Report to the Massachusetts Legislature

Implementation of Health Care Reform

Fiscal Year 2009

October 23, 2009

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1.0 Preface

Three years after passage of chapter 58 of the acts of 2006, Massachusetts' landmark health reform, over 97% of the state's residents have health insurance. This positions Massachusetts as a leader among the states, with by far the lowest rate of uninsured in the country.

As federal efforts to reform the health care system mount, much attention is being paid to the Massachusetts model and the remarkable progress of the state in providing near universal health insurance coverage for its residents. The first report issued by the Commonwealth Health Insurance Connector Authority (Health Connector) in October 2008 provides a thorough description of the start-up and developmental activities associated with the first two years of health reform in Massachusetts.[1] This report provides an update on the status of health reform and highlights some of the activities of the Health Connector during Fiscal Year (FY) 2009. The significant findings are all summarized in section 2.0; sections 3 – 5 go into greater detail about the Health Connector's programmatic and policy developments for FY 2009.

Health reform has been implemented as a cooperative effort of numerous state agencies, all of whom share in its success. The Health Connector would like to thank and acknowledge the Executive Office for Administration and Finance, the Department of Revenue, the Executive Office of Health and Human Services, MassHealth, the Division of Health Care Finance and Policy, the Department of Public Health, the Division of Insurance, the Division of Unemployment Assistance, the Group Insurance Commission, the Massachusetts Board of Higher Education, and the Registry of Motor Vehicles.

The Directors of the Health Connector, who volunteer their time to oversee policy, regulatory and programmatic decisions of the Authority, have played a crucial role in the success of reform. We would like to acknowledge the considerable time, talent and energy provided by the Board of Directors during FY 2009: Leslie A. Kirwan, Chair of the Board and Secretary of Administration and Finance; Nonnie Burnes, Commissioner of the Division of Insurance; Tom Dehner, Medicaid Director; Ian Duncan, Founder and President of Solucia, Inc.; Jonathan Gruber, Ph.D., Economics professor at MIT; Richard C. Lord, President and CEO of Associated Industries of Massachusetts; Louis F. Malzone, Secretary of the Massachusetts Coalition of Taft-Hartley Funds; Dolores Mitchell, Executive Director of the Group Insurance Commission; Nancy Turnbull, Associate Dean at Harvard School of Public Health; and Celia Wcislo, Assistant Division Director of 1199 SEIU United Health Care Workers East have dedicated to this initiative.

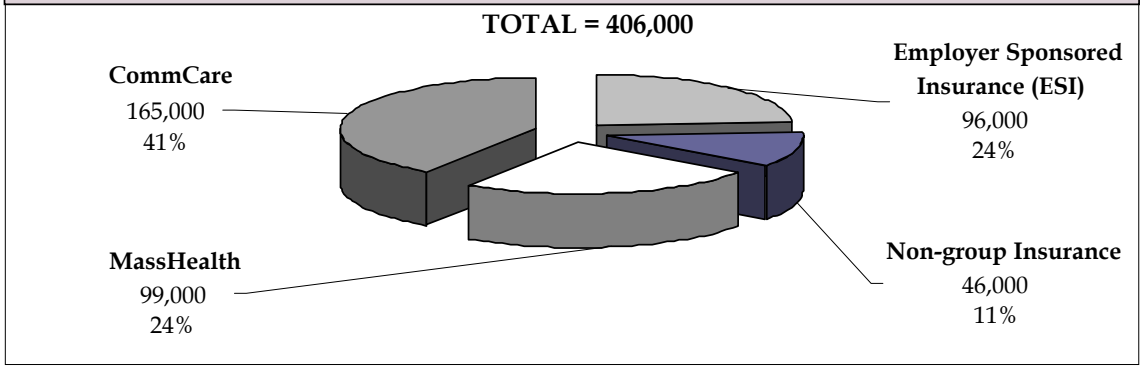
2.0 Update on the Status of Health Care Reform in MA

2.1 Insurance Coverage

According to the state's official annual survey, conducted between March and June 2009, the percentage of uninsured residents in Massachusetts was 2.7%.[2] For the second year in a row, despite a severe recession which cost Massachusetts hundreds of thousands of jobs, the percentage uninsured remains below 3%. Insuring over 97% of a state's population is an unprecedented accomplishment in American history and serves as a definitive indication of the progress made in the first few years of implementing health reform.

Since passage of health reform, there has been a dramatic increase in the number of individuals with health insurance coverage. According to membership reports provided by MassHealth and private health plans, the mix of newly insured by coverage type has begun to change in recent months, likely as a result of the economic downturn. From June 2006 to June 2008, the number of people with health insurance coverage increased by 425,000 – 431,000 (the exact count of newly insured individuals at a given point in time has changed over time, as health plans revise enrollment information due to retroactivity). During this time period, individuals newly covered in either Employer Sponsored Insurance (ESI) or non-group private plans represented nearly half (45%) of the newly insured. The count of the newly insured began to decline slightly midway through 2008, however, dropping to 406,000 by March 2009 (Figure 1).

Figure 1. Newly Insured Massachusetts Residents (June 2006 through March 2009)



This very small decline is likely attributed to significant job losses over this period (the unemployment rate increased from 5.1% in June 2008 to 7.7% in March 2009[3]) and the loss of ESI as a result. Total enrollment in private group insurance declined over this time period (from December 2008 to March 2009), but enrollment in the state's Medical Security Program (MSP), a health care program for low and moderate income Massachusetts residents receiving unemployment insurance, grew by more than 50%. Enrollment in private non-group insurance also grew over this time period (See Table 1 below). According to the most recent membership reports, of the 406,000 newly insured, about 35% are enrolled in either ESI or non-group private plans.[4] In a state with minimal population growth over this same time period,[5] this marks a significant expansion in private coverage. It also corroborates initial evidence that expanded insurance coverage does not have to mean that people are simply shifted from the private to the public sector.[6]

Table 1. Health Insurance Enrollment. June 30, 2006 – March 31, 2009*				
Non-Medicare Enrollment	June 30, 2006	June 30, 2008	December 31, 2008	March 31, 2009
Private Group Total (including MSP)	4,333,000	4,467,000	4,474,000	4,429,000
└MSP	4,473	9,494	15,067	22,684
Individual Purchase	40,000	76,000	81,000	86,000
MassHealth	705,000	785,000	781,000	804,000
Commonwealth Care	N/A	176,000	163,000	165,000
Total	5,078,000	5,503,000	5,499,000	5,484,000

*As noted in the text of this report, the exact count of newly insured individuals at a given point in time may change, as health plans revise enrollment information due to retroactivity. The enrollment numbers included here are the most recent available from the following source: Division of Health Care Finance and Policy (2009, August). *Health care in Massachusetts: Key indicators, August 2009*. Boston, MA: Author. Available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/key_indicators_aug_09.pdf

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

Successful implementation of the individual mandate in tax year 2007 was reflected in the 98.6% compliance rate with the tax filing requirement. These filings indicated that 95% of some 3.9 million Massachusetts tax filers had health insurance at the end of calendar year 2007, halfway through implementation of Massachusetts health care reform. Among those without health insurance, approximately 58% (about 118,000) were deemed able to afford insurance, and approximately 37% (about 76,000) were deemed unable to afford health insurance. Among those deemed able to afford insurance, 43% (about 51,000) had sufficiently low incomes to qualify for No Tax Status (NTS) or Limited Income Credit (LIC), nullifying or reducing the penalty for tax filers in these categories.[7] About 9,000 (5.5%) of those without insurance indicated they had a religious exemption. Only about 7,200 tax filers indicated the intent to appeal the penalty for failure to have health insurance, and about 2,300 actually completed their appeals (see Table 2).

Table 2. Distribution of Uninsured Tax-filers. Tax Year 2007	
Able to Afford Health Insurance	118,000
└NTS or LIC	51,000
└Intent to Appeal Penalty	7,200
Unable to Afford Health Insurance	76,000
Religious Exemption	9,000
Total*	~204,000

*Sub-categories may not sum to total due to rounding.
Source: Massachusetts Department of Revenue (2008, October). *Data on the individual mandate and uninsured tax filers, tax year 2007*. Boston, MA: Author. Available online at, http://www.mass.gov/Ador/docs/dor/News/PressReleases/2008/2007_Demographic_Data_Report_FINAL_(2).pdf

Based on the 2007 tax filers data provided by the Department of Revenue (DOR) and the results of the Division of Health Care Finance and Policy's (DHCFP) Health Insurance Survey (HIS) (conducted in the summer of 2008), it is possible to develop a profile of the state's remaining uninsured (Table 3 below).[8] For example, the remaining uninsured are likely to be "young," as nearly 60% of uninsured tax filers were under the age of 40. Uninsured individuals are more likely to be single, as the single population is

about 25% of the state's population, but represents well over half of the uninsured. Finally, the remaining uninsured in Massachusetts are more likely to be lower income (i.e., have income less than 300% of the Federal Poverty Level (FPL)), male, and Hispanic. The Hispanic population represents about 7% of the state's total population, but survey data reveal nearly 20% of the uninsured are Hispanic. This socio-demographic profile also characterizes the original pool of uninsured (pre-Reform) and those who have become newly insured since 2006.

Table 3. Profile of the Uninsured

- Young
  - Nearly 60% of uninsured tax-filers were under age 40
- Single
  - More than half of uninsured tax-filers were single
  - Statewide the single population is about 25%, but 56% of the uninsured are single
- Lower-income (less than 300% FPL)
- Male
  - 57% of uninsured are male
- Hispanic
  - Statewide the Hispanic population is about 7%, but 19% of the uninsured are Hispanic

Source: Long, S.K., and Stockley, K. (2009, March). *Health insurance coverage and access to care in Massachusetts: Detailed tabulations based on the 2008 Massachusetts health insurance survey*. Boston, MA: Division of Health Care Finance and Policy; and Massachusetts Department of Revenue (2008, October). *Data on the individual mandate and uninsured tax filers, tax year 2007*. Boston, MA: Author.

Analysis of the 2008 tax-filers data has not been completed; however, preliminary analyses indicate a continued high rate of compliance with the tax-filing requirement. Moreover, these analyses suggest a positive trend with respect to increasing the number of Massachusetts individuals with insurance coverage.

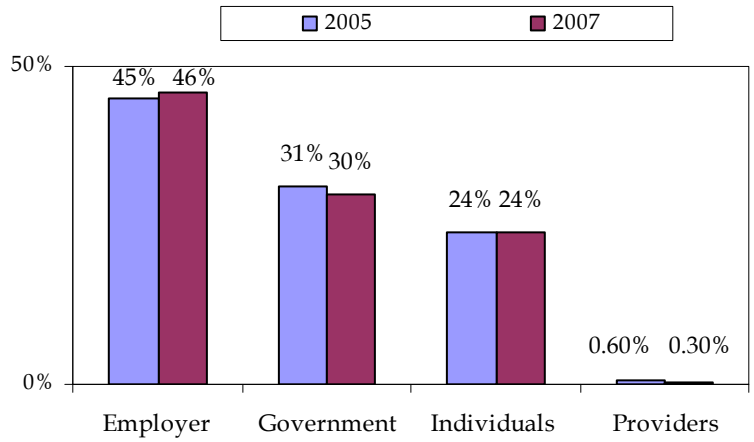
2.3 Costs

Health care reform in Massachusetts has proven affordable. Shared financial responsibility, prudent health care purchasing, and the successful transition of individuals from the free care pool into insurance programs have enabled dramatic expansions in insurance coverage at reasonable costs. In fact, additional spending by state government for health care reform amounts to only 1.3% of the state budget. The real issue causing cost pressure– for all state programs – is the current economic downturn and a structural gap of $5 billion due to declining revenues for the FY10 state budget.

The real issue for health care inflation is the rate of increase in total health care spending, most of which does not fall on the state budget. The Special Commission on the Health Care Payment System unanimously recommended bold changes in financial incentives to reduce the rate of increase in overall health care spending.

A recent study assessing the distribution of costs associated with insuring hundreds of thousands of additional Massachusetts residents found, for example, that the relative share of spending by employers, government, and individuals has remained consistent since passage of reform (see Figure 2 below).[9] This finding illustrates that the principle of shared responsibility - which was critical to passage of reform – has been maintained.

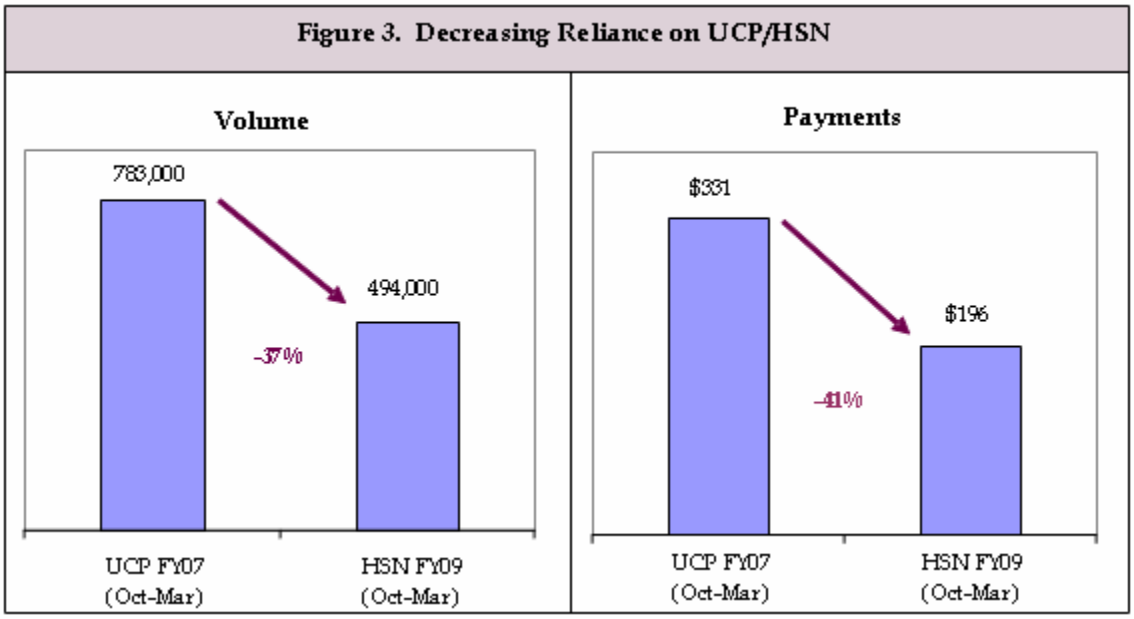
Figure 2. Combined Spending for Coverage and Uncovered Services



With respect to public spending, a study released by the Massachusetts Taxpayers Foundation (MTF) in May 2009 estimated that health reform has resulted in a $707 million increase in government spending on health care in comparing FY06 to FY10. [10] This additional spending is split approximately evenly between net state and federal increases. While FY10 projections continue to evolve, it is clear that the costs of health care reform have been relatively modest for the state. Like individuals and other employers, the state does face challenges in keeping with rising health care costs, but this challenge pre-dated health care reform and continues to be a major area of policy focus for the Commonwealth.

