of Health and Human Services (EOHHS), MassHealth, the Division of Insurance (DOI), the Group Insurance Commission (GIC), the Department of Revenue (DOR), the Division of Health Care Finance and Policy (DHCFP), the Department of Public Health (DPH), the Division of Unemployment Assistance (DUA), and the Massachusetts Board of Higher Education for their commitment to Massachusetts health reform.

The Health Connector experienced change in key leadership positions in Fiscal Year 2010 (FY10). Leslie Kirwan stepped down from her post as Secretary of ANF, the ex-officio chair of the Health Connector Board of Directors (the Board). In September 2009, Tom Dehner and Nonnie Burnes also stepped down from their positions as Medicaid Director and the Commissioner of the DOI respectively, two ex-officio representatives on the Board. Finally, in June 2010, Jon Kingsdale resigned from his position as the Executive Director of the Health Connector. The Health Connector would like to thank them for their leadership and the time they dedicated to ensuring the success of Massachusetts health reform. Thanks and gratitude are also extended to the following Directors of the Health Connector for their continued commitment to health reform in FY10: ANF Secretary Jay Gonzalez, Chair of the Board; Terry Dougherty, Medicaid Director; Ian Duncan, Founder and President of Solucia, Inc.; Jonathan Gruber, Professor of Economics at MIT; Richard C. Lord, President and CEO of Associated Industries of Massachusetts; Louis F. Malzone, Executive Director of the Massachusetts Coalition of Taft-Hartley Funds; Dolores Mitchell, Executive Director of the GIC; Joseph Murphy, Commissioner of the DOI; Nancy Turnbull, Senior Lecturer on Health Policy and Associate Dean at Harvard School of Public Health; and Celia Wcislo, Assistant Division Director of 1199 SEIU United Health Care Workers East.

This represents the third annual report issued by the Health Connector. The first annual report, released in October 2008, detailed the initial start-up and implementation activities conducted throughout the first

two years of health care reform in Massachusetts. The second report, released in October 2009, as well as this report, provide updates on the status of health care reform and describe notable activities throughout state FY09 and FY10 respectively.

2.0 Update on the Status of Health Care Reform in Massachusetts

2.1 Insurance Coverage

Massachusetts has successfully maintained the highest rate of insurance coverage among all states in the nation, with 97.3% of the population insured.[1] Recent surveys validate that despite a severe economic recession, the most serious since the Great Depression, the state continues to demonstrate record low uninsurance rates.[2]

Since passage of reform, there have been significant gains in the number of individuals enrolled in health insurance coverage with no evidence of crowd-out. As described in last year's report, between June 2006 and June 2008, the number of people with health insurance coverage increased by 425,000. A significant portion of this increase was attributable to private coverage gains. There has been a very small decline in the number of newly-insured residents and some change in the distribution of newly insured by coverage type, however, which is likely attributable to the economic downturn and the rise in the state's unemployment rate (from 6.4% in December 2008 to 9.3% in December 2009).[3]

Total enrollment in private group insurance began to decline after June 2008, presumably as a result of job loss and the associated loss of Employer Sponsored Insurance (ESI). At the same time, there was significant growth in the state's Medical Security Program (MSP), a health insurance program for low and moderate income individuals receiving unemployment insurance. Enrollment in MSP more than doubled from December 2008 to December 2009. Not surprisingly, there was also a significant increase in enrollment in the state's Medicaid program, MassHealth, over this time period. Nonetheless, the vast majority (82%) of Massachusetts residents are enrolled in private coverage. Moreover, recent data suggest the continued commitment on behalf of employers in Massachusetts to provide insurance coverage in marked contrast to national trends. Among employers in Massachusetts, 76% offer insurance to their employees, up from 69% in 2001, while the national rate declined from 68% to 60% during the same time period.[4] Of employees eligible for coverage, 80% enrolled in the health insurance plans offered to them by their employers in 2009, equal to the national take-up rate.[5] These high employer offer and employee take-up rates reflect employers' commitment to health reform in Massachusetts.

According to a recent study, health reform in Massachusetts is responsible for reducing the rate of uninsurance among nonelderly adults in the state by half.[6] Among those who have been admitted and discharged from a hospital, uninsurance rates have fallen 36%.[7] Also as a result of health reform, Massachusetts has the lowest rate of uninsurance for children (1.8%) among all states in the nation. The rate of uninsurance for children has declined by more than 60% since passage of reform with the greatest gains in coverage for children in lower income (i.e., income at or below 300% Federal Poverty Level (FPL)) families.[8]

Health reform has also reduced disparities in access to coverage by age, sex, and race and ethnicity. The Urban Institute released a report this year noting significant gains in coverage for young adults. The study found that while more than 20% of adults ages 19-26 were uninsured prior to health reform in Massachusetts, only 8.2% of adults in this age bracket remain uninsured.[9] Pre-reform, women were insured at higher rates than men (90% vs. 84%), in part due to wider eligibility for women for MassHealth. Coverage gains have been made for both men and women, and the gap between sexes in coverage rates is closing: women experienced a 5.7 percentage point increase in coverage from 2006 to 2009, while the rate of insurance coverage for men increased by more than 10 percentage points.[10] Prior

to health reform minority adults were much more likely to be uninsured than were white adults. From fall 2006 to fall 2009, insurance coverage increased by 11.8% for minority adults, compared to 6.7% for white adults. As a result, the percentage of minority adults with coverage was equal to that of white adults by the fall of 2009 when controlling for differences in health status and other demographics.[11]

2.2 Compliance with the Individual Mandate and Profile of the Remaining Uninsured

Preliminary analyses from DOR indicate that the vast majority of tax filers in Massachusetts, 98.3%, continued to comply with the individual mandate in 2008.[12] The reporting requirements to comply with the individual mandate changed between 2007 and 2008. In 2008, tax filers were required to report coverage for each month in tax year 2008, whereas tax filers in 2007 only reported coverage as of December 31, 2007. In 2007, 95% of tax filers were insured. Compliance was maintained in 2008, with 95% of filers insured for the full year and 96.4% of tax filers insured at any point in 2008.

Tax filers who are uninsured but have affordable insurance options available to them are subject to a penalty. Of the small percentage of tax filers who remain uninsured, the majority (approximately 60%) are exempt from the penalty because their household income is below 150% FPL or available coverage is deemed unaffordable. The number of tax filers subject to a penalty decreased from approximately 67,000 in 2007 to 53,000 in 2008. The number of tax filers

Table 1. Tax-filers Insurance Data, Tax Year 2007 vs. Tax Year 2008

	Tax Year 2007 [1]	Tax Year 2008 [2]
Compliance with tax filing requirement:	98.60%	98.30%
Insured tax-filers:	95%	just over 95% (for full year)
Uninsured tax-filers:	~204,000	~140,000 for full year ~155,000 for part of the year*
Among the uninsured tax-filers:		
Uninsured, subject to penalty because insurance affordable:	67,000	53,000
└ Intent to appeal penalty:	└7,000	└8,000
Uninsured, no penalty because insurance unaffordable:	76,000	45,000
Uninsured, no penalty because of income status:	51,000 (NTS or LIC[3])	135,000 (income below 150% FPL)
Uninsured, no penalty because allowable gap:	N/A	50,000
Uninsured, no penalty because religious exemption or certificate of exemption:	9,200	5,400

