Commonwealth of Massachusetts

Request for a State Innovation Waiver

Under Section 1332 of the Affordable Care Act

February 2, 2016

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1.0 Executive Summary

The Commonwealth of Massachusetts has long embraced innovation and reform in its health insurance market. In 2006, Massachusetts enacted landmark health reform legislation that yielded the highest rate of insurance in the nation, protected insurance consumers, and paved the way for national health reform. Starting in 2010, Massachusetts implemented the additional reforms of the Patient Protection and Affordable Care Act (Affordable Care Act). In 2010 and 2012, Massachusetts enacted legislation to promote health care quality and cost-containment.

Today, the Massachusetts health insurance market is thriving. Over 96 percent of Massachusetts residents are insured, 89 percent of residents report regular access to health care, and the Commonwealth is beginning to make strides toward better value in health care purchasing.[1] The employer-based insurance market is robust—76 percent of Massachusetts employers offer insurance to their workers, compared to 55 percent nationally,[2] and a unique "merged market" structure supports affordability and continuity by requiring issuers to offer the same health insurance products to individuals and small employers, with rates based on their pooled experience.

Massachusetts now seeks to enhance these gains with a State Innovation Waiver under Section 1332 of the Affordable Care Act. Massachusetts appreciates the Affordable Care Act's recognition that local circumstances may merit a state-specific approach to supporting the overall goals of the law. Massachusetts seeks this flexibility to preserve the Commonwealth's long-standing version of a merged market, which blends the shared risk pool and common products of a federally-defined merged market with two features of a typical small group market: currently, (1) small groups can enroll and renewal on a rolling basis throughout the year, and (2) issuers can offer new products and refresh their rates for small group plans on a quarterly basis, in addition to submitting filings for the broader merged market annually.

While this hybrid merged market structure has functioned effectively for nearly a decade in Massachusetts, it does not fully align with the federal definition of a merged market, which requires not only a shared risk pool but also calendar-year enrollment and rating. Without a waiver, the Commonwealth will need to ensure that all aspects of its merged market meet federal requirements by 2018. The Commonwealth expects that meeting these requirements by transitioning small groups to a calendar-year cycle will cause significant disruption and costs for small employers and their employees, which could destabilize the merged market as a whole.

To avoid this disruption, the Commonwealth seeks a modest accommodation to preserve its innovative hybrid version of a merged market. The Commonwealth requests latitude to continue its merged single risk pool to promote affordability and continuity for individuals, while maintaining the rolling enrollment and quarterly rating that ensures stability and flexibility for small employers. The Affordable Care Act contemplates state flexibility under Section 1332 for precisely this reason—to permit local variations in implementation, so long as the state's proposal is equivalent to the federal law. The Commonwealth's proposal is consistent with the purposes of the Affordable Care Act, as it mirrors the federal policies permitted for other, non-merged states.

Massachusetts appreciates federal consideration of this initial proposal, and looks forward to future collaboration through the Affordable Care Act's many opportunities for state flexibility and innovation.

2.0 Assurances

Massachusetts anticipates that its proposal will meet the safeguards set forth in Section 1332 of the Affordable Care Act because the proposal will maintain equivalent coverage at no greater cost to its residents, employers, insurance issuers, the Commonwealth, or the federal government. Indeed, the Commonwealth seeks a waiver because it expects federal waiver flexibility will promote *greater* stability of coverage and affordability in its merged market, over the baseline under the Affordable Care Act that would otherwise apply.

The Commonwealth of Massachusetts provides the following assurances:

- Equivalent or greater scope of coverage. The Commonwealth's proposal will not decrease the number of Massachusetts residents covered or the number of Massachusetts' employers offering coverage. The Commonwealth does not anticipate any negative coverage impacts on vulnerable populations due to the proposed waiver.

- Equivalent or greater affordability of coverage. The Commonwealth's proposal will not increase the costs of health coverage for its residents or employers. Rather, the proposal will promote affordability by allowing issuers to continue pricing their small group plans accurately and without disruption. The Commonwealth does not anticipate negative cost impacts on vulnerable populations due to the proposed waiver.

- Equivalent comprehensiveness of coverage. The Commonwealth's proposal will not decrease the comprehensiveness of benefits for Massachusetts' residents or employers. Individuals and employers accessing insurance through the merged market will continue to receive the Commonwealth's Essential Health Benefits and additional benefits required by state law. The Commonwealth does not anticipate negative benefit impacts on vulnerable populations due to the proposed waiver.

- Deficit neutral. The Commonwealth's proposal will not increase federal spending, net of federal revenues, in any one year or in total over the ten-year budget period. The proposal will not require any additional direct spending or administrative costs, and the Commonwealth anticipates that any indirect economic impacts would be minimal and deficit neutral. The proposal does not request pass-through funding.

- No impact on federally-facilitated marketplace. The Commonwealth's proposal will not impact the federally-facilitated marketplace since the Commonwealth maintains a state-based marketplace for individuals and small groups and expects to continue to do so.

- No impact on other public programs. The proposal will not impact public coverage programs, such as Medicaid and the Children's Health Insurance Program.

- Meaningful public input. The Commonwealth has engaged in an extensive public stakeholder process to develop and refine the proposed waiver. The application and related materials have been publicly posted for notice and the public has had an opportunity to be heard at hearings and through written comments. The Commonwealth provided equal access for individuals with limited English proficiency or disabilities to participate in its public notice-and-comment process on the proposed waiver. In addition, the Commonwealth has engaged in a separate consultation process with the federally-recognized tribes residing within its borders.

3.0 Characteristics of Massachusetts

3.1 Health Insurance Market Overview

Over the course of the last three decades, the Commonwealth of Massachusetts has engaged deeply in comprehensive reform of its health insurance market and health care system.

Starting in the late 1980s, Massachusetts embarked on a series of ambitious reforms that generated the highest rate of insurance coverage in the nation, introduced critical protections for health insurance consumers, and launched initial steps toward cost containment and quality improvement. These reforms accelerated in 2006 with the introduction of Massachusetts' landmark comprehensive health reform law, which served as a foundation for the Affordable Care Act. In the commercial market, key reform milestones have included:[3]

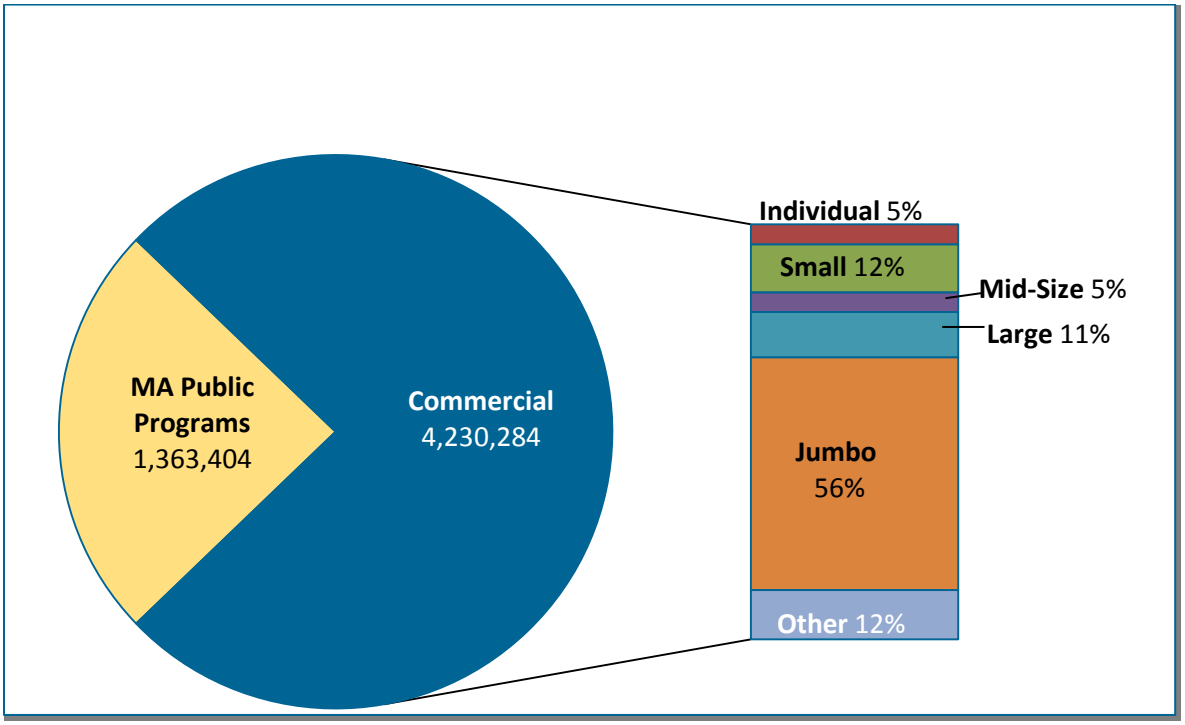
1989
• Massachusetts enacted one of the first insurance mandates in the nation, a mandate for students enrolled in higher education to maintain health insurance.
1998
• Massachusetts enacted a first effort at broad reform, introducing a preliminary version of an employer mandate and investments in the health care safety net for vulnerable populations.
1992 - 1996
• Massachusetts introduced consumer protections to the non-group and small group market, including guaranteed issue and adjusted community rating.
2006 - 2008

• Massachusetts enacted Chapter 58 of the Laws of 2006 (Chapter 58), comprehensive reforms that aimed to achieve near-universal health coverage.
• Key components of Chapter 58 and subsequent amendments included:
  ○ The creation of the Health Connector Authority (Health Connector), an independent agency that serves as an "exchange" marketplace to assist individuals and small employers in accessing health insurance, as well as subsidies to promote affordable coverage for residents with incomes up to 300% of the Federal Poverty Level (FPL), through the Commonwealth Care program.
  ○ Individual mandate for adults to have minimum creditable coverage, if it is considered affordable based on a state schedule.
  ○ Employer mandate to contribute to employee coverage or pay a penalty.
  ○ The merger of the non-group and small group markets into a single risk pool to stabilize premiums for individuals purchasing their own insurance in the Commonwealth.

2010 - 2014
• Massachusetts embarked on robust implementation of the Affordable Care Act, including adopting the Medicaid expansion and opting to retain its state-based marketplace. With federal support, Massachusetts maintained its subsidies for individuals in the Health Connector. • Massachusetts enacted comprehensive cost-containment legislation, including Chapter 288 of the Acts of 2010 (Chapter 288) and Chapter 224 of the Acts of 2012 (Chapter 224), to limit the growth of health care costs, improve health care access and quality, and promote public health.
2014 - 2016
• Massachusetts retained its state-based marketplace, the Health Connector, ensuring smooth enrollment and renewal for more than 190,000 enrollees by January 2016. • Successful transition of Commonwealth Care enrollees to ConnectorCare, using new federal premium tax credits and cost-sharing reductions to support affordable coverage for residents.

