Report to the Massachusetts Legislature

Implementation of Health Care Reform

Fiscal Year 2012

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1.0 Preface

Massachusetts's landmark health care reform law continues to serve as a model at the national level for how to expand health care access and reach near-universal levels of coverage. Thoughtfully crafted regulatory and program initiatives, as well as collaboration with stakeholders and interested consumers, have paved the way for dramatic improvements in access to care without significantly increasing costs or disrupting the existing market. Massachusetts Health Care Reform has expanded health insurance coverage to more than 400,000 residents, making care more accessible and affordable for this population of newly insured. In the years following the passage of Chapter 58 of the Acts of 2006, the Commonwealth expanded its focus in order to better address the impact of increasing health care costs on Massachusetts residents and businesses. Innovative procurement strategies for government-sponsored insurance programs, expanded rate reviews in the non- and small-group market, and the implementation of cost-containment legislation have resulted in savings both to the system and to consumers. The Health Connector has been privileged to serve as the organization at the forefront of newly available health insurance programs for the previously uninsured and to have played key roles in the implementation of this pioneering effort.

These achievements, while significant, are still only the beginning of the Commonwealth's work to improve access, quality and costs. As explained throughout this report, the Patient Protection and Affordable Care Act (ACA), signed into law by President Barack Obama in March 2010, will bring many of Massachusetts's successes to other states, while at the same time providing the Commonwealth with opportunities to enhance and improve the reforms already in place. Consequently, inter-agency leaders are again collaborating with key stakeholders and consumers to take advantage of all the opportunities for improvement afforded under national health care reform.

The ACA, though modeled after the success in Massachusetts, brings significant legal, policy and programmatic changes to agencies and residents. Differences between the two laws require some changes to the Massachusetts model. Implementation, therefore, requires a very informed and engaged stakeholder community to ensure individuals and small businesses are aware of the benefits the ACA offers and that their perspectives are incorporated into policy and programmatic decision-making processes. The state's Inter-Agency Task Force on Implementation of Health Care Reform (Task Force), chaired by the Secretary of the Executive Office of Health and Human Services (EOHHS), convenes quarterly open meetings, where any interested stakeholder or member of the general public can hear updates on implementation activities. The Task Force's subsidiary inter-agency workgroups are also able to utilize stakeholder feedback to identify and make recommendations for the resolution of issues that arise as a result of the intersection of state and federal law. The Commonwealth has a strong foundation of consumer and stakeholder engagement in health care reform and has designed its approach to this transition to ACA compliance to prioritize transparency, collaboration and inclusion.

In addition to the broad cross-state government efforts towards ACA implementation, the Health Connector is in the process of transitioning to an ACA-compliant Affordable Health Benefits Exchange (Exchange). In May 2012, Governor Patrick signed into law legislation formally designating the Health Connector as the entity responsible to carry out the responsibilities necessary to comply with the Exchange-related provisions of the ACA. In transitioning the Health Connector to an ACA-compliant state-based Exchange, Massachusetts is analyzing the impact the ACA will have on existing populations served by the Exchange as well as populations it is preparing to serve in 2014 and beyond.

The Health Connector is committed to not only meeting ACA requirements, but also leveraging the law to continue to excel at delivering value to the individuals and small businesses of Massachusetts and bringing value to the Commonwealth's health care market. As part of this effort, the Health Connector is collaborating with MassHealth and the University of Massachusetts Medical School (UMMS) to design and implement a new approach to individual eligibility and enrollment that will transform and further improve the way in which residents shop for and enroll in health insurance. Through the Health Insurance Exchange (HIX)/Integrated

Eligibility System (IES) project, the Commonwealth is building a single, integrated "real-time" eligibility and enrollment system to determine eligibility for state and federally-subsidized health insurance programs as well as for non-subsidized individuals and small businesses. Inter-agency leaders are committed to creating a single, integrated process to determine eligibility for the full range of health insurance programs, which will provide a significant value to the shopper and will enhance the capacity of the Exchange and other state-subsidized health insurance programs to serve residents in need of health insurance options.

As we move forward with implementation of federal health reform initiatives, the Health Connector continues to learn from our own experiences to further fashion an impactful, successful Exchange in a rapidly evolving health care landscape while, at the same time, ensuring our existing programs continue to deliver high-value to the individuals and businesses we serve. In Fiscal Year (FY) 2012, as this report details, we continued to refine and enhance our existing model. Through an innovative procurement process, the Health Connector and participating health plans have again achieved great success in controlling costs within the subsidized Commonwealth Care (Commonwealth Care) program. In addition, the Health Connector continues to identify and implement improvements to the shopping experience and ensure that the products offered through the unsubsidized Commonwealth Choice program deliver unparalleled value to consumers and the Massachusetts marketplace.

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

There have been several leadership changes to the Health Connector Board of Directors in Fiscal Year (FY) 2012. In July 2011, Julian Harris, M.D., was named Medicaid Director. Additionally, in September 2011, George W. Gonser Jr., CEO of Spring Consulting Group, was appointed by Governor Patrick to serve as the broker representative to the Board.[1] Thanks and gratitude are extended to the following Directors of the Health Connector for their continued commitment to health reform in FY12: Secretary of the Executive Office of Administration and Finance Jay Gonzalez, Chair of the Board; Julian Harris, M.D., Medicaid Director; Ian Duncan, Founder and President of Solucia, Inc.; Jonathan Gruber, Professor of Economics at MIT; Andrés López, Principal of AJL Consultants; George W. Gonser Jr., CEO of Spring Consulting Group; Louis F. Malzone, Executive Director of the Massachusetts Coalition of Taft-Hartley Funds; Dolores Mitchell, Executive Director of the GIC; Joseph Murphy, Commissioner of the DOI; Nancy Turnbull, Senior Lecturer on Health Policy and Associate Dean at Harvard School of Public Health; and Celia Wcislo, Assistant Division Director of 1199 SEIU United Health Care Workers East.

2.0 Update on the Status of Health Care Reform in Massachusetts

2.1 Insurance Coverage & Access to Care

With 439,000 newly insured since the passage of Massachusetts Health Care Reform in 2006, the Commonwealth continues to boast the highest rate of coverage in the nation.[2] Over 98 percent of residents had health insurance coverage in 2010, the most recent year for which data is available, representing a significant accomplishment in any context, but particularly given the tumultuous national economic climate of recent years. Children (ages 0-18) saw the largest insurance coverage gains since 2009, allowing Massachusetts to remain the state with the highest rate of insured children (99.8 percent) in the country. Of the roughly 6.5 million Massachusetts residents, only 120,000 are estimated to be uninsured.[3,4]

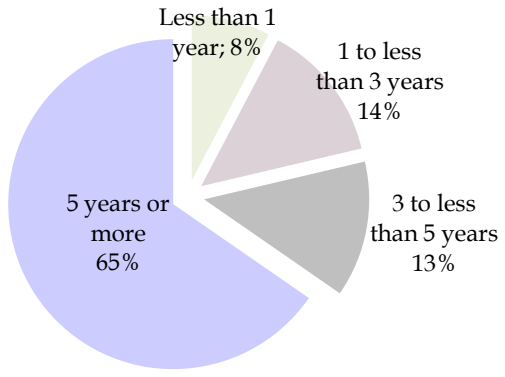
The impact of the national recession on the Commonwealth has been measurable, causing the state's unemployment rate to increase more than two percentage points between December 2008 and December 2009 and private group enrollment (which is predominantly employer-based insurance) to decline by nearly 3 percent in that same one-year period.[5] Despite these shifts, private group market enrollment remains the predominant type of coverage in the Commonwealth, with 79 percent of residents receiving coverage through the private group market in 2010.[6]