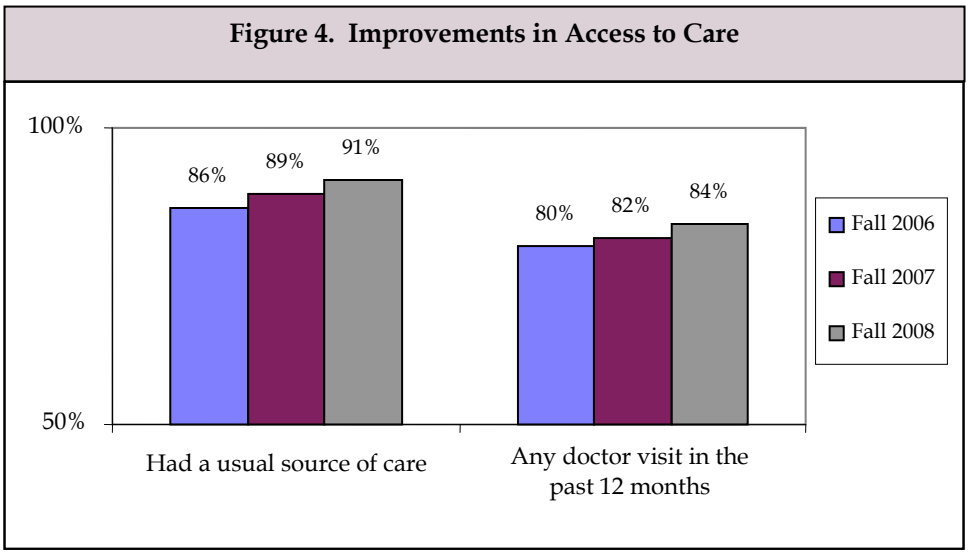
Moreover, as a result of innovative procurement strategies designed to rein in costs through competitive bidding, Commonwealth Care (CommCare) experienced an annualized premium trend of less than 5% from program inception through the most recent round of health plan bidding for FY10. This compares favorably to private market trends of eight to ten percent over the same time period. Innovative procurement strategies have saved Commonwealth Care well over $100 million through FY 2010.

Finally, one of the fundamental objectives of health reform was to minimize the number of individuals accessing health care through the Uncompensated Care Pool (UCP)/Health Safety Net (HSN) by transferring those who had previously accessed health care through the UCP into new insurance programs. Illustrative of the success of this transition, utilization of the HSN declined by 37% in the first six months of HSN FY09 as compared to the same period in UCP FY07 and HSN costs declined by 41% in the first six months of HSN FY09 as compared to the same period in UCP FY07 (see Figure 3 below).



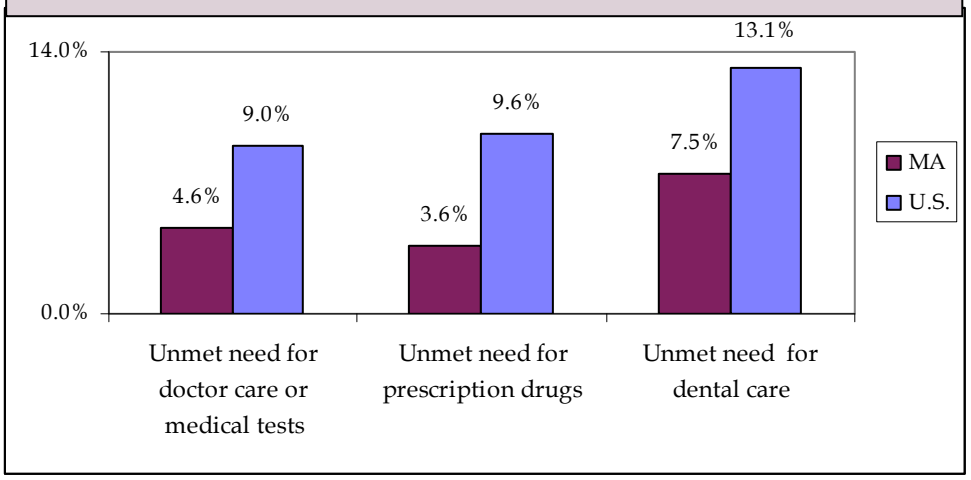
2.4 Access to Care

A primary objective of health reform is to provide improved access to medical care. And in fact, a series of longitudinal surveys illustrate that adults across income categories in Massachusetts have experienced sustained improvements in access to care since implementation of reform.[11] For example, adults have been more likely to report that they had a usual source of care and they were more likely to report that they had had a doctor's visit in the past twelve months (see Figure 4 below).



Though there is still work to be done, Massachusetts residents are faring better than the rest of the nation with respect to cost-barriers to care (see Figure 5 below).[12] For example, only 4.6% of Massachusetts adults report any unmet need because of costs for doctor care or medical tests in the past twelve months, while nearly twice as many U.S. residents report unmet need for these services because of costs.

Figure 5. Cost-Barriers to Care
MA as compared to U.S.



The Commonwealth Fund's State Scorecard on Health System Performance for 2009 ranks Massachusetts number 1 among all states in the category of access, reflecting the gains realized in Massachusetts as a result of reform. Overall, based on an analysis of over 38 indicators of access, quality, costs, and health outcomes, Massachusetts was among the top seven performers.[13]

2.5 Public Support of Health Care Reform

As highlighted in last year's report, initial support for the reform law was strong. Importantly, additional surveys since that publication reveal sustained or increased support for health reform and the individual mandate.

For example, a series of surveys conducted by the Harvard School of Public Health (HSPH) and the Blue Cross Blue Shield of Massachusetts (BCBSMA) Foundation revealed that support for reform increased from 61% in 2006, to 67% in 2007, to 69% in 2008. The most recent round of this survey, conducted in September 2009 in the midst of a severe recession and divisive public debate over national reform, indicated that though support for reform has declined, it is still overwhelmingly strong, with 59% of respondents supporting reform. [14] This same series of surveys revealed that support for the mandate grew from 52% in 2006, to 57% in 2007, to 58% in 2008.[15] In the most recent survey, when asked if they favored repeal of the state's health care reform law, only 11% did. Asked if additional changes in the law were necessary, nearly 60% of respondents responded affirmatively; not surprisingly, of these respondents, 30% focused their comments on the need to lower health care costs.[16]

Strong public support for health care reform is corroborated by additional surveys. The Massachusetts Health Reform Survey, sponsored by the Urban Institute and the BCBSMA Foundation, reported that among working-age adults, support for health reform was 68% in fall 2006, but grew to 71% by fall 2007 and this level of support was sustained as of fall 2008. Moreover, support for health reform was demonstrably high across different regions of the state, and across different income, gender and racial segments of the population.[17] Finally, according to DHCFP's HIS, three out of every four Massachusetts households supported health reform in 2008 and again in its spring 2009 survey.[18]

3.0 Commonwealth Care

3.1 Program Description

Eligibility and enrollment
CommCare is designed to provide health insurance coverage to adults who are uninsured and meet specific statutorily-defined eligibility requirements. These requirements include:[19]

- U.S. citizen/national, qualified alien, or alien with special status;
- resident of the Commonwealth for the previous six months; [20]
- ineligible for any MassHealth program or for Medicare;
- age 19 or older;
- not offered health insurance coverage through an employer in the last six months for which he/she is eligible and for which the employer covers 20% of the annual premium cost for a family insurance plan or at least 33% of the cost for an individual insurance plan;
- not accepted a financial incentive from his/her employer to decline ESI; and
- family income at or below 300% FPL.

In addition to these criteria, the Board approved additional eligibility regulations in setting up the CommCare program. These guidelines specify that individuals eligible for TriCare;[21] the Massachusetts Fishermen's Partnership; Qualifying Student Health Insurance Programs (QSHIP); or the Massachusetts Division of Unemployment Assistance's MSP are not eligible for CommCare.[22]

Plan types, benefits and co-payments
If determined eligible and enrolled in CommCare, members are assigned a Plan Type, based solely on income, as illustrated in Table 4 below.

Table 4. CommCare Plan Types

Income (relative to Federal Poverty Level)	Plan Type
0 – 100% FPL	1
100.1 – 150% FPL	2A
150.1 – 200% FPL	2B
200.1 – 300% FPL	3

The package of medical benefits provided to CommCare members has been maintained since program inception (see Appendix 2) with only modest changes to enrollee contributions or member cost-sharing at the point-of-service.[23]

3.2 Health Plan Procurement Process

FY10 was the first year in which the CommCare program was open to new health plan entrants; the Health Connector was no longer statutorily restricted to contract exclusively with the four Medicaid Managed Care Organizations (MMCOs) under contract with MassHealth.[24] The Health Connector worked extensively throughout the fall and winter of 2008 to leverage this enhanced competition by developing a procurement model that would redress bidding issues that emerged in FY09, while minimizing cost increases, expanding plan options available to members, and enhancing the program's value. In December 2008, the Health Connector issued a Request for Proposals (RFP) to health plans to provide health insurance for individuals enrolled in the CommCare program.

The Health Connector's publicly-shared goals for the program were ambitious, and included the following: to secure fair and reasonable (not excessive) rates; to mitigate risk selection and bidding gamesmanship; to protect members from large premium differentials; to align health plan payment with actual health risk and care management goals; and to increase transparency and simplicity.

At the conclusion of the procurement process, which ended in March 2009, the Health Connector had achieved all of these goals, as indicated by the following results:

- A *reduction* in costs for government and members alike (estimated $16 – $20 million savings for the state and a reduction in average cost per month for enrollees);
- An increase in the number of plans and physicians available to members, resulting from successfully attracting the first new health plan to enter the state in nearly two decades;
- Simplification of bidding process from 600 separate bids for each plan to five (one for each region), minimizing opportunities for gamesmanship;
- A fairer allocation of payments among the competing health plans by introducing sophisticated yet easy-to-understand predictive modeling to risk-adjust payments to health plans;
- Less member disruption from gyrating prices due to simplified bidding structure and re-vamped, progressive enrollee contribution model; and
- Introduction of quality incentives to enhance member access to primary care.

The strategy and procurement structure employed by the Health Connector to achieve these results are described below.

First, the Health Connector established a target capitation rate for the entire CommCare population and introduced a transparent methodology to adjust this rate by health plan based on each health plan's membership distribution by region, benefit design (which are specific to each income group), and health risk. Health plans could not bid higher than this rate, which represented a 2% increase over FY09 rates, but they were invited to bid lower by offering a percentage discount off of the target rate based on incentives offered by the Health Connector for low-bidding plans. As part of this methodology, the Health Connector introduced the use of DxCG predictive modeling software to develop individual and health plan acuity scores. By introducing predictive modeling that would better align payment to population acuity, the Health Connector hoped to level the playing field amongst health plans, allowing for competitive bidding amongst a greater number of plans.

Second, the Health Connector developed a series of incentives to encourage low bids. Similar to the prior year, these incentives included auto-assignment for non-premium payers who did not select a plan. Preferential pricing for premium paying members was also included, meaning members who select a health plan other than the lowest cost would pay the base premium, plus the differential between the plan they selected and the lowest cost plan. Beginning in FY10, the differential faced by members will be calculated progressively so that lower-income members face a lower differential than higher-income members.

In addition to auto-assignment and preferred pricing, the Health Connector introduced a number of new strategies to encourage low bids. The Health Connector allowed the lowest-price plan in any service area to propose an enhanced benefit that would allow them to differentially appeal to members, and thus attract greater enrollment. Responses from health plans generated some innovative ideas, such as a healthy rewards account that provides financial incentives for healthy behaviors (e.g., completing a health risk assessment). In addition, low-bidding plans were given the option to enhance the state's

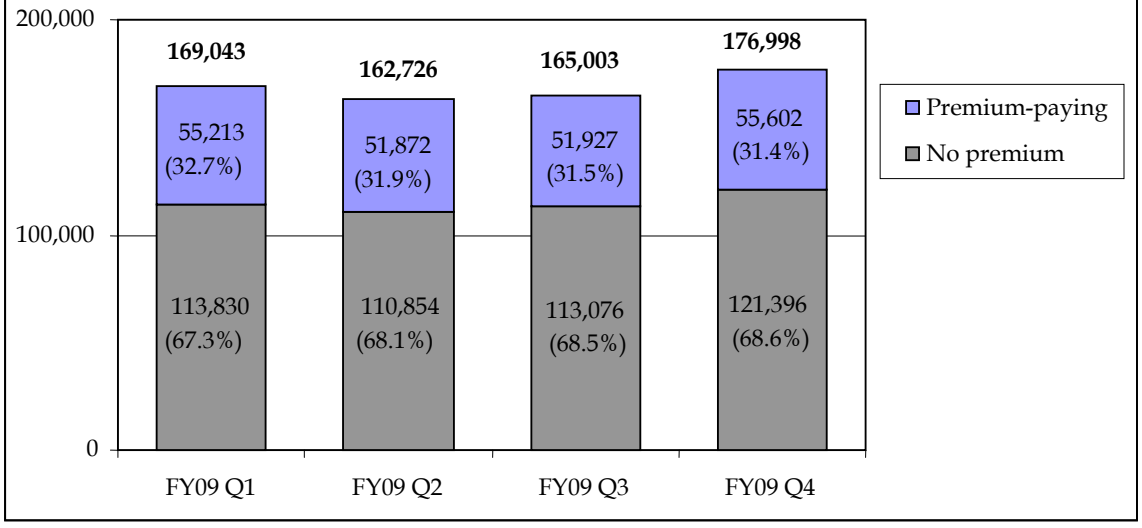
participation in aggregate risk sharing. By introducing this incentive, the Health Connector signaled that the state would mitigate some of the risk assumed by plans offering very competitive prices.

As a result of this procurement, the Health Connector achieved all of its stated objectives. Most significantly, it achieved discounts off the target rate from all prospective bidders, with at least one plan bidding the maximum discount (5.4%) in all regions of the state. This result means that payment rates will actually decline by approximately 2% from expected cost, saving the state an estimated $16-$20 million in FY10. In addition to these financial results, the Health Connector also succeeded in attracting a new, out-of-state health plan – CeltiCare Health Plan (CeltiCare) - to participate in the program, which has not occurred in Massachusetts in two decades, and reduced the financial exposure to members selecting higher-priced health plans.

3.3 CommCare Enrollment

Largely as a result of the annual re-determination process, enrollment in CommCare declined from 169,000 members at the end of the first quarter of FY09 to about 163,000 members by the end of the second quarter of FY09. As expected, however, beginning in the third quarter of FY09, the volume of re-determination-related closures decreased significantly, and at the same time, gross additions to the program increased. Enrollment climbed throughout the third and fourth quarters of FY09, with significant increases in enrollment from members who had not previously been covered by the HSN or MassHealth, suggesting the weak economy is having a positive impact on CommCare enrollment (see Figure 6 below). At the end of FY09, approximately 177,000 adults were enrolled in the CommCare program.

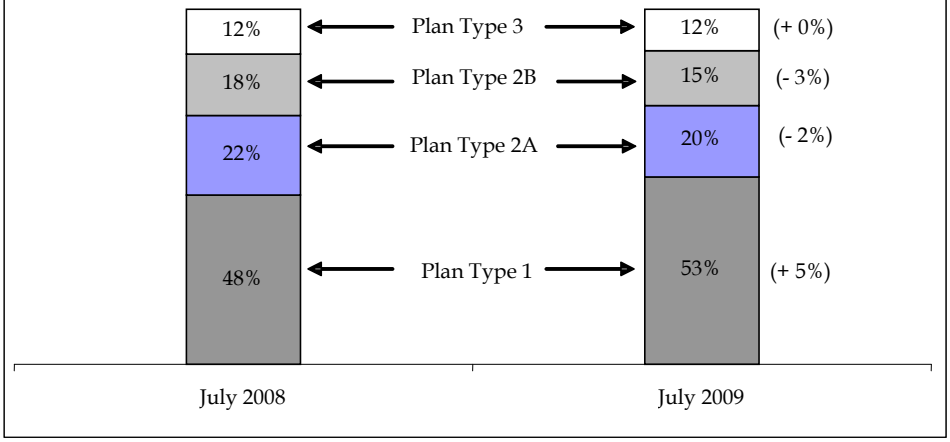
Figure 6. Total CommCare Enrollment for FY09



Enrollment by Plan Type

Plan Type 1 enrollees continue to represent the largest share of enrollment. This is likely due to both the auto-conversion and auto enrollment processes (which were operational through June 2009) and the fact that there is no monthly premium for members in this income category. The figure below illustrates the distribution of CommCare membership by Plan Type in July 2008 versus July 2009.