Today, Massachusetts has one of the most robust health insurance markets in the nation. Roughly two-thirds of non-elderly Massachusetts' residents have commercial health insurance.[4] The commercial market is competitive, with over a dozen companies actively marketing coverage throughout the Commonwealth.[5] The vast majority of premium dollars (89 percent) goes toward member health care, rather than administration, profits, or other overhead—exceeding the national medical loss ratio standards set in the Affordable Care Act.[6]

Figure 1. Massachusetts Non-elderly Enrollment by Commercial Market Sector (Snapshot as of March 2015)



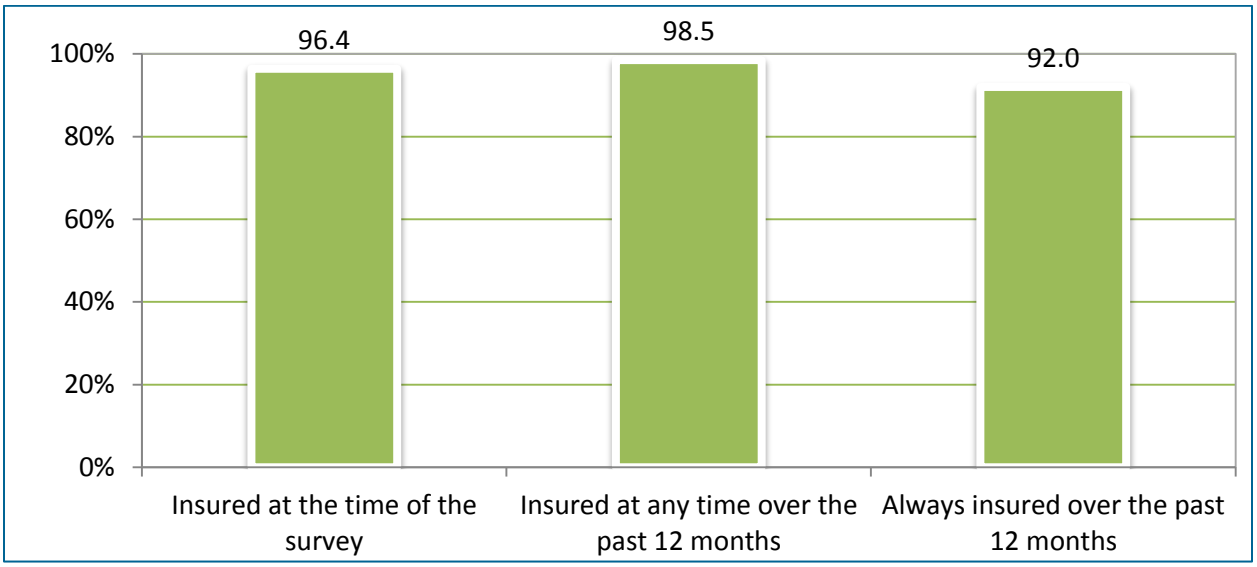
Source: CHIA, March 2015 Massachusetts Health Insurance Enrollment Trends

As of 2015, 96.4 percent of Massachusetts' residents are estimated to have health coverage, compared to 90.8 percent for the rest of the nation.[7] Of the state's nearly 6.8 million residents, only roughly 200,000 residents are estimated to remain without coverage at any given point—the majority of whom are working age adults, disproportionately male, single, Hispanic, and with family income below 400% of the Federal Poverty Level (FPL).[8] More than half of the remaining uninsured report cost of coverage as a key factor in their uninsurance (54.8 percent); other key factors include loss of employer-based coverage (31.5 percent) and lack of availability of employer-based coverage (20 percent).[9] The Commonwealth continues to work to reach and enroll the remaining uninsured using tailored outreach strategies.

The Commonwealth's coverage gains are reflected in greater access to care as well. Continuity of coverage has become the norm in Massachusetts, with fewer than one in ten residents reporting a period of uninsurance over the past twelve months.[10] Residents are usually able to access care, with 89 percent reporting a usual source of care and 88.6 percent reporting a visit to a general doctor or non-physician practitioner in the past twelve months.[11] Four out of five residents report that the quality of care they receive is very good or excellent.[12]

Despite these improvements and Massachusetts' investments in subsidized coverage, health care costs remain a concern. Among residents surveyed in 2015, roughly one in six reported difficulty paying medical bills or deferring health care due to costs.[13]

Figure 2. Health Insurance Coverage in Massachusetts (2015)

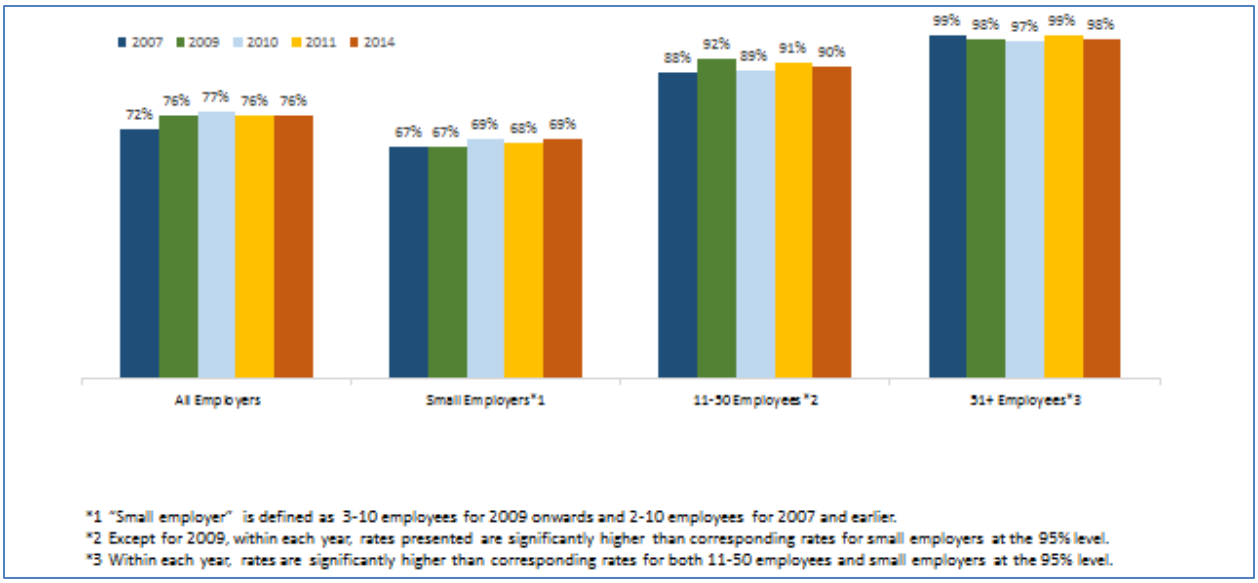


Source: CHIA, 2015 Massachusetts Health Insurance Survey

3.2 Employer-Based Coverage in Massachusetts

Employer-based coverage is the dominant source of coverage in Massachusetts, accounting for about 60 percent of all covered lives.[14] For years, Massachusetts employers have offered insurance to their workers at rates much higher than the national average: in 2014, for instance, 76 percent of Massachusetts employers offered insurance, compared to 55 percent nationally.[15] Smaller employers offer at a decreasingly lower rate corresponding to the size of the firm—while 98 percent of those with over 50 workers offer insurance, only 90 percent of those with between 11 to 50 workers offer, and this declines further to 69% percent of those with under 10 workers.[16] Across all employer sizes, roughly three out of four eligible employees choose to enroll.[17]

Figure 3. Massachusetts Employers Offering Health Insurance, By Employer Size (2007-2014)



Source: CHIA, 2014 Massachusetts Employer Survey

Though Massachusetts employers offer health coverage at a high rate overall, this type of coverage is not evenly distributed among different populations of Massachusetts' residents. Those with employer-based coverage are most likely to be non-elderly, male, white and non-Hispanic, in good health, and with higher household incomes.[18] These employees are also more likely to live in certain geographic regions, such as the Metro West area (65.7 percent) versus the South Coast area (40.8 percent).[19]

Table 1. Characteristics of Massachusetts Residents with Employer-Based Coverage (2015)

	Children (0 to 18)	Non-elderly Adults (19 to 64)	Elderly Adults (65 and older)	Total Population
Number with ESI	920,146	2,419,164	398,759	3,738,069
Percent with ESI	63.4%	59.6%	40.2%	57.5%

	Male	Female	Total Population
Number with ESI	1,801,282	1,936,787	3,738,069
Percent with ESI	58.4%	56.7%	57.5%

	White, non-Hispanic	Black, non-Hispanic	Other/Multiple Race, non-Hispanic	Hispanic	Total Population
Number with ESI	3,105,334	216,676	196,049	220,010	3,738,069
Percent with ESI	62.2%	48.7%	57.7%	30.5%	57.5%

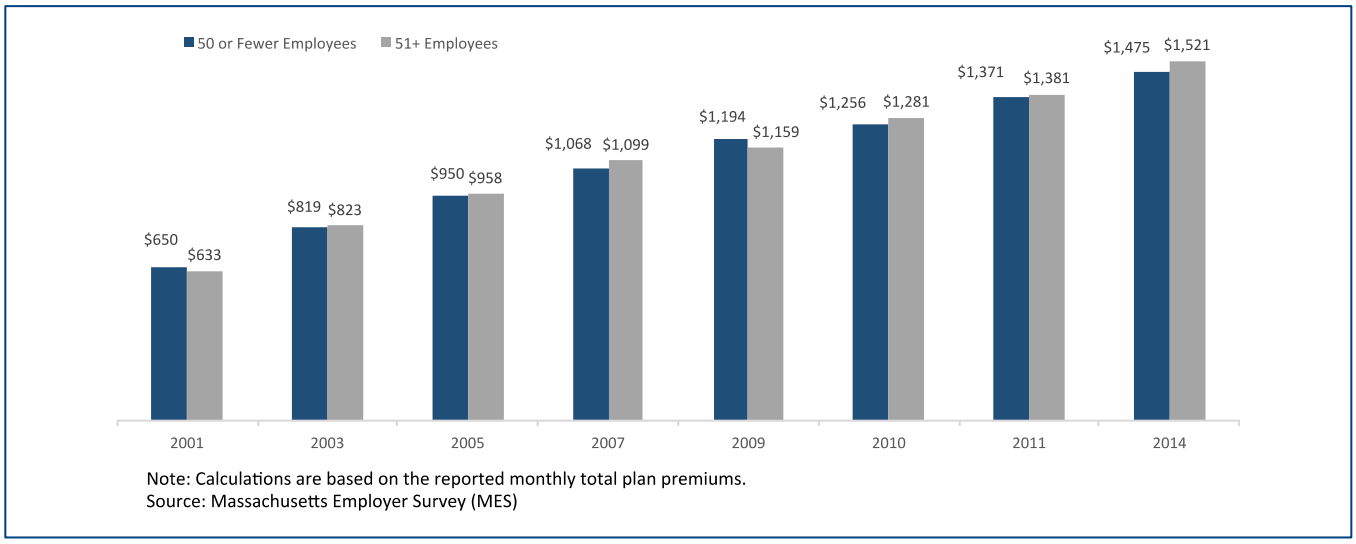
	Good, Very Good, or Excellent Health and No Activity Limitation	Fair or Poor Health or an Activity Limitation	Fair or Poor Health and an Activity Limitation	Total Population
Number with ESI	2,943,478	586,430	208,161	3,738,069
Percent with ESI	65.8%	44.6%	29.2%	57.5%

	Family Income At or Below 138% FPL	Family Income Between 138 and 299% FPL	Family Income Between 300 and 399% FPL	Family Income At or Above 400% FPL	Total Population
Number with ESI	264,849	736,944	524,513	2,211,763	3,738,069
Percent with ESI	16.2%	46.1%	75.7%	85.8%	57.5%

Source: CHIA, 2015 Massachusetts Health Insurance Survey

Despite Massachusetts' high rate of employer-based coverage, Massachusetts' employers report significant concerns with the cost of coverage. Massachusetts' employers pay approximately 70 percent of premiums for their workers.[20] Over the past decade, the total median monthly premium for family health insurance plans has grown from $650 in 2001 to $1,479 in 2014.[21] Nearly 90 percent of those employers that do not offer coverage cite high costs as a top reason for not offering coverage.[22] Employers that provide coverage cite cost and flexible plan design as their most important criteria when selecting a plan, with cost cited as particularly important to smaller employers.[23]

Figure 4. Massachusetts Median Monthly Total Premium for Family Health Insurance Plans by Firm Size (2014)



Source: CHIA, 2014 Massachusetts Employer Survey

Increasingly, employees are shouldering a greater share of the costs of their employer-based coverage. Over the past decade, Massachusetts' median monthly employee contribution to family plan premiums has grown from $172 in 2001 to $456 in 2014.[24] While the percentage of premium contribution between employer and employees has remained relatively stable in recent years, high-deductible health plans and other cost-sharing arrangements are becoming more common. Nearly half of Massachusetts' employers offered high-deductible health plans in 2014, more than double the national average.[25]

Facing rising costs, some employers have also opted not to participate in the fully-insured market. In 2011, roughly 11 percent of employers with fewer than 10 employees and 10 percent of employers with fewer than 50 employees offered self-funded plans. By 2014, these rates had risen to 19 percent of employers with fewer than 10 employees and 15 percent of employers with fewer than 50 employees.[26]

3.3 Massachusetts' Merged Market

One of the most exceptional aspects of Massachusetts' insurance market is its merged market for individuals and small employers with up to 50 employees.[27] Only Vermont, Washington D.C., and Massachusetts feature a merged market.[28] In 2015, Massachusetts' merged market included nearly 80,000 employers[29] and 473,811 enrollees in small group plans and 257,175 enrollees in non-group plans.[30] The merged market accounts for 17 percent of the commercial market as a whole, with 5 percent of the commercial market enrolled in non-group plans and 12 percent enrolled in small group plans.[31]

Massachusetts merged its non-group and small group markets in 2007, as part of the implementation of state health reform under Chapter 58. The Commonwealth did so for a number of reasons, including ensuring consistent consumer protections across the market, improving continuity of coverage for residents transitioning between group and non-group insurance due to changes in employment, and broadening the risk pool to improve overall affordability in the market. Studies performed prior to the merger of the markets estimated that non-group rates would decrease by 15 percent and small group rates would increase by only 1 to 1.5 percent as a result of the merger.[32] While small group rates actually increased by 2.6 percent following the merger,[33] the merger has still yielded significant increases in overall affordability for Massachusetts' residents.