The Commonwealth's small remaining uninsured population continues to be predominantly composed of non-elderly adults (ages 19 to 65). More than 90 percent of those without health insurance coverage have incomes below 500 percent of the Federal Poverty Level (FPL),[7] suggesting that there will be significant opportunity for reaching this population when additional subsidies become available to higher income populations in 2014 under national health care reform. Evidence also suggests that the new affordable insurance programs and the expanded outreach and education efforts that will be taking place as a result of the implementation of the ACA[8] may present an opportunity to reach other population groups that continue to experience higher rates of uninsurance, such as Hispanic residents and those reporting to be in poor or fair health (see Section 2.6 and Section 7 for additional details on the state's ACA implementation efforts).[9]

Health care reform has provided Massachusetts residents better access to important health care services, as well as protection against the financial risks of serious illness and injury by enabling them to obtain and maintain sufficient health insurance coverage. In 2010, 84 percent of non-elderly adults stated that they were confident in their ability to maintain their health insurance for the coming year. Only nine percent reported being underinsured.[10]

As explained in the FY11 Annual Report,[11] Massachusetts residents continued to indicate that they were able to access necessary health care services in 2010, the most recent year for which data is available. Approximately 93 percent of residents had a usual source of care in 2010, an increase from 2009.[12] Of those residents who reported having a usual source of care, more than 90 percent have had that relationship for more than a year and almost a third reported having that relationship for five years or more (see Figure 1).[13] Further, 2010 saw significant

Figure 1. Reported length of relationship with provider, non-elderly adults



decreases in emergency department use by non-elderly adults, including a three percent decrease in the percentage of adults who visited an emergency department for non-emergent care since 2009.[14] This data suggests that health care reform can successfully improve access to care as well as promote continuity of care, which is essential to building and protecting a smart, responsive and effective health care delivery system.

Despite these advancements, there remain opportunities for improvement. Nearly a quarter of Massachusetts residents reported having difficulty accessing health care in at some point in 2010.[15] According to a 2010 survey, the most common reason among those reporting difficulty accessing care reported for unmet need was cost (about 60 percent), with difficulty getting an appointment being the second most common cause. Adults with a total household income below 300 percent FPL reported greater difficulty finding a provider who would see them than those at a higher income level. Among those adults who reported using the emergency department for non-emergent care, three-quarters indicated that it was because they needed care after normal physician office hours.

Adults with incomes below 300 percent FPL were less likely to have a usual source of care (84.2 percent compared with 95.2 percent of higher income adults).[16] A population traditionally served by Community Health Centers (CHC), these individuals will benefit from opportunities provided by the ACA to improve the Commonwealth's ability to meet their medical needs. In October 2011, thirteen Massachusetts CHCs were selected to participate in the Federally Qualified Health Center Advanced Primary Care Practice Demonstration to improve coordination and quality of care. Under this demonstration project, CHCs are paid based on the quality of care they deliver. Additionally, in May 2012, more than $33 million in Federal grants were awarded to six CHCs in Massachusetts (under §10503 of the ACA) for renovation and new construction projects.[17]

EOHHS has also received federal financial support, including grants and demonstrations awarded under the ACA, to improve access to and integration of care. In 2009, EOHHS coordinated an inter-agency Patient-Centered Medical Home Initiative (PCMHI) to promote comprehensive, coordinated, cost-effective care. As explained in the FY10 Annual Report,[18] the PCMHI strives toward a better patient experience by ensuring that all of an individual's health care needs are coordinated through a primary care physician (PCP). As in prior years, the Health Connector, as part of the PCMHI, has requested that Commonwealth Care Managed Care Organizations (MCO) participate in this initiative and work with providers to better coordinate care for members.[19]

MassHealth is also developing a new Integrated Care model for Dual Eligible adults (adults eligible for Medicare and Medicaid) ages 21-64, known as "Dual Eligibles," for statewide implementation.[20] Through a Duals Demonstration grant awarded by the Centers for Medicare and Medicaid Services (CMS), MassHealth proposes to combine Medicare and Medicaid funding for Dual Eligibles in order to provide both MassHealth- and Medicare-funded services. By combining Medicare and Medicaid funding, MassHealth intends to offer a broader menu of services that will better meet the needs of the population in the most cost effective way. The contracted entities will be evaluated as part of the ongoing monitoring of the Demonstration based on a comprehensive set of quality metrics.

Additional information on grants and waivers awarded under the ACA is available on the EOHHS National Health Reform webpage, www.mass.gov/nationalhealthreform.

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

Most Massachusetts adult residents are required to maintain affordable health insurance for each month of the year. Beginning in Tax Year (TY) 2009, adults are required to obtain a health insurance policy that meets the state's Minimum Creditable Coverage (MCC) standards (*i.e.*, provides a minimum value or level of coverage) if an affordable plan is available to them.

Residents are allowed a gap of three or fewer consecutive calendar months between insurance coverages before a penalty is assessed. This requirement is enforced by DOR through the income tax filing process, where residents are required to report information about their health insurance coverage on the Schedule HC.

Analysis of data from the TY10 Schedule HC was published by the Health Connector and Department of Revenue in June 2012.[21] In TY10 there were no significant changes in the majority of findings from the analysis of Schedule HC data when compared to the analysis of the previous year. Compliance with the state's health insurance reporting requirements continued to be high, with 99 percent of tax filers who were required to file a Schedule HC complying with the reporting requirement. In addition, there continued to be high rates of insurance coverage, with 92 percent of adults who filed a Schedule HC reporting having MCC-compliant coverage for the full-year (Table 1). Relatively few filers were assessed a penalty for TY10 (approximately 24,000 who were uninsured for the full-year and 20,000 with part-year insurance, despite having affordable insurance available to them).

Table 1. Tax filers Insurance Data, Tax Year 2010[22]	
Compliance with the tax filing requirement: (*i.e.*, the percent of tax filers who were required to file a Schedule HC that complied with the reporting requirement)	99%
Percent of adult tax filers with full-year MCC-compliant coverage: (*i.e.*, the percent of adult tax filers who filed a Schedule HC and reported having MCC-compliant coverage for the full-year)[23]	92%
Number of adult tax filers without MCC-compliant insurance:	~170,000 for full-year, ~150,000 for part-year
Among the adult tax filers without MCC-compliant coverage:	
• No penalty because income at or below 150% of FPL:	~110,000 for full-year, ~49,000 for part-year
• No penalty because affordable insurance was not available (based on the tax filer's application of the affordability schedule):	~27,000 for full-year, ~17,000 for part-year
• No penalty because appeal was requested:	~4,400 for full-year, ~3,100 for part-year
• No penalty due to religious exemption:	~6,500 for full-year, ~810 for part-year
• No penalty due to Certificate of Exemption:	~190 for full-year, ~80 for part-year
• No penalty due to a permissible gap in coverage of three or fewer consecutive calendar months:	~57,000
• Penalty assessed since affordable insurance was available:	~24,000 for full-year, ~20,000 for part-year

There was an increase in penalty appeal approvals from TY09 to TY10 due, in large part, to more appellants meeting the criteria for hardship waivers. Early receipts indicate that the recovering economy has reduced the number of hardship waiver requests, but with more than half of the appeals submitted to the Health Connector Appeals Unit by the end of FY12 pending, it is too early to determine how the appeals will trend for TY11.[24]

2.3 Costs

The Commonwealth's successful implementation of landmark health care reform legislation confirms that, with carefully crafted policies and programs, as well as responsible leadership, expansions of health insurance coverage and access to medical care can be implemented in a fiscally responsible fashion. In FY11, additional state spending attributable to health care reform was held at just 1.4 percent of the total state budget.[25] In addition to ensuring that the reform initiative itself has not burdened the state budget, the Commonwealth also continues to identify and implement initiatives that not only make these reforms affordable, but also address the rising per capita cost of health care.