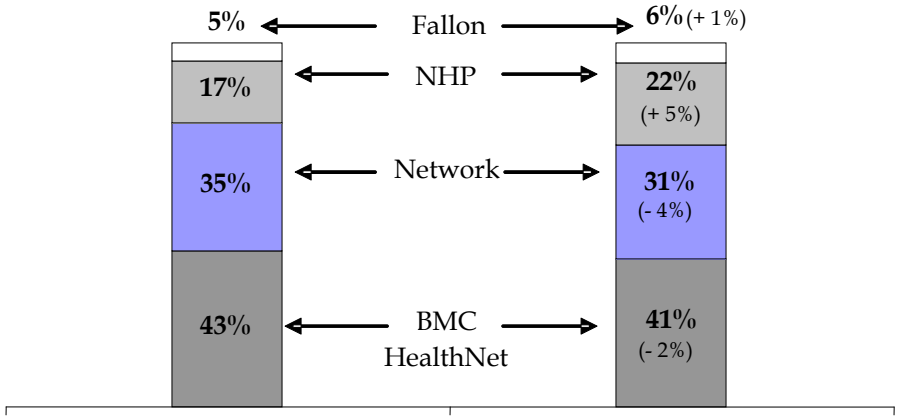
Figure 7. CommCare Enrollment by Plan Type.
July '08 compared to July '09



While the proportion of Plan Type 3 members has remained the same, Plan Type 1 members represent a slightly greater share of total enrollment (53% vs. 48%) and Plan Type 2 members represent a slightly smaller share of enrollment (40% vs. 35%) in July 2009 as compared to July 2008. Though the increase in membership experienced in recent months was the result of growth in all Plan Types, growth in Plan Type 1 membership has driven most of the increase.

Enrollment by Health Plan:
There continues to be variability in enrollment by health plan.[25] As of July 2009, there are approximately 74,000 enrollees (41% of enrollees) in BMC HealthNet, 57,000 enrollees in Network Health (31% of enrollees), 40,000 enrollees in Neighborhood Health Plan (NHP) (22% of enrollees), 10,000 enrollees in Fallon Community Health Plan (FCHP) (6% of enrollees), and about 200 enrollees in CeltiCare (less than 1% of enrollees).[26] Though BMC HealthNet and Network Health continue to enroll the largest percentage of members, their respective shares of enrollment have declined slightly since last year by 2% and 4%, respectively. Over this same time period, the percentage of enrollees in FCHP and NHP increased by 1% and 5%, respectively (see Figure 8 below).

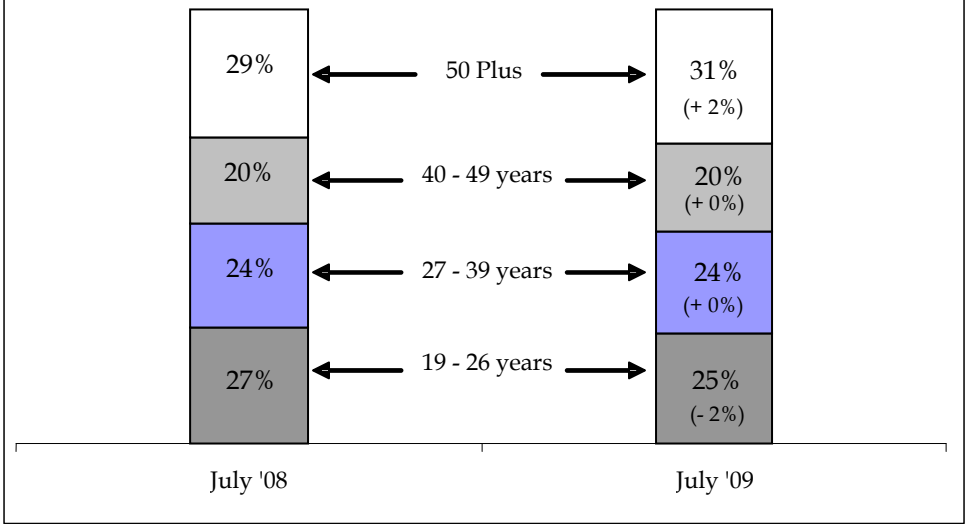
Figure 8. CommCare Enrollment by Health Plan.
July '08 compared to July '09



Enrollment by Age

The distribution of members by age cohort has held relatively steady over time. Individuals in the youngest and oldest age cohorts continue to represent the greatest proportion of total enrollment (see Figure 9 below). In addition, the mean age of CommCare enrollees has held steady at 40.0 years old since May of 2008.

Figure 9. CommCare Enrollment by Age Category. July '08 compared to July '09



3.4 CommCare Budget

While chapter 58 does not include an explicit provision to regulate provider or health insurance premiums, the Health Connector has effectively used innovative competitive bidding models to control the cost to the state for CommCare. In fact, over the three years, the Health Connector estimates the "prudent purchasing" practices it implemented as part of the procurement processes (described in section 3.2) have saved the state well over $100 million.

The tables below summarize the budgeted and actual expenditures for the program for FY07, FY08, FY09, and FY10 (budgeted only).

Table 5. Commonwealth Care Expenditures FY07

SFY 2007 Budget and Actuals	SFY07 (Budget)	SFY07 (Actual)	SFY07 (Var)
Year End Membership	67,500	79,209	11,709
Member Months	359,462	364,823	5,361
Capitation Rate	$343.62	$353.30	$9.68
Total Spending[1]	$127,782,322	$132,364,368	$4,582,046
Aggregate Risk Sharing	$0	$0	$0
Total Spending Including Risk Sharing	$127,782,322	$132,364,368	$4,582,046

[1] *Total spending is net of administrative costs and enrollee contribution collections.*

Table 6. Commonwealth Care Expenditures FY08			
SFY 2008 Budget and Actuals	**SFY08 (Budget)**	**SFY08 (Actual)**	**SFY08 (Var)**
Year End Membership	147,774	175,617	27,843
Member Months	1,327,267	1,779,967	452,700
Capitation Rate	$358.64	$351.76	($6.88)
Total Spending[1]	$463,937,546	$627,406,104	$163,468,558
Aggregate Risk Share	$8,000,000	$252,639	($7,747,361)
Total Spending Including Risk Sharing	$471,937,546	$627,658,743	$155,721,197
[1] Total spending is net of administrative costs and enrollee contribution collections.			

Table 7. Commonwealth Care Expenditures FY09			
SFY 2009 Budget and Actuals	**SFY09 (Budget)**	**SFY09 (Actual)**	**SFY09 (Var)**
Year End Membership	225,689	176,999	(48,690)
Member Months	2,387,980	2,021,094	(366,886)
Capitation Rate	$380.65	$398.40	$17.75
Total Spending[1]	$865,361,456	$797,129,334	($68,232,122)
Aggregate Risk Share[2]	$4,000,000	$3,448,249	($551,751)
Total Spending Including Risk Sharing	$869,361,456	$800,577,583	($68,783,873)
[1] Total spending is net of administrative costs and enrollee contribution collections. *[2] Risk share figure for FY09 Actual includes final settlement for the Jan - Jun 2008 period and interim payments for FY09. Estimated Final Settlement of FY09 Risk Sharing Period is reflected in FY10 budget below.*			

Table 8. Commonwealth Care Expenditures FY10 (Budgeted)	
SFY 2010 Budget	**SFY10 (Budget)**
Year End Membership [1]	164,315
Member Months	1,936,905
Capitation Rate[2]	$391.08
Total Spending[3]	$738,089,601
Aggregate Risk Share/Other Cash[4]	($15,000,000)
Total Spending Including Risk Sharing	$723,089,601
[1] Total budgeted member months includes a one-time reduction for the elimination of coverage for Aliens with Special Status (AWSS), with an assumed effective date of July 31, 2009. *[2] Capitation rate is not adjusted for AWSS budget adjustment.* *[3] Total spending is net of administrative costs and enrollee contribution collections.* *[4] Risk share figure includes estimate for net final settlement of FY09 risk sharing programs and Connector cash contribution of $5 million.* *Note: Due to timing issues and updates based on actual results, figures presented here may differ slightly from other information previously published by the Connector Authority.*	

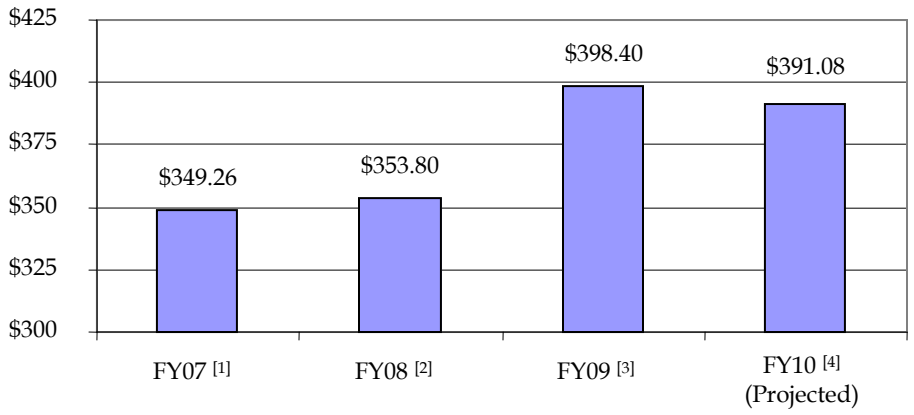
In FY08, the CommCare program cost $627.7 million, about $155.7 million above budgeted amounts. This variance is due entirely to higher than anticipated enrollment as the number of eligible uninsured was higher than expected and the pace of enrollment was quicker than expected. For FY09, actual costs for the CommCare program are expected to be about $800.6 million, approximately $68.8 million below

initially budgeted amounts due to lower than anticipated enrollment. The budget for FY10 is $723 million.

CommCare capitation rate

The average PMPM capitation rate paid to health plans remained fairly steady from FY07 to FY08. In FY09, the capitation rate increased to about $398, largely as a result of changes in enrollee demographics and increases in expected medical costs. For FY'10, the average capitation rate will actually decline to about $391 (see Figure 10 below).

Figure 10. Average CommCare Capitation Rate (PMPM)
FY07 – FY10 (Projected)



[1] This figures reflects payments made for the fifteen month period from 10/1/06 - 12/31/07.
[2] This figure reflects actual payments made for the six month period from 1/1/08 - 6/30/08.
[3] This figure reflects payments made for the 12 month period from 7/1/08 - 6/30/09. Due to timing differences and updated information the amount reflected may differ from figures previously released by the Health Connector.
[4] This figure is an estimate for payments to be made for the 12 month period from 7/1/09 - 6/30/10. Due to changes made in connection with the state budget for FY10, this figure may differ slightly from other figures previously released by the Health Connector.

Though there was an increase in the average capitation rate in FY09, the Health Connector anticipates that this will be mitigated by recouping a significant amount of money (estimated at about $10 million net collection as shown in Table 8 above) for the Commonwealth as part of the FY09 final risk share settlement. Due to the lag time between the date on which claims are incurred versus when they are reported, this is an estimate based on experience through the third quarter of FY09. As intended, the risk-sharing program will provide a mechanism to balance risk between the state and the health plans, and across the health plans, protecting both the state and the health plans from large and unforeseen changes in expected costs.

3.5 Program Integrity and Customer Service

The integrity of the CommCare program continues to be a fundamental focus of the Health Connector. To this end, the Health Connector performs several activities to validate that the CommCare program is serving the intended target population and minimizing crowd-out (i.e., the substitution of publicly subsidized insurance in places where private insurance is available) and monitors the CommCare program to ensure it is satisfying the customer service needs of enrollees. The Health Connector conducts the following activities to monitor and ensure the integrity of the CommCare program: annual eligibility re-determinations; a match process with DOR to ensure the correct income information is on file with MassHealth (for eligibility verification purposes); and a screening process to validate that

individuals enrolled in CommCare do not have access to ESI (See Appendix 3 for more information on these activities).

CommCare Network Adequacy
The Health Connector is also dedicated to ensuring that the CommCare program is meeting the customer service needs of its enrollees. In March 2009, the BCBSMA Foundation released a report conducted by Bailit Health Purchasing that evaluated network adequacy in the CommCare program.[27] The report reviewed the geographic, temporal, cultural, linguistic, and appointment access provided by the MMCOs that offer health insurance coverage through the CommCare program (at the time of the study, CeltiCare was not yet participating in the CommCare program).

To conduct this analysis, Bailit conducted a comprehensive review of: national standards and geo-access data from CommCare MMCOs, CommCare network adequacy standards as compared to those employed by both MassHealth and a commercial benchmark plan, and stakeholder interviews including Health Connector staff, MMCO staff, provider associations, community health center staff, and consumer advocates. Using this multi-faceted approach, Bailit concluded that the CommCare program has exhibited sufficient network adequacy. In instances where adequacy concerns were identified, such as for delays in obtaining appointments or wait times at physician's offices, the delays did not appear any greater than those experienced by all other Massachusetts consumers.

The report also recommended that the Health Connector analyze provider overlaps across MMCOs to ensure continued or improved network adequacy. The Health Connector has already begun to examine this issue and will continue to work with the health plans to collect information from members regarding their ability to access care and to ensure the plans continue to meet network adequacy requirements.

MMCO Operational Audit Results
The Health Connector issued an RFP in the summer of 2008 for an operational audit of the CommCare MMCOs. Navigant Consultant was selected to conduct this audit. The results were provided to the Health Connector in late 2008.

The results of the audit informed the re-contracting process for FY10; the Health Connector added elements to the contracts with health plans intended to address areas identified by the audit as in need of improvement. For example, newly included in the contracts are: enhanced Coordination of Benefit (CoB) requirements; a provision requiring the health plan to submit a detailed process describing the co-pay accumulator system used to determine out-of-pocket maximum thresholds and a provision allowing the Health Connector to audit this functionality; a provision requiring health plans to have at least one health/wellness plan in place focused on members with medical and behavioral health issues; new behavioral health access and availability standards that identify appropriate behavioral health wait time standards; and finally, new requirements for health plans to develop policies related to monitoring access and availability of the behavioral health network. These provisions are intended to facilitate continued improvement of enrollee experience in the CommCare program.

Call Center and Premium Billing
In the fall of 2008, the Health Connector successfully transitioned to Perot Systems, a new customer service and premium billing vendor. Several enhancements to member experience accompanied this transition. For example, there were improvements in the first call resolution rate; that is, there was a targeted effort for customer service representatives to resolve members' issues and questions in one phone call to enhance administrative efficiency for members. Similarly, the new customer service center expedited the processing of health plan transfer requests, hardship waivers, and eligibility-related changes. There were also changes designed to simplify the premium billing system for members. Collectively, these changes were implemented with the intent of improving member experience and thus far, member response has been positive.

3.6 CommCare Waivers and Appeals[28]

Since June 2007, the Health Connector has operated a Review and Appeals Unit that responds to three types of waivers and appeals:

- a waiver or reduction of premiums or co-payments due to extreme financial hardship;[29]
- a request to change health plans at a time other than open enrollment; or
- an appeal to challenge decisions related to CommCare.

The specific details about the rules and procedures governing the process for filing requests and appeals are explained in 956 CMR 3.00 et al.