Over time, the merged market has evolved in Massachusetts to feature a blend of typical merged market characteristics and some remaining characteristics of a typical small group market. This hybrid structure allows Massachusetts residents the benefits of a shared market while maintaining features attractive to small employers, such as enrollment cycles that can respond to industry-specific business characteristics (*e.g.*, different fiscal years or seasonal business). Today, Massachusetts' merged market includes:

- A common risk pool that combines the experience of non-group and small group enrollees for the purpose of setting rates;
- Common insurance products for individuals and small employers, with identical benefits, cost-sharing, and provider network designs (although subsidies are available for some enrolled through the Health Connector, and catastrophic plans are only available to eligible individuals);
- A calendar-year enrollment and renewal cycle for non-group enrollees, but a rolling enrollment and renewal cycle for small groups;
- Establishment of index rates each calendar year, but also quarterly updates to the index rate for small groups enrolling or renewing at other points in the year; and
- Certain small group rating factors which differ from the rating factors specified in the Affordable Care Act, but which Massachusetts has been permitted to use during a transition period.

In recognition of Massachusetts' well-functioning market under state health reform, Massachusetts received federal approval in 2013 for a transition period for certain elements of its merged market to come into full alignment with the Affordable Care Act, such as the small group rating factors not specified under federal law. During this transition period, the federal Department of Health and Human Services (HHS) has not required Massachusetts' version of a merged market to fully meet the federal definition of a merged market. The Commonwealth has appreciated this federal flexibility to date, authorized under Section 1321(e) of the Affordable Care Act.[34] Unless additional flexibility becomes available, Massachusetts is preparing to sunset its state-specific rating factors for all plans sold on or after January 1, 2018.[35] At that point, Massachusetts' merged market would need to align with all aspects of the federal definition of a merged market, including calendar-year enrollment and renewal.

The Commonwealth anticipates that fully transitioning the current merged market to the federal definition of a merged market will cause significant market disruption and instability in pricing. An analysis in 2013 indicated that 181,000 small employer enrollees could see premiums increase by more than 10 percent under the rating factors transition.[36] Of these enrollees, 6,000 could face premium increases of more than 30 percent. Given the potential impact of these pending changes, the Commonwealth seeks to maximize stability for its merged market. This is particularly important in light of other market trends impacting the small group portion of the merged market, such as declining enrollment and recent premium increases, as illustrated in **Table 2** and **Table 3** below.

Table 2. Enrollment Trends for Small Group Plans Within the Merged Market (2014 to 2015)[37]

Small Group Enrollment							Sept. 2014- Sept. 2015 Change	
3/31/14	6/30/14	9/30/14	12/31/14	3/31/15	6/30/15	9/30/15	Absolute	Percentage
523,271	509,422	502,656	494,279	484,512	478,862	473,811	-28,845	-5.7%

Source: CHIA, Sept. 2015 Enrollment Data

Table 3. Weighted Rate Changes for Small Groups Within the Merged Market, Annually in the 2nd Quarter[38]

	2012 - 2013 (Second Quarter)	2013 – 2014 (Second Quarter)	2014-2015 (Second Quarter)
Weighted Rate Change	2.7%	2.8%	6.1%

Source: DOI rate filings

4.0 Proposed Waiver

Massachusetts seeks federal approval for Section 1332 waiver flexibility to preserve key features of the Commonwealth's local variation on a merged market. Flexibility under Section 1332 will allow the Commonwealth to preserve structural elements of the current merged market that promote continuity and stability. This will be particularly important for small employers and their employees as their issuers prepare to phase down state-specific rating factors in 2018, buffering 12 percent of the Commonwealth's insurance market from these changes by preventing additional disruption.[39]

4.1 Provisions State Seeks to Waive

Massachusetts seeks to modify one section of the Affordable Care Act: 42 U.S.C. § 18032(c)(3), the provision of the Affordable Care Act that allows states the option of a merged risk pool for the non-group and small group market. Massachusetts does not anticipate any impact of this limited proposal on other sections of the Affordable Care Act.

Section 1312(c) of the Affordable Care Act, codified at 42 U.S.C. 18032(c), generally requires a single risk pool for all enrollees in a non-group market and a single risk pool for all enrollees in a state's small group market, unless a state chooses to merge the two markets into a single risk pool.[40] This provision may be waived or modified under Section 1332 because it corresponds to ACA Section 1312, which falls under Subtitle D, Part 2 of the Affordable Care Act, a section that is listed as waivable in Section 1332(a)(2).

Massachusetts does not seek to waive the federal merged market provision entirely – indeed, Massachusetts wishes to preserve its merged market under a single risk pool. Massachusetts simply requests flexibility to implement its merged market in a manner consistent with single risk pool principles, but modified to permit the traditional rate filing, enrollment, and renewal timing that would otherwise be permitted in a small group risk pool. If its waiver is granted, Massachusetts will continue to align its small group rate filing, enrollment, and renewal timing practices to the federal regulatory approach permitted for small group plans in other states.

In **Figure 5**, the Commonwealth provides language that illustrates the nature of the modifications it seeks, side-by-side with the current language of the federal statute. This illustrative language is modeled after amendments to 45 C.F.R. § 156.80 that have been proposed in the federal Notice of Benefit and Payment Parameters for 2017.[41] The Commonwealth provides this illustration to demonstrate that its proposed waiver is consistent with the federal law that applies in states with a small group single risk pool. With its waiver, Massachusetts only seeks parity with these other states.

Figure 5. Illustrative Modification to Section 1312(c)(3) of the Affordable Care Act

42 U.S.C. § 18032. Consumer choice

"(c) Single risk pool

(1) Individual market—A health insurance issuer shall consider all enrollees in all health plans (other than

grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(2) Small group market—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) Merger of markets—A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate. A State that merges its individual and small group insurance markets into a single risk pool may nonetheless elect to permit issuers of small group plans to modify the index rate and permitted plan-level adjustments, no more frequently than quarterly and only for small group plans. Any changes to rates must have effective dates of January 1, April 1, July 1, or October 1. Such rates may only apply to coverage issued or renewed on or after the rate effective date and will apply for the entire plan year of the group health plan...

4.2 Rationale for Waiver

The Affordable Care Act includes strict risk pooling requirements to prevent the kind of risk segmentation that could lead to discrimination for populations with higher health care needs. Massachusetts recognizes and supports the overarching purpose of the single risk pool requirement, and approving the Commonwealth's request will not diminish this requirement.

The Commonwealth maintains that under Massachusetts' specific circumstances, strict application of the current federal regulatory scheme for merged markets may have deleterious unintended consequences. Under current federal law, Massachusetts' small employers are disadvantaged, compared to small employers in other markets. Specifically:

- In states with a single risk pool for the small group market, issuers are permitted to enroll small groups on a rolling monthly basis throughout the year.[42] In states with a federally-defined merged risk pool, however, issuers may only enroll small group plans on a calendar year basis.[43]

- In states with a single risk pool for the small group market, issuers are permitted to file index rates: (1) annually, (2) annually with quarterly trend updates, or (3) annually and quarterly.[44] In states with a federally-defined merged single risk pool, however, issuers are only permitted to file index rates annually. By federal regulation, issuers in merged market states may not file a change to index rates quarterly.[45]

Without a waiver, the Commonwealth would need to ensure that its merged market meets federal requirements by January 1, 2018 when its current federal flexibility expires, including transitioning to a calendar year enrollment and rating cycle.[46, 47] After this date, issuers may only sell to small employers annually for a January effective date, and may only file index rates on an annual basis. The impact of these federal requirements are unique to Massachusetts because of its merged market—other states have flexibility to permit quarterly rating and rolling enrollment for their small groups.[48]

The Commonwealth is concerned that this transition to the federal definition of a merged market will cause undue disruption and risk for employers and employees participating in small group plans. For nearly a decade, Massachusetts has operated a merged market under a hybrid structure that offers the best of both worlds: the stability and continuity of a single risk pool, with the ability to customize business practices for the different needs of individuals and employers.

Without federal flexibility, Massachusetts' small employers and their employees could experience disruptions in coverage, additional cost-sharing, and additional premiums. These changes could weaken the delicately-balanced merged market structure that Massachusetts' issuers, employers, and residents have come to support over the years, threatening to destabilize the broader merged market. Without a waiver, Massachusetts could experience:

- Disruptions to coverage and care for nearly one-half million residents

Today, small employers in Massachusetts can enroll and renew their small group plans at any month of the year, so long as they comply with requirements meant to minimize adverse selection, such as minimum participation and contribution. Many small employers currently participating in the merged market renew their coverage during a month other than January. For example, of groups sold through the Health Connector in 2014, 234 groups had renewal anniversaries in April 2015, versus 107 groups with renewal anniversaries in January 2015.[49] Group coverage sold outside the Health Connector is similarly spread across the calendar year, as indicated in **Table 4** below.[50] This differs from other merged markets – for example, when Vermont transitioned its small group plans to the calendar year in 2014, the majority of its groups already renewed in January.[51]

Table 4. Distribution of Small Group Members Enrolling By Calendar Month and Metal Level

Metal Level	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Total
Bronze	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%
Silver	2%	1%	2%	5%	2%	2%	2%	1%	2%	1%	1%	3%	24%
Gold	6%	3%	5%	11%	4%	4%	3%	2%	3%	3%	3%	7%	53%
Platinum	2%	1%	2%	7%	1%	1%	1%	1%	1%	1%	1%	2%	22%
Total	**10%**	**5%**	**9%**	**23%**	**7%**	**7%**	**6%**	**5%**	**6%**	**5%**	**5%**	**12%**	**100%**

Source: Oliver Wyman analysis of DOI 2015 rate filings

If Massachusetts were to switch to calendar-year enrollment in 2018 to align with current law for federal merged markets, 90 percent of small employers and employees participating in the Massachusetts' merged market would experience a mid-year disruption to their coverage because they currently renew during another month. For example, an employer whose plan is due for renewal in July 2017 would face a difficult choice – to forgo coverage for a gap period until calendar-year enrollment begins in January 2018, or to purchase a plan for the remainder of 2017 and then again in January 2018, recognizing that the covered employees could lose accruals to their deductibles and maximum out-of-pocket limits with the start of the 2018 plan year.

These additional cost-sharing losses could be significant, as detailed in Section 5.3 below, particularly because 43 percent of those receiving coverage through small employers were enrolled in a high-deductible health plan at last count (defined as a deductible exceeding $1,250). Each transition to a new plan also presents risks to continuity of care, if employees need to select from new participating provider networks or face short gaps in coverage due to administrative processes.

- Risk of rate increases or other cost volatility

As detailed below in Section 5.3, the Commonwealth is concerned that transitioning to annual rating could contribute to higher premiums for small group plans in the merged market. By extension, any increases in

premiums for small group plans would also impact non-group plans, including plans offered through the Health Connector that are subject to federal premium tax credits.