**About 7,000 of these tax-filers reported coverage at some point of 2008, but manual review is required by DOR to determine applicability of the individual mandate.*

[1] Massachusetts Department of Revenue (2008, October). Data on the Individual Mandate and Uninsured Tax Filers, Tax Year 2007. Boston, MA: Author. Available online at, http://www.mass.gov/Ador/docs/dor/News/PressReleases/2008/2007_Demographic_Data_Report_FINAL_(2).pdf

[2] Massachusetts Department of Revenue (2009, December). Individual Mandate 2008 Preliminary Data Analysis. Boston, MA: Author. Available online at, http://www.mass.gov/Ador/docs/dor/News/PressReleases/2009/2008_Health_Care_Report.pdf

[3] No Tax Status (NTS) filers are those with income below $8,000 for an individual, $13,975 + $1,000 per dependent for head of household filers, or $15,850+ $1,000 per dependent for joint filers. NTS filers are not required to pay Massachusetts income tax. Limited Income Credit (LIC) are filers with slightly higher income thresholds ($14,000 for an individual, $24,456 + $1,750 per dependent for head of household filers, or $27,738 + $1,750 per dependent for joint filers). LIC may lose their personal exemption due to uninsurance status, but would subsequently qualify for a larger income credit that offsets the penalty.

****The data above for both Tax Year 2007 and 2008 are based on analysis of 96% of expected tax returns. Data presented is illustrative, but not directly comparable due to differences in filing requirements and insurance coverage requirements in 2007 and 2008. An updated analysis of data for Tax Year 2008 will soon be available.*

indicating intent to appeal the penalty increased slightly, from about 7,000 in 2007 to 8,000 in 2008. As of June 2010, 8,027 tax filers completed their appeal application for tax year 2008. The number of tax-filers claiming a religious exemption or Certificate of Exemption declined from 9,200 in 2007 to less than 5,400 in 2008.

2.3 Costs

Massachusetts has carefully managed the finances of health care reform, delivering expansions in coverage in a fiscally responsible manner. Since its inception, the incremental net cost of health care reform to the state (net of federal reimbursement) is a little more than one percent of the state's entire annual budget.[13] This is because health care reform is working as intended. Our state has retained a strong base of employer-sponsored coverage. Seventy-six percent of employers in the Commonwealth now offer insurance to their employees, a figure that has risen since the enactment of health care reform. This rate outpaces the national average of 60% of employers offering coverage.[14] Moreover, new investments in state-subsidized health insurance have been significantly offset by decreased spending on care for the uninsured and underinsured. Massachusetts is also leveraging good value for its new expenditures on health insurance. Notably, since the inception of Commonwealth Care (CommCare) in 2006 through FY10, the average annual rate of increase in CommCare premiums per covered person has been held under 5% – about half the rate of growth in commercial health insurance. Indeed, the Health Connector's use of a competitive bidding process to procure health plan participation for the CommCare program has resulted in an estimated savings of $16-$20 million for the state in FY10. For FY11, an estimated $21 million is expected to be saved by the state due to this process.

Nonetheless, rising health care costs continue to challenge Massachusetts and states across the nation. These challenges were not created by health care reform. Rather, they are longtime national and state challenges, rooted in the fundamentals of how we deliver and pay for care. Our health care costs to some extent reflect the price of high-quality care. Yet they are also driven by care that is unnecessary, duplicative, or even harmful to patients. Experts believe that approximately 30% of today's health care spending produces no benefit to patients.[15] In Massachusetts, we spend a substantial amount of money per year on preventable and unnecessary emergency room visits, hospitalizations and readmissions, while the United States has the dubious distinction of leading the world in duplicative medical tests.[16] At the same time, fewer than half of adults with diabetes in Massachusetts receive recommended preventive care.[17] A better coordinated system of care would address the challenges the health care industry is currently facing in Massachusetts and nationally.

In response to these challenges, the Legislature authorized and the Governor appointed a special commission charged with developing recommendations for reforming how we pay for health care. The predominant form of paying for health care in Massachusetts has been a "fee-for-service" approach widely recognized as rewarding the delivery of *more* and *more expensive* care regardless of whether it is the *right* care for patients – and promoting fragmentation instead of coordination among doctors and hospitals. The recommendations unanimously approved by the commission in July 2009 would dramatically alter this payment system, moving from the predominantly fee-for-service based system to a global payment based system. Rather than rewarding doctors and hospitals for increased health care utilization, a global payment model offers incentives for efficiency in the delivery of services, and encourages improvements in quality and access to appropriate, coordinated care.[18]

The Massachusetts Health Care Quality and Cost Council (HCQCC) also released a report in October 2009 with recommendations for containing health care costs. Short-term strategies included administrative simplification, consumer engagement efforts, health promotion and increased transparency. The HCQCC recommended a four-pronged long-term strategy: (1) payers should increase their use of payment methodologies that support delivery system redesign, (2) the state should encourage

the use of global payments, (3) the HCQCC should set cost control targets and explore regulatory options if targets are not met, and (4) the state should work with the Centers for Medicare & Medicaid Services on alternative payment models that coordinate incentives for high-quality, efficient care, such as medical homes.

Following the HCQCC's report, DHCFP and the Attorney General's office (AGO) analyzed health care spending in the state and examined factors contributing to increased spending.[19] Key findings from their analyses align with the findings of the HCQCC. These include: (1) price increases account for the majority of growth in medical costs, (2) wide price variation exists across insurers and merits intervention, (3) fee-for-service payments are pervasive, yet do not promote an integrated delivery system, (4) more integration in the health delivery system as well as a system-wide health information technology infrastructure would help contain health care costs, (5) non-competitive contracts between providers and insurers impede competition and innovation, which could lead to higher prices, (6) limited and tiered network products may be an opportunity for insurers to direct care to the most efficient, lower cost providers, and (7) consumers have minimal information available about price and quality of care to make informed purchasing decisions.

According to the report by DHCFP, immediate actions for Massachusetts associated with these findings include leveraging federal reform opportunities to fund cost control innovations, implementing oversight of health insurance premiums and provider rates, developing market-oriented insurance products, and initiating legislative review of provider contract provisions that currently limit competition. Action on comprehensive payment and delivery system reform is expected next year. In the meantime, the state's EOHHS is pushing forward on this issue by coordinating an interagency Patient Centered Medical Home (PCMH) initiative. The PCMH is an alternative approach to the delivery of primary care services that promises better patient experience and better results than traditional care.[20] This initiative is a three year multi-payer initiative to implement the PCMH model in selected primary care practice sites. The PCMH model will be implemented in a diverse group of practices in terms of primary care specialty (internal medicine, pediatric, and family practice), practice structure and size, practice affiliation, clinical setting, geographic location, and payer mix in order to evaluate the effectiveness of this transformation.