During the past year, from July 2008 to June 2009, there were 1,780 requests to waive or reduce premiums or co-payments, which is more than twice the number of requests received from June 1, 2007 (which is when the Review and Appeals Unit was initiated) through June 30, 2008 (see Table 1 in Appendix 4). This increase is due likely to both greater public awareness of the waiver process and a faltering economy. Among those who have filed requests with the Health Connector Review and Appeals Unit, the majority have been approved. Among those whom have been denied, the primary reason for denial continues to be failure to provide appropriate documentation or evidence of a hardship. Some individuals are requesting a waiver for a premium reduction because of a change in economic status (e.g., a job loss). In these types of instances, where the member has experienced a true "change in status" he/she may be denied a waiver, but often finds relief by seeking a re-determination of eligibility, as this change may likely mean he/she is now eligible for a different plan type (with a lower required premium contribution) or eligible for another state subsidized health insurance program, like MassHealth.

There has been a dramatic reduction – on the order of over 50% - in the number of health plan change requests filed with the Health Connector Review and Appeals Unit when comparing the above referenced time periods (see Table 2 in Appendix 4). This decline is attributable to improved communications with CommCare members, and a successful open enrollment period, both of which helped to decrease the demand for health plan changes during times outside of open enrollment. In addition, as of January 1, 2008, the CommCare regulations were amended to allow enrollees to change plans within 60-days of enrollment without submitting a health plan change request.

There was a considerable increase in the number of CommCare appeals this year (see Table 3 in Appendix 4). This increase was largely a result of a change in the locus of adjudication of these appeals as this responsibility was transferred from MassHealth to the Health Connector. Previously, when an individual appealed the determination that he/she was ineligible for CommCare based on the availability of ESI, the appeal was handled by MassHealth. Beginning in the spring of 2008, the Health Connector assumed this responsibility. Simultaneously, there were other operational process changes that presented individuals applying for government-sponsored insurance programs more opportunities to appeal eligibility for CommCare. These processes were streamlined in the spring of 2009, accompanied with clearer notification, in order to enhance efficiency and minimize premature or moot appeals. At the same time, the economic recession appears to have also impacted CommCare appeals volume, as changes in employment status (and therefore available insurance) led to an increase in the number of individuals who thought they might be eligible for CommCare. In most instances it was determined that the individual had other insurance available to them (e.g., MSP), and therefore was ineligible for CommCare. As a result, consistent with last year's experience, over three quarters of these appeals were "dismissed" because they were resolved, or determined to be without merit, prior to a formal hearing by the Health Connector's Review and Appeals Unit. However, it is important to note that among appeals that went to a hearing, the Health Connector Review and Appeals Unit was able to cut the wait time from receipt of an appeal to a hearing date in half - from nearly 120 to 60 days - as a result of process improvements implemented in the spring of 2009.

4.0 Commonwealth Choice

4.1 Program Description

Commonwealth Choice (CommChoice) is the non-subsidized insurance program established by the Health Connector to facilitate the availability, choice, and purchase of health insurance products for eligible individuals and small groups.

A procurement process is used to solicit health plans offered through the CommChoice program. The Board of the Health Connector awards the Seal of Approval (SoA) to plans it deems to be of good quality and value, and these plans are offered through the CommChoice program. As part of the initial procurement, the Board of the Health Connector awarded the SoA to six health insurance carriers, including: BCBSMA, FCHP, Harvard Pilgrim Health Care (HPHC), Health New England (HNE), NHP, and Tufts Health Plan (THP). Together, they provide coverage to the vast majority of privately insured residents of Massachusetts. In the spring of 2008, the Health Connector renewed contracts with these carriers through December 31, 2009. In April 2009, the Health Connector issued a Request for Responses (RFR) to solicit responses from health plans seeking the Health Connector SoA for plans to be sold through the Health Connector with an effective date of coverage beginning January 1, 2010. This will be discussed in more detail in section 4.4 below.

To help consumers navigate the various products available for purchase through CommChoice, the Health Connector grouped the health plans into four tiers: Gold, Silver, Bronze, and Young Adult Plans (YAPs). Gold, Silver and Bronze plans may be purchased by a person of any age, while YAPs are only available to young adults, ages 18-26. Consistent with the specifications issued in the initial procurement, the first three levels are based on the actuarial value of the plans; the fourth level represents a somewhat slimmer benefit level and is available only to young adults. Below, Table 9 illustrates the range in monthly premium rates for each of these plan levels as of September 2009.

Table 9. Commonwealth Choice Monthly Premium Ranges by Plan Tier. September 2009

	September 2009 Monthly Premium Range*
Gold	$374 - $601
Silver	$299 - $459
Bronze	$214 - $325
Young Adult Plan (with Rx)	$174 - $223
Young Adult Plan (without Rx)	$146 - $198

**The premium range reflected here represents the range in monthly premium costs among those plans available to a single 35-year-old living in the Boston area. For Young Adult Plans, the premium range represents the range in monthly premium rates among those plans available to a single 25-year-old living in the Boston area. Rates are rounded to the nearest whole dollar.*

Beginning in May 2007, individuals (non-group purchasers) were able to shop for health insurance products from the Health Connector for a July 2007 effective date of coverage. Beginning in September 2007, employees without access to ESI were able to purchase a CommChoice health insurance plan with pre-tax dollars, if their employer established an IRS Section 125 plan with the Health Connector. Under this arrangement (known as the Voluntary Program (VP)), the employer does not contribute to the purchase of health insurance, but creates a Section 125 plan to allow part-time, contract, or other employees ineligible for ESI to deduct premium contributions from their gross wages on a pre-tax basis.

This can reduce the net, after-tax costs of health insurance by 28% to 48%, depending on the individual's income tax bracket.

The Health Connector routinely conducts consumer research to help define the products it should offer, member or consumer communication preferences, and the role it should assume. Research to date has included several focus groups, one-on-one interviews, and surveys of consumers (including CommChoice members and non-members) and employers. The results of research conducted in 2007 and 2008 revealed consumers think the role of the Health Connector should be: to provide affordable health plans, to make it easy to research and buy a health plan, and to serve as a trusted resource or advisor for health insurance information.

Focus groups and member surveys suggest that the Health Connector is responding well to this call. For example, in focus groups conducted in July 2008 consumers cited the ease of the shopping experience through the Health Connector. Consumers also reported that state involvement is beneficial, enhancing the perception that the Health Connector is an objective and trustworthy resource. Consumer interviews in November 2008 corroborated these findings, with participants indicating they valued the ability to compare plans backed by an unbiased authority in one online location. This research also highlighted interest in improved account management tools as well as additional decision support tools (such as, for example, a benefit plan selection tool, a cost calculator, and a provider search feature). The Health Connector has responded to this feedback; an e-pay feature for CommChoice members was added to the Health Connector website in the spring of 2009. In addition, the Health Connector has begun to investigate adding a cost comparison tool and a provider directory tool. Finally, in an April 2009 survey of prior CommChoice members (individuals who had cancelled or allowed their coverage to lapse), 60% indicated the cancellation was due to the subscriber becoming eligible for another form of health insurance coverage. The majority of respondents, 60%, indicated they were very satisfied or satisfied with CommChoice and nearly 80% indicated they would recommend CommChoice to a friend.

4.2 Helping Small Employers: Launching the Contributory Plan Pilot

In January 2009, the Health Connector launched a new product for small employers (i.e., 50 or fewer employees) called the Contributory Plan (CP). Through CP, employers may subsidize the purchase of health insurance by their employees through the CommChoice program. This new product is designed to substantially change the health insurance purchasing model for participating small employers and their employees. Under the traditional model, employee choice is generally quite limited; CP is designed to provide employees of small employers significant choice in making their health care purchasing decisions, just as many large employers provide to their employees.

Under CP, an employer first selects one of the coverage tiers available through CommChoice (i.e., Gold, Silver, or Bronze). Next, the employer selects a specific health insurance plan within that tier as the Benchmark Plan, and decides how much it will contribute to the cost of that plan. In order to participate in this program, a small employer must contribute at least 50% toward the Benchmark Plan premium for employees and 25% toward the Benchmark Plan premium for dependents.

After an employer has selected a coverage tier, a benchmark plan, and specified contribution levels, eligible employees may then select either the Benchmark Plan (as selected by the employer) or another available CommChoice plan within the same coverage tier. If an employee chooses a plan other than the Benchmark plan, he/she pays (or pockets) the difference in monthly premium contributions.

Given the substantial differences between the traditional purchasing model for small employers and the CommChoice CP product, CP was launched as a pilot program. Participation is currently restricted to small employers working in conjunction with a broker specially trained by the Health Connector. During the pilot program, only these "pilot brokers" have been able to request rate quotes for CP products.

Quotes may only be provided to existing clients, employers with no broker as of coverage effective date, and/or employers who do not currently offer insurance.

A preliminary evaluation of this pilot has recently been completed. This evaluation included an analysis of: product demand and participation patterns, operational effectiveness of the model, and risk selection associated with the model. The assessment was based on administrative data acquired through enrollment processes as well as through surveys and interviews of employers, employees, brokers, and carriers. Overall, the results of the evaluation were positive, revealing that employees and employers value the option of choice offered by the CP model and that no significant adverse risk selection issues have emerged. However, enrollment in CP is growing more slowly than anticipated for a number of reasons including: some operational challenges for users, the limited choice of insurance products available through the Health Connector (e.g., currently only Health Maintenance Organization (HMO) products are available), the limited distribution channel for this product, and the inherent complexity of the existing model. The evaluation has reinforced the Health Connector's interest in continuing this offering, and also highlighted that some improvements are necessary. Therefore, the Health Connector plans to implement some improvements and gather additional experience with this offering before making it more broadly available to small employers.

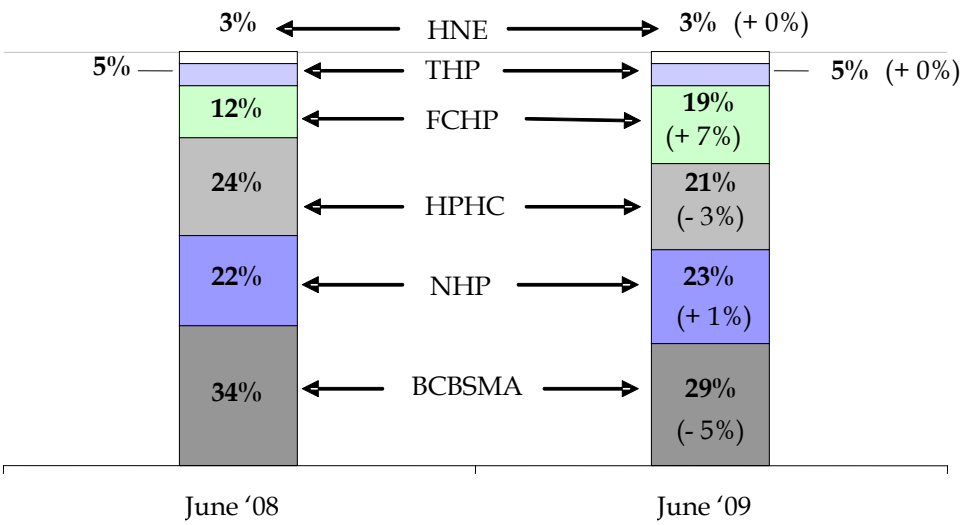
4.3 CommChoice Enrollment

As of July 2009, nearly 22,000 members were enrolled in health insurance policies purchased through the CommChoice program.[30] During FY09, CommChoice enrollment continued to grow steadily, by 3-4% quarterly, except for a 10% surge in membership in the third quarter of FY09.

Enrollment by plan tier
Among CommChoice subscribers, Bronze continues to be the most popular plan tier, representing about 42% of enrollment. YAPs have also remained popular, constituting about 28% of enrollment, followed by Silver (24%) and Gold (7%) plans. Over recent months, the proportion of enrollees in Bronze and YAPs has held relatively steady. At the same time, there has been a small but gradual decrease in the proportion of members in Gold plans and a simultaneous increase in the proportion of members in Silver plans. YAPs are the only plans that are available through the Health Connector which are offered both with and without prescription drug coverage. Among those enrolled in YAPs, about 70% choose a YAP with prescription drug coverage.

Enrollment by carrier
Since program inception, there has been considerable variation in enrollment by carrier. Blue Cross Blue Shield of Massachusetts continues to enroll the largest portion of CommChoice subscribers, accounting for 29% of CommChoice subscribers in July 2009. Neighborhood Health Plan is now the second most popular CommChoice carrier, enrolling nearly a quarter of CommChoice subscribers (23%), followed closely by Harvard Pilgrim Health Care (21%) and Fallon Community Health Plan (19%). Tufts Health Plan offers only a select provider network in the Eastern and Central regions of the state, and has attracted only 5% of CommChoice enrollment. Health New England has the smallest overall enrollment, but actually accounts for 30% of CommChoice membership within its Western Massachusetts service area. As shown in Figure 11, since last year's report the relative share of membership by carrier has changed slightly. Blue Cross Blue Shield of Massachusetts and Harvard Pilgrim Health Care experienced small decreases (despite increases in the absolute number of subscribers), and Neighborhood Health Plan and Fallon Community Health Plan experienced increases.

Figure 11. CommChoice Enrollment by Health Carrier.
June '08 compared to June '09



Enrollment demographics
The proportion of male subscribers (54%) continues to exceed the number of female subscribers (46%) in the CommChoice program. This differential has remained fairly constant over the past year.

The age distribution of CommChoice members has not changed significantly since last year's report. Consistent with the profile of the "typical" uninsured person in Massachusetts, CommChoice subscribers tend to be younger, with a mean age of 37 years old. Individuals in the 18-26 year old age bracket continue to represent the largest cohort of subscribers (30%). As highlighted in last year's report, a high percentage of these individuals (about 85%) choose to purchase YAPs, suggesting the appeal of this product to the young adult population. Subscribers age 27-39 represent about 28% of CommChoice subscribers, followed by those ages 40-52 (23%), and 53 and over (19%).

Enrollment by program type
As of July 2009, there were 15,385 subscribers purchasing insurance through the CommChoice individual/non-group market. This corresponds to nearly 20,000 members and represents approximately 43% of the growth in individual-non group market (as reported for March 2009). Though individual/non-group purchasers represent over 90% of enrollment in the CommChoice program, membership in the VP and CP products continues to rise. As of July 2009, there were nearly 700 employers who had established Section 125 plans and had employees actively using this account. In total, 1,352 employees were taking advantage of the tax savings associated with the Section 125 account by purchasing health insurance through the CommChoice VP product. Finally, just six months into the launch of the pilot, 42 employers and 145 employees had enrolled in the CommChoice CP product.

The merger of the small and non-group insurance markets has increased access to more affordable health insurance products for those purchasing in the non-group market. Many more options are now available, and the non-group market has more than doubled in size (from 40,000 members in June 2006 to 86,000 members as of March 2009). Following passage of health care reform in Massachusetts, an actuarial assessment estimated that as a result of this merger non-group rates would decrease approximately 15% and small group rates would increase approximately 1- 1.5%.[31] In fact, as a result of health care reform, premium prices for those purchasing health insurance through the non-group market have declined roughly 20%, on average, for comparable or better coverage.[32] DHCFP's Health Care Cost Trends project,

expected to be released in December 2009, will include an analysis of premium trends by market segment providing insight into the impact of reform on the small group market.

4.4 Procurement and Seal of Approval Process for Plans with Coverage Effective 1/1/2010

In April 2009, the Health Connector issued an RFR to solicit responses from health plans seeking the Health Connector SoA for plans to be sold through the Health Connector with an effective date of coverage beginning January 1, 2010. Informed by market research data and information garnered through consumer surveys and focus groups conducted in March 2009, the Health Connector dramatically re-structured the procurement process. Previously, the RFR included benefit design specifications for a Gold level plan only and then requested that carriers submit health insurance plans for each of the other tiers (i.e., Silver, Bronze, and YAPs) according to certain actuarial value ranges. As a result, the benefit designs offered in a given tier varied considerably.