Diverse stakeholders have expressed concerns that transitioning to annual rating could lead to overly-conservative pricing as issuers prepare for the uncertainty of a new and unfamiliar rating cycle.[52] Health insurance issuers, brokers, and business representatives attest that small group rates are likely to rise in response to a calendar-year rating cycle, as issuers will be less able to respond to market dynamics throughout the year. Because Massachusetts has a merged market structure with a shared index rate for all non-group and small group plans effective in January, any increases in premiums for small group plans under a calendar-year cycle would also negatively impact non-group plans.

These concerns are exacerbated by other factors in the market, including: (1) the alignment of state small group rating factors with federal rating factors; (2) the end of the federal reinsurance and risk corridors program, and (3) other market changes, such as the introduction of high-cost prescription medication.[53] Each of these factors is likely to contribute to rate instability and conservative pricing. Recent rate filings for 2016 reflect significant rate increases for the merged market, and Massachusetts would like to take all available steps to mitigate additional premium increases.[54]

- Risk of employer flight from the merged market

While Massachusetts has traditionally enjoyed relatively strong participation from small employers in the merged market, there are some indications that the disruption discussed above could amplify the risk of employers exiting the merged market altogether.

Facing changes to the market that would occur without a waiver and in the absence of a mandate for small employers with 50 or fewer employees to offer coverage, some employers may decide to stop offering coverage altogether. If this were to occur, Massachusetts could incur significant additional liability from lower-income employees who would qualify for subsidized coverage. At last estimate, Massachusetts has approximately 1,526,306 residents whose incomes are below 400 percent FPL and have employer-based coverage.[55] If even a small portion of these residents were to lose their current employer-based coverage and seek public coverage, this would represent a major cost to the Commonwealth and could also increase costs for the federal share of subsidy programs.

4.2 Statutory Authority for Waiver

With the support of the Massachusetts General Court (legislature), Massachusetts has explicit statutory authority to apply for and implement the proposed waiver application. Ch. 119, Sec. 20 of the Acts of 2015 authorizes the Commonwealth Health Insurance Connector Authority to apply for and implement a Section 1332 waiver application.[56]

Specifically, the Health Connector has authority "to make applications to the United States Secretary of Health and Human Services to waive any applicable provisions of the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended from time to time, as provided for by 42 U.S.C. § 18052, and to implement the state plans of any such waiver in a manner consistent with applicable state and federal laws, as authorized by the United States Secretary of Health and Human Services pursuant to said 42 U.S.C. § 18052."

4.3 Waiver Implementation Plan

Because Massachusetts seeks to preserve current market conditions through its proposed waiver, the Commonwealth's proposed implementation plan is modest. The proposed waiver would not require additional resources or extensive planning, beyond current insurance market and regulatory activities.

The responsibility to implement the proposed waiver would reside primarily with the Commonwealth's Division of Insurance (DOI), with support from the Commonwealth Health Insurance Connector Authority (Health Connector) and the Baker-Polito Administration more broadly. DOI and the Health Connector have worked collaboratively for a decade to ensure that quality, affordable health plans are available to small employers and their employees, and the two agencies are well equipped to implement the proposed waiver together. The Commonwealth also expects substantial waiver implementation support from sister agencies within the Baker-Polito administration, as well as merged market stakeholders that have indicated their support for the proposal, including small group plan issuers, brokers, and representatives of the business community.

- Implementation Oversight from the Division of Insurance

The DOI administers the laws of the Commonwealth as they pertain to the protection of the insurance consumer through the regulation of the insurance industry. The DOI monitors financial solvency, licenses insurance companies and producers, reviews and approves rates and forms, and coordinates the takeover and liquidation of insolvent insurance companies and the rehabilitation of financially-troubled insurance issuers. The DOI also investigates and enforces state insurance laws and regulations, responds to consumer inquiries and complaints, and provides small employers and other members of the public with information regarding various types of insurance.

Under the proposed waiver, DOI would continue its current role as the primary regulatory entity for the merged market, including supervision of issuers' rating and enrollment practices. By state law, DOI has authority to review and approve rates for health insurance products offered in the merged market by insurance issuers, health maintenance organizations, non-profit hospital service corporations, and medical service corporations.[57]

DOI's current regulatory guidance supports the policies in this waiver request. DOI Bulletin 2014-11 indicates that "eligible small businesses or groups continue to have the right to apply for coverage anytime during the year…"[58] 211 CMR 66.09 supports a quarterly cycle for the timing of rate filings, requiring issuers to file small group base premium rates and rating factors 90 days before their proposed effective dates.[59] These policies could serve as a regulatory foundation for the proposed waiver, with DOI supplying additional guidance to issuers as needed.

- Implementation Support and Outreach from the Health Connector

The Health Connector is an independent quasi-governmental authority that has helped residents and small employers compare and enroll in high-quality, affordable health plans since its inception in 2006.[60] In addition to serving as a source of coverage, the Health Connector also serves as a policymaker and regulator regarding elements of state health reform, including the state's individual mandate. In 2014, the Health Connector began serving as a designated state-based marketplace under the Affordable Care Act, refining its offerings to meet new federal requirements.

As part of this marketplace role, the Health Connector operates the Commonwealth's Small Business Health Options Program (SHOP), facilitating health insurance enrollment for over 5,544 small group enrollees and 1,223

employer groups.[61] The Health Connector also offers educational resources and incentives to small employers offering coverage, including access to the federal small business tax credit and Wellness Track, a state rebate program that supports workplace wellness with financial assistance for participating employers. Further, Health Connector staff have established relationships with the employer and broker community over the years through its licensed on-staff brokers, advisory councils and other outreach mechanisms. This has allowed effective education and collaboration with members of those communities on key policy changes in the past.

Given its historical role in administering the Commonwealth's version of an employer mandate and its current role as an enrollment facilitator for small employers, the Health Connector is well-equipped to serve as an ongoing educational resource for small employers and employees with questions about the proposed waiver.

- Implementation Timeline

Implementation Activity	Timing	Entity	Specific Activity
(Assumes waiver approval by early fall 2016)			
Notify public of waiver approval	Fall 2016	DOI	Release information sheet via DOI regulatory webpage
			Encourage outreach about waiver in continuing education seminars for licensed agents and brokers
		Health Connector	Release waiver approval document and other information describing the waiver via Section 1332 webpage and stakeholder distribution list
			Provide update at Broker Advisory Council, Employer Advisory Council, and other educational fora with small employer stakeholders
		Issuers	Release advisory to agents and brokers
Review regulatory guidance to ensure clarity in expectations	Fall 2016	DOI	If needed for clarity, release bulletin to health insurance issuers regarding implementation roll-out and timeline
(Waiver period begins January 1, 2017)			
Rate filing instructions	Spring 2017	DOI	Remind health insurance issuers of waiver terms and implementation in filing instructions, all-filer seminar, or other appropriate industry fora
Post-award public forum	Summer 2017	DOI and Health Connector	Hold public forum to solicit comments on the progress of the waiver (publishing the date, time, and location on the DOI and/or Health Connector websites, 30 days in advance)
Monitor market trends and seek ongoing public feedback	Annually	DOI and Health Connector	Following public release of merged market rates effective January of each year, hold public forum to solicit comments on the progress of the waiver (publishing the date, time, and location on the DOI and/or Health Connector websites, 30 days in advance)
		DOI and Health Connector	
Determine whether to seek waiver renewal	Fall 2020	DOI and Health Connector	Hold public forum to solicit comments
Prepare for waiver wind-	Winter	DOI and	Seek extension of waiver authority or prepare for

down or renewal	2021	Health Connector	transition from waiver, in partnership with HHS
(Waiver period ends January 1, 2022)			

Though Massachusetts is seeking Section 1332 flexibility to accommodate its current merged market conditions, the Commonwealth recognizes that market conditions could change over the course of the waiver period. If the proposed waiver is granted, Massachusetts requests the ability to revert to the federal merged market approach, if: (1) market conditions require a calendar-year approach to rating and enrollment, and (2) the Commonwealth engages in an appropriate process with HHS to withdraw from the waiver and prepare the insurance market for transition.

4.4 Public Waiver Development Process

The Commonwealth began exploration of a possible Section 1332 waiver in fall 2015 at the direction of Governor Charlie Baker and the Massachusetts General Court.[62] The Health Connector was asked to lead a collaborative interagency effort to engage the public about potential opportunities available under Section 1332.

In October 2015, the Health Connector launched a series of public meetings to discuss possibilities under Section 1332. The Health Connector included partners in the executive and legislative branches of the Commonwealth in the public meetings, including representatives from:

- The Office of the Governor;
- The Office of the Attorney General;
- General Court committees, including the Joint Committee on Health Care Financing and other committees related to health insurance;
- The Health Connector's governing Board of Directors;
- The Executive Office of Housing and Economic Development and its Division of Insurance (DOI);
- The Executive Office for Administration and Finance;
- The Executive Office of Health and Human Services and its MassHealth Division;
- The Center for Health Information and Analysis;
- The Group Insurance Commission; and
- The Health Policy Commission.

The Health Connector convened seven public meetings in the initial stakeholder series, as detailed below. These meetings were announced publicly, via a dedicated e-mail distribution list and a dedicated webpage on the Health Connector's website: https://betterhealthconnector.com/about/policy-center/state-innovation-waiver. The public was notified of the opportunity for language or disability accommodations for each meeting, and the dedicated webpage offers language and disability assistance options and meets applicable "Section 508" standards. Meeting materials were distributed via the distribution list and posted after each meeting on the dedicated webpage. The Health Connector encouraged public comment at each meeting, and kept a record of comments.

Topic(s)	Meeting Details
Introductory Launch • Overview of Section 1332 waivers and federal guidance to date	**Wednesday, October 7, 2016** Boston location

Open Policy Forum # 1 • Individual mandate • Employer mandate	**Friday, October 16, 2015** Boston location and phone
Open Policy Forum # 2 • Exchange and qualified health plan structure • Individual and group market structure • Essential health benefits	**Friday, October 23, 2015** Boston location and phone
Open Policy Forum # 3 • Exchange subsidies • Exchange eligibility	**Friday, October 30, 2015** Boston location and phone
Roll-up of Discussion To Date • Roll-up of discussion to date • Timeline of possible next steps in Commonwealth's consideration of a waiver	**Friday, November 6, 2015** Boston location and phone
Targeted Policy Forum # 1 • Draft policy options for consideration	**Wednesday, November 25, 2015** Boston location and phone
Targeted Policy Forum # 2 • Draft policy options for consideration	**Wednesday, December 9, 2015** Phone

Massachusetts is fortunate to have a deeply engaged health care stakeholder community. Because of its historical experience implementing multiple waves of health reform, the Commonwealth has developed strong working relationships across a diverse array of stakeholders, including consumer representatives, health plan issuers, provider entities, agents and brokers, business representatives, labor representatives, and others. The Health Connector drew upon this list of known interested stakeholders to develop its initial distribution list of stakeholder participants in its public meetings, and updated this dedicated list over time as new stakeholders expressed interest. Stakeholders attending the meetings most frequently included representatives from:

Consumer representatives	• Community Catalyst • Health Care For All • Health Law Advocates • Massachusetts Law Reform Institute
Health plan issuers	• Blue Cross and Blue Shield of Massachusetts, Inc. • Boston Medical Center Health Plan, Inc. • CeltiCare Health Plan of Massachusetts, Inc. • Dental Service of Massachusetts, Inc. (Delta Dental of Massachusetts) • Fallon Community Health Plan, Inc. • Harvard Pilgrim Health Care, Inc. • The Guardian Life Insurance Company of America • Health New England, Inc. • Massachusetts Association of Health Plans • Metropolitan Life Insurance Company • Minuteman Health Plan of Massachusetts, Inc. • Neighborhood Health Plan, Inc. • Tufts Associated Health Plan • United Health Care Insurance Company
Provider	• Massachusetts Hospital Association

entities	• Massachusetts Council of Community Hospitals • Massachusetts League of Community Health Centers • Partners Health Care • Steward Health Care
Business entities	• Associated Industries of Massachusetts • Boston Chamber of Commerce • Massachusetts Business Roundtable • Massachusetts Food Association • Massachusetts Municipal Association • Massachusetts Retailers Association
Agents & Brokers	• Borislow Insurance
Labor representatives	• Massachusetts Coalition of Taft-Hartley Trust Funds • SEIU 1199 United Health Care Workers East
Other	• Blue Cross Blue Shield Foundation of Massachusetts • Massachusetts Budget and Policy Center

Throughout the course of its initial public meetings, the Health Connector accepted written public comment regarding possible Section 1332 waiver content. The Health Connector received seven public comments during this pre-proposal phase, all of which were made publicly available on the Health Connector's dedicated Section 1332 webpage. Two of the comments were from health plan issuers, specifically supporting the Commonwealth's proposed waiver to retain the current timing of enrollment, renewal, and rating for small group plans. The remaining comments did not address the proposed waiver content, but instead suggested other possible waiver topics for the Commonwealth's future consideration. The Commonwealth continues to explore these remaining policy topics.