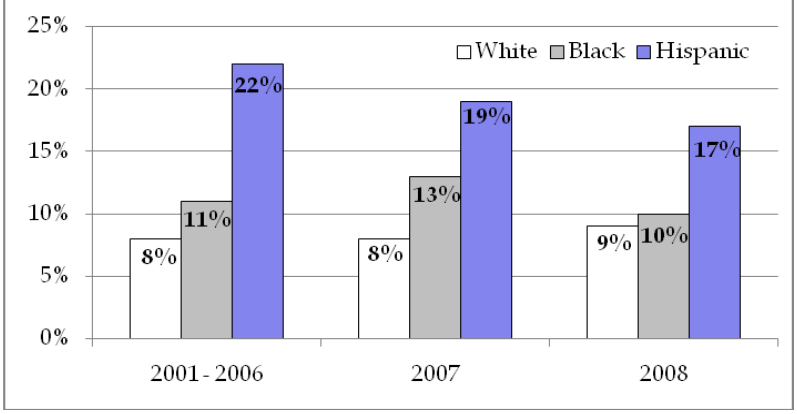
In the spring and summer of 2010, the Patrick Administration and the Legislature undertook a series of administrative and legislative actions to address health care costs and help lay the groundwork for more fundamental payment and delivery system reform. The state's DOI released emergency regulations in the spring of 2010 requiring health insurance companies to file proposed changes to small business and individual premium rates in advance of their effective date to facilitate regulatory review of these rates. Operating under these regulations, DOI in April rejected more than 85% of proposed rate increases as excessive and unreasonable. In the fall of 2010, DOI and health insurers reached settlements that determined appropriate premiums for 2010. DOI was also awarded $1 million from the federal Office of Consumer Information and Insurance Oversight (OCIIO) to enhance their health insurance premium rate oversight in FY11. Furthermore, in August, legislation was enacted to provide additional relief to small businesses and individuals by encouraging limited or tiered network plans, allowing small businesses to form cooperatives to strengthen their purchasing power, requiring insurers to maintain a medical loss ratio of almost 90%, and providing for additional premium relief for certain small businesses that adopt wellness programs in purchasing coverage for their employees through the Health Connector.

2.4 Access to Care

Longitudinal surveys continue to illustrate that adults in Massachusetts have experienced sustained improvements in access to care since implementation of reform.[21] For example, the Massachusetts Health Reform Survey (MHRS) indicates increases from fall 2006 to fall 2009 in adults reporting a usual source of

care and a doctor's visit. This same survey suggests an over 20% decline from fall 2006 to fall 2009 in the percentage of adults reporting they did not get needed care in the past 12 months.

Figure 1. Massachusetts Women 18-64 Without a Personal Doctor: 2001 - 2008



Significant gains in reducing disparities in access to care among women and racial/ethnic minorities have been made since 2006. Improvements in access to care, utilization, and affordability have been noted among all women, as well as among specific subgroups, including women under 300% FPL, non-white or Hispanic women, older women ages 55-64, and women without dependent children.[22] As shown in Figure 1, the percentage of women who identify a personal doctor increased among black and Hispanic residents. Although Hispanic women were less likely than white women to have a personal doctor in 2008, the gap in access to care between the two populations has narrowed.[23] Additionally, more than 90% of women had been to the doctor for a general visit and 82% had visited the doctor for preventive care in the past 12 months, as compared to 85% and 77% respectively in the fall of 2006.[24] There was also a significant drop, 3.7 percentage points, in the share of women who reported that they did not receive necessary care due to costs. This trend was consistent for physician visits, medical tests, treatment, follow-up care, prescription drugs, and dental care.[25] Among all women ages 18-64, utilization of dental care increased 6.4% from the fall of 2006 to the fall of 2009.[26]

The Urban Institute and the Blue Cross Blue Shield of Massachusetts (BCBSMA) Foundation found improvements in racial and ethnic disparities for both women and men in access to care from 2006 to 2009. For example, the difference in access to care between minority adults and white adults decreased in the following metrics: the probability of a general doctor visit, unmet health care needs, problems paying medical bills, and unmet preventive care needs. [27]

2.5 Public Support for Health Care Reform

The Health Connector's first annual report to the Legislature described strong initial support for health reform in Massachusetts.[28] Public support has been sustained since the initial stages of implementation, as described by the annual report for FY09,[29] with almost three out of every four households supporting health care reform.[30]

Support among physicians has been equally essential to the success of Chapter 58. A survey of practicing physicians published in the *New England Journal of Medicine* reported a high level of satisfaction with health care reform in Massachusetts—70% support Chapter 58, and only 13% oppose the health care system changes. Almost 80% of physicians report being satisfied or somewhat satisfied with their medical practice in Massachusetts post-reform.[31]

3.0 Commonwealth Care

3.1 Program Updates

CommCare provides health insurance coverage to uninsured adults who meet program eligibility requirements. A detailed program description can be found in the annual reports for 2006-2008 and FY09.[32] CommCare Managed Care Organizations (MCOs) continue to provide high quality coverage to members. Three of the MCOs that participate in CommCare were ranked among the top five MCOs in the nation by the National Committee for Quality Assurance (NCQA) in 2009.[33]

Several operational improvements were implemented to enhance the CommCare member experience throughout FY10. Most notably, the Health Connector launched a project to implement a new premium billing system. The new system was live in May 2010. This new system, Xcelys, provides improved functionality for members and increases operational efficiency. Members can pay their premiums online through Electronic Funds Transfer and contact customer service through an electronic messaging system. Members can also access a detailed provider search function. Also, Xcelys equips customer service representatives with an interface similar to that of a customer, which eases troubleshooting discussions between customers and customer service. From a program management perspective, Xcelys provides improved reporting capabilities and additional billing functionality.

As a result of unprecedented tax revenue declines and significant state budget gaps, several programmatic changes were made to the CommCare program in FY10. These included the suspension of the auto-assignment process in August 2009[34] for non-premium payers who did not select a plan and the termination of eligibility for some legal immigrants, referred to as Aliens With Special Status (AWSS) beginning in September 2009 (discussed in more detail in Section 4.1). Auto-assignment was re-established for three months (April - June 2010), and nearly 8,000 eligible new members were enrolled into a health plan during this time. Almost half of new auto-assigned members were enrolled in CeltiCare Health Plan (CeltiCare).

3.2 CommCare FY11 Procurement Process

Despite particularly challenging circumstances, the Health Connector achieved each of its goals for the FY11 procurement of health plans participating in the CommCare program. Consistent with the FY10 procurement, these goals were to: (1) establish fair and reasonable capitation rates, (2) remain within budget constraints, (3) maintain continuity of health plan participation, (4) preserve and enhance competition among participating health plans, and (5) protect members from large premium increases. All five MCOs with FY10 contracts bid and contracted with the Health Connector for FY11.[35]

Program changes, as described above (particularly the suspension of auto-assignment and the termination of eligibility for AWSS), made assessing claims costs challenging, which is a critical component for determining the target capitation rate set by the Health Connector in the bidding process. At the same time, available data suggested early signs of lower MCO margins in FY10 despite solid historical three year cumulative experience, and higher than anticipated claims costs at the start of FY10.

The Health Connector worked with an actuary to develop an actuarially sound rate range (ASRR) for capitation. This recommended range accounted for historical claims costs (with adjustments based on estimated programmatic changes), medical trend, managed care efficiency, and a presumption of minimal increases in cost sharing to members.[36]

Enrollment trends and a continued economic downturn also led staff to project enrollment increases in FY11. Consequently, in an effort to provide some room for program growth, the Health Connector set the target capitation rate for medical costs at the bottom of the recommended ASRR. Illustrative of the continued commitment to maintaining a competitive element to the bidding process and encouraging low bids, the Health Connector allowed plans to compete based on a proposed discount to the administrative fee. The incentive to bid low was based on the concept of preferential pricing, meaning Plan Type (PT) 2 and PT3 members who select an MCO other than the lowest cost plan would pay the base premium plus the differential between the plan they selected and the lowest cost plan.