Focus groups revealed that consumers felt this array of choice was "confusing" and "overwhelming." Participants expressed a desire for a "manageable" number of plans (e.g., three to four) offered by four to six carriers. In addition, consumers expressed difficulty making plan comparisons under the existing model, given the high level of variability in benefit designs. Instead, consumers preferred for information to be presented in a simple and standardized format that clearly distinguished between different benefit design options. Finally, the surveys and focus groups revealed the information of greatest interest to consumers when purchasing a health insurance plan include: monthly premium cost, co-payments for doctor's office visits, co-pays for prescription drugs, and inclusion of his/her Primary Care Physician (PCP) in the provider network covered by the plan.

In addition to the information collected through surveys and focus groups, the Health Connector also reviewed data pertaining to the distribution of enrollment in the Massachusetts small and non-group market. This analysis highlighted the most popular plan benefit designs in the small and non-group market.

Consistent with the research findings highlighted above, the primary objectives of the RFR issued by the Health Connector in April 2009 were to: align choice of benefit designs and carriers with consumer demand, select and offer high value plans, enhance simplicity of the consumer shopping experience, minimize risk selection, and maintain continuity of coverage for existing CommChoice members. To meet these objectives, the Health Connector maintained the Gold, Silver, Bronze, and YAP tiers and provided specific plan design parameters for all of the products within each of the tiers. The Health Connector stipulated the annual deductible and out-of-pocket maximum amounts, as well as cost-sharing for services such as doctor's office visits, outpatient surgery, ER visits, inpatient hospital admissions, and prescription drugs, among others (see Appendix 5 for detailed plan design specifications). For the most part, carriers were asked to provide plans that would adhere exactly to the plan design specifications included in the RFR; however, there were some "value added" options that allowed carrier variation (from the plan design specifications and possibly across carriers), so long as divergence from the specification resulted in an enhanced benefit for consumers. For example, carriers may waive co-payments for preventive care office visits. Carriers were not required to institute this practice, but several elected to do so.

In June 2009, staff of the Health Connector recommended responses from seven insurance carriers. These included the six incumbent CommChoice carriers (i.e., BCBSMA, FCHP, HPHC, HNE, NHP, and THP) as well as a new health plan, CeltiCare, which also began participating in CommCare as of July 2009. The Board granted the SoA to all plans submitted by these seven carriers as part of their RFR responses.

Under this new model, CommChoice will continue to allow choice among different benefit designs and carriers, but the available options will be streamlined through standardization. For example, under the new model there will be essentially nine benefit designs available through CommChoice, as opposed to

about 27 different options under the existing model. Consequently, this should translate into an easier shopping experience for consumers, making distinctions between different plan benefit designs more apparent. Furthermore, by enhancing transparency across carriers, this approach should enhance price competition.

5.0 Policy and Regulatory Responsibilities

5.1 Minimum Creditable Coverage

The health reform law requires most Massachusetts adults to be covered by an insurance policy that meets Minimum Creditable Coverage (MCC), a particular level of value or standard of benefits. While certain coverage types are designated as meeting creditable coverage by statute (e.g., TriCare, MassHealth, Medicare Parts A or B, etc.), the Board of the Health Connector was charged with developing regulations to define what constitutes MCC for the majority of people covered by commercial insurance.

As described in last year's report, in June 2007, regulations defining MCC were adopted by the Board. Following adoption of the regulations, however, the Health Connector received additional comments from employers, administrators of union-sponsored plans, health insurers, and individuals requesting clarification of certain MCC provisions and/or flexibility in the application of certain standards. In an effort to address some of these concerns and to minimize the number of tax-payers that might be subject to the penalty despite having robust and comprehensive insurance coverage, the Board adopted revised regulations in October 2008. These revised regulations provided enhanced flexibility to enable employers, unions, and health carriers to demonstrate that their plans meet the intent of the standards, while ensuring plans deemed MCC compliant provide "real" health insurance coverage.[33]

For example, the revised regulations included a provision that allows the Health Connector to review a collectively-bargained health plan in force as of January 1, 2009 and, at its discretion, determine that the plan is compliant with MCC for up to one year following the expiration of the collectively-bargained agreement. Also included in the regulations is a provision that allows carriers or plan sponsors to request Health Connector certification of MCC compliance in instances where a plan does not meet every element of the regulations, but does provide sufficiently robust and comprehensive coverage so as to meet the intent of the MCC standards. These provisions became effective January 1, 2009. As of August 1, 2009, the Health Connector has reviewed approximately 475 plans, granting MCC certification to about 380 and denying certification to about 15. Approximately 80 plans that were submitted were dismissed by the Health Connector as there was no apparent deviation from the MCC standards.

The amended regulations also included a few elements that raised the MCC standards from those initially adopted by the Board in 2007. For example, the "broad range of medical benefits" for which a health plan must provide coverage was expanded to include diagnostic imaging and screening, maternity and newborn care, medical/surgical care, and radiation therapy and chemotherapy. The regulations also sought to clarify acceptable benefit limits on some of the "broad range" of medical benefits covered by the plan in response to specific inquiries on this topic. In addition, the regulations added elements pertaining to High Deductible Health Plans (HDHPs), including that HDHPs provide a broad range of medical benefits and that preventive care services are covered prior to the deductible, to the degree that it is not inconsistent with federal regulations. These requirements, however, will not become effective until January 1, 2010.

Establishing MCC standards has been a groundbreaking initiative; no other state has undertaken such an endeavor. These revisions, particularly the decision to delay imposition of more stringent requirements until January 2010, are illustrative of the phased approach adopted by the Board for implementation of these regulations. The Board is committed to minimizing unnecessary disruption to ESI and to providing employers, plan administrators, health insurers, and individuals sufficient time to transition to plans that meet new requirements. Revisiting and adjusting the MCC regulations highlights the experimental nature of reform, and the Health Connector's role as a learning organization.

5.2 Individual Mandate and the Affordability Schedule

Another regulatory task delegated to the Health Connector is the establishment and annual update of an affordability schedule. The affordability schedule specifies maximum affordable monthly premiums (for an MCC compliant plan) for individuals, couples and families based on a progressive, sliding scale of income.[34] The affordability schedule is used to determine application of the individual mandate. Under this schedule, an adult will be considered able to purchase affordable health insurance if the monthly contribution to ESI or the monthly premium for the lowest cost insurance plan available through the Health Connector does not exceed the corresponding maximum monthly premium for his or her income bracket.

In February 2009, the Board approved an updated affordability schedule for calendar year 2009 (see Table 10, Table 11, and Table 12).[35] The schedule adopted in 2009 included changes to all income ranges and changes to the maximum monthly premium contributions for those with income above 300% FPL.

Table 10. Affordability schedule for INDIVIDUALS

2008			2009		
Annual Gross Income	**Maximum Monthly Premium**		**Annual Gross Income**	**Maximum Monthly Premium**	**Amount increase from 2008**
$0 - $15,612	$0		$0 - $16,248	$0	$0
$15,613 - $20,808	$39		$16,249 - $21,660	$39	$0
$20,809 - $26,016	$77		$21,661 - $27,084	$77	$0
$26,017 - $31,212	$116		$27,085 - $32,496	$116	$0
$31,213 - $37,500	$165		$32,497 - $39,000	$171	$6
$37,501 - $42,500	$220		$39,001 - $44,200	$228	$8
$42,501 - $52,500	$330		$44,201 - $54,600	$342	$12
>$52,500	n/a		>$54,600	n/a	n/a

Table 11. Affordability schedule for COUPLES

2008			2009		
Annual Gross Income	**Maximum Monthly Premium**		**Annual Gross Income**	**Maximum Monthly Premium**	**Amount increase from 2008**
$0 - $21,012	$0		$0 - $21,864	$0	$0
$21,013 - $28,008	$78		$21,865 - $29,148	$78	$0
$28,009 - $35,016	$154		$29,149 - $36,432	$154	$0
$35,017 - $42,012	$232		$36,433 - $43,716	$232	$0
$42,013 - $52,500	$297		$43,717 - $54,600	$307	$10
$52,501 - $62,500	$396		$54,601 - $65,000	$410	$14
$62,501 - $82,500	$550		$65,001 - $85,800	$569	$19
>$82,500	n/a		>$85,800	n/a	n/a

Table 12. Affordability schedule for FAMILIES					
2008			2009		
Annual Gross Income	Maximum Monthly Premium		Annual Gross Income	Maximum Monthly Premium	Amount increase from 2008
$0 - $26,412	$0		$0 - $27,468	$0	$0
$26,413 - $35,208	$78		$27,469 - $36,624	$78	$0
$35,209 - $44,016	$154		$36,625 - $45,780	$154	$0
$44,017 - $52,812	$232		$45,781 - $54,936	$232	$0
$52,813 - $70,000	$352		$54,937 - $72,800	$364	$12
$70,001 - $90,000	$550		$72,801 - $93,600	$569	$19
$90,001 - $110,000	$792		$93,601 - $114,400	$820	$28
>$110,000	n/a		>$114,400	n/a	n/a

The Health Connector website offers an interactive affordability tool to assist individuals in determining if an affordable plan is available to them. A paper version is also available.

Penalty schedule for failure to comply with the individual mandate
Effective July 1, 2007, most adult residents of Massachusetts are required to have minimum creditable health insurance coverage. If it is determined that an individual has access to an affordable insurance plan but does not obtain it, then a penalty is assessed when the individual files a tax return.[36] In the first year of the mandate, individuals were required to indicate if they had insurance as of December 31, 2007 (rather than July 1, 2007).[37] As was defined in statute, the penalty for noncompliance with the individual mandate in 2007 was the loss of one's personal income tax exemption, or $219. As highlighted in section 2.2 of this report, data from DOR illustrate strong compliance with the individual mandate requirement in tax year 2007, as over 95% of tax-filers had health insurance coverage in 2007.

The reform legislation authorized a higher maximum penalty starting in January 2008 of up to 50% of the insurance premium for creditable coverage for every month the individual fails to comply with the mandate.[38] In filing 2008 tax returns, individuals were required to indicate whether they had coverage in each month of 2008. For individuals not complying with the mandate, the DOR, in consultation with the Health Connector, established a penalty schedule in 2008. This schedule was updated for 2009.

In developing tax penalties for 2009, to ensure simplicity and fairness, the penalty is equal to no more than half of the monthly premium for the lowest priced CommCare plan as of January 2008 for individuals with income up to 300% FPL.[39] Individuals earning up to 150% FPL will not be penalized because the premium contribution for CommCare for people in this income bracket is $0.

For adults up to age 26 whose income is above 300% FPL, the penalty is equal to half the monthly premium of the lowest cost Young Adult Plan without prescription drug coverage offered through the Health Connector's CommChoice program using January 2009 premium rates.

For adults 27 and older whose income is above 300% FPL, the penalty is equal to half of the monthly premium for the lowest cost Bronze plan using January 2009 premium rates. The table below summarizes the penalty schedule for 2009.

Table 13. Penalty Schedule for Failure to Comply with the Individual Mandate. 2009		
	per month	**per year***
150.1-200% FPL	$17	$204
200.1-250% FPL	$35	$420
250.1-300% FPL	$52	$624
Above 300% FPL. Age 18-26	$52	$624
Above 300% FPL. Age 27+	$89	$1,068
**If the individual is without insurance for all twelve months of the year.*		

The individual mandate appeals

If the affordability schedule indicates that an affordable plan was available, but an individual feels that because of a hardship or extenuating circumstances insurance was not affordable, he/she can file an appeal to request a waiver of the mandate based on hardship.

The appeals data pertaining to tax year 2008 are preliminary, but to date, among over three million tax-filers in tax year 2008, fewer than 7,000 have indicated the intent to appeal the penalty for failure to have health insurance. This represents a slight decline in the number of appeals as compared to those associated with tax year 2007, and likely reflects the higher penalties for failure to comply with the individual mandate that began in January 2008. Given the large proportion of pending appeals for tax year 2008, it is too early to compare the outcomes of appeals between tax year 2007 and 2008.

6.0 Concluding Comments

Health reform has helped hundreds of thousands of Massachusetts residents. Throughout the past year, the Health Connector has accomplished much with respect to the implementation and ongoing administration of key elements of reform.

The experience in Massachusetts has had clear impacts on the national health reform debate. Key proposals emerging from both the House and the Senate draw heavily on the experience in Massachusetts, incorporating the philosophy of "shared responsibility" which was critical to passage of chapter 58 in Massachusetts. Moreover, though the details differ and will continue to evolve as the debate unfolds, many of the policy options being debated now in the U.S. Congress include elements of the Massachusetts model: an individual mandate, new requirements for employers, expansion of public programs, government sponsored subsidies for private insurance, insurance market reforms, and insurance exchanges.

As the national debate intensifies, the Massachusetts experience has become increasingly politicized. Those opposed to national reform efforts have routinely attacked the Massachusetts model, arguing it is unaffordable, ineffective (i.e., the number of uninsured in Massachusetts remains high despite the law), unpopular, and has resulted in public coverage "crowding out" private insurance. These arguments have fueled opposition to reform, often based on erroneous information or misrepresentation of the Massachusetts experience. The Health Connector and several other Massachusetts stakeholders have aligned efforts to respond to such rhetoric with information that accurately reflects the experience in Massachusetts. To that end, the Health Connector has recently published a document designed to dispel the top ten myths of health reform (see Appendix 6).

Health Connector staff are dedicated to sharing lessons and best practices with other state and national policymakers interested in elements of the Massachusetts model. In addition, the Health Connector strives to be innovative and creative in its efforts to inform citizens of the individual mandate and to facilitate access to insurance coverage options. In recognition of these attributes, the Ash Institute at Harvard University's Kennedy School has recently awarded the Health Connector an "Innovations in American Government" award. As the Institute describes, "this award program is designed to promote excellence in the public sector and seeks to demonstrate that government can work to improve the quality of life for citizens. By highlighting exemplary models of governments' innovative performance, the program serves as a catalyst for continued progress in addressing the nation's most pressing public concerns." Among over a thousand applicants, the Health Connector was selected as one of six award winners and will receive a grant to disseminate its experiences and best practices to other government agencies across the country.

Though Massachusetts and the Health Connector have accomplished many successes, challenges remain. In particular, the rate of growth in the cost of health care for everyone in Massachusetts continues to be of critical concern. The Health Connector will continue to work with the health carriers participating in both the CommCare and CommChoice programs to identify ways to slow the rise in these health care premiums, but these are just a very small share of overall health care spending in Massachusetts. Fundamental reform of financial incentives in health care will be necessary to begin to reign in overall health care spending and thereby sustain near-universal health insurance coverage.

Recognizing this, the state has begun to tackle the issue of cost as the next phase of reform. In 2008, the Legislature authorized and the Governor appointed a special commission charged with developing recommendations for comprehensive payment reform. The proposals released by the commission in July 2009 would dramatically alter existing payment systems, moving from a predominantly fee-for-service based system to a global payment based system. Rather than the current fee-for-service system that rewards doctors and hospitals for increased health care utilization, a global payment model offers

incentives for efficiency in the delivery of services, and encourages improvements in quality and access to appropriate, coordinated care. A global payment model will help reign in health care costs and promote coordinated care.[40] Most experts agree with the panel recommendations and the hospitals, insurers and doctors on the special commission voted for it, an encouraging sign of support for this reform strategy.