In addition to the aforementioned public meetings, the Health Connector engaged in a separate consultation with the sovereign federally-recognized tribes within Massachusetts borders. Together with MassHealth, the Health Connector engaged members of the agencies' joint Tribal Workgroup through a separate outreach effort, including a tribal consultation meeting on January 14, 2015. Tribal members did not express any comments or concerns regarding the proposed waiver.

The Health Connector also conducted specific outreach to other key stakeholders during this pre-proposal phase, including members of the Health Connector's Broker Advisory Committee and representatives from the General Court (legislature).

At the conclusion of this initial policy exploration, on February 2, 2016, the Health Connector announced its specific intention to apply for a Section 1332 waiver, and made the draft application available for public comment. The notice provided a description of the proposed waiver, a web link to access the draft application and instructions to obtain paper copies, information about the public comment period and process, information about public hearings, and information about how to request language or disability accommodations. The notice was disseminated through the Health Connector's dedicated distribution list and publicly available website, as well as through the State Register and a specific outreach message to tribal representatives. The draft application was made available through the Health Connector's distribution list and publicly available website for a public comment period of at least 30 days, from February 2, 2016 through March 4, 2016.

During the public comment period, the Health Connector accepted written public comments on a rolling basis and held two open public hearings in locations that ensured accessibility for members of the public from different regions of the state. The first was held February 5, 2016 in Boston, Massachusetts, and the second was held February 19, 2016 in Springfield, Massachusetts. These public meetings were held in locations accessible to residents with disabilities.

The Health Connector received the following public comments during the course of the formal comment period: *[This section will be added following the public comment period].*

5.0 Estimated Waiver Impact

5.1 Affected Population

The Commonwealth anticipates that the proposed waiver will directly impact only the small group portion of its merged market. This includes nearly 80,000 employers[63] and 473,811 enrollees in small group plans.[64]Based on available data, the Commonwealth expects that the small group portion of the merged market likely reflects similar demographics as the broader commercial market in Massachusetts as a whole (as detailed in **Table 1**). While race, income, and health status information are not available with granularity at this time, the age and gender of small group enrollees closely mirrors the broader commercial market population (**Table 5**).

Table 5. Age and Gender of Massachusetts Residents with Small Group Insurance (Snapshot as of Sept. 2015)[65]

	Gender		
	Female	Male	Total
Small Group	49%	51%	473,811
Total Commercial Insurance	51%	49%	4,162,231

	Age (In Years)						
	0-9	10-19	20-26	27-44	45-64	65+	Full Population
Small Group	10%	14%	11%	26%	37%	2%	473,811
Total Commercial Insurance	10%	13%	11%	26%	34%	5%	4,162,231

Source: CHIA, Enrollment Trends Jan. 2016

The Commonwealth does not expect the proposed waiver to impact large group (employers with over 50 employees) coverage. Since Massachusetts regulates the merged market and other insurance plans under a different set of laws and procedures, the Commonwealth would not expect any aspect of the proposed waiver to impact the large group market. Per the federal PACE Act of 2015, Massachusetts has elected not to expand its small group plans to include groups with up to 100 employees at this time, so there is no risk of larger employers being subject to small group rules.[66]

Similarly, the Commonwealth does not expect the proposed waiver to appreciably impact public coverage, such as Medicaid and the Children's Health Insurance Program. To the extent that the proposed waiver promotes the affordability and stability of small group coverage, as described in Section 5.3 below, the Commonwealth anticipates that the proposed waiver could potentially prevent small employers from shedding insurance for

their workers. While this could prevent these employees from seeking public coverage, it would not negatively impact the employees themselves, who would be expected to remain in the same employer-based insurance they have today. The Commonwealth does not anticipate any specific impact to coverage as a result of the proposed waiver for those already enrolled in public coverage programs.

Lastly, while non-group and small group plans are linked through the merged market structure, the Commonwealth does not anticipate any negative impact to the non-group market under the proposed waiver. Under the proposed waiver approach, the Commonwealth would continue to pool the insurance risk of non-group and small group members together on an annual basis. Non-group enrollees would continue to benefit from the broader risk pool of the merged market during calendar year rating, which improves affordability overall, and would continue to enroll and renew on a calendar year cycle without any disruption. Moreover, to the extent that the waiver keeps rates steady, as described in Section 5.3 below, the waiver could potentially maintain or improve affordability for individuals in the non-group market.

5.2 Comprehensiveness of Coverage

The Commonwealth expects that the proposed waiver would have no impact on the comprehensiveness of coverage otherwise available to its residents under the Affordable Care Act. Under the proposed waiver, small group enrollees and other enrollees in the merged market would continue to be guaranteed the Essential Health Benefits and applicable state-required benefits.

Under the Affordable Care Act, enrollees of non-grandfathered small group plans are assured benefits that meet both applicable state requirements and the federal Essential Health Benefits, as defined in Section 1302(b) of the Affordable Care Act and further specified in 45 C.F.R. § 156.100. This benchmark package includes items and services in ten categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

For plan year 2017, Massachusetts has selected the following base benchmark plan and supplemented the plan to meet the Essential Health Benefits requirements:

Plan Type	Small Group Market
Issuer Name	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Product Name	HMO Blue With Deductible
Plan Name	HMO Blue New England $2,000 Deductible
Supplemented Categories	Pediatric dental (CHIP); Pediatric vision (FEDVIP)

This plan also meets Massachusetts's own "Minimum Creditable Coverage" standards, the level of coverage adult residents must carry in Massachusetts to meet the state-specific individual mandate. Further details about Massachusetts' Essential Health Benefits benchmark and applicable state-required benefits are available at: www.cms.gov/cciio/resources/data-resources/ehb.html#Massachusetts.

Under the proposed waiver, enrollees of non-grandfathered small group plans would continue to be assured the same state-required benefits and Essential Health Benefits that would otherwise be required under the Affordable Care Act, including all ten categories of benefits. While the timing of a small group's plan year could impact the specific benchmark plan applicable to enrollees—for example, the specific month in 2018 during

which the 2017 Essential Health Benefits benchmark transitions to the 2018 Essential Health Benefits benchmark for a given group—this timing will not impact the ability of small group enrollees to access the same Essential Health Benefits to which they would otherwise be entitled within their plan year.

Regardless of the timing of the applicable plan year, all residents currently receiving the Essential Health Benefits would continue to do so for each year of the proposed waiver. As such, there would not be any impact on particularly vulnerable residents, such as low-income individuals, elderly individuals, or those with serious health issues or who have a greater risk of developing serious health issues.

5.3 Affordability of Coverage

The Commonwealth expects that the proposed waiver would have a positive impact on the affordability of coverage otherwise available to its residents under the Affordable Care Act. Independent actuarial analysis performed by Oliver Wyman indicates that the proposed waiver is likely to *decrease* out-of-pocket spending for health coverage and services by small group enrollees compared to the Affordable Care Act baseline, particularly for vulnerable enrollees with high health needs who are likely to incur more out-of-pocket spending overall. This analysis also found that there would be no measurable impact on affordability for other portions of the market.

Oliver Wyman performed two analyses to determine the affordability impact of a move to calendar year rating and enrollment for small group plans: (1) an analysis of the impact of applying cost-sharing to groups on a calendar year basis, particularly when this yields a plan year that is shorter than 12 months during the transition to a calendar year cycle; and (2) an analysis of the impact on premiums of setting rates once per year, rather than setting rates quarterly for groups that enroll throughout the year. (See **Appendix D** for details of both analyses, including methodology and assumptions). Both analyses demonstrated that the proposed waiver is likely to yield more favorable premiums and cost-sharing for small group enrollees than these enrollees would otherwise experience without a waiver.

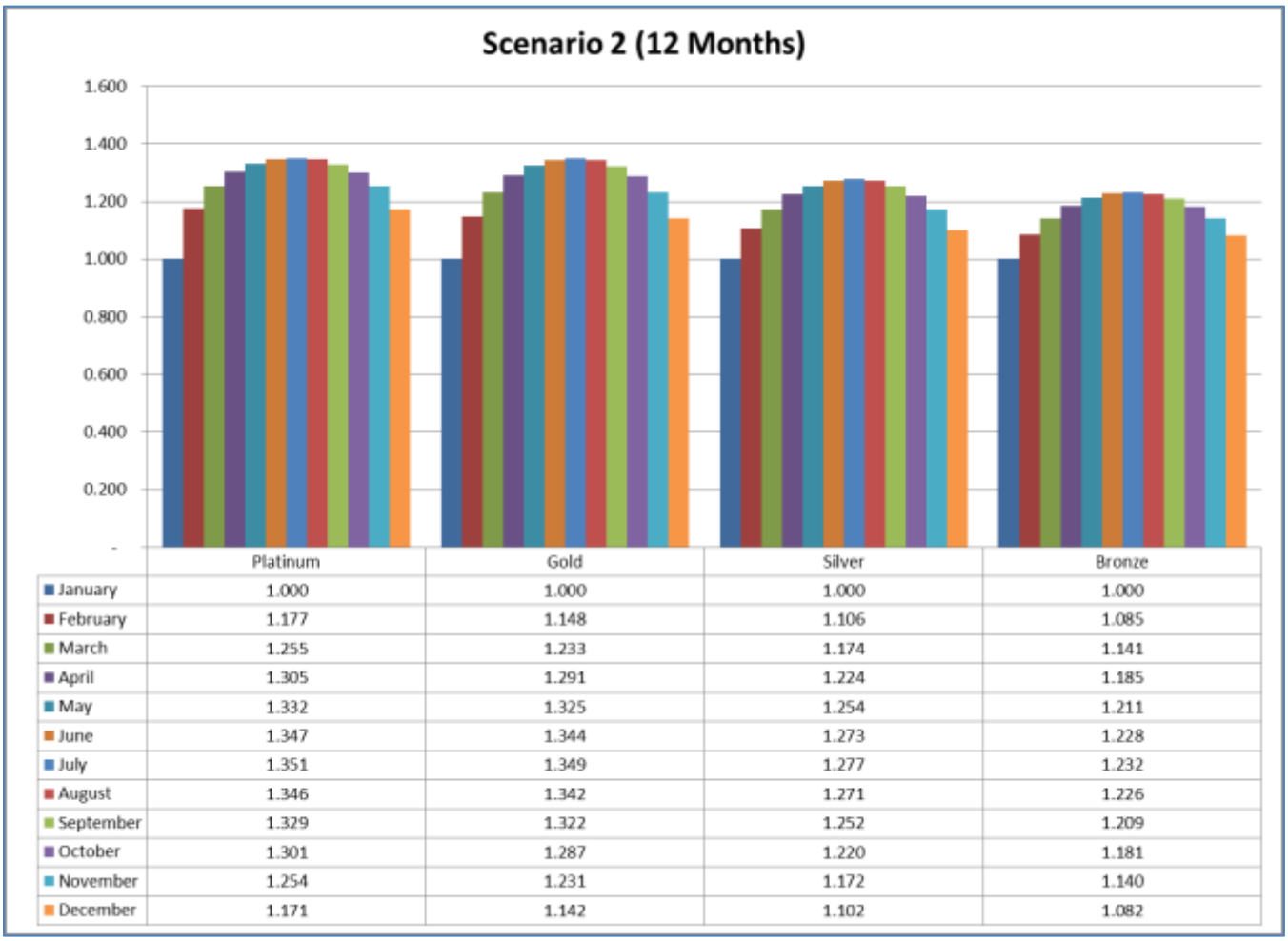
- Summary of Cost-sharing Analysis and Results

Oliver Wyman used Massachusetts claims and enrollment data from a proprietary database to model cost-sharing (including deductibles and out-of-pocket maximums) for four plan designs: bronze, silver, gold, and platinum. Member cost-sharing was then calculated under four scenarios, by effective month and metal level

- *Scenario 1*. Continuation of rolling enrollment; calculating cost-sharing for the 12 months following the 2017 enrollment date.
- *Scenario 2*. Rolling enrollment in 2017 with policy periods lasting only until December 31, 2017; calculating cost-sharing for the 12 months following the 2017 enrollment date.
- *Scenario 3*. Continuation of rolling enrollment; calculating member cost-sharing for the period from the 2017 enrollment date through December 31, 2108.
- *Scenario 4*. Rolling enrollment in 2017 with policy periods lasting only until December 31, 2017; calculating cost-sharing for the period from the 2017 enrollment date through December 31, 2018.