Three of the five bidders proposed a discounted administrative fee, while ensuring that they could cover the health plans' variable costs. The results of the competitive bidding process translate to an estimated budget savings of about $21 million in FY11. These savings will be partially offset by risk-share payments due in FY11, but this savings should still help provide room for enrollment growth.

3.3 CommCare Enrollment

CommCare provides health insurance coverage for over 150,000 Massachusetts residents. The 15% enrollment decline seen between the last quarter of FY09 and the first quarter of FY10, as shown in Figure 2, can be attributed mainly to a change in eligibility for the AWSS population. (The change in eligibility was required by the legislature and is described in Section 4.0 of this report.) Additionally, as described above, the Health Connector used its discretion in employing the auto-assignment process as a lever to control enrollment during a time of extreme budgetary stress.

If determined eligible and enrolled in CommCare, members are assigned a PT, based solely on income.[37] As shown in Figure 3, nearly half (48%) of enrollees are in PT1, 38% are enrolled in PT2, and 15% in PT3. The 5% decline in PT1 enrollment from July 2009 is primarily due to loss of eligibility for AWSS. Among AWSS now covered by CommCare Bridge (as described in Section 4.0), 70% were previously enrolled in PT1, which is a disproportionately high percentage compared to the total CommCare membership distribution.

Figure 2. Total CommCare Enrollment for FY 2010

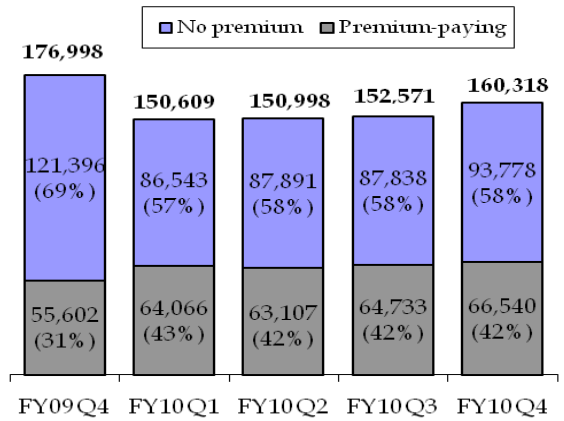
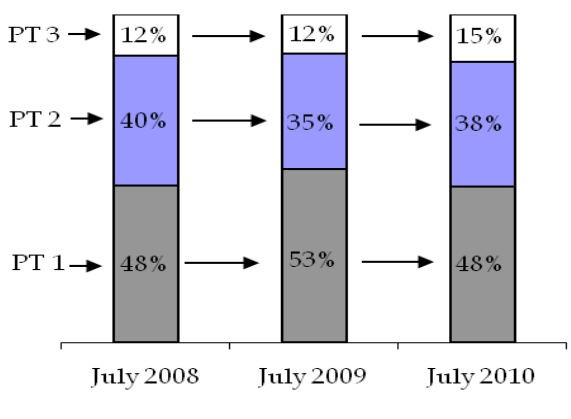


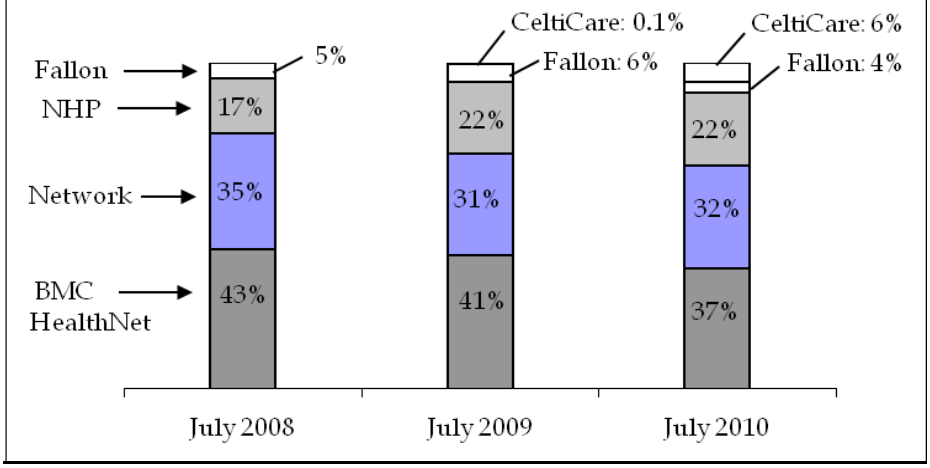
Figure 3. CommCare Enrollment by Plan Type



The distribution of CommCare enrollees by health plan and age has remained essentially stable since July 2009. As shown in Figure 4, there was little to no growth in membership for Fallon Community Health Plan (FCHP), Neighborhood Health Plan (NHP), and Network Health, with 4% (5,668), 22% (35,157), and 32% (50,185) of total CommCare enrollees respectively in July 2010. BMC HealthNet has the largest

percent of members (37%), but their share of CommCare membership declined 4% since July 2009. As a result of the FY10 procurement, CeltiCare entered the market in July 2009 as the first non-Medicaid MCO participating in CommCare. In its first year offered, CeltiCare provided coverage for 6% (9,105) of CommCare members as of July 2010.

Figure 4. CommCare Enrollment by Health Plan



The age profile of CommCare members has remained stable over time. As of July 2010, 25% of members were 18-26 years of age, 41% were between 27 and 49 years of age, and 33% were 50 years or older.

3.4 CommCare Budget

The CommCare program is expected to be on or under budget for FY10. As of July 2010, the program is below budget, and, depending on risk-share settlements, total spending is projected to come in $5.8 million under budget. Table 2 below compares the budgeted and actual expenditures for FY10. Table 2 also shows the projected enrollment and budgeted expenses for FY11. Please refer to the FY09 annual report for the budgeted and actual expenditures for the CommCare program for FY07, FY08, and FY09.

Table 2. CommCare Expenditures FY10

FY 2010 Budget and Actuals	FY10 (Budget)	FY10 (Actual)	FY10 (Var)	FY11 (Budget) per the House 2 budget
Year End Membership	164,315	160,318	3,997	173, 481
Member Months	1,936,905	1,888,274	48,631	1,985,799
Capitation Rate	$391.08	$396.36	($5.28)	$426.00
Total Spending[1]	$738,089,061	$737,115,749	$973,852	$ 830,106,245
Aggregate Risk Share[2]	($15,000,000)	($19,869,879)	$4,869,879	-
Total Spending Including Risk Sharing	$723,089,601	$717,245,870	$5,843,731	$ 830,106,245

[1] Total spending is net of administrative costs and enrollee contribution collections.
[2]FY10 risk sharing collections are based on FY09 health plan experience.
Note: Due to timing issues and updates based on actual results, figures presented here may differ slightly from other information previously published by the Health Connector.

As described in Section 3.2, several factors prompted the Health Connector to recommend an increase in the capitation rate and program enrollment for FY11, leading to an increase in total projected spending for FY11. The capitation rates for FY11 range across MCOs from $405 to $426 per member per month, representing an increase of approximately 3% to 7% over the FY10 capitation rate. This increase is significantly lower than average rate increases throughout the Massachusetts individual commercial market in FY10.[38]

Figure 5. Average CommCare Capitation Rate (PMPM)
FY07 - FY11 (Projected)

[1] This figure reflects payments made for the fifteen month period from 10/1/06 - 12/31/07.
[2] This figure reflects actual payments made for the six month period from 1/1/08 - 6/30/08.
[3] This figure reflects payments made for the twelve month period from 7/1/08 - 6/30/09. Due to timing differences and updated information the amount reflected may differ from figures previously released by the Health Connector.
[4] This figure reflects actual payments for the twelve month period from 7/1/09 - 6/30/10.