Thanks to the leadership of Governor Patrick and a statewide, inter-agency commitment to "bending the cost curve," multiple state health care programs have been able to identify significant cost savings in FY12 without limiting the populations eligible for affordable health insurance. Through rate restructuring, program integrity enhancements and payment strategies, MassHealth is on track to save approximately $588 million in FY12. The GIC will continue to realize significant savings through an incentive program for state employees to enroll in low-cost health plans. Further, as explained in Section 2.4, the Medical Security Program (MSP) Direct Coverage re-procurement resulted in a new managed care plan, saving $16 million.

For the second year in a row, the Health Connector Board of Directors approved an average 5 percent reduction in per person costs paid to carriers for covering Commonwealth Care members. The ambitious and innovative FY12 procurement saved $35 million from the year-over-year decrease in rates, and the FY13 bidding process is projected to generate an additional $62 million in savings (see Section 3).

Additional savings have been achieved by the Commonwealth thanks to decreases in the use of free care by uninsured and underinsured residents. During the first two years of reform, Health Safety Net (HSN) spending decreased by a third. As the national recession set in, HSN utilization and costs increased slightly in FY09 and FY10, but continue to remain below pre-reform levels.[26]

The state's DOI continues to exercise its authority to conduct regulatory review of individual and small business health insurance premium rates in advance of their effective dates (please refer to the Health Connector's FY10 Annual Report for further details).[27] Operating under regulations issued in FY10, DOI works with health insurers to oversee proposed premium increases for the plan year, shielding consumers from potentially unsustainable rate increases. Through this process, premium rate increases were held at an average 2.3 percent in 2012. Self-only employee premiums rose, on average, by only 2.8 percent in 2010 (compared with a 5.8 percent increase nationwide).[28]

The ACA will allow Massachusetts to build on these successes and further increase transparency, accountability and cost-control. As of September 1, 2011, carriers seeking rate increases of 10 percent or more in the individual and small-group markets must submit a rate review request. If the proposed rate increase is found unreasonable upon review, carriers must publicly justify the premium rate increases. To support these rate review processes, the ACA makes Health Insurance Rate Review Grants available to states. On September 22, 2011, Massachusetts was one of 28 states and the District of Columbia to receive a grant from HHS under ACA §1003 to "help fight unreasonable premium increases and protect consumers." Under this grant, DOI was awarded $3,385,165 to expand the scope of rate review, improve rate filing requirements, improve transparency and consumer interfaces, hire new staff and improve information technology (IT).[29]

Additionally, the ACA establishes Medical Loss Ratio (MLR) standards defining the minimum dollar percentage that health insurance companies must spend of consumers' health insurance premiums on medical care, not on income, overhead or marketing. Beginning in 2011, plans are required to have an MLR of at least 80 percent in the individual and small-group markets, and at least 85 percent in the large group market.[30] Effective January 1, 2011, Massachusetts implemented a stricter MLR standard of 88 percent. The Massachusetts MLR was further increased

to 90 percent effective January 1, 2012. Insurers that do not meet the MLR standard are required to provide rebates to their members. In June 2012, the HHS announced that insurance companies will provide 12.8 million Americans with $1.1 billion in rebates due to the ACA's MLR requirements. According to HHS, 163,949 Massachusetts residents will receive an average rebate per family of $140.[31]

Massachusetts families are realizing substantial savings as a result of both state- and federally-driven reforms. Only six percent of non-elderly adults in Massachusetts reported spending 10 percent or more of total family income on health care in 2010, a significant improvement since 2006. Reform has also resulted in fewer residents having unmet medical needs due to cost.

Despite these significant achievements, health care costs continue to be a challenge for Massachusetts residents and businesses. More than a quarter of non-elderly adults reported financial problems due to health care spending in 2010, with lower-income adults more likely to have difficulty affording health care costs. Additionally, employers, struggling with the rising costs of health insurance, have been forced to shift some of those increased costs to their workers. According to DHCFP's 2010 survey of Massachusetts employers, the most recent year for which data is available, the median employee dollar contribution toward employer-sponsored insurance (ESI) for an individual plan in 2010 was $120, three times the 2001 median employee dollar contribution.[32] Small employers, in particular, are struggling to afford the rising cost of health insurance for their employees and have sought to further mitigate premium increases in recent years by "buying down" to lower value benefit packages.[33] Among those firms that do not offer employer-sponsored insurance, almost all (92 percent) report that cost is a deciding factor.[34]

Without additional state and federal action, per capita health care spending is projected to nearly double between 2009 and 2020 in Massachusetts.[35] Consequently, the Patrick Administration and the Legislature began actively working on legislation to reverse the trend. On August 6, 2012, the Governor signed into law chapter 224 of the Acts of 2012, "An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation." The purpose of the law is to change the way that health services are paid for and delivered in the Commonwealth. The legislation enhances the regulatory authority of the DOI, while beginning to move providers and payers, including state purchasers of health care such as MassHealth, the GIC and the Health Connector, away from fee-for-service methods of payment by encouraging the use of alternative payment methods (*i.e.*, global payments, bundled payments and other alternatives). These kinds of payments are intended to provide for more integrated and coordinated care for patients to reduce costs and improve quality and health outcomes. This new coordinated system is designed to benefit patients by giving providers the flexibility to provide the right services to patients in the most appropriate manner. In addition, the law reorganizes an existing state entity, the Health Care Quality and Cost Council, into the Health Policy Commission and establishes a new quasi-public independent entity to transition the market, the Center for Health Information and Analysis (CHIA). The law also establishes a statewide healthcare cost growth target for the health care industry equal to the potential growth of the Commonwealth's gross state product (GSP) from years 2013 to 2017, then dropping it to 0.5 percent below GSP from 2018 to 2022 and back to GSP for 2023 and beyond. The growth rate of potential GSP is the long-run average growth rate of the Commonwealth's economy, ignoring fluctuations due to business cycles. A performance improvement plan must be submitted by and fines may be imposed on any health care entities (*i.e.*, hospitals, physician groups, payers) that miss the target.

While the state charts its own course for thoughtful health care cost containment, the ACA will also continue to promote opportunities for the state to make health care more affordable. As of February 2012, the Commonwealth has received nearly $200 million in Federal grants to support statewide efforts to reduce costs. Detailed information on the grants awarded to Massachusetts can be found at www.mass.gov/nationalhealthreform.

2.4 Supporting Value-Based Purchasing in the Commonwealth

The Health Connector continues to partner with other state entities to help promote system-wide cost savings through value-based purchasing (see FY11 Annual Report for additional details).