This analysis shows that over the 12 months following the enrollment date, enrollee cost-sharing under a shortened plan year scenario would exceed that of rolling enrollment on average by about 23 percent. Enrollees would experience this significant initial spike in cost-sharing because issuers would need to reset cost-sharing to the calendar year, rather than allowing cost-sharing features such as deductibles to accrue over a full year. This would result in much higher overall maximum out-of-pocket costs for consumers in late 2017 and early 2018.

Figure 6. Ratio of Average PMPM Cost-sharing In 12 Months Following 2017 Renewal – Transition to Calendar Year (Scenario 2) Over Continuing of Rolling Enrollment (Scenario 1)



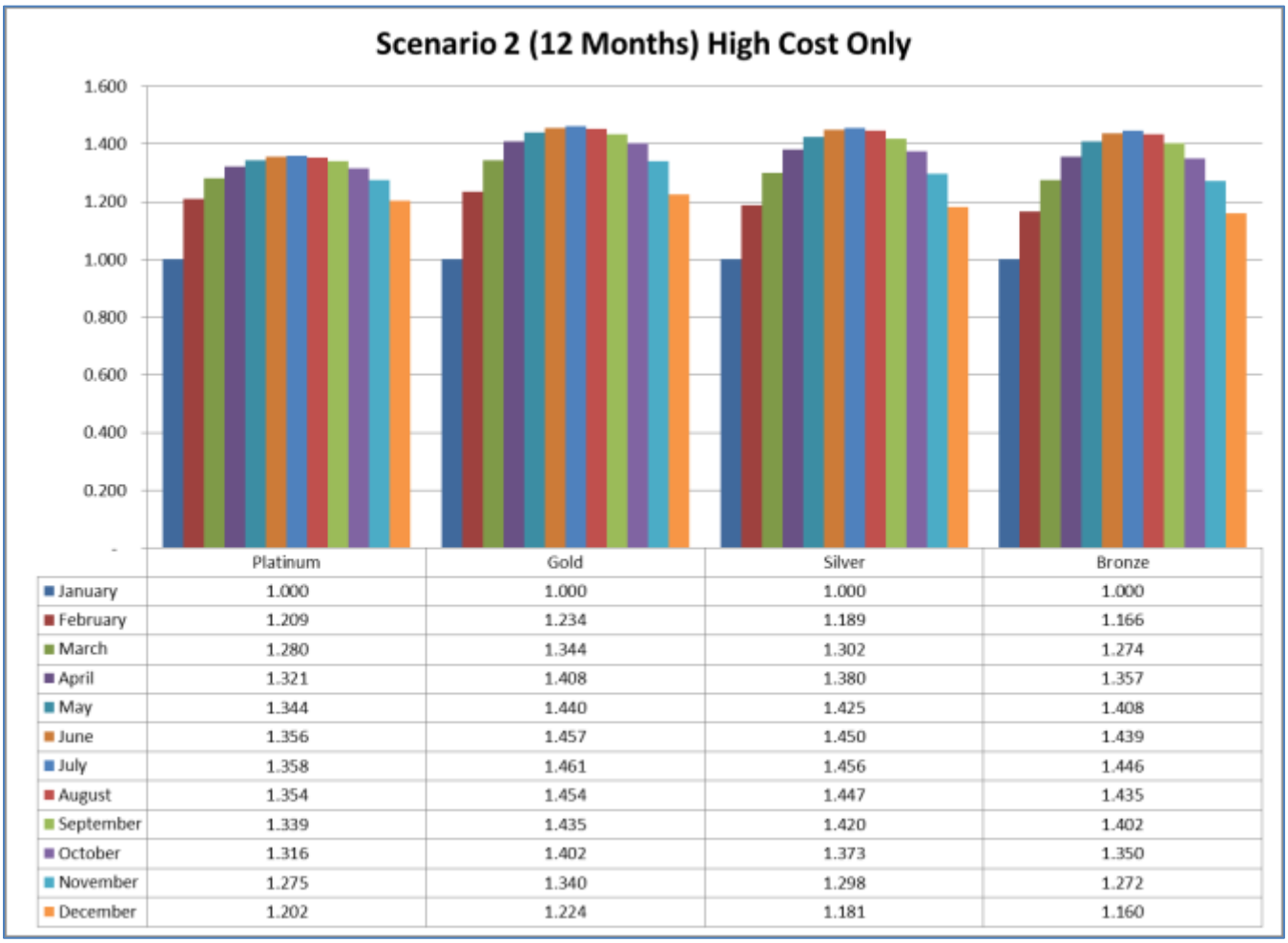
	Platinum	Gold	Silver	Bronze
January	1.000	1.000	1.000	1.000
February	1.177	1.148	1.106	1.085
March	1.255	1.233	1.174	1.141
April	1.305	1.291	1.224	1.185
May	1.332	1.325	1.254	1.211
June	1.347	1.344	1.273	1.228
July	1.351	1.349	1.277	1.232
August	1.346	1.342	1.271	1.226
September	1.329	1.322	1.252	1.209
October	1.301	1.287	1.220	1.181
November	1.254	1.231	1.172	1.140
December	1.171	1.142	1.102	1.082

Source: Oliver Wyman, 2016

Over time, cost-sharing would begin to stabilize; returning to just over baseline by the end of 2018—but the one-time spike could still cause significant shock to the small group market.

This impact would be particularly marked for enrollees with high health care needs who are likely to meet their deductibles or out-of-pocket maximums, such as older individuals or individuals with serious health conditions. Oliver Wyman analysis found that for small group enrollees with the highest claim costs (top 20 percent), the transition to a calendar-year plan could cause a one-time increase of up to 32% increase in cost-sharing in the twelve-month period following the 2017 renewal, versus continuing rolling enrollment.

Figure 7. Ratio of PMPM Cost-sharing for High-Cost Claimants In 12 Months Following 2017 Renewal - Transition to Calendar Year (Scenario 2) Over Continuing of Rolling Enrollment (Scenario 1)



	Platinum	Gold	Silver	Bronze
January	1.000	1.000	1.000	1.000
February	1.209	1.234	1.189	1.166
March	1.280	1.344	1.302	1.274
April	1.321	1.408	1.380	1.357
May	1.344	1.440	1.425	1.408
June	1.356	1.457	1.450	1.439
July	1.358	1.461	1.456	1.446
August	1.354	1.454	1.447	1.435
September	1.339	1.435	1.420	1.402
October	1.316	1.402	1.373	1.350
November	1.275	1.340	1.298	1.272
December	1.202	1.224	1.181	1.160

Source: Oliver Wyman, 2016

- Summary of Premium Analysis and Results

Oliver Wyman used rate filings submitted to the Massachusetts Division of Insurance to determine the experience periods used by issuers in rate development, and the resulting number of months of trend used by the issuers in setting rates for a given combination of filing date and effective date. Oliver Wyman then used distribution of enrollment by month (from rate filings) to determine the average number of months of trend assumed across all small groups using the current practice of quarterly rating with rolling enrollment, compared to the number of months of trend for calendar-year rating and enrollment. The trends from the rate filings were used to observe the variations in trends assumed by different issuers over the four quarterly filings in a given year, to estimate the impact of uncertainty related to additional months of trending in setting rates.

This analysis demonstrates that issuers use varying amounts of trend to fill in gaps in their experience when setting rates at different times of the year. Filings effective for January have the greatest number of months of trend, due to the earlier filing due date needed to finalize rates prior to the open enrollment period for individuals and other marketplace implementation needs. When issuers are permitted to refresh rates on a quarterly basis, however, they have the benefit of two more months of experience from which to draw, rather than relying on trend projections for those two months.

Table 6. Claim Trend by Issuer, 2015 Filings with the Division of Insurance

	Q1	Q2	Q3	Q4
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc	8.12%	8.28%	8.42%	8.18%
Blue Cross and Blue Shield of Massachusetts, Inc	8.12%	8.28%	8.42%	8.18%
BMCHP	8.33%	8.27%	8.22%	12.45%
CeltiCare Health Plan	n/a	n/a	n/a	n/a
Connecticare of Massachusetts, Inc.	10.42%	10.20%	10.21%	10.08%
Fallon Community Health Plan (FCHP)	6.90%	4.70%	7.60%	8.28%
Fallon Community Health Plan (FHLAC)	6.90%	4.70%	7.60%	8.28%
Harvard Pilgrim Health Care, Inc.	7.09%	7.18%	7.11%	7.67%
HPHC Insurance Company, Inc.	7.09%	7.18%	7.11%	7.67%
HNE	6.26%	6.26%	6.26%	6.26%
Minuteman Health, Inc.	0.00%	0.00%	0.00%	0.00%
Neighborhood Health Plan	-1.46%	-0.92%	-0.06%	0.42%
Tufts Associated Health Maintenance Organization	7.34%	7.44%	6.87%	6.81%
Tufts Insurance Company	9.52%	9.72%	7.76%	8.75%
Tufts Public Health Plans	9.86%	10.55%	11.51%	9.39%
United Healthcare	5.20%	6.19%	6.51%	6.51%

Source: Oliver Wyman, 2016

Issuers include a risk charge or contribution to surplus in rates for uncertainty in trending. Because of the substitution of additional risk charge for two months of experience data that would be associated with rate filings without the proposed waiver, issuers' average risk charge would likely be higher if all groups were to renew in January rather than throughout the year on a quarterly basis. A rough estimate of this risk charge indicates that issuers may add up to 1 percent to their rates if all groups renew in January.

This impact would be most apparent to small groups with employees who are older or have high health needs. Since older individuals are charged higher premiums than non-elderly, the dollar impact of increased premiums under calendar year rating would be greater for older individuals. To the extent those with serious health issues select richer benefit plans, they too would see greater dollar premium increase due to the higher premium of richer benefit plans. Such selection might occur if the employer is aware of health issues within the group or if more than one plan is offered to employees.