3.5 CommCare Waivers and Appeals

The Health Connector has operated a Review and Appeals Unit since June 2007. This team processes three types of waivers and appeals relating to the CommCare program:

(1) A waiver or reduction of premiums or co-payments due to extreme financial hardship;
(2) A request to change health plans at a time other than open enrollment; or
(3) An appeal to challenge decisions related to CommCare.

Rules and procedures governing the process for filing waiver requests and appeals can be found in 956 CMR 3.00 et al.

Approximately the same quantity of requests for premium waivers or co-pay reductions were made in FY10 as compared to FY09. Slightly more than half (940 requests) were approved, as shown in Table 3. Health plan change requests increased in FY10, aligning with 2008 levels. Nearly all change requests were approved. The high approval rate and zero percent dismissal rate can be attributed to increased training for customer service representatives who guide members through the appropriate health plan change request process.

Most CommCare appeals are from individuals who have been denied eligibility on the grounds that they already have subsidized insurance or that they have access to it. In many cases, the appellant states that the other insurance offered to them is unaffordable, not that they are not eligible for it. The majority of appeals, 71%, are dismissed, which includes those resolved before a hearing, cases without merit, cases dismissed for failure to appear at hearing, withdrawals, and cases transferred to the Office of Medicaid's Board of Hearings.

Table 3. CommCare Waivers, Change Requests, and Appeals						
	June 1, 2007 [1] - June 30, 2008		FY 2009		FY 2010	
	#	%	#	%	#	%
CommCare Waivers Requests (for premium or co-pay reduction)						
Total:	**722**		**1,780**		**1,714**	
# approved:	344	48%	939	53%	940	55%
# denied:	221	31%	841	47%	774	45%
# dismissed:	10	1%	0	0%	0	0%
# pending:[2]	147	20%	0	0%	0	0%
CommCare Health Plan Change Requests						
Total:	**507**		**227**		**554**	
# approved:	283	56%	204	90%	543	98%
# denied:	209	41%	1	0%	11	2%
# dismissed:	13	3%	19	8%	0	0%
# pending:[2]	2	0%	3	1%	0	0%
CommCare Appeals						
Total:	**1,193**		**5,668**		**5,389**	
# approved:	6	1%	80	1%	349	6%
# denied:	6	1%	347	6%	861	16%
# dismissed:	811	68%	4,315	76%	3,804	71%
# pending:[2]	370	31%	926	16%	375	7%

[1] The waiver and appeals program began on June 1, 2007.
[2] Requests pending on June 30, 2008 were resolved and appear in FY09.

Changes in the structure of the Appeals Unit made in the spring of 2009 have reduced the number of pending appeals dramatically. Currently, the wait time from receipt of an appeal to a hearing date is approximately 30 days, down from 60 days a year ago, and 120 days two years ago. Because appeals are being reviewed almost immediately upon receipt, more appeals are being sent to hearing. In FY09, a higher percentage of appeals were dismissed because they were resolved before a hearing could be scheduled.

4.0 Commonwealth Care Bridge

4.1 Program Development

In light of particularly challenging budgetary circumstances, legislation passed in the spring of 2009 modified the eligibility criteria for the CommCare program. The costs associated with providing health insurance coverage for legal immigrants who have been in the United States for less than five years, known as AWSS, are not eligible for federal reimbursement. Massachusetts is one of only a few states that provide health insurance coverage for this population.

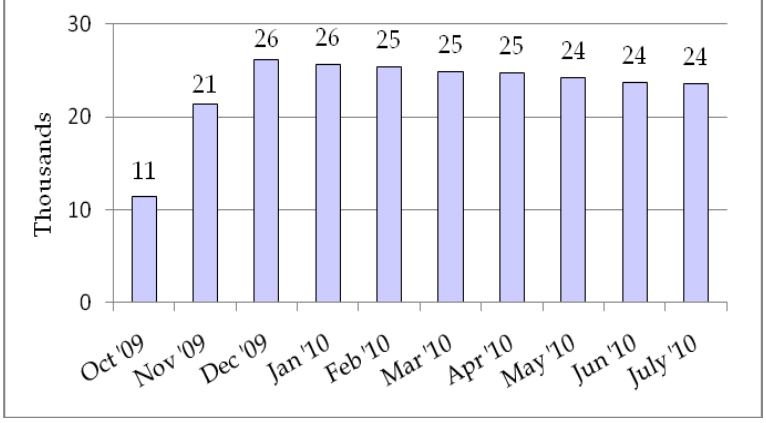
Though this population was no longer eligible to be covered under CommCare, $40 million was allocated in the FY10 state budget to support coverage for this population for the period from October 2009

through June 2010. The CommCare Bridge program was born out of this allocation. ANF, EOHHS, and the Health Connector worked together to design and implement CommCare Bridge. Each MCO participating in CommCare was invited to submit a proposal to provide coverage for this population within the appropriated budget. After review by the three agencies, the Governor accepted a proposal from CeltiCare for a fully-capitated coverage plan (the only proposal to continue comprehensive coverage for this population). The current CommCare regulations do not apply to CommCare Bridge; therefore, the program is administered using a unique governance structure with joint leadership from EOHHS, ANF, and the Health Connector.[39]

4.2 Program Description

The CommCare Bridge program has been successful in achieving rapid enrollment and prompt customer service. As of August 1, 2009, there were 31,000 eligible individuals. CeltiCare enrolled individuals in the Greater Boston area effective October 1, Northern and Southern regions as of November 1, and Western and Central regions as of December 1, 2009. Members were auto-assigned from CommCare to the plan per this implementation schedule. By July 2010, 23,600 members remained enrolled in CommCare Bridge, as shown in Figure 6.[40]

Figure 6. Enrollment in CommCare Bridge



CommCare Bridge coverage has a single benefit design that is fairly comprehensive and meets the needs of most members. Unlike CommCare, cost sharing does not differ by income level.[41]

EOHHS was responsible for determining eligibility and enrolling members, and the Health Connector provides customer service support to enrollees. The contract ran through the end of FY10. Continued coverage under CommCare Bridge for FY11 will be dependent on available funding.

5.0 Commonwealth Choice

5.1 Program Update

Commonwealth Choice (CommChoice) is the non-subsidized insurance program established by the Health Connector in May 2007 to facilitate the availability, choice, and purchase of health insurance products for eligible individuals and small groups. A detailed program description can be found in the annual reports for 2006-2008 and FY09.[42] All carriers participating in CommChoice offer high quality coverage. Of the six carriers with sufficient experience to be rated,[43] all receive four stars or an "Excellent" accreditation status according to NCQA's health plan report card. This is the highest rating a health plan can obtain. Four of the seven carriers were ranked among the top ten health plans in the nation by NCQA in 2009.[44]

As part of the Seal of Approval (SoA) process for calendar year 2010, the Health Connector sought to streamline its product offerings thereby enhancing transparency and better enabling consumers to more simply compare and enroll in health plans. This new approach prompted a redesign of the online

shopping experience. The enhanced website was launched in November 2009, aligning with the sale of health plans with a coverage effective date of January 1, 2010 or later. The new website design is shown in Figure 7.