APPENDIX 1: Abbreviations

The following abbreviations are used in this report:

BCBSMA ..... Blue Cross Blue Shield of Massachusetts
BMC ..... Boston Medical Center
Board ..... Board of the Commonwealth Health Insurance Connector Authority
CeltiCare ..... CeltiCare Health Plan
CoB..... Coordination of Benefit
CommCare ..... Commonwealth Care
CommChoice ..... Commonwealth Choice
CP ..... Contributory Plan
DHCFP ..... Division of Health Care Finance & Policy
DOR ..... Massachusetts Department of Revenue
ER..... Emergency Room
ESI ..... Employer-Sponsored Insurance
FCHP ..... Fallon Community Health Plan
FPL ..... Federal Poverty Level
FY ..... Fiscal Year
HDHP..... High Deductible Health Plan
Health Connector ..... Commonwealth Health Insurance Connector Authority
HIS ..... Health Insurance Survey
HNE ..... Health New England
HPHC ..... Harvard Pilgrim Health Care
HSN ..... Health Safety Net Fund
HSPH ..... Harvard School of Public Health
LIC ..... Limited Income Credit
MCC ..... Minimum Creditable Coverage
MSP ..... Medical Security Plan
MTF ..... Massachusetts Taxpayers Foundation
MMCO ..... Medicaid Managed Care Organizations
NHP ..... Neighborhood Health Plan
NTS ..... No Tax Status
PMPM ..... Per Member Per Month
PCP ..... Primary Care Physician
QSHIP ..... Qualifying Student Health Insurance Plan
RFP ..... Request for Proposals
RFR ..... Request for Responses
SoA ..... Seal of Approval
THP ..... Tufts Health Plan
UCP ..... Uncompensated Care Pool
VP ..... Voluntary Plan
YAP ..... Young Adult Plan

APPENDIX 2: CommCare Member Benefits and Co-Payments

Health Benefits and Copays - Plan Type I effective 7/1/09

Benefit	Copay
Outpatient care	
Office visit to your primary care provider (PCP)	$0
Office visit to a specialist	$0
Radiology, imaging (x-rays), lab work	$0
Outpatient surgery at a hospital or ambulatory surgery center	$0
Abortion	$0
Inpatient care	
Hospital stay, may include surgery, x-rays, lab services, and room and board (copay is per stay)	$0
Emergency care	
Emergency room visit	$0
Prescription drugs	
30 day supply from a pharmacy	
• Generic drug	$1* /$2
• Drug on your plan's preferred list	$3
• Drug not on your plan's preferred list	$3
Alcohol, drug abuse and mental health care	
Outpatient or office visit	$0
Inpatient care (copay is per stay)	$0
Methadone maintenance (dosing, counseling, screens)	$0
Dental	
Check-ups/cleanings/fillings/X-rays/restorations	$0
Vision	
Eye exam every 24 months	$0
Free glasses every 24 months	$0
Diabetes care	
Office visit to PCP or podiatrist for routine foot care (may include foot orthotics)	$0
Visit to specialist (may include foot orthotics)	$0
Rehabilitation services	
Extended inpatient care (100 total days per year)	$0
• In a skilled nursing facility	$0
• In a rehabilitation hospital or chronic disease hospital (copay is per stay)	$0
Physical therapy, speech or hearing therapy, pulmonary or occupational therapy (need plan approval for more than 20 visits)	$0
Cardiac rehabilitation	$0
Home health care	$0
Maternity and family planning	
Outpatient office visit	$0
Other benefits	
Ambulance (emergency only)	$0
Prosthetics, oxygen and respiratory therapy equipment, other durable medical equipment	$0
Hospice	$0
Maximum copays	
Maximum amount a member will need to pay for all prescriptions in a benefit year **	$200
Maximum amount a member will need to pay for services excluding prescription drugs in a benefit year **	$0

** Limited to generic prescription drugs for high blood pressure, high cholesterol and diabetes*
*** The benefit year is from July 1, 2009 – June 30, 2010.*

Health Benefits and Copays - Plan Type 2 effective 7/1/09

Benefit	Copay
Outpatient care	
Office visit to your primary care provider (PCP)	$10
Office visit to a specialist	$18
Radiology, imaging (x-rays), lab work	$0
Outpatient surgery at a hospital or ambulatory surgery center	$50
Abortion	$50
Inpatient care	
Hospital stay, may include surgery, x-rays, lab services, and room and board (copay is per stay)	$50 *
Emergency care	
Emergency room visit (no copay if you are admitted to the hospital)	$50
Prescription drugs	
30 day supply from a pharmacy	
• Generic drug	$10
• Drug on your plan's preferred list	$20
• Drug not on your plan's preferred list	$40
3-month supply, by mail	
• Generic drug	$20
• Drug on your plan's preferred list	$40
• Drug not on your plan's preferred list	$120
Alcohol, drug abuse and mental health care	
Outpatient or office visit	$10
Inpatient care (copay is per stay)	$50 *
Methadone maintenance (dosing, counseling, screens)	$0
Vision	
Eye exam every 24 months	$10
Free glasses every 24 months	$0
Diabetes care	
Office visit to PCP or podiatrist for routine foot care (may include foot orthotics)	$5
Visit to specialist (may include foot orthotics)	$10
Rehabilitation services	
Extended inpatient care (100 total days per year)	
• In a skilled nursing facility	$0
• In a rehabilitation hospital or chronic disease hospital (copay is per stay)	$50 *
Physical therapy, speech or hearing therapy, pulmonary or occupational therapy (need plan approval for more than 20 visits)	$10
Cardiac rehabilitation	$0
Home health care	$0
Maternity and family planning	
Outpatient office visit	$0
Other benefits	
Ambulance (emergency only)	$0
Prosthetics, oxygen and respiratory therapy equipment, other durable medical equipment	$0
Hospice	$0
Maximum copays	
Maximum amount a member will need to pay for all prescriptions in a benefit year **	$500
Maximum amount a member will need to pay for services excluding prescription drugs in a benefit year **	$750

** Copay waived if transferred from another inpatient unit*
*** The benefit year is from July 1, 2009 – June 30, 2010.*

Health Benefits and Copays - Plan Type 3 effective 7/1/09

Benefit	Copay
Outpatient care	
Office visit to your primary care provider (PCP)	$15
Office visit to a specialist	$22
Radiology, imaging (x-rays), lab work	$0
Outpatient surgery at a hospital or ambulatory surgery center	$125
Abortion	$100
Inpatient care	
Hospital stay, may include surgery, x-rays, lab services, and room and board (copay is per stay)	$250 *
Emergency care	
Emergency room visit (no copay if you are admitted to the hospital)	$100
Prescription drugs	
30 day supply from a pharmacy	
• Generic drug	$12.50
• Drug on your plan's preferred list	$25
• Drug not on your plan's preferred list	$50
3-month supply, by mail	
• Generic drug	$25
• Drug on your plan's preferred list	$50
• Drug not on your plan's preferred list	$150
Alcohol, drug abuse and mental health care	
Outpatient or office visit	$15
Inpatient care (copay is per stay)	$250 *
Methadone maintenance (dosing, counseling, screens)	$0
Vision	
Eye exam every 24 months	$20
Free glasses every 24 months	$0
Diabetes care	
Office visit to PCP or podiatrist for routine foot care (may include foot orthotics)	$10
Visit to specialist (may include foot orthotics)	$20
Rehabilitation services	
Extended inpatient care (100 total days per year)	
• In a skilled nursing facility	$0
• In a rehabilitation hospital or chronic disease hospital (copay is per stay)	$250 *
Physical therapy, speech or hearing therapy, pulmonary or occupational therapy (need plan approval for more than 20 visits)	$20
Cardiac rehabilitation	$0
Home health care	$0
Maternity and family planning	
Outpatient office visit	$0
Other benefits	
Ambulance (emergency only)	$0
Prosthetics, oxygen and respiratory therapy equipment, other durable medical equipment.	10%
Hospice	$0
Maximum copays	
Maximum amount a member will need to pay for all prescriptions in a benefit year **	$800
Maximum amount a member will need to pay for services excluding prescription drugs in a benefit year **	$1500

** Copay waived if transferred from another inpatient unit*
*** The benefit year is from July 1, 2009– June 30, 2010.*

APPENDIX 3: CommCare Program Integrity Activities

Re-determination
The Health Connector initiated annual eligibility re-determinations beginning in late 2007. Under this process, information that impacts a member's eligibility is updated (e.g., income, household size, the availability of other health insurance, etc.). This process is critical to ensure that the program is meeting state and federal requirements, and to ensure that individuals are enrolled in the most appropriate health insurance program for their circumstances. To date (as of June 2009), about 68,000 members have been closed through the re-determination process and the number of members closed as a result of re-determination has stabilized around 3,000 per month in the last few months.

Department of Revenue (DOR) Match
Another practice designed to protect the integrity of the CommCare program is a system whereby DOR provides MassHealth a file indicating changes in the reported income of Massachusetts residents. As part of the eligibility monitoring process, throughout the year information provided by DOR is compared with membership in MassHealth and CommCare. Differences between information contained on the DOR file and the CommCare membership file prompt the Health Connector to contact the member with a discrepancy to determine what income changes, if any, have occurred. This process not only re-determines eligibility, but ensures if an individual is still eligible for CommCare or MassHealth that they are enrolled in the most appropriate program or Plan Type. For example, a job change might result in a change in income, causing an individual to qualify for a different Plan Type (e.g., subsidy or benefit level) within CommCare.

In addition to the aforementioned process, MassHealth and DOR also conduct a14-day new hire match. The purpose of this match is to identify persons who may be actively receiving a subsidized insurance benefit through MassHealth or CommCare, who have not reported a new job to MassHealth. If this type of match is found, additional information is requested from the impacted individual, and, if necessary, eligibility is re-determined.

Screening for Access to Employer-Sponsored-Insurance (ESI)
In an effort to minimize crowd-out, the eligibility process for CommCare requires individuals to indicate if they currently have ESI or had access to ESI in the last six months. If an individual provides a positive response to this question, or provides information that suggests this possibility, the Connector follows up directly with the applicant to obtain additional information to verify if ESI is available, and if so, if there is an exception under which they might still be eligible for CommCare.[41] In this circumstance, the individual would not be enrolled in CommCare until the Health Connector is in receipt of the exception letter explaining why he/she may be eligible for CommCare (despite the initial positive response to the question pertaining to ESI) and the claimed exception has been validated. A recent Health Connector analysis of this process revealed in 97% of investigated cases involving part-time workers (defined as working 100 hours or less per month), requisite information indicating eligibility for CommCare was provided. As a result of this experience and analysis, as of March 2009, this process was modified to allow part-time workers to become eligible for CommCare prior to the Health Connector's receipt of the exception letter information.

Access to ESI is also re-evaluated as part of the re-determination process. As a result of the Health Connector's experience, this process was also modified beginning in April 2009. Historically, if the re-determination process revealed a change with respect to access to ESI, the individual would be terminated from CommCare, pending receipt of the letter explaining why he/she may be eligible for CommCare, despite the positive response to the question pertaining to ESI. In the vast majority of these cases, individuals were re-enrolled in CommCare because they provided sufficient evidence of their continued eligibility. Consequently, now, if a question regarding a change in access to ESI arises during the re-determination process, an individual is still sent a letter requesting documentation regarding the ESI access and his/her continued eligibility for CommCare, but he/she remains in the CommCare

program so long as he/she responds within thirty days with the necessary information. This revised process enhances continuity for the member, while also ensuring maintenance of program integrity.

APPENDIX 4: CommCare Waivers and Appeals

Table 1. CommCare Waivers Requests (for premium or co-pay reduction)				
	June 1, 2007 [1] - June 30, 2008		**July 1, 2008 - June 30, 2009**	
	#	**%**	**#**	**%**
Total:	**722**		**1,780**	
# approved:	344	48%	939	53%
# denied:	221	31%	841	47%
# dismissed:	10	1%	0	0%
# pending:[2]	147	20%	0	0%

[1] June 1, 2007 is when the waiver and appeals program began.

[2] The requests that were pending on June 30, 2008 were resolved and appear in the following time period of July 1, 2008 - June 30, 2009.

Table 2. CommCare Health Plan Change Requests				
	June 1, 2007 [1] - June 30, 2008		**July 1, 2008 - June 30, 2009**	
	#	**%**	**#**	**%**
Total:	**507**		**227**	
# approved:	283	56%	204	90%
# denied:	209	41%	1	0%
# dismissed:	13	3%	19	8%
# pending:[2]	2	0%	3	1%

[1] June 1, 2007 is when the waiver and appeals program began.

[2] The requests that were pending on June 30, 2008 were resolved and appear in the following time period of July 1, 2008 - June 30, 2009.

Table 3. CommCare Appeals				
	June 1, 2007 [1] - June 30, 2008		**July 1, 2008 - June 30, 2009**	
	#	**%**	**#**	**%**
Total:	**1,193**		**5,668**	
# approved:	6	1%	80	1%
# denied:	6	1%	347	6%
# dismissed:	811	68%	4,315	76%
# pending:[2]	370	31%	926	16%

[1] June 1, 2007 is when the waiver and appeals program began.

[2] The appeals that were pending on June 30, 2008 were resolved and appear in the following time period of July 1, 2008 - June 30, 2009.

APPENDIX 5: CommChoice Plan Design Specifications for 1/1/2010

Gold Plan Design

PLAN FEATURE / SERVICE	CO-PAYMENT
Annual Deductible	None
Annual Out-of-Pocket Maximum	Unlimited
Outpatient Medical Care	
PCP Office Visit	$20
Specialist Office Visit	$30
Outpatient Surgery	$150
Diagnostic X-rays / Labs	$25
Inpatient Medical Care	
Room and Board (includes deliveries / surgeries / x-rays / labs)	$150
Prescription Drugs	
Prescription Drug Deductible (i.e., Rx deductible)	None
Retail (up to 30-day supply) (generic / preferred brand / non-preferred brand)	$15 / $30 / $50
Mail order (up to 90-day supply) (generic / preferred brand / non-preferred brand)	$30 / $60 / $150
Emergency Room (co-payment is waived if ER visit results in hospital admission)	$75
Outpatient Mental Health (non-biologically based conditions)	$20
Rehabilitation Services Inpatient Skilled Nursing Facility (SNF) / Inpatient rehabilitation hospital	$150
Other Benefits	
Ambulance (emergency only)	No charge
Routine Vision Exam	$30

Silver Plan Design A

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	None
Annual Out-of-Pocket Maximum	$2,000 per individual, $4,000 per family
Outpatient Medical Care	
PCP Office Visit	$25
Specialist Office Visit	$25
Outpatient Surgery	$500
Diagnostic X-rays / Labs	$0
Inpatient Medical Care	
Room and Board (includes deliveries / surgeries / x-rays / labs)	$500
Prescription Drugs	
Prescription Drug Deductible (i.e., Rx deductible)	None
Retail (up to 30-day supply) (generic / preferred brand / non-preferred brand)	$15 / 50% co-insurance / 50% co-insurance
Mail order (up to 90-day supply) (generic / preferred brand / non-preferred brand)	$30 / 50% co-insurance / 50% co-insurance
Emergency Room (co-payment is waived if ER visit results in hospital admission)	$100
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services Inpatient Skilled Nursing Facility (SNF) / Inpatient rehabilitation hospital	$500
Other Benefits	
Ambulance (emergency only)	No charge
Routine Vision Exam	$25