5.4 Scope of Coverage

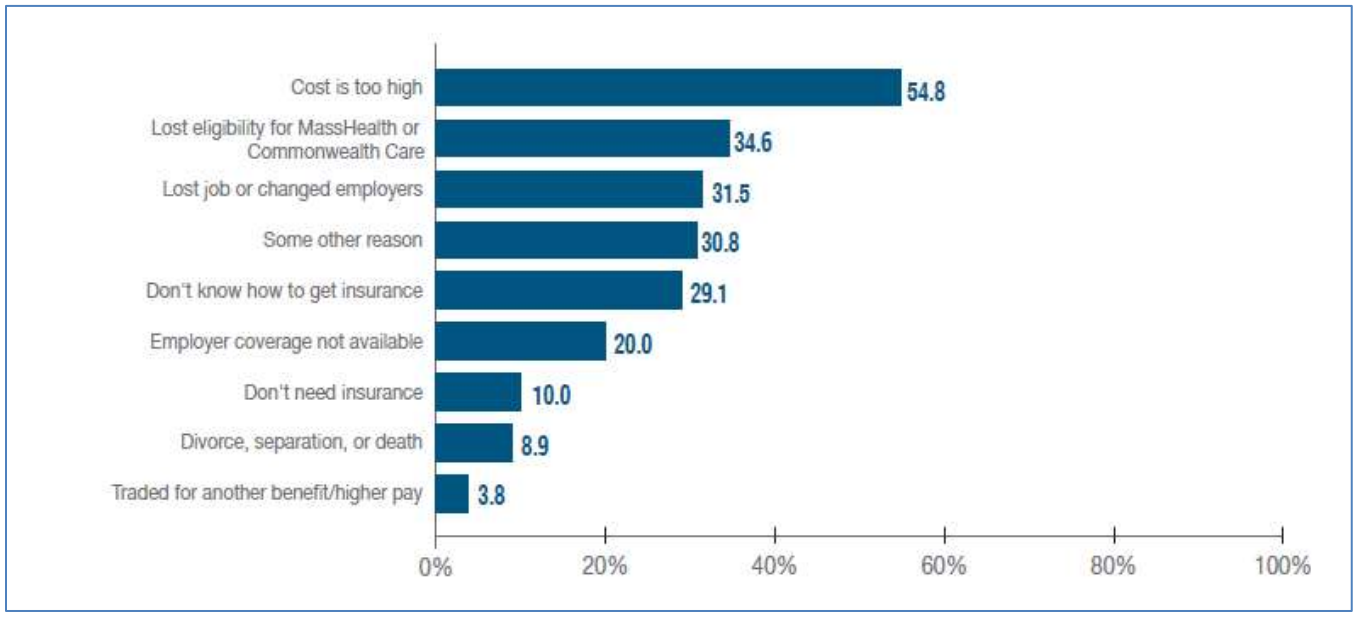
The Commonwealth expects that the proposed waiver would have a positive impact on the number of covered residents, compared to the scope of those covered under the Affordable Care Act without a waiver. Because benefits would remain constant and affordability is likely to improve under the proposed waiver, the Commonwealth anticipates that the number of employers offering coverage and the number of employees choosing to take up coverage would remain at least equivalent under the waiver (after adjusting for other variables, such as rising health care costs overall).

According to a 2014 survey of employers in Massachusetts, cost is a key factor in employer decisions about whether to offer insurance and what level of coverage to offer. When small employers that offer insurance were

surveyed about their decision-making, 33.6 percent of employers with under 10 employees cited cost as a key decision factor, and 39.4 percent of employers with between 11 and 50 employees cited cost as a key decision factor.[67] Among employers of all sizes that choose not to offer insurance to their workers, 89% cited high premiums as a critical factor for this decision.[68] Given this price-sensitivity among employers, the Commonwealth expects that any ability to maintain stability of premium rates under the proposed waiver, even if only to prevent additional increases, would promote stability in the number of small employers offering insurance.

Survey data indicates that Massachusetts' residents are equally sensitive to price in their decisions to take up insurance. Among residents without insurance in 2015, 54.8 percent of those surveyed indicated that the cost of insurance was too high.[69] Given this data, the Commonwealth expects that more stable cost-sharing under the proposed waiver will also enable more employees to take up or remain in their employer-based plans, rather than face a gap in coverage during the transition to calendar-year plans. Again, the Commonwealth expects that the stabilizing effect of the proposed waiver would be particularly important to lower-income individuals and other vulnerable populations, who are most likely to be sensitive to changes in health care costs.

Figure 8. Reported Reasons for Being Uninsured in Massachusetts in 2015



Source: CHIA, 2015 Massachusetts Health Insurance Survey

5.5 Access to Care Out-of-State

The Commonwealth does not expect any impact from the proposed waiver on Massachusetts' residents' ability to access coverage or care out of state. Nothing in the proposed waiver will impact provider networks or other aspects of out-of-state care.

5.6 Administrative Burden

Massachusetts does not anticipate any increase in administrative burden as a result of the proposed waiver. Rather, the proposed waiver is likely to decrease administrative burden because it will spare the Commonwealth, health plan issuers, agents and brokers, small employers, and small employees from

transitioning to a calendar-year business cycle for small groups. Aside from the evaluation and reporting requirements associated with the waiver itself, there will be no new reporting, record-keeping, or other administrative requirements associated with the waiver proposal.

- Health plan issuers and producers

The proposed waiver will save health plan issuers and related insurance professionals, such as agents and brokers, the significant burden of transitioning their enrollees or clients to a calendar year cycle. Under the proposed waiver, there will be no need for issuers or brokers to educate their small groups about the impact of a short plan year on accrued benefits, update and re-issue member material during the middle of a plan year, or conduct special outreach to groups that fail to renew timely due to confusion.

The proposed waiver will also help issuers and brokers spread resources appropriately throughout the year, rather than condensing all activity related to the merged market into one brief timeframe associated with open enrollment. As a result, issuers and brokers will be less likely to need to hire temporary workers, pay over-time, or take other costly measures to keep up the demands of re-rating, renewing, and enrolling the entire merged market during a single time period.

- Small employers and their employees

The proposed waiver will also decrease administrative burdens on small employers and their employees. Under the proposed waiver, small employers can continue to renew their plans at the time of the year that corresponds to their industry-specific business needs, such as a given fiscal year calendar. Small employers will not need to renew, shop or engage in other plan sponsor duties during the middle of their previous plan year, and will not need to educate their workers about calendar-year changes. Small employers who need one-on-one assistance will not need to "compete" for attention from issuers or brokers with the non-group portion of the market during open enrollment, a time when issuers and brokers are likely to have less customer service bandwidth.

Similarly, the proposed waiver will spare employees the hassle of making insurance decisions, such as choosing a new plan, more than once in a given year. The proposed waiver will also ensure that employees do not need to learn about new rules related to their cost-sharing as a result of a shortened plan year.

- Other consumers

While other Massachusetts residents would not be directly impacted, the waiver proposal could potentially avert market confusion and congestion that could indirectly cause administrative burden for consumers. Without a waiver, consumers could be confused by educational materials related to the small group transition, and believe that their insurance is changing.

- Commonwealth of Massachusetts

The proposed waiver would not add new administrative burdens or workload to Commonwealth agencies involved in regulating and administering health insurance, such as the Health Connector and the DOI. Because the proposed waiver seeks to retain the status quo, agencies would not need to make any changes to implement the waiver. Further, agencies would not need to issue regulatory guidance to assist in transitioning to market, as it would without a waiver.

- Federal agencies

The proposed waiver would not create any new administrative burdens or costs to the federal government. Federal agencies would not need to make any new changes to Uniform Rate Review or federal processes or submissions to accommodate the proposed waiver.

5.7 Waste, Fraud, and Abuse

Massachusetts does not expect any impact on waste, fraud, and abuse as a result of the proposed waiver. Because the waiver proposes to preserve current market conditions, currently operating programs will continue to detect and prevent waste, fraud, and abuse in the merged market. For example:

- Health Connector

The Health Connector engages in a robust and continuous program integrity and oversight process that extends to all its business areas, including its interactions with small group issuers through the SHOP. Per 45 C.F.R. §155.1200, the Health Connector engages an independent auditing entity which follows generally-accepted governmental auditing standards to perform an annual independent external programmatic audit. The Health Connector provides the results of this audit to HHS and publishes a public summary of the results. Similarly, the Health Connector engages an independent entity to provide a standard and "A-133" financial audit.

- Division of Insurance

DOI's Financial Surveillance department plays a vital role in monitoring the solvency of health plan issuers chartered in Massachusetts. DOI's staff financial examiners and external consultants conduct statutorily required on-site audits of issuers with domestic licenses, ensuring their financial solvency and ability to continue to meet reserve requirements and pay claims.

DOI's Consumer Service department responds to inquiries and intervenes on behalf of consumers to resolve complaints against health plan issuers and other licensees. Consumer Service provides consumers with general insurance information and intervenes on behalf of consumers to resolve complaints, including consumer complaints involving fraud and abuse.

- Office of the Attorney General

The Attorney General's Consumer Protection Division uses investigation and enforcement actions to protect consumers from fraud, deception, and other unfair business practices. The Attorney General's Health Care Division enforces health care laws to protect the rights of Massachusetts' consumers and to halt unfair or deceptive practices that may harm consumers. The Health Care Division also operates a health care hotline to help consumers understand their health care rights and to mediate consumer disputes with health care payers and providers.

In addition to these government resources, the Commonwealth expects to continue to rely on issuers and their internal systems to monitor and curb waste, fraud, and abuse under the proposed waiver.

6.0 Waiver Deficit Impact

6.1 Assurance of Deficit Neutrality

The Commonwealth does not anticipate any increase in the federal deficit as a result of the proposed waiver. Massachusetts' proposal will not require additional spending from the federal government because it preserves status quo conditions in Massachusetts' health insurance market, using a policy approach that is permitted without federal approval or appropriations for other states. The waiver proposal:

- Will not require any new investments, infrastructure, or administrative processes

The proposal will not require new resources from the federal government. If approved, Massachusetts regulatory entities, insurers, and small group administrators and members are ready to implement the waiver immediately, without additional support.

- Will not appreciably impact other deficit variables, such as changes in revenue

Any possible indirect impacts would be negligible and well within the federal government's existing estimates, since the waiver proposal is aligned with a policy option permitted for other states and its economic impacts will balance to neutrality.

6.2 Discussion of Deficit Neutrality Assessment

The Commonwealth reached the conclusion that the proposed waiver would be deficit neutral after analyzing possible direct and indirect impacts to the federal budget and deficit. The Commonwealth's deficit analysis included the following steps:

- A Landscape Scan Revealed Few Budget Items for Further Analysis

The Commonwealth reviewed available descriptions of the federal budget and deficit to catalogue any possible line items that could be impacted by its waiver proposal, including outlays and revenue estimates from: (1) the President's Fiscal Year 2016 Budget, as originally proposed and later amended in the Mid-Session Review by the Office of Management and Budget (OMB); and (2) Congressional Budget Office (CBO) publications related to the budget and deficit impact of the Affordable Care Act.[70] In the course of this landscape analysis, the Commonwealth first identified the budget items most likely to be impacted by the terms of any Section 1332 waiver – as detailed in **Appendix E** – and then systemically reviewed each item for any interaction with the specific waiver proposal under consideration.

Most of the direct outlays and revenue sources identified in the landscape analysis were irrelevant to the topic of the Commonwealth's waiver. Massachusetts seeks only to impact rating and enrollment practices for the small group portion of the broader merged market. This limited proposal does not directly impact federal outlays, such as financial subsidies through the state-based marketplace or Medicaid/CHIP expenditures (except to the extent that it may keep premiums and subsidies in the merged market lower than they otherwise would be), and it does not directly impact federal revenue sources, such as the shared responsibility penalties applicable to individuals and employers. Further, the proposed waiver would not increase federal administrative expenses because federal agencies are already well-equipped to handle quarterly rating and enrollment for other states— for example, the Uniform Rate Review process already accommodates quarterly rating for states with a single risk pool for the small group market.

In an abundance of caution, the Commonwealth engaged in deeper analysis of two items: direct federal outlays related to the small business tax credit, and indirect revenue impact due to economic decision-making.

- Analysis of Specific Budget Items Did Not Indicate Deficit Impacts

Because Massachusetts' proposed waiver impacts the small group portion of its merged market, the Commonwealth carefully considered whether the waiver could impact federal outlays through changes in take-up of the small business health care tax credit.

At the outset, it is unlikely that Massachusetts' employers would respond to the proposed waiver through increased utilization of the small business health care tax credit. A report by the Government Accountability Office (GAO) found two key factors in small employers' decision-making around the health care tax credit: the amount of the credit, and the perceived complexity of the tax credit process.[71] Neither factor would be impacted by the terms of the proposed waiver.

In the unlikely event that Massachusetts' proposal to maintain the timing of rating and enrollment yielded changes in employer take-up of the small business health care tax credit, any changes would be negligible for three reasons:

First, CBO forecasts static utilization of the small business health care tax credit for the next decade nationwide—estimating that the program will require one billion dollars for each of the next ten years, regardless of other significant shifts in the domain of employer-based coverage.[72] This indicates that the program is not expected to be sensitive to changes in premium or other known variables, such as the decisions of states with single small group risk pools to permit quarterly rating updates.