Massachusetts law, M.G.L. chapter 15A, §18, requires all students enrolled in at least 75 percent of the full-time curriculum at an institution of higher learning in Massachusetts to participate in a qualifying student health insurance program (QSHIP) or in a health benefit plan with comparable coverage. In 2009, DHCFP began reporting on QSHIPs, and their first study found that QSHIP plans with lower levels of coverage often have coverage gaps that can result in high out-of-pocket expenses. Subsequent reports found that, compared to typical private health insurance in Massachusetts, QSHIPs are broadly characterized by relatively low take-up rates, less comprehensive benefits and a greater penetration of out-of-state carriers with low medical loss ratios.

In 2009, the Department of Higher Education (DHE) commissioned the "Student Health Program Steering Committee" to explore opportunities for improving the value of health insurance for public college students. For the past three years, the Health Connector, in collaboration DHE, ANF and DHCFP, has played an active role in procuring and renegotiating health insurance coverage to improve benefits for students while restraining costs. In year one of the initiative, the partnership conducted competitive procurements for the State Universities (collectively) and the Community Colleges (collectively). In the first year of the partnership, the procurement yielded a 15 percent upgrade in benefits with only a five percent increase in premiums. In year two, the Health Connector supported the reprocurement of coverage for the State Universities (collectively), the Community Colleges (collectively) and the University of Massachusetts campuses (individually). Key improvements were made to QSHIP plans for year two, including adding prescription drug coverage for community college students, maintaining high-value QSHIP plans for state university students, and eliminating benefit caps and improving access to care for over 14,000 University of Massachusetts students.

In year three of the initiative, the Health Connector assisted the schools in aggressive negotiations to renew coverage for the 2012 – 2013 academic year with current carriers. Skillful negotiation, along with a strong commitment by carriers and brokers to serve these students, helped manage overall trend while also adding ACA-required benefit upgrades such as the elimination of cost-sharing for preventive care services and the elimination of any remaining benefit caps.

The Health Connector, DHE, ANF and DHCFP have significantly improved health insurance coverage for the Commonwealth's public college and university students. Today, thousands of students have improved access to providers and wellness programs. In addition, nearly 20,000 students newly have out-of-pocket maximums (i.e., a limit on the amount of dollars that can be spent on point-of-service health care services), 7,500 students newly have access to prescription drug coverage and close to 20,000 students newly have coverage without benefit caps. In the upcoming academic year, more than 22,000 students will newly have coverage for preventive services, including women's wellness visits and contraceptive services, without cost-sharing.

Because of the Health Connector's track record as an entity with procurement expertise that has benefited the public interest and delivered increased value for Massachusetts taxpayers, in FY11, the Patrick Administration requested that the Health Connector work with the DUA to launch a competitive re-procurement for the MSP Direct Coverage program. The MSP Direct Coverage program offers subsidized health insurance for low-income Massachusetts residents receiving unemployment insurance benefits.[36] The Medical Security Trust Fund, which finances MSP and is funded by employer contributions, had been under major financial stress due to increases in the number of residents eligible for unemployment benefits and federal legislation extending the duration of unemployment benefits. The goals of this partnership with DUA are to achieve savings to help sustain this important program, while aligning benefits to match those provided to similarly situated populations in other state-subsidized programs, and to facilitate continuity of coverage.

The MSP procurement was conducted in 2011 by DUA, with operational and analytical support, including actuarial assistance, supplied by the Health Connector. A Request for Responses (RFR) was released in July 2011. After careful review of the responses, staff from the Health Connector, DUA and ANF, recommended that DUA select Network Health's statewide capitation bid of $335.37 per member per month (PMPM) to provide MSP Direct Coverage, saving the program $16 million in CY12, even without factoring in enrollee premium collection. In addition to programmatic cost savings, MSP members saw significant improvements in coverage, such as the reduction of co-payments, the elimination of deductibles, and improved continuity of coverage as they transition to other subsidized health insurance programs. Under the new plan, premiums vary by family income and cost-sharing is more progressive than the previous structure, with the lowest income tier paying no premium and lower co-pays going forward. Coverage under the new plan, called Network Health Extend, began January 1, 2012.

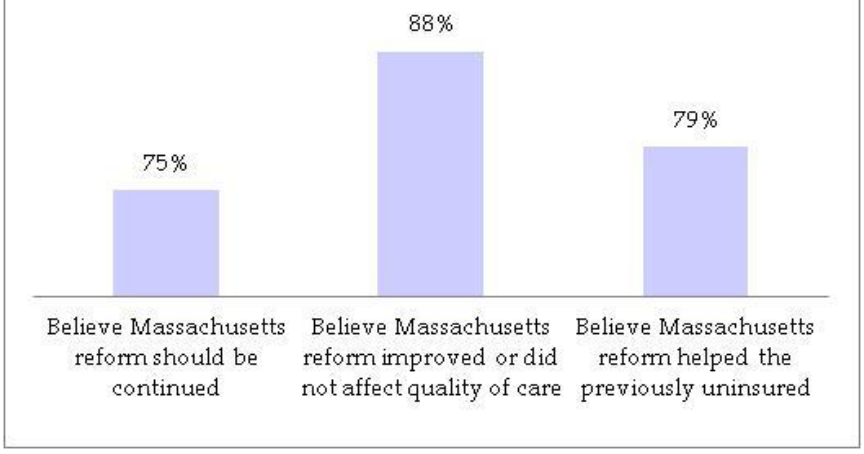
2.5 Public Support for Health Care Reform

Six years after its implementation, support for health care reform in Massachusetts remains strong. According to a report released by the Blue Cross Blue Shield of Massachusetts Foundation in January 2012, nearly two-thirds of non-elderly adults stated they support reform. This high-level of public support is consistent across various population groups.[37]

Key to the success of reform in Massachusetts is the continued strong support from key stakeholder groups. More than half of employers believe that health care reform has been good for the Commonwealth and three quarters of Massachusetts employers agree that employers bear some responsibility for providing employee health benefits.[38]

Physicians in Massachusetts have also expressed a positive view of reform. As Figure 2 shows, nearly 80 percent of physicians believe reform has helped the previously uninsured and three out of four physicians believe reform should continue in Massachusetts.[39]

Figure 2. Physician Views of Massachusetts Health Care Reform, Percent of Massachusetts Physicians Reporting Belief, 2009



2.6 Planning for National Reform

As the model for national health care reform and with significant prior state-level health care reform experience, the Commonwealth stands to benefit tremendously from the many opportunities presented by the ACA to

further improve the way in which individuals, families, and small businesses receive health coverage. As explained in Section 7.0, the ACA is allowing Massachusetts to build on the successes of chapter 58 and, working together with the Governor Patrick Administration, the Legislature and inter-agency leaders, the Health Connector has already made significant progress laying the foundations to operate the Health Connector as an ACA-compliant, state-based Exchange.

In January 2012, Governor Deval Patrick filed a supplemental budget which included language designating the Health Connector as the state's Health Benefits Exchange for purposes of the ACA. This legislation, signed into law as § 7 of chapter 96 of the Acts of 2012,[40] retains the existing structure of the Health Connector while empowering it to perform those new duties and responsibilities required by the ACA of an Exchange.[41] While the Health Connector is already equipped with many of the authorities and responsibilities necessary to comply with the ACA, pursuant to M.G.L. chapter 176Q, there were a few exceptions which required legislative action to reconcile (*i.e*, administering Advance Payment Premium Tax Credits, operating a Navigator program, managing appeals). The Health Connector, as the Commonwealth's ACA-compliant Exchange, will maintain its current governance structure, by which the powers of the Health Connector are to be exercised by or under the supervision of a Board of Directors.