New features allow customers to search for health insurance by benefit tier, monthly cost, annual deductible and insurance carrier among other options. Customers can see the standardized benefits available for each tier from all health plans, as well as a detailed comparison of benefits for up to three health plans at one time.

Figure 7. Website Re-Design for Comparative Shopping Among 2010 SoA Products

The Health Connector has conducted many member surveys and focus groups to ensure that product offerings are in line with the preferences of consumers and to monitor current member customer service experiences. In March 2010, McKinsey & Company surveyed current non-group members and developed a series of programmatic recommendations to enhance the Health Connector's value. Their recommendations included specific improvements to the CommChoice website to simplify a customer's shopping experience and to facilitate increased e-pay enrollment. McKinsey & Company also recommended the addition of decision-making tools such as a health care cost calculator, a physician finder, and access to peer and third-party reviews of plans. These findings corroborate earlier consumer research conducted by the Health Connector. A few recommendations have already been implemented, such as displaying NCQA ratings for each plan on the Health Connector's website. Some of the other recommendations from the McKinsey study will be implemented in the coming months.

5.2 Helping Employers

Small employers in Massachusetts have voiced the need for relief from rising health insurance premiums. The Health Connector has responded to this need, in part through its launch of Business Express (BE) in April 2010. BE allows small employers to compare different plans, select the one plan that best fits their needs and the needs of their employees, and complete the enrollment process entirely online. Seminars with brokers were scheduled in February 2010 throughout the state to explain BE as an option and opportunity for their clients. These seminars were held in Worcester, Springfield, and Newton.

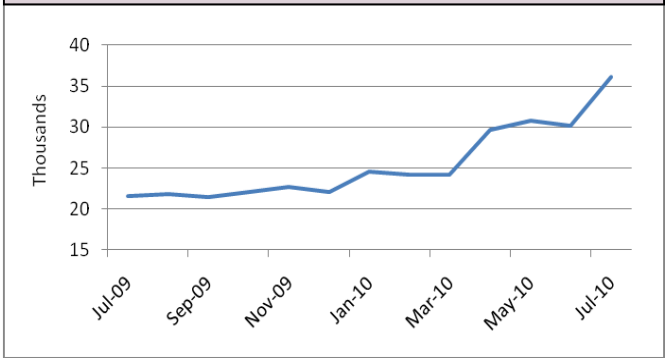
The Health Connector formed an alliance in February 2010 with the Small Business Service Bureau (SBSB) to transition mini-groups (i.e., small businesses with five or fewer eligible employees) from SBSB to BE. A higher volume of members provides an opportunity for the Health Connector to lower costs for mini-groups. The benefits to small employers include a reduced administrative fee for certain employers (saving them approximately $300 per subscriber per year), as well as a simplified shopping experience. The alliance with SBSB enabled the Health Connector to reduce its administrative fee by 22%, from 4.5% to 3.5%, as of July 1, 2010. An initial transition of 1,641 subscribers (representing more than 3,300 members) became effective April 1, 2010. The Health Connector anticipates subsequently transitioning up to an additional 11,000 subscribers.

The Health Connector also operates the Voluntary Plan (VP) and offered the Contributory Plan (CP) on a pilot basis to facilitate the purchase of insurance for employees through the CommChoice program. VP allows employees without access to ESI to purchase a CommChoice health insurance plan using pre-tax dollars if their employer established an IRS Section 125 plan with the Health Connector. As of July 2010, approximately 2,100 members were enrolled in CommChoice through VP. The Health Connector piloted CP in January 2009 to increase flexibility in health insurance options for small employers. CP was designed to increase choice among health insurance products for small business employees and is a model that has been included in PPACA. (CP is described in detail in Section 4.2 of the Health Connector's FY09 Annual Report to the Legislature.) As of July 2010, approximately 360 members were enrolled in CommChoice through the CP pilot program. An evaluation of the CP pilot indicated that employees and employers value the option of choice offered by the CP model and that no significant adverse risk selection issues had emerged. It also highlighted several improvements necessary to enhance participation in this program. In response, the Health Connector closed enrollment to new business in the CP pilot in March 2010 to implement improvements to the program. Current CP subscribers may continue to renew their plan.

5.3 CommChoice Enrollment

Membership in the Health Connector's CommChoice program has steadily risen throughout FY10. As of July 2010, more than 30,000 members were enrolled in health insurance through CommChoice. This represents a year-over-year growth of more than 45%. Much of the growth occurred in the spring of 2010 with the launch of BE and the transition of small business customers to BE through the alliance with SBSB.

Figure 8. Enrollment in CommChoice (members)

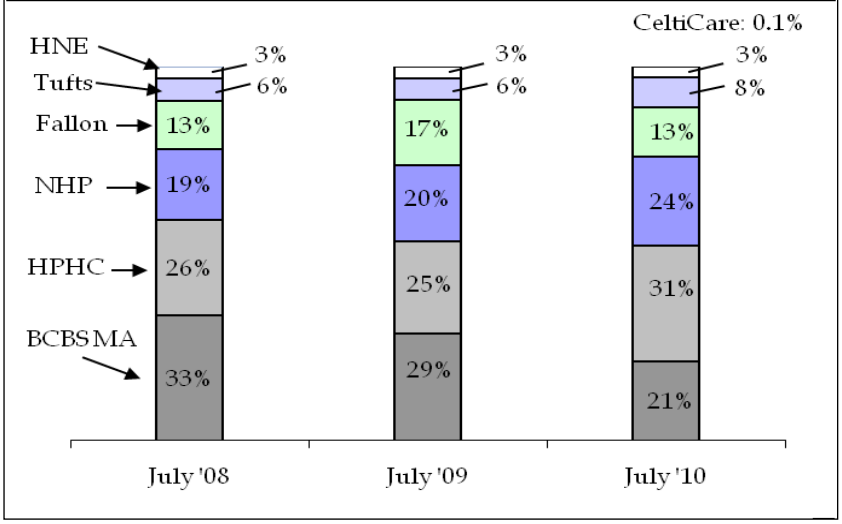


Bronze level products remain the most popular coverage option for CommChoice subscribers, with 41% of members choosing Bronze. The richest benefit packages, those at the Gold

level, have only 7% of the CommChoice enrollment, the lowest percentage of enrollment among the four tiers. The proportion of members in Silver products grew from 28% in July 2009 to 36% in July 2010. The portion of enrollees in Young Adult Plans (YAPs) decreased from 21% in July 2009 to 15% in July 2010. This redistribution is largely a result of alliance conversion members (72%) transitioning into Silver level products.

Products available as YAPs are offered through the Health Connector with a choice of including or excluding prescription drug coverage (this choice is required by law). Among YAP enrollees, approximately two-thirds have chosen to include prescription drug coverage in their plan.

Figure 9. CommChoice Enrollment by Health Carrier (members)



The distribution of CommChoice enrollees across carriers has shifted over time. As shown in Figure 9, Harvard Pilgrim Health Care (HPHC), NHP, and BCBSMA enroll 76% of CommChoice subscribers, while FCHP, Tufts Health Plan (THP), Health New England (HNE), and CeltiCare comprise the remaining 24%. However, in the past year, HPHC has seen a 6% increase in enrollment as a percentage of the total program.