Silver Plan Design B

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$500 per individual, $1,000 per family
Annual Out-of-Pocket Maximum	$2,000 per individual, $4,000 per family
Outpatient Medical Care	
PCP Office Visit	$20
Specialist Office Visit	$20
Outpatient Surgery	deductible, then $0
Diagnostic X-rays/Labs	deductible, then $0
Inpatient Medical Care	
Room and Board (includes deliveries / surgeries / x-rays / labs)	deductible, then $0
Prescription Drugs	
Prescription Drug Deductible (i.e., Rx deductible)	None
Retail (up to 30-day supply) (generic / preferred brand / non-preferred brand)	$15 / $35 / $60
Mail order (up to 90-day supply) (generic / preferred brand / non-preferred brand)	$30 / $70 / $120
Emergency Room (co-payment is waived if ER visit results in hospital admission)	$100
Outpatient Mental Health (non-biologically based conditions)	$20
Rehabilitation Services Inpatient Skilled Nursing Facility (SNF) / Inpatient rehabilitation hospital	deductible, then $0
Other Benefits	
Ambulance (emergency only)	deductible, then $0
Routine Vision Exam	$20

Silver Plan Design C

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$1,000 per individual, $2,000 per family
Annual Out-of-Pocket Maximum	$2,000 per individual, $4,000 per family
Outpatient Medical Care	
PCP Office Visit	$20
Specialist Office Visit	$20
Outpatient Surgery	deductible, then $0
Diagnostic X-rays/Labs	deductible, then $0
Inpatient Medical Care	
Room and Board (includes deliveries / surgeries / x-rays / labs)	deductible, then $0
Prescription Drugs	
Prescription Drug Deductible (i.e., Rx deductible)	None
Retail (up to 30-day supply) (generic / preferred brand / non-preferred brand)	$15 / $30 / $50
Mail order (up to 90-day supply) (generic / preferred brand / non-preferred brand)	$30 / $60 / $150
Emergency Room (co-payment is waived if ER visit results in hospital admission)	deductible, then $100
Outpatient Mental Health (non-biologically based conditions)	$20
Rehabilitation Services Inpatient Skilled Nursing Facility (SNF) / Inpatient rehabilitation hospital	deductible, then $0
Other Benefits	
Ambulance (emergency only)	deductible, then $0
Routine Vision Exam	$20

Bronze Plan Design A

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$250 per individual, $500 per family
Annual Out-of-Pocket Maximum	$5,000 per individual, $10,000 per family
Outpatient Medical Care	
PCP Office Visits	$25
Specialist Office Visit	$40
Outpatient Surgery	deductible, then 35% co-insurance
Diagnostic X-rays / Labs	deductible, then 35% co-insurance
Inpatient Medical Care Room and Board (includes deliveries / surgeries / x-rays / labs)	deductible, then 35% co-insurance
Prescription Drugs Prescription Drug Deductible (i.e., Rx deductible)	$250 per individual, $500 per family (for Tiers 2 and 3; for Retail and Mail order)
Retail (up to 30-day supply) (generic / preferred brand / non-preferred brand)	$15 / Rx deductible, then 50% co-insurance / Rx deductible, then 50% co-insurance
Mail order (up to 90-day supply) (generic/preferred brand/non-preferred brand)	$30 / Rx deductible, then 50% co-insurance / Rx deductible, then 50% co-insurance
Emergency Room (co-payment is waived if ER visit results in hospital admission)	$150
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services Inpatient Skilled Nursing Facility (SNF) / Inpatient rehabilitation hospital	deductible, then 35% co-insurance
Other Benefits Ambulance (emergency only)	deductible, then 35% co-insurance
Routine Vision Exam	$15

Bronze Plan Design B

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$2,000 per individual, $4,000 per family
Annual Out-of-Pocket Maximum	$5,000 per individual, $10,000 per family
Outpatient Medical Care	
PCP Office Visit	$30
Specialist Office Visit	$45
Outpatient Surgery	deductible, then $250
Diagnostic X-rays / Labs	deductible, then $0
Inpatient Medical Care Room and Board (includes deliveries / surgeries / x-rays / labs)	deductible, then $500
Prescription Drugs Prescription Drug Deductible (i.e., Rx deductible)	$250 per individual, $500 per family (for Tiers 2 and 3; for Retail and Mail order)
Retail (up to 30-day supply) (generic / preferred brand / non-preferred brand)	$10 / Rx deductible, then $30 / Rx deductible, then $50
Mail order (up to 90-day supply) (generic / preferred brand / non-preferred brand)	$20 / Rx deductible, then $60 / Rx deductible, then $90
Emergency Room (co-payment is waived if ER visit results in hospital admission)	deductible, then $150
Outpatient Mental Health (non-biologically based conditions)	$30
Rehabilitation Services Inpatient Skilled Nursing Facility (SNF) / Inpatient rehabilitation hospital	deductible, then $500
Other Benefits	
Ambulance (emergency only)	deductible, then $0
Routine Vision Exam	$30

Bronze Plan Design C
HSA compliant

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$2,000 per individual, $4,000 per family
Annual Out-of-Pocket Maximum	$5,000 per individual, $10,000 per family
Outpatient Medical Care PCP Office Visit	deductible, then $25
Specialist Office Visit	deductible, then $25
Outpatient Surgery	deductible, then 20% co-insurance
Diagnostic X-rays / Labs	deductible, then 20% co-insurance
Inpatient Medical Care Room and Board (includes deliveries / surgeries / x-rays / labs)	deductible, then 20% co-insurance
Prescription Drugs Prescription Drug Deductible (i.e., Rx deductible)	None
Retail (up to 30-day supply) (generic / preferred brand / non-preferred brand)	deductible, then $15 / deductible, then 50% co-insurance / deductible, then 50% co-insurance
Mail order (up to 90-day supply) (generic / preferred brand / non-preferred brand)	deductible, then $30 / deductible, then 50% co-insurance / deductible, then 50% co-insurance
Emergency Room (co-payment is waived if ER visit results in hospital admission)	deductible, then $100
Outpatient Mental Health (non-biologically based conditions)	deductible, then $25
Rehabilitation Services Inpatient Skilled Nursing Facility (SNF) / Inpatient rehabilitation hospital	deductible, then 20% co-insurance
Other Benefits Ambulance (emergency only)	deductible, then 20% co-insurance
Routine Vision Exam	deductible, then $25

Young Adults Plan Design A (offered with and without Prescription Drug Coverage)

PLAN FEATURE / SERVICE	COST-SHARING
Annual Deductible	$250
Annual Out-of-Pocket Maximum	$5,000
Outpatient Medical Care	
PCP Office Visit	$25
Specialist Office Visit	$25
Outpatient Surgery	deductible, then 30% co-insurance
Diagnostic X-rays / Labs	deductible, then 30% co-insurance
Inpatient Medical Care Room and Board (includes deliveries / surgeries / x-rays / labs)	deductible, then 30% co-insurance
Prescription Drugs	
Prescription Drug Deductible (i.e., Rx deductible)	None
Retail (up to 30-day supply) (generic / preferred brand / non-preferred brand)	$15 / 50% co-insurance / 50% co-insurance
Mail order (up to 90-day supply) (generic / preferred brand / non-preferred brand)	$30 / 50% co-insurance / 50% co-insurance
Emergency Room (co-payment is waived if ER visit results in hospital admission)	$250
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services Inpatient Skilled Nursing Facility (SNF) / Inpatient rehabilitation hospital	deductible, then 30% co-insurance
Other Benefits	
Ambulance (emergency only)	deductible, then 30% co-insurance
Routine Vision Exam	$10

Young Adults Plan Design B (offered with and without Prescription Drug Coverage)

PLAN FEATURE/SERVICE	COST-SHARING
Annual Deductible	$2,000
Annual Out-of-Pocket Maximum	$5,000
Outpatient Medical Care	
PCP Office Visit	$25
Specialist Office Visit	$25
Outpatient Surgery	deductible, then 20% co-insurance
Diagnostic X-rays / Labs	deductible, then 20% co-insurance
Inpatient Medical Care Room and Board (includes deliveries / surgeries / x-rays / labs)	deductible, then 20% co-insurance
Prescription Drugs Prescription Drug Deductible (i.e., Rx deductible)	$250 (for Tiers 2 and 3; for Retail only)
Retail (up to 30-day supply) (generic/preferred brand/non-preferred brand)	$15 / Rx deductible, then 50% co-insurance / Rx deductible, then 50% co-insurance
Mail order (up to 90-day supply) (generic / preferred brand / non-preferred brand)	$30 / 50% co-insurance / 50% co-insurance
Emergency Room (co-payment is waived if ER visit results in hospital admission)	$250
Outpatient Mental Health (non-biologically based conditions)	$25
Rehabilitation Services Inpatient Skilled Nursing Facility (SNF) / Inpatient rehabilitation hospital	deductible, then 20% co-insurance
Other Benefits	
Ambulance (emergency only)	deductible, then 20% co-insurance
Routine Vision Exam	$25

APPENDIX 6: Dispelling the Top Ten Myths about Massachusetts Health Care Reform

1. Commonwealth Care cost the state $1.3 billion in FY 2009 and has risen 85% faster than projected.

False. The legislative conference committee that ironed out the landmark health care reform law in 2006 estimated spending for the Commonwealth Care program at $725 million during FY 2009. Commonwealth Care actually cost about $800 million in FY 2009, about 10% over the 2006 projection.

Some critics of Massachusetts healthcare reform continue to cite a higher figure, using a worst-case scenario from a state bond prospectus that was issued nearly a full year before the completion of fiscal year 2009. This figure of $1.3 billion is incorrect.

The main reason for the increased spending on Commonwealth Care is higher-than-expected enrollment. (Premiums per enrollee have actually increased less than 5% a year since inception of the program.) In FY 2008, program costs grew more rapidly than projected because the state was working with estimates of the eligible population, based on 2006 survey data, which turned out to be low. The Connector enrolled the larger pool of eligible uninsured individuals faster than anticipated. As a result, costs grew in concert with the rapid enrollment, not because of medical inflation. As of August 1, 2009, enrollment is about 179,000.

2. Massachusetts health reform is unaffordable.

False. Against the new costs of Commonwealth Care and some expansion of MassHealth (Medicaid), there have also been offsets from reduced government spending under health reform on uncompensated charity care, such that the full, net new cost of reform to government is probably less than $800 million. A recent report by the independent Massachusetts Taxpayers Foundation concludes that total, net government spending on Massachusetts health reform, since it began in FY 2007, will have increased by $707 million in FY10.[42] (About half of this $707 million net new state spending on reform is offset by federal matching payments.) While FY10 projections continue to evolve, it is clear that the costs of health care reform have been relatively modest for the state. Like individuals and other employers, the state does face challenges in keeping up with rising health care costs, but this challenge pre-dated health care reform and continues to be a major policy focus for the Commonwealth.

3. Health care premiums have increased dramatically since (and because of) reform.

False. Commercial insurance premiums have risen annually in Massachusetts at a slightly slower pace since 2006 than before, as they have nationally. A recent report by the Commonwealth Fund found that the average family health premium offered by employers in Massachusetts is the highest in the nation.[43] Massachusetts had high premium costs before reform, so this is not surprising news and is no reflection on the reform law. It does, however, underscore the need for payment reform, and Massachusetts is now taking action to put cost controls in place.

The one exception is that reform brought substantial rate relief to the non-group market in Massachusetts. The merger of the non-group and the small group markets, implementation of a requirement that individuals who can afford it purchase insurance, and the development of an insurance exchange have *reduced* premiums substantially for Massachusetts residents who buy insurance directly (non-group).[44] Their premiums for comparable coverage dropped on average about 20% in 2007, and in 2008, the Connector held the average premium increase for commercial, non-group Commonwealth Choice plans

to 5%. This is significant progress in a market that had typically experienced double-digit annual premium increases.

4. Reform has caused a shortage of primary care physicians and waits to see PCPs are excessively long.

False. The diminishing supply of primary care physicians is a national problem. (Massachusetts has more physicians per capita than any other state and more than the average number of primary care physicians.) While there are waiting times in parts of the state, recent surveys have found that over 90% of individuals reported having a primary care provider and only 5% said there was a time in the past year that they needed medical care, tests or treatment that they did not get.[45] Access to care is far better in Massachusetts than nationally: for 2007, about 20% of the U.S. population reported not getting or delaying needed medical care at some point in the previous 12 months.[46]

Moreover, Massachusetts reform has stimulated creative approaches to further improve access. In 2008, the state and private sector partners developed a loan repayment program for medical and nursing students who make a two- to three-year commitment to practice primary care in Massachusetts after graduation. Some 92 primary care clinicians, able to care for some 140,000 patients, have been recruited or retained because of the new incentive program designed to make coverage expansion work for patients. Additionally, the state's decision in 2007 to allow (carefully regulated) development of primary care nursing services in commercial pharmacies is also expanding access for minor ailments.

5. The number of uninsured in Massachusetts remains high, despite the reform law.

False. According to the latest comprehensive survey, completed for the state Division of Health Care Finance and Policy by the Urban Institute, Massachusetts has an insured rate of over 97%.[47] "Near-universal" insurance is a historic accomplishment, which compares very favorably with the U.S. rate of over 15% uninsured (and probably climbing during the recession of 2008 and 2009).[48]

6. The only real coverage expansion is Medicaid-like, free government coverage.

False. Of the 406,000 newly insured as of March 31, 2009, about 165,000 were enrolled in the subsidized Commonwealth Care program, 99,000 were receiving MassHealth (Medicaid), and 142,000 were enrolled in private commercial insurance through their employers, the Commonwealth Choice program or because they purchased directly from a carrier.[49] The 35% who are enrolled in private, commercial health insurance plans represent the first significant increase in such coverage in Massachusetts in decades.

Moreover, nearly 50 percent of the new 406,000 enrollees contribute significantly toward their monthly premiums, whether they pay all of it - as do some 46,000 direct buyers – or part. In addition to 46,000 new direct purchasers, 96,000 new enrollees contribute to their employer's offer of insurance, and 52,000 enrollees in government-subsidized Commonwealth Care contribute toward their monthly premiums.[50]

7. Reform has caused the public sector to take-over or crowd-out private insurance.

False. There is no evidence of a shift in enrollment from the private to the public sector. Most Massachusetts employers have continued to offer insurance to their employees, some have newly offered health benefits, and more employees have taken up their employer's offer of insurance. A survey by the state Division of Health Care Finance and Policy showed that, while nationally the number of employers offering health insurance to employees dropped from 68 to 60% between 2001 and 2007, in Massachusetts, the rate of employers offering insurance increased from 69 to 72% for the same period.[51]

The state's subsidized Commonwealth Care program is structured so that co-pays and premium contributions for enrollees above 200% of the federal poverty line are in line with employer-sponsored health insurance. This alignment discourages "crowd out," or the shifting of costs from the private to the public sector.

8. The law is unpopular.

False. Popular support in Massachusetts has remained strong. It was substantial immediately after passage of the law —61% of likely voters surveyed in the summer of 2006 supported the initiative. Three years later in the midst of a severe economic recession and confusion over national reform efforts, favorability of the law is at 59%, meaning it is favored by a two to one margin. [52] One survey released in December of 2008 and completed by the Urban Institute for the state Division of Health Care Finance and Policy showed public support as high a 75%.[53]

9. Health care reform has mandated over 40 new benefits, like in vitro fertilization.

False. Certain mandated benefits existed in Massachusetts statute prior to the advent of reform, including in vitro fertilization. The reform law (Chapter 58 of the Acts of 2006) actually placed a moratorium on legislating new mandated benefits, pending a study.

Under reform, the Connector has established Minimum Credible Coverage ("MCC"), which does require adults who can afford insurance to have coverage for a broad range of medical services, including physicians, hospitals, diagnostic services and drugs; limits out-of-pocket spending on most services to $5,000 per person or $10,000 per family, per year; and caps annual deductibles at $2,000/$4,000 per individual/family. It also allows federally qualified, high-deductible health plans with higher patient cost-sharing, to satisfy the MCC requirement.