On July 10, 2012, Massachusetts officially declared its intention to operate a state-based ACA-compliant health insurance Exchange through the Health Connector by submitting to HHS a declaration letter signed by Governor Patrick. The letter marks the first formal step towards receiving final federal approval for the operation of the Health Connector as the Massachusetts state-based Exchange.

The transition to ACA compliance is a statewide effort. The Health Connector is one of 20 state agencies actively participating in the state's Inter-Agency Task Force on Implementation of Health Care Reform. The Task Force, chaired by the Secretary of EOHHS, convenes quarterly open meetings where any interested stakeholder or member of the general public can hear an update on implementation activities and have an opportunity to ask questions. Several subsidiary inter-agency workgroups have also been established by the Secretary to identify and make recommendations for resolution of issues resulting from the intersection of state and federal law. These workgroups are charged with convening stakeholders to identify relevant issues of concern and to provide feedback through open meetings on particular issues within the purview of a given workgroup. Health Connector staff actively lead or participate in the following workgroups: Private Insurance Market Reform Workgroup; Risk Adjustment, Reinsurance and Risk Corridors (3Rs) Workgroup; Employer Workgroup; Subsidized Insurance Workgroup; and Individual Mandate Workgroup. Workgroup meeting schedules and materials are available on the Health Connector website, Health Care Reform: Planning for national reform.

In the fall of 2010, the Subsidized Insurance Workgroup, co-chaired by the Health Connector and MassHealth, was convened to analyze the options available to the state for providing subsidized coverage. To inform the evaluation of different approaches to subsidized coverage under the ACA, including the Basic Health Plan (BHP) Option,[42] the Workgroup engaged a consulting firm to conduct a robust analysis of Massachusetts's current subsidized health care coverage landscape and future options available under the ACA.

Informed by this analysis, the Subsidized Insurance Workgroup concluded that adoption of the BHP, administered by MassHealth, would promote continuity of coverage and maintain a familiar coverage and care experience for a low-income, vulnerable population. In June 2012, Governor Patrick signed legislation authorizing the election of the Basic Health Plan option and designating MassHealth as the agency to administer the program (§ 24 of chapter 118 of the Acts of 2012).[43] By December 2012, federal guidance detailing the requirements for a BHP had not been released in time for the Commonwealth to be able to implement a BHP in 2014, and therefore several state agencies, including EOHHS, MassHealth, ANF, and the Health Connector, have begun to develop an alternative to the BHP.

To make coverage more affordable for adults with income up to 300% FPL who are not eligible for Medicaid in 2014, as an alternative to the BHP, leadership from these state agencies have proposed providing an enrollee

premium and cost-sharing "wrap" (i.e., an additional state subsidy to defray premium and cost-sharing expenses) through a subset of QHPs within the Health Connector. This assistance would help to make insurance more affordable than the plans that this population would otherwise be eligible for (*i.e.*, QHPs with federal subsidies), which would be more expensive than what members currently pay in Commonwealth Care. The proposed approach includes a reasonable ceiling on the number of carriers that could qualify as wrap plans in order to ensure that consumers have adequate choice and access to needed providers, while at the same time encouraging carriers to price aggressively in order to qualify. As in Commonwealth Care today, members who choose the least expensive "wrap plan" would pay the lowest premium applicable for their income level, while members who choose more expensive plans would pay higher premiums. Point-of-service cost sharing at a given income level will not vary, and member benefits will be the same at all income levels. MassHealth is seeking Federal Financial Participation (FFP) through the 1115 Demonstration for the state wrap for enrollees up to 300% FPL, building on federal support for Commonwealth Care.

This proposed approach would protect member access to and continuity of care with needed providers, including the population that transitions between the Health Connector and MassHealth. MassHealth and the Health Connector are working together and with CMS to develop strategies to minimize any interruptions in coverage as members transition between the two programs. In FY13, MassHealth and the Health Connector will continue discussions with CMS and CCIIO to seek approval for the proposed approach and for FFP. The Commonwealth is also working closely with other stake holders, including our state and federal partners to develop strategies to minimize gaps in coverage, promote continuity of care, and provide excellent customer service.

In addition to working with colleagues from other state agencies, the Health Connector has developed an internal National Health Care Reform Transition Governance Structure to carefully manage its successful transition into an ACA-compliant Exchange. The Health Connector's internal Transition Governance Structure is a matrix model approach comprised of eight workgroups and six work threads, generally led by members of the senior team and actively supported by the Health Connector Program Management Office. Health Connector leadership oversees all workgroup and work thread leads. This includes facilitation of Board engagement on key issues and decision points.

Integral to the Health Connector's Exchange transition efforts is collaboration with the Health Connector Board of Directors, state agencies, legislators, employers, insurers, providers and consumer advocacy groups. The Health Connector also continues to identify new consumer and stakeholder groups, seek guidance from stakeholders, conduct open meetings and provide publicly available minutes of all open meetings on a regular basis. Interested individuals can access information regarding the Commonwealth's implementation on the Health Connector's website as well on EOHHS's national health reform webpage at www.mass.gov/nationalhealthreform. The Health Connector has, and will continue to, regularly engage stakeholders and consumers to obtain feedback as a formal outreach and education campaign is developed and implemented.

As an existing Exchange, the Health Connector provides access to affordable health insurance for nearly 230,000 members. Informed by that experience, the Health Connector will be re-platforming its entire online experience and supporting infrastructure through the HIX/IES project and, by 2014, will have a common suite of systems tailored to support all customer segments. The HIX/IES project is a single, integrated project to create the IT systems needed to support an ACA-compliant Exchange for both subsidized (*i.e.*, MassHealth and persons receiving federal tax credits) and non-subsidized populations. This project is critical to meeting ACA requirements and will also allow for the enhancement of the current technology model to improve the Exchange shopping experience for all customers.

In February 2011, HHS awarded UMass Medical School a $35.6 million Early Innovators grant. Massachusetts officials, specifically staff from UMass, the Health Connector and EOHHS, are using these funds to support work with other New England states to design and implement an information technology infrastructure that will improve how individual consumers and small businesses shop for health insurance. The primary focus of the Massachusetts Early Innovators grant is to build the HIX/IES for Massachusetts, and create "reusable technology

components (*i.e.*, business rules engine, interfaces with Federal data services hub)" that can be used by other participating New England states.

Federal support has been critical to ensuring a seamless and efficient transition for the Health Connector. As explained in the FY11 Annual Report,[44] in September 2010, the Health Connector was awarded a $1 million planning grant from the Center for Consumer Information and Insurance Oversight (CCIIO) to assist in activities related to transitioning the current model to an Exchange that is compliant with the ACA. Under this grant award, the Health Connector, in collaboration with state agency partners, leadership and stakeholders, was able to complete much of the analytical work necessary to identify differences between the state and federal health care reform laws that require changes to the Massachusetts model.