The age distribution of members shifted slightly since FY09. From July 2009 to July 2010, the percentage of subscribers aged 55-64 increased from 15% to 18%, while the percentage of subscribers aged 18-26 decreased from 25% to 19%. The distribution of members by sex has not changed; in July 2010 the proportion of male subscribers continued to exceed that of female subscribers, 57% to 43% respectively.

Membership in non-group CommChoice products represents 75% of total membership in the program. The remaining 25% participate in CommChoice through the VP, CP, BE, and the alliance conversion. These programs are described in more detail in Section 5.2.

5.4 Procurement and Seal of Approval for Plans with Coverage Effective January 1, 2011

For the calendar year 2011, the Health Connector's goals for the SoA included: (1) to maintain simplified product structure, and (2) minimize disruption and administrative burden. The Health Connector's approach was largely consistent with prior SoA procurements. Rather than issuing a full Request For Proposals (RFP), however, the Health Connector issued a letter to each of the carriers participating in CommChoice for FY10 with a set of proposed amendments to the existing contract. These amendments were intended to: (1) enhance consistency across contracts, (2) clarify termination provisions, and (3) allow for automatic renewal with mutual consent.

The Health Connector is currently reviewing responses from carriers. A decision as to the health plans that will be awarded the SoA will be made by the Board in the November/December timeframe.

6.0 Policy and Regulatory Responsibilities

6.1 Minimum Creditable Coverage

An adult resident must have health insurance coverage that provides a minimum level or value of benefits to meet Minimum Creditable Coverage (MCC) requirements, the standards necessary to satisfy the individual mandate. The Health Connector was charged with developing regulations that define MCC. The Board adopted initial MCC regulations in June 2007, as described in the 2006-2008 report.[45] Upon implementation, the Health Connector received comments from interested parties including employers, administrators of union-sponsored plans, health insurers, consumer advocates, and individuals. Consequently, the Board adopted revised regulations in October 2008, which enhanced the flexibility for compliance with MCC for those plans that met the spirit, but not the letter, of the requirements. These revisions are described in the FY09 annual report.

Further amendments to the MCC regulations were made in December 2009. These amendments include: (1) prohibiting an annual benefit dollar maximum on prescription drugs, (2) clarifying that federally qualifying High Deductible Health Plans (HDHPs) may be found to meet MCC standards as of January 1, 2010, when used in connection with either a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA), and (3) requiring that plans that cover dependents must provide coverage for all core services and a broad range of medical benefits in accordance with that available to the primary subscriber. To provide further explanation of these revisions, in May 2010, the Health Connector issued an administrative bulletin offering additional guidance.[46] For example, as of January 1, 2011, health plans with an overall annual dollar benefit maximum for prescription drugs will not be deemed compliant with MCC. The administrative bulletin also clarifies that all core services and a broad range of medical benefits must be provided to all persons covered by a health plan. This provision is designed, in part, to ensure that maternity services are covered for a pregnant dependent of any subscriber.

As described in the FY09 annual report, the revised MCC regulations included a provision to allow carriers or plan sponsors to request Health Connector certification of MCC compliance in instances where a plan does not meet every element of the regulations, but provides sufficiently robust and comprehensive coverage so as to meet the intent of the MCC standards. This process, called "MCC Certification" is further described in a Health Connector Administrative Bulletin (released in November, 2008).[47] As of June 2010, the Health Connector has reviewed 9,288 plans in FY10. The majority (97.6%) of plans reviewed were granted MCC certification by the Health Connector, signifying that coverage provided by the plan was equivalent or more robust than coverage provided by the Health Connector's Bronze level plans. This high rate of approval reflects the Health Connector's flexibility in defining MCC to minimize unnecessary disruption to ESI while ensuring that all Massachusetts' residents have health insurance coverage that provides a sufficiently robust level of benefits.

6.2 Individual Mandate and the Affordability Schedule

Setting the affordability schedule is a key annual regulatory function of the Health Connector. The affordability schedule defines the maximum affordable monthly premiums for an MCC compliant plan and is used to determine application of the individual mandate. Since rates in the individual market depend, in part, on family composition, the Health Connector publishes affordability schedules for individuals, couples, and families. In March 2010, the Board approved an updated affordability schedule for calendar year 2010. The schedules are delineated in Tables 4, 5, and 6.

The affordability schedule has traditionally aligned with the premium contribution requirements for CommCare members. In 2010, the Board opted to maintain this alignment. Moreover, federal Maintenance of Effort requirements precluded the Health Connector from changing premium contribution levels for CommCare members. Therefore, there were no increases to the schedule for those at or below 300% FPL. The schedule is increased modestly for those above 300% FPL, with a larger increase for those in higher income brackets. The graduated approach increases the affordability schedule by 0% for individuals with income of 0 - 300% FPL, 2.5% for individuals with income of 300.1 – 360% FPL (or 300.1 – 374%, and 300.1 – 398%, for couples and families, respectively), 3% for individuals with income of 360.1 – 408% FPL (or 374.1 – 446%, and 398.1 – 511% for couples and families, respectively), and 3.5% for individuals with income of 408.1 – 504% FPL (or 446.1 – 588%, and 511.1 – 625%, for couples and families, respectively). The 2010 Affordability Schedules for Individuals, Couples, and Families are reflected in Tables 4, 5, and 6 below.

Table 4. Affordability schedule for INDIVIDUALS

Income Bracket (% of FPL)	Annual Gross Income	Maximum Monthly Premium		
		2009	2010	Increase from 2009
0 - 100%	$0 - $10,836	$0	$0	$0
100.1 - 150%	$10,837 - $16,248	$0	$0	$0
150.1 - 200%	$16,249 - $21,660	$39	$39	$0
200.1 - 250%	$21,661 - $27,084	$77	$77	$0
250.1 - 300%	$27,085 - $32,496	$116	$116	$0
300.1 - 360%	$32,497 - $39,000	$171	$175	$4
360.1 - 408%	$39,001 - $44,200	$228	$235	$7
408.1 - 504%	$44,201 - $54,600	$342	$354	$12
Above 504%	above $54,600	n/a	n/a	n/a

Table 5. Affordability schedule for COUPLES

Income Bracket (% of FPL)	Annual Gross Income	Maximum Monthly Premium		
		2009	2010	Increase from 2009
0 - 100%	$0 - $14,580	$0	$0	$0
100.1 - 150%	$14,581 - $21,864	$0	$0	$0
150.1 - 200%	$21,865 - $29,148	$78	$78	$0
200.1 - 250%	$29,149 - $36,432	$154	$154	$0
250.1 - 300%	$36,433 - $43,716	$232	$232	$0
300.1 - 374%	$43,717 - $54,600	$307	$315	$8
374.1 - 446%	$54,601 - $65,000	$410	$422	$12
446.1 - 588%	$65,001 - $85,800	$569	$589	$20
Above 588%	above $85,800	n/a	n/a	n/a

Table 6. Affordability schedule for FAMILIES				
Income Bracket (% of FPL)	Annual Gross Income	Maximum Monthly Premium		
		2009	2010	Increase from 2009
0 - 100%	0 - $18,312	$0	$0	$0
100.1 - 150%	$18,313 - $27,468	$0	$0	$0
150.1 - 200%	$27,469 - $36,624	$78	$78	$0
200.1 - 250%	$36,625 - $45,780	$154	$154	$0
250.1 - 300%	$45,781 - $54,936	$232	$232	$0
300.1 - 398%	$54,937 - $72,800	$364	$373	$9
398.1 - 511%	$72,801 - $93,600	$569	$586	$17
511.1 - 625%	$93,601 - $114,400	$820	$849	$29
Above 625%	above $114,400	n/a	n/a	n/a

The Health Connector offers an interactive affordability tool on its website to assist Massachusetts residents in determining the availability of an affordable health insurance plan for them.