Second, the small business health care tax credit has a cushion to account for minor changes in take-up. In 2014, the Internal Revenue Service reported 171,000 tax returns claiming the tax credit, in the amount of $502,900,000.[73] This amount is well within the billion-dollar amount estimated for the program by the CBO in 2016 and beyond, allowing room within the current parameters of the program for expansion. Moreover, the President's Fiscal Year 2016 and Mid-Session Review for Fiscal Year 2016 provide for a significant expansion of the program from 2016 through 2025. If these additional investments are appropriated, the cushion for additional take-up within the small business health care tax program would grow still larger.

Third, because Massachusetts administers its own state-based SHOP and has a history of innovation in the small group market, the Commonwealth can nimbly respond to any unexpected changes in take-up through state-specific policy levers. Massachusetts has a demonstrated commitment to flexible policies that respond to emerging needs for small group plans and their sponsors. For example, in 2011, the Commonwealth responded to affordability concerns among small employers by introducing a state-funded rebate for small group wellness programs, the Wellness Track.[74] Given this history of innovation, Massachusetts could be prepared to respond to any emerging market trends.

- Analysis of Broader Economic Behavior Did Not Indicate Deficit Impacts

In addition to assessing any possible impact on specific budget items, the Commonwealth considered any broader shifts in employer or employee behavior that could occur as a result of the proposed waiver, and any subsequent impacts on federal spending or revenue.

This analysis focused on potential changes to premiums for small employers under the proposed waiver, the likely impact of these rate changes on employers' decisions to offer coverage to their employees, and the possible impact of employers' decision-making on the federal deficit.

Small employers can react to changes in their health insurance premiums in a number of ways. Because there is no legal mandate to offer insurance to their employees, small employers can decide to limit or withdraw their offer of insurance or limit their share of contributions toward insurance. However, studies suggest that employers are more likely to respond by lowering wages, rather than limiting their offers of health coverage.[75] This economic principle is supported by Massachusetts' experience – despite increases in premiums in recent years, Massachusetts' small employers have maintained relatively constant rates of insurance offers for their employees.[76]

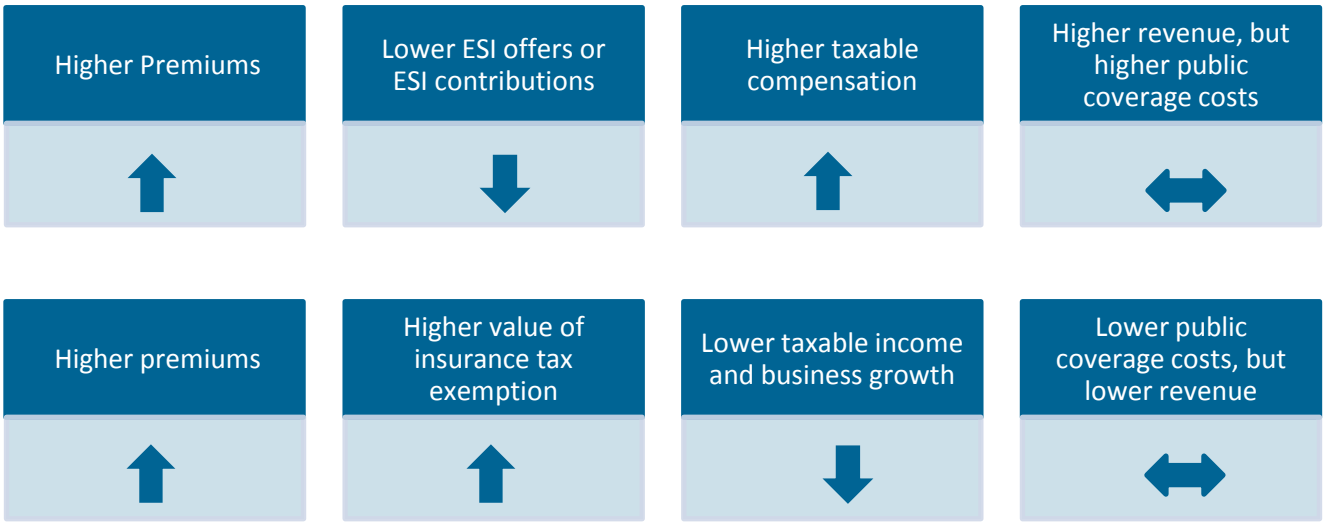
In 2012, Massachusetts-based economists studied the relationship between health insurance premiums and employer compensation behavior in Massachusetts' labor market. Using the Gruber Microsimulation Model (GMSIM), the study estimated the effects of possible increases in health insurance premiums on Massachusetts' employers and employees. The study estimated that a decrease in health insurance premiums by even a single percentage point could result in significant savings to employers that could be reinvested in compensation and other economic benefits: over a period of 2011-2019, employers would save $10 billion on their health spending, preserve $7.8 billion in employee take-home pay, and preserve $1 billion for workforce investments and business profit.[77] This study demonstrates the significant economic importance of the waiver proposal to Massachusetts' economy – the ability to maintain stable rates for small insurers could yield billions in savings for Massachusetts over the course of the waiver period.

While the waiver proposal could yield significant benefits for the local Massachusetts economy, the Commonwealth does not expect the waiver to impact the federal deficit because of the balancing interplay of different budgetary factors.

Changes in the extent of employer-based coverage can potentially affect federal revenue because most payments toward that coverage are exempt from income and payroll tax. If employers increase or decrease the amount of nontaxable compensation they provide in the form of health insurance, they are likely to hold total compensation steady by offsetting these changes in wages or other forms of taxable compensation, which can increase or decrease federal revenue.[78] However, the Congressional Budget Office (CBO) has also recognized that decisions about employer-based coverage have multi-faceted effects on the deficit that tend to converge at neutrality.[79] In addition to revenue from taxable compensation, decisions about employer-based coverage also impact the value of the tax exclusion for employees and employers, take-up of public coverage such as Medicaid and subsidies available through the exchange marketplaces, and economic growth overall.

Given these balancing factors, CBO has concluded that even substantial changes to employer-based coverage have "limited effects on the budgetary impact" because changes in the availability and take-up of such insurance affect the federal budget in several ways that are offsetting.[80] **Figure 9** includes two possible employer responses to changes in premiums, and illustrates the balancing factors that tend toward deficit neutrality.

Figure 9. Possible Employer Responses to Higher Premiums Balance to Neutrality



7.0 Expected Evaluation and Reporting

If the proposed waiver is approved, Massachusetts will hold public fora six months after the proposed waiver is granted and annually thereafter. The date, time, and location of each forum will be posted on the Commonwealth Health Connector Authority and Division of Insurance websites and also be shared with known interested stakeholders, such as tribal representatives, health insurance issuers participating in the merged market, business associations, and consumer representatives. As with previous public meetings in the waiver process, these meetings will afford equal access to those with limited English proficiency or disabilities.

While the Commonwealth is open to providing quarterly reports to the Secretary, the proposed limited waiver does not seem to warrant such scrutiny. In the interest of administrative simplification, Massachusetts respectfully proposes to report upon the completion of the first six months of the waiver and annually thereafter, following the public forum. The Commonwealth will, of course, cooperate fully with any independent evaluation conducted by the Secretary or the Secretary of the Treasury.

In its reports, which will be made publicly available, Massachusetts proposes to include:

- Evidence of compliance with public forum requirements, including date, time, place, description of attendees, the substance of public comment, and the Commonwealth's response, if any;
- Information about any challenges the Commonwealth may face in implementing and sustaining the waiver program and its plan to address the challenges;
- A description of any substantive changes in Massachusetts' insurance landscape applicable to the terms of the waiver, such as trends in the costs of small group insurance and enrollment trends in the merged market; and
- Any other information applicable to the terms and conditions in the State's approved waiver.

8.0 State Contact Information

The Commonwealth wishes to acknowledge the array of partner agencies contributing to this application. Special thanks are due to partners at the Division of Insurance, Executive Office for Administration and Finance, and Executive Office of Health and Human Services, and the Center for Health Information and Analysis. Inquiries regarding Section 1332 or this application can be directed to the Health Connector, with support from its partner DOI, as follows.

Waiver Application	Audrey Morse Gasteier (lead contact) Director of Policy & Outreach Commonwealth Health Insurance Connector Authority 617-388-5832 audrey.gasteier@state.ma.us Emily Brice (lead contact) Senior Advisor on State Innovation Waivers Commonwealth Health Insurance Connector Authority 617-933-3156 emily.brice@state.ma.us Kevin Beagan Deputy Commissioner, Health Care Access Bureau Massachusetts Division of Insurance 617-521-7323 kevin.beagan@MassMail.State.MA.US Niels Puetthoff Senior Health Research Analyst Massachusetts Division of Insurance 617-521-7326 Niels.puetthoff@state.ma.us
Permanent Contact	Commonwealth Health Insurance Connector Authority 100 City Hall Plaza Boston, MA 02108 617-933-3030 StateInnovations@state.ma.us

9.0 Appendixes

Appendix A: Frequently Used Abbreviations

ACA	Patient Protection and Affordable Care Act of 2010
CBO	Congressional Budget Office
CCA or the Connector	Commonwealth Health Insurance Connector Authority
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DOI	Massachusetts Office of Consumer Affairs and Business Regulation, Division of Insurance
FPL	Federal Poverty Level
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
JCT	Joint Committee on Taxation
OMB	Office of Management and Budget
Secretary	Secretary of the Department of Health and Human Services

Appendix B: Text of State Enabling Legislation

Ch. 119, Sec. 20 of the Acts of 2015 (HB 3829) authorizes the Commonwealth Health Insurance Connector Authority to apply for and implement a Section 1332 waiver application.

Under the language therein, the Connector has authority "to make applications to the United States Secretary of Health and Human Services to waive any applicable provisions of the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended from time to time, as provided for by 42 U.S.C. § 18052, and to implement the state plans of any such waiver in a manner consistent with applicable state and federal laws, as authorized by the United States Secretary of Health and Human Services pursuant to said 42 U.S.C. § 18052."

Appendix C: Public Notice and Comment Materials

[This section will be added following the public comment period].

Appendix D: Actuarial Analysis and Certification

[Attached].

Appendix E: Deficit Neutrality Worksheet

[Attached].

[1] Center for Health Information and Analysis. (2015, Dec.). *Findings from the 2015 Massachusetts Health Insurance Survey (report)*. Prepared by Skopec, L. and Long, S.K., Urban Institute and Sherr, S. Dutwin, D., and Langdale, K., SSRS. Retrieved from www.chiamass.gov/massachusetts-health-insurance-survey/.

[2] Center for Health Information and Analysis. (2014, Oct.) *2014 Massachusetts Employer Health Insurance Survey (chartbook).* Retrieved from www.chiamass.gov/massachusetts-employer-health-insurance-survey. *Citing* Kaiser Family Foundation and Health Research and Educational Trust. (2014). *Survey of Employer Sponsored Benefits*. Retrieved from: http://kff.org/health-costs/report/2014-employer-health-benefits-survey/.

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[12] Center for Health Information and Analysis. (2015, Dec.). *Findings from the 2015 Massachusetts Health Insurance Survey (report)*. Prepared by Skopec, L. and Long, S.K., Urban Institute and Sherr, S. Dutwin, D., and Langdale, K., SSRS. Retrieved from www.chiamass.gov/massachusetts-health-insurance-survey/.

[13] Center for Health Information and Analysis. (2015, Dec.). *Findings from the 2015 Massachusetts Health Insurance Survey (report)*. Prepared by Skopec, L. and Long, S.K., Urban Institute and Sherr, S. Dutwin, D., and Langdale, K., SSRS. Retrieved from www.chiamass.gov/massachusetts-health-insurance-survey/.

[14] Center for Health Information and Analysis. (2015, Dec.). *Findings from the 2015 Massachusetts Health Insurance Survey (report)*. Prepared by Skopec, L. and Long, S.K., Urban Institute and Sherr, S. Dutwin, D., and Langdale, K., SSRS. Retrieved from www.chiamass.gov/massachusetts-health-insurance-survey/.

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