To assist with the implementation phase, on February 22, 2012, the Health Connector was awarded a Level One Establishment Grant.[45] Under this grant, the Health Connector was awarded $11.6 million to fund the activities of existing staff as well as staff at collaborating state agencies and key consultants to effectuate implementation of major ACA market reforms and the transition to an ACA-compliant Exchange. Transition efforts will also focus on enhancing the experience, products and services provided to individuals and small businesses shopping for health insurance through the Health Connector. The Health Connector's current Level One Establishment Grant provides federal assistance through February of 2013. Additional information on this grant award and the Health Connector's progress under this grant can be found on the Health Connector website at Health Care Reform: Planning for national reform.

The Health Connector is grateful for the ongoing Federal support of ACA transition activities.

3.0 Commonwealth Care

3.1 Commonwealth Care Enrollment

Commonwealth Care provides subsidized health insurance to adult residents earning up to 300 percent FPL that generally do not have access to other health insurance. Members may choose from among the approved MCOs that serve their region. As in prior years, all of the MCOs that participate in Commonwealth Care with sufficient experience to be rated received high rankings from the National Committee for Quality Assurance (NCQA),[46] with all four rated plans receiving the highest overall accreditation status of "Excellent" in NCQA's thorough and rigorous evaluation of health plans for quality measurement and continuous quality improvement.[47]

For a more detailed description of the Commonwealth Care program, please refer to the 2006-2008, FY09 and FY10 Annual Reports.[48]

As of the end of FY12, nearly 190,000 Massachusetts residents receive assistance with their health care costs through the Commonwealth Care program. Commonwealth Care membership remained stable at around 160,000 members during the first half of FY12; however, enrollment increased in the third and fourth quarters of FY12 due to the reintegration of the AWSS population (see Section 4.1 for additional details).

Depending on their income level, Commonwealth Care members may be responsible for paying a monthly premium. Eligible individuals earning up to 100 percent FPL (Plan Type[49] 1 members) are not subject to a premium. Individuals earning between 100 and 150 percent FPL (Plan Type 2A members) always have at least one health plan option without a premium. As Figure 3 below illustrates, the percent of non-premium-paying members increased between FY11 Q4 and FY12 Q1 due to more Plan Type 2A members enrolled in zero-premium plans. Additionally, because the vast majority of the new AWSS members are Plan Type 1 members who are not subject to a premium, the percentage of non-premium paying members further increased during the second half of FY12.

Figure 3. Total Commonwealth Care Enrollment for FY2012

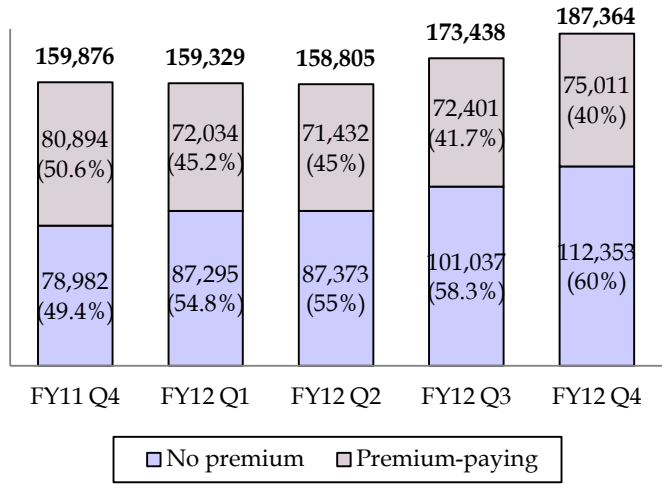
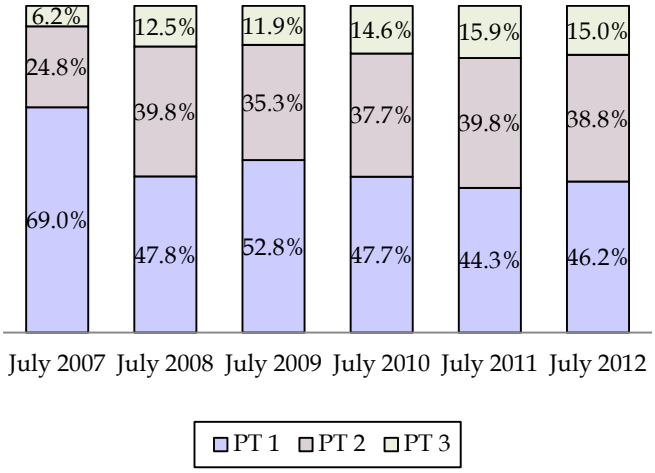
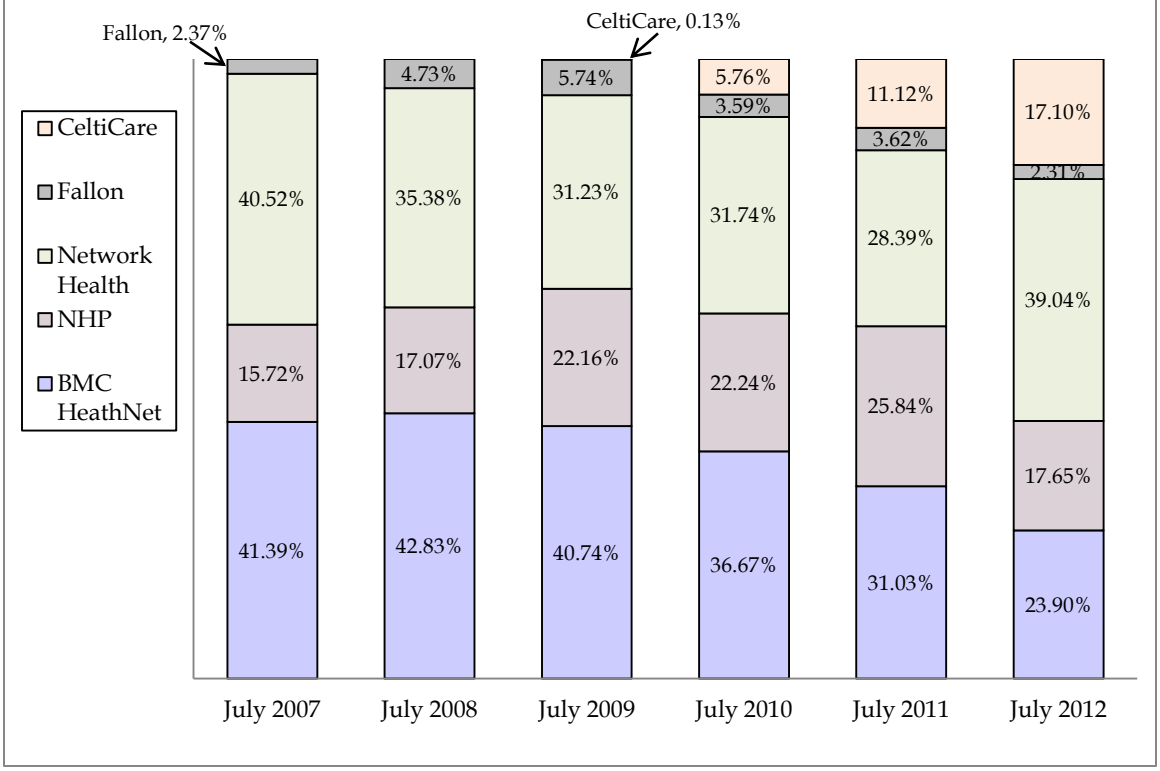


Figure 4. Commonealth Care Enrollment by Plan Type



CeltiCare and Network Health experienced the most significant changes to their membership size in FY12, with Network Health enrollment increasing by nearly 11 percent and CeltiCare enrollment increasing by about six percent from July 2011 to July 2012. Neighborhood Health Plan (NHP) and Boston Medical Center HealthNet Plan (BMCHP) experienced the most significant declines in enrollment during the same period. These changes are likely attributable to FY12 procurement results in which Network Health and CeltiCare were the two lowest cost plans for most of the state.