As described in the FY09 report, Massachusetts' residents who have access to affordable health insurance coverage but do not obtain it are subject to a tax penalty. The penalty is assessed when an individual files a tax return. Statute sets the penalty as equal to no more than half of the lowest cost insurance premium for coverage available through the Health Connector. For those with income below 300% FPL, the penalty schedule is based on the lowest cost premium contributions for enrollment in a CommCare plan. Since individuals with income at or below 150% FPL are not required to make a premium contribution, there is no penalty for individuals in this income cohort. For those with income above 300% FPL, the schedule is based on half of the premium of the lowest cost Bronze plan in January 2010, or half of the premium of the lowest cost YAP plan for adults up to age 26. The penalties for 2010 are shown in Table 7.

Table 7. Penalty Schedule for Failure to Comply with the Individual Mandate 2010		
	2010	
	per month	per year*
150.1 - 200% FPL	$19	$228
200.1 - 250% FPL	$38	$456
250.1 - 300% FPL	$58	$696
Above 300% FPL. Age 18-26	$66	$792
Above 300% FPL. Age 27+	$93	$1,116
**If the individual is without insurance for all twelve months of the year.*		

7.0 Concluding Comments

Health reform in Massachusetts has succeeded in achieving many of its goals. Massachusetts continues to be the state with the highest rate of health insurance coverage in the nation, and there is no evidence of crowd-out as growth in insurance has occurred in both public and private coverage and the percent of employers in Massachusetts offering health insurance continues to be higher than the national average. Compliance with the individual mandate for health insurance remains high. Support for health care reform has remained strong among Massachusetts residents and health care providers. Preliminary studies have shown decreasing health care costs and utilization associated with the implementation of health care reform. There is evidence that health reform has reduced some of the disparities in access to coverage by age, sex, and race and ethnicity.

In light of these successes, it is no surprise that PPACA contains many features that were a part of reform in Massachusetts. Most of the changes introduced by national health care reform will be phased in gradually through 2014. The Health Connector will be working with many other state agencies in Massachusetts to come into compliance with the federal statute and take advantage of many of the benefits it offers Massachusetts residents. For example, the Health Connector will extend the availability of premium subsidies to those up to 400% FPL in 2014 and educate small employers about new federal tax credits.[48]

Though Massachusetts and the Health Connector have achieved many successes, there is much work ahead. As mentioned in last year's annual report, the state has begun to tackle the issue of cost as the next phase of reform. Adequate cost controls and continual improvements in affordability are key challenges to the sustainability of health reform. Pursuing payment reform is one pathway to trying to improve on both cost and quality, and in the next year the Health Connector will look for ways to promote payment reform, such as participating in the state's multi-payer medical home initiative.

Appendix I: Abbreviations

The following abbreviations are used in this report:

AGO	Attorney General's Office
ANF	Executive Office for Administration and Finance
ASRR	Actuarially Sound Rate Range
AWSS	Aliens with Special Status
BCBSMA	Blue Cross Blue Shield of Massachusetts
BMC	Boston Medical Center
Board	Board of the Commonwealth Health Insurance Connector Authority
BE	Business Express
CeltiCare	CeltiCare Health Plan
CommCare	Commonwealth Care
CommChoice	Commonwealth Choice
CP	Contributory Plan
DHCFP	Division of Health Care Finance & Policy
DOI	Division of Insurance
DOR	Department of Revenue
DPH	Department of Public Health
DUA	Division of Unemployment Assistance
EOHHS	Executive Office of Health and Human Services (Massachusetts)
ESI	Employer-Sponsored Insurance
FCHP	Fallon Community Health Plan
FPL	Federal Poverty Level
FY	Fiscal Year
GIC	Group Insurance Commission
HCQCC	Health Care Quality and Cost Council
HDHP	High Deductible Health Plan
Health Connector	Commonwealth Health Insurance Connector Authority
HNE	Health New England
HPHC	Harvard Pilgrim Health Care
LIC	Limited Income Credit
MCC	Minimum Creditable Coverage
MHRS	Massachusetts Health Reform Survey
MSP	Medical Security Program
MCO	Managed Care Organization
NCQA	National Committee for Quality Assurance
NHP	Neighborhood Health Plan
NTS	No Tax Status
OCIIO	Office of Consumer Information and Insurance Oversight
PCMH	Patient Centered Medical Home
PMPM	Per Member Per Month
PPACA	Patient Protection and Affordable Care Act
PT	Plan Type
RFP	Request for Proposals
SoA	Seal of Approval
SBSB	Small Business Service Bureau
THP	Tufts Health Plan
VP	Voluntary Plan
YAP	Young Adult Plan

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[34] The Board approved emergency regulations in June 2009 revising the auto-assignment provisions in 956 CMR 3.00, Eligibility and Hearing Process for CommCare. Those emergency regulations gave the Health Connector the discretion to operate, or not, auto-assignment for the purpose of re-enrolling previously terminated CommCare PT I members. This change allowed the Health Connector to stop auto-assignment for these members as one of few mechanisms available to curb the growing CommCare membership during a time of extreme budgetary stress. Individuals who are not auto-assigned remain eligible for CommCare and can re-enroll at any time if the member initiates re-enrollment.

[35] While all carriers are participating in CommCare for FY2011, Fallon is no longer offering coverage in the northeastern and southeastern areas of the state.

[36] A few minor benefit changes were made during the FY11 procurement. For example, the co-pay for generic prescription drugs was increased from $2 to $3, while the co-pay for most other drugs remained at $1. The dental benefit was altered to align Plan Type 1 (PT1) with MassHealth (covering preventive and emergency dental services but not restorative services).

[37] Eligible individuals with 0-100% FPL are enrolled in PT 1, with 100.1-200% FPL in PT 2, and 200.1-300% FPL in PT3.

[38] As shown in the DOI report on Small Group Health Premiums in Massachusetts, rate increases for commercial sales among four statewide HMOs ranged from 8.2 to 15.3%.

[39] In November 2009, the Health Connector issued *Administrative Bulletin 01-09: Guidance regarding the Commonwealth Care Bridge Program.* The Administrative Bulletin is available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Regulations/documents/Administrative%2520Bulletin%252001-09.pdf

[40] The CommCare Bridge program is subject to natural attrition. Members may, for example, become eligible for employer-sponsored insurance, or meet the residency requirements and become eligible for other programs.

[41] Details regarding CommCare Bridge benefit design and cost sharing may be accessed via http://www.massresources.org.

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[43] CeltiCare Health Plan is a new health plan and therefore is not yet rated.

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[46] In May 2010 the Health Connector issued *Administrative Bulletin 02-10: Guidance Regarding Minimum Creditable Coverage (MCC) Certification.* The Administrative Bulletin is available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Regulations/documents/Administrative%2520Bulletin%252002-10.pdf

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