10. The law is fraying the safety net in Massachusetts.

False. One of the fundamental goals of health reform is to move individuals accessing health care through the Uncompensated Care Pool (UCP)--which is now called Health Safety Net (HSN)—from public "charity care" into insurance, without under-cutting "safety-net providers." The health benefits provided to Commonwealth Care members are more comprehensive than the episodic acute care that was generally available through UCP.

As of July 2008, nearly 70% of Commonwealth Care enrollees had previously been either UCP eligible or had used the UCP at some point in 2004 through 2007, and over 90% of Commonwealth Care enrollees joined one of three non-profit health plans sponsored and controlled by safety-net providers. Commonwealth Care has substantially increased their enrollments and medical surplus margins: medical capitations paid to them, less claims they paid out for the contract periods through the third quarter of fiscal year 2009 averaged 3%. (On the other hand, several safety-net hospitals do allege substantial harm from recent cuts in traditional Medicaid payment rates.)

As intended, utilization of the HSN declined by 36% in the first six months of HSN '08 compared to the same period in the prior year of the UCP. HSN services are still available and finance emergency, inpatient acute, and other selected medical services for residents with income at or below 400% FPL who do not qualify for or cannot afford other coverage.

[1] The Commonwealth Health Insurance Connector Authority (2008, October 2). *Report to the Massachusetts legislature: Implementation of the health care reform law, chapter 58*. Boston, MA: Author.

[2] Long, S., Phadera, L., Stockley, K., (2009, October). *Health insurance coverage in Massachusetts 2008 and 2009, Massachusetts health insurance surveys.* Boston, MA: Division of Health Care Finance and Policy.

[3] Bureau of Labor Statistics (2009). *Local area unemployment statistics*. Washington, D.C.: Author.

[4] Division of Health Care Finance and Policy (2009, August). *Health care in Massachusetts: Key indicators, August 2009*. Boston, MA: Author. Available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/key_indicators_aug_09.pdf

[5] From July 1, 2006 to July 1, 2008, the population of Massachusetts increased by less than 1%. See, U.S. Census Bureau, Population Division (2008, December). *Annual estimates of the resident population for the United States, regions, states, and Puerto Rico: April 1, 2000 to July 1, 2008*. Washington, D.C.: Author. Available online at, http://www.census.gov/popest/states/tables/NST-EST2008-01.xls

[6] See for example, Gabel, J., Whitmore, H., and Pickreign, J. (2008). Report from Massachusetts: Employers largely support health care reform, and few signs of crowd-out appear. *Health Affairs* 27(1), w13 – w23; Long, S. (2008, June 3). On the road to universal coverage: Impacts of reform in Massachusetts at one year. *Health Affairs* 27(4), w270 – w284; and Long, S. and Masi, P. (2008, October 28). How have employers responded to health reform in Massachusetts? Employees' views at the end of one year. *Health Affairs* 27(6), w576 – w583.

[7] Massachusetts Department of Revenue (2008, October). *Data on the individual mandate and uninsured tax filers, tax year 2007*. Boston, MA: Author. Available online at, http://www.mass.gov/Ador/docs/dor/News/PressReleases/2008/2007_Demographic_Data_Report_FINAL_(2).pdf

[8] See, Long, S.K., and Stockley, K. (2009, March). *Health insurance coverage and access to care in Massachusetts: Detailed tabulations based on the 2008 Massachusetts health insurance survey*. Boston, MA: Division of Health Care Finance and Policy. Available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/survey/08his_detailed_tabulations.pdf and Massachusetts Department of Revenue (2008). *Data on the individual mandate and uninsured tax filers, tax year 2007*. Boston, MA: Author. Available online at, http://www.mass.gov/Ador/docs/dor/News/PressReleases/2008/2007_Demographic_Data_Report_FINAL_(2).pdf

[9] Seifert, R., and Swoboda, P. (2009, March). *Shared responsibility: Government, business, and individuals, who pays what for health reform?* Boston, MA: Blue Cross Blue Shield Foundation of Massachusetts. Available online at, http://bluecrossfoundation.org/foundationroot/en_US/documents/090406SharedResponsibilityFINAL.pdf

[10] Raymond, A. (2009, May). *Massachusetts health reform: The myth of uncontrolled costs*. Boston, MA: Massachusetts Taxpayers Foundation. Available online at, http://www.masstaxpayers.org/files/Health%20care-NT.pdf

[11] Long, S., and Masi, P. (2009, May 28). Access and affordability: An update on health reform in Massachusetts, fall 2008. *Health Affairs* 28(4), w578 – w587.

[12] Personal communication with Sharon Long. Massachusetts data is derived from the 2008 round of the Massachusetts Health Reform Surveys and the U.S. data is derived from the 2007 National Health Interview Survey.

[13] McCarthy, D., How, S.. Schoen, C., Cantor, J., and Belloff, D. *Aiming higher: Results from a state scorecard on health system performance, 2009*. New York, New York: The Commonwealth Fund. Available online at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Oct/1326_McCarthy_state_scorecard_2009_full_report_FINAL.pdf

[14] Blendon, R., Gil, G., SteelFisher, G., Benson, J., and Weldon, K. (2009, September 28). *Massachusetts health reform poll*. Boston, MA: Harvard School of Public Health and Boston Globe. Available online at, http://www.hsph.harvard.edu/news/press-releases/files/Mass_Health_Reform_2009_topline.doc

[15] Blendon, R., Buhr, T., Sussman, T., and Benson, J. (2008, October 28). Massachusetts health reform: A public perspective from debate through implementation. *Health Affairs* 27(6), w556-w565.

[16] Blendon, R., Gil, G., SteelFisher, G., Benson, J., and Weldon, K. (2009, September 28). *Massachusetts health reform poll*. Boston, MA: Harvard School of Public Health and Boston Globe. Available online at, http://www.hsph.harvard.edu/news/press-releases/files/Mass_Health_Reform_2009_topline.doc

[17] Long, S (2009, May 28). *An update on health reform in Massachusetts as of fall 2008: Access to and affordability of care.* Presentation at the Blue Cross Blue Shield Foundation Summit: Boston, MA. Available online at, http://bluecrossfoundation.org/~/media/Files/Policy/Policy%20Publications/090528UrbanInstMHRSPPTSummit.pdf

[18] Long, S., Cook, A., and Stockley, K. (2009, March). *Health insurance coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey*. Boston, MA: Division of Health Care Finance and Policy; and Long, S., Phadera, L., Stockley, K., (2009, October). *Health insurance coverage in Massachusetts 2008 and 2009, Massachusetts health insurance surveys.* Boston, MA: Division of Health Care Finance and Policy.

[19] M.G.L. c. 118H § 3(a).

[20] Though this is an eligibility criterion by statute, it is not enforced due to its inconsistency with federal laws.

[21] TriCare is the managed care component of the United States Department of Defense Military Health System. TriCare provides civilian health benefits for military personnel, military retirees, and their dependents, including some members of the Reserve Component.

[22] For more information, see 956 CMR 3.09 § 2. Available online at http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Regulations/documents/CommCareRegs956CMR3000408Revision.pdf

[23] In July 2009, there were some modest changes to prescription drug co-payments for Plan Type 1 members. These changes were instituted in order to maintain consistency in co-payments between Plan Type 1 CommCare members and MassHealth members, as required by statute. In addition, Plan Type 2A members (those with income of 100.1 – 150% FPL) were required to pay the full delta in premium between the lowest cost plan and the plan he/she selects, if the lowest cost plan is not selected.

[24] Pursuant to section 123 of chapter 58 of the acts of 2006, from July 1, 2006 through June 30, 2009, the Health Connector was only able to contract with the MMCOs under contract with MassHealth for the delivery of managed care services to individuals enrolled in the CommCare program.

[25] As described in last year's report, there are a number of factors including the auto assignment process, region of residence, and personal preference that can impact enrollment in each MMCO.

[26] July 2009 was the first month that CeltiCare health plan was available to CommCare members.

[27] Bailit Health Purchasing (2009, March 9). *Network adequacy in the Commonwealth Care program*. Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. Available online at, http://bluecrossfoundation.org/~/media/Files/Policy/Policy%20Publications/090422NetworkStandardsFINAL.pdf

[28] This section addresses waivers and appeals related to the Commonwealth Care program, specifically. A later section of the report, Section 5.2, addresses appeals related directly to the individual mandate.

[29] The circumstances defining what constitutes a "hardship" are detailed in 956 CMR 3.12(5). This is available online at, http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/Current/Connector%2520board%2520meeting%2520June%25205%252C%25202007/956%2520CMR%25203.00%2520Final%2520060507.pdf

[30] As of July 2009, the Health Connector employed a revised methodology for calculating enrollment. Only paid subscribers and dependents will be included in membership counts.

[31] Gorman Actuarial, LLC, DeWeese Consulting, Inc., and Hinckley, Allen & Tringale LP (2006, December). *Impact of merging the Massachusetts non-group and small group health insurance markets*. Boston, MA: Division of Insurance. Available online at, http://www.mass.gov/Eoca/docs/doi/Legal_Hearings/NonGrp_SmallGrp/FinalReport_12_26.pdf

[32] This is based on the average premium (among the three largest HMOs) for a single, 25-year old in Boston purchasing the standard guaranteed issue plan in 2006 versus the same individual purchasing a "Gold" plan through the Health Connector in July 2007. Though the schedule of benefits for the standard guaranteed issue HMO and the Health Connector's Gold plans may not align exactly, this is the closest possible comparison. In fact, the Health Connector's Gold plans are likely richer in benefits than the standard issue plan (e.g., the Gold plans do not have deductibles, and they have lower co-payments for inpatient hospital admissions, for example). This analysis relied on Guaranteed Issue Plan Rates and Non-Group Guaranteed Issue Membership Reports on file with the Massachusetts Division of Insurance.

[33] The revised MCC regulations are available online at, http://preview.tinyurl.com/d9h85d

[34] MG.L. c. 176Q, § 3.

[35] As a result of clarification from the Centers for Medicare and Medicaid Services (CMS), modest revisions were made to the affordability schedules for individuals and couples in May 2009. These adjustments ensured consistency with the income guidelines used for MassHealth and CommCare eligibility determination.

[36] M.G.L. c. 111M, § 2.

[37] In December 2007, the Connector issued *Administrative Bulletin 05-07: Guidance regarding the implementation of individual mandate penalties for 2007*, to provide clarification on imposition of the mandate for those individuals enrolled in CommCare or a Young Adult Plan through the CommChoice program with a plan effective date of January 1, 2008. The Administrative Bulletin is available online at, http://tinyurl.com/l7oyt3

[38] M.G.L. c. 111M, § 2.

[39] The lowest cost Young Adult Plan without prescription drugs actually declined from $112 as of January 1, 2008 to $104 as of January 1, 2009, translating to a decline in the penalty for individuals in this category from $56 per month to $52 per month. As a result, if premium rates as of January 1, 2009 were used as the benchmark for developing penalties across all income categories, individuals ages 18-26 and with earnings above 300% FPL may have a lower penalty ($52) than those with income of 250.1 – 300% FPL (who would have a penalty of $58 per month). As a result, for fairness, DOR utilized CommCare premium contributions as of January 1, 2008 as the benchmark for penalties for those with earnings up to 300% FPL and CommChoice premium rates as of January 1, 2009 as the benchmark for penalties for those with earnings above 300% FPL. In addition, for administrative simplicity, DOR rounded penalties down to the nearest whole dollar in the 2009 penalty schedule.

[40] Kirwan, L. and Iselin, S. (2009, July). *Recommendations of the special commission on the health care payment system*. Boston, MA: Division of Health Care Finance and Policy. Available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf

[41] Specifically, the health reform law states that if ESI is offered, and the employer covers at least 20% of the annual premium cost for a family insurance plan or at least 33% of the cost for an individual insurance plan, then the applicant is not eligible for CommCare.

[42] Raymond, A. (2009, May). *Massachusetts health reform: The myth of uncontrolled costs*. Boston, MA: Massachusetts Taxpayers Foundation. Available online at, http://www.masstaxpayers.org/files/Health%20care-NT.pdf

[43] Schoen, C., Nicholson, J., and Rustgi, S. (2009, August 20). *Paying the price: How health insurance premiums are eating up middle-class incomes--State health insurance premium trends and the potential of national reform*. New York, New York: The Commonwealth Fund. Available online at, http://www.commonwealthfund.org/~/media/Files/Publications/Data%20Brief/2009/Aug/1313_Schoen_paying_the_price_db_v3_resorted_tables.pdf

[44] This is based on the average premium (among the three largest HMOs) for a single, 25-year old in Boston purchasing the standard guaranteed issue plan in 2006 versus the same individual purchasing a "Gold" plan through the Health Connector in July 2007. Though the schedule of benefits for the standard guaranteed issue HMO and the Health Connector's Gold plans may not align exactly, this is the closest possible comparison. In fact, the Health Connector's Gold plans are likely richer in benefits than the standard issue plan (e.g., the Gold plans do not have deductibles, and they have lower co-payments for inpatient hospital admissions, for example). This analysis relied on Guaranteed Issue Plan Rates and Non-Group Guaranteed Issue Membership Reports on file with the Massachusetts Division of Insurance.

[45] Blue Cross Blue Shield Foundation and The Boston Globe (2008). *Massachusetts health care access survey*. Boston, MA: Author.

[46] Cunningham, P. and Felland, L. (2008, June). *Falling behind: Americans' access to medical care deteriorates, 2003-2007*. Washington, DC: Center for Studying Health System Change. Available online at, http://www.hschange.com/CONTENT/993/?topic=topic02#ib1

[47] Long, S., Cook, A., and Stockley, K. (2009, March). *Health insurance coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey*. Boston, MA: Division of Health Care Finance and Policy.

[48] Some critics have argued that Massachusetts should use the federal CPS survey for 2007 in calculating the number of uninsured rather than the most recent survey by the state Division of Health Care Finance and Policy. The advantage in using the state survey is threefold: The federal survey asked about insurance coverage during 2007, while the state survey calculated more recent coverage between June and August of 2008. This distinction is important, as the tax penalty for failure to have coverage only went into effect on the last day of 2007 and then increased in 2008, likely resulting in increased take up. Additionally, the federal estimate

is based on surveys of 1,000 households in Massachusetts, while the state survey sampled approximately 4,000 households. And finally, the state survey does not impute or estimate data as does the national survey.

[49] Division of Health Care Finance and Policy (2009, August). *Health care in Massachusetts: Key indicators, August 2009*. Boston, MA: Author. Available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/key_indicators_aug_09.pdf

[50] Connector Summary Report. Available online at, http://tinyurl.com/nex6rt

[51] Division of Health Care Finance and Policy (2008, December). *Massachusetts employer survey*. Boston, MA: Author. Available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/08/employer_report_2007.ppt

[52] Blendon, R., Buhr, T., Sussman, T., and Benson, J. (2008, October 28). Massachusetts health reform: A public perspective from debate through implementation. *Health Affairs* 27(6), w556-w565; and Blendon, R., Gil, G., SteelFisher, G., Benson, J., & Weldon, K. (2009, September 28). *Massachusetts health reform poll*. Boston, MA: Harvard School of Public Health and Boston Globe. Available online at, http://www.hsph.harvard.edu/news/press-releases/files/Mass_Health_Reform_2009_topline.doc

[53] Long, S., Cook, A., and Stockley, K. (2009, March). *Health insurance coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey*. Boston, MA: Division of Health Care Finance and Policy.