Figure 5. Commonwealth Care Enrollment by Health Plan



3.2 Program Updates

As explained in the FY11 Annual Report,[50] a greater percentage of Commonwealth Care members are covered under lower-cost, narrower-network health plans in FY12 than in previous years. This is attributable to certain programmatic changes implemented as a result of the FY12 MCO procurement. Specifically, a subset of the incoming PT1 members (those without coverage experience with an alternative MCO under either Commonwealth Care or MassHealth in the prior 180 days) is limited to choosing from the lowest-cost plans. In addition, member premium is reflective of the relative capitation rates among MCOs, with lower-cost MCOs more competitively priced for members. This procurement strategy was developed to promote competition and innovation by MCOs in order to achieve the goal of preserving coverage and affordability of the program under an exceptionally tight fiscal budget. The procurement was highly successful and resulted in aggressive bidding by many participating MCOs, including two of them (CeltiCare and Network Health) reducing their capitation rates from FY11 and serving as the lowest-cost plans for FY12 (see further discussion of the procurement efforts in later sections).

In September 2011, the Health Connector launched the Commonwealth Care performance analysis and oversight initiative to evaluate and report on the program's performance in access, quality and cost efficiency, particularly in light of the FY12 program changes. The initiative is part of the Health Connector's role in ensuring members have access to necessary care, supporting MCOs' innovations, and promoting program-wide cost containment efforts. Specific work streams have included data collection and analysis, MCO workgroup meetings, and stakeholder reporting. The Health Connector has provided periodic updates on this initiative in FY12 at Health Connector Board meetings.

Thanks to funding included in the Commonwealth's FY13 state budget, Commonwealth Care members now have access to enhanced tobacco cessation benefits.[51] The benefit will include individual and group tobacco cessation counseling as well as pharmacotherapy treatment, including nicotine replacement therapy. To implement this new benefit, the Health Connector gathered information from various sources, including the MassHealth program, to develop the specific requirements of the Commonwealth Care Tobacco Cessation program, which was launched in early FY13.

3.3 Commonwealth Care Member Survey

In the fall of 2011, the Health Connector worked with the survey research firm Market Decisions to perform its second annual comprehensive Commonwealth Care member survey. The second Commonwealth Care member survey is a core component of the FY12 Commonwealth Care performance analysis and oversight initiative.

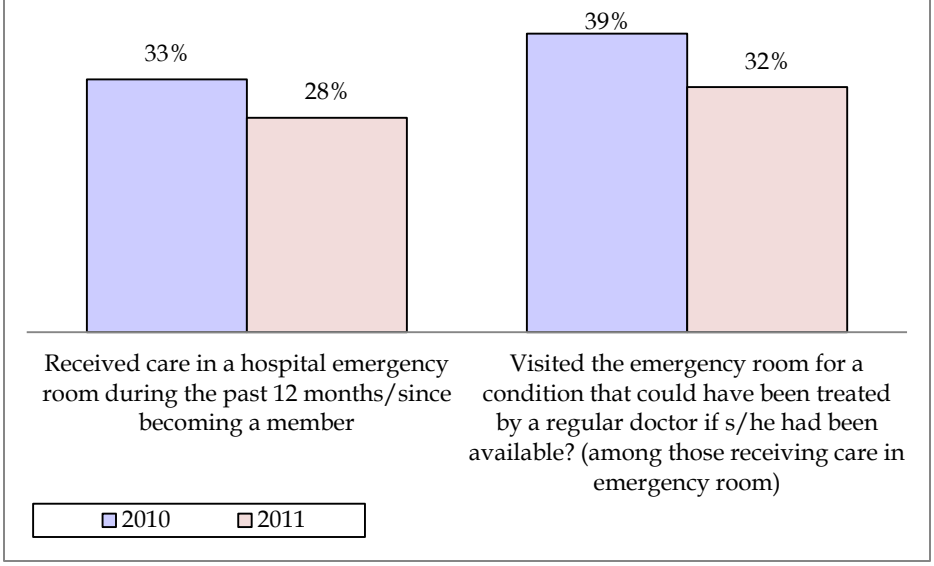
The first Commonwealth Care member satisfaction survey, conducted during FY11, showed very positive results for the program. By repeating the survey in FY12, the Health Connector has been able to track program performance against the baseline set by the FY11 survey. Member experience and satisfaction are key indicators of program success in FY12 and therefore must be measured in order to assess the impact of FY12 program changes.

The methodology of the 2011 survey was very similar to the 2010 survey (for additional information on the 2010 Commonwealth Care member survey, please refer to the FY11 Annual Report).[52, 53] The 2011 survey added a series of new questions that focused on member experience during Open Enrollment and their decision-making process as well as the experience of members who experienced provider network changes.

The 2011 survey found that Commonwealth Care continues to have high member satisfaction, with more than three quarters (77 percent) of respondents stating that they were extremely satisfied or satisfied. The primary drivers of overall member satisfaction continues to be (1) satisfaction with the choice of health plans, (2) the helpfulness of the benefit materials, and (3) knowledge about plan benefits.

Access to care remains robust for all members. Eighty-one percent of members reported they had a usual source of care and indicated that they saw a general doctor at least once during the past 12 months. Additionally, fewer members reported visiting the emergency room than in 2010. Among those visiting an emergency room, the percentage of members who indicated that they received such care for a condition they thought could be treated by a regular doctor, if available, also declined from 2010 (see Figure 6).

Figure 6. Emergency Room Use by Commonwealth Care Members, 2010 vs. 2011



Members increasingly report that premiums and copayments are affordable. Among those respondents who pay premiums, 66 percent strongly agree or agree that the premium they pay is reasonable, an increase of three percent from 2010. Very few members (three percent) indicated that they postponed or did not get needed care due to cost.

The 2011 survey also allowed for an assessment of the impact of programmatic changes introduced that year on member satisfaction. These program changes included limited health plan choice for certain Plan Type 1 members, as well as provider network changes made by certain MCOs. Overall, the survey demonstrates that these changes have not had a negative impact on enrollee satisfaction, nor have they resulted in degradation of access to or quality of health care provided.

The survey also identified areas where the Health Connector could make improvements. Members reported some concerns with education and communication materials and with customer service. While the majority of members found the support tools currently provided to be beneficial, survey respondents noted a few difficulties with the materials. This is most likely attributable to the new and more complex program rules for certain Plan Type 1 members and changes made by MCOs. Excellence in member education, communication and customer service are critical elements of member satisfaction, and the Health Connector is evaluating how to improve these resources as staff plans for the FY14 Open Enrollment and, ultimately Open Enrollment in October 2013 for qualified health plans available through the ACA-compliant Exchange.

Overall, the 2010 and 2011 surveys show that the Commonwealth Care program remains strong with high levels of member satisfaction. The Health Connector will continue to monitor health plans and member experience utilizing other metrics to ensure continued success of the program.

3.4 Commonwealth Care Waivers and Appeals

The Health Connector processes three types of waivers and appeals relating to the Commonwealth Care program: (1) a waiver or reduction of premiums or co-payments due to extreme financial hardship; (2) a request to change health plans at a time other than open enrollment; or (3) an appeal to challenge decisions related to Commonwealth Care. The Health Connector Appeals Unit, in operation since June 2007, processes all appeals relating to Commonwealth Care decisions.

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

The number of premium and co-pay waiver requests in FY12 did not change significantly since FY11. As explained in the FY11 Annual Report,[54] programmatic changes instituted during FY11 resulted in a 26.8 percent increase in waiver requests between FY10 and FY11.

Due to a change in the reporting process, the number of health plan change requests increased significantly between FY11 and FY12. To be approved for a health plan transfer, Commonwealth Care members must meet one of seven qualifying events.[55] Prior to FY12, Commonwealth Care only reported on one of the seven qualifying events, whereas, in FY12, the program began reporting on all seven. The increase in transfer requests might also be attributable to network changes during the FY11 procurement.

Table 2. Commonwealth Care Waivers, Change Requests, and Appeals										
	June 1, 2007[1] - June 30, 2008		FY 2009		FY 2010		FY 2011		FY 2012	
	#	%	#	%	#	%	#	%	#	%
Commonwealth Care Waivers Requests (for premium or co-pay reduction)										
Total:	**722**		**1,780**		**1,714**		**2,173**		**2,237**	
# approved:	344	48%	939	53%	940	55%	1,240	57%	1,391	62%
# denied:	221	31%	841	47%	774	45%	933	43%	846	38%
# dismissed:	10	1%	0	0%	0	0%	0	0%	0	0%
# pending:[2]	147	20%	0	0%	0	0%	0	0%	0	0%
Commonwealth Care Health Plan Change Requests										
Total:	**507**		**227**		**554**		**362**		**1230**	
# approved:	283	56%	204	90%	543	98%	259	72%	814	66%
# denied:	209	41%	1	0%	11	2%	20	6%	217	18%
# dismissed:	13	3%	19	8%	0	0%	83	23%	199	16%
# pending:[2]	2	0%	3	1%	0	0%	0	0%	0	0%
Commonwealth Care Appeals										
Total:	**1,193**		**5,668**		**5,389**		**4,723**		**5,341**	
# approved:	6	1%	80	1%	349	6%	354	7%	559	10%
# denied:	6	1%	347	6%	861	16%	680	14%	657	12%
# dismissed:	811	68%	4,315	76%	3,804	71%	3,210	68%	3,581	67%
# pending:[2]	370	31%	926	16%	375	7%	479	10%	544	10%

[1] The waiver and appeals program began on June 1, 2007.

[2] Requests pending on June 30, 2008 were resolved and appear in FY09. Requests pending on June 30, 2009 were resolved and appear in FY10. Requests pending on June 30, 2010 were resolved and appear in FY11.

A month by month analysis shows that Commonwealth Care appeal receipts have averaged 403 appeals per month in FY12. Average monthly receipts in FY11 were 371 appeals per month. The Health Connector Appeals Unit held 2,701 Commonwealth Care hearings in FY12.

The increase in Commonwealth Care appeal receipts is partially attributable to implementation of revised Commonwealth Care regulations that shortened the length of time members can fail to pay premiums from three months to two months before being disenrolled. Additionally, enhanced data matching capabilities between MassHealth and the Department of Labor and Workforce Development to identify individuals with unemployment income may also have contributed to the rise in appeals, as individuals found to be receiving unemployment benefits are not eligible for Commonwealth Care due to access to coverage through MSP.

3.5 Commonwealth Care FY13 Procurement Process

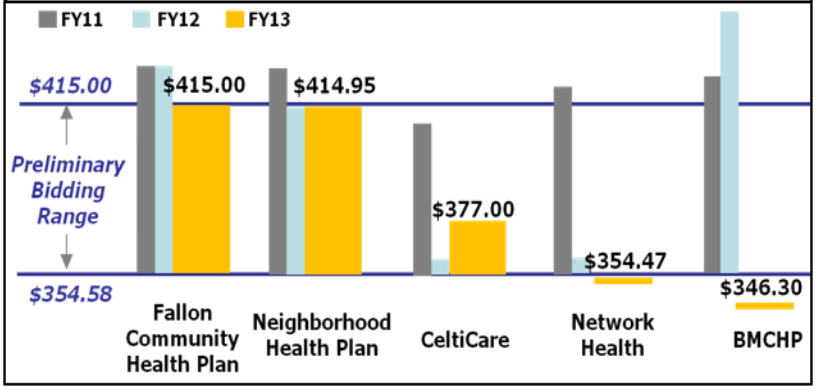
In the six years since Massachusetts health care reform became law, the Health Connector has demonstrated that, through the power of competition, high quality and dependable coverage can be provided at an affordable cost. In that time period, the per member per month rate the state pays to insurance carriers for Commonwealth Care coverage has increased by an average of less than two percent. This is in contrast to trends in the Massachusetts private market where, between 2008 and 2010, commercial insurance premiums grew by 7.5 percent.[56] The Health

Connector has demonstrated that innovation and collaboration can actually *reduce* health care costs. The average Commonwealth Care capitation rate achieved a year-over-year reduction of 5% in each of the most recent two fiscal years (FY12 and FY13). Significant savings were achieved through these procurements with no benefit reductions and minimal member co-pay increases.

As detailed in the FY11 Annual Report,[57] the Health Connector conducted an aggressive competitive procurement in an effort to achieve a flat-funded budget target for FY12, allowing for accommodation of an anticipated enrollment increase while preserving benefits and without implementing drastic increases in cost-sharing. The procurement was designed to encourage aggressive bidding by creating a wide actuarially sound rate range (ASRR) and multiple incentive mechanisms that tied membership to low bids. Through this innovative procurement process, the Health Connector was able to achieve a five percent aggregate capitation rate decrease for FY12 relative to FY11.

Statewide fiscal challenges are projected to continue in FY13. The slow economic recovery coupled with increases in Commonwealth Care enrollment resulting from the reintegration of the AWSS population (see Section 4.0 for additional information) and MSP members transitioning to Commonwealth Care (as federal unemployment insurance extensions expire) demanded another aggressive procurement. Consequently, the FY13 procurement strategy pursued the same basic framework as in FY12 with certain refinements: (1) the bid ceiling was set at $415 PMPM; (2) bidders could bid below the preliminary ASRR floor, subject to independent actuarial review and certification; (3) enrollee premium differentials would be set based on bid position; (4) a subset of incoming Plan Type 1 members would have limited choice of the low-cost MCO(s) available in their service areas, including the lowest-cost MCO and the second lowest-cost MCO, provided that the second–lowest-cost MCO bid no higher than $380 PMPM; and (5) an active open enrollment[58] for Plan Type 1 members would be triggered if fewer than two current statewide Commonwealth Care MCOs bid at or below $380 PMPM.

Figure 7. Medical and Administrative Capitation Bid (PMPM)



The results of the procurement were, once again, tremendously successful, yielding another five percent decrease in aggregate capitation rates relative to FY12, for a total aggregate decrease of 10 percent over FY11. As Figure 7 shows, the majority of plans proposed a rate cut for FY13, with BMCHP and Network Health as the two lowest cost plans for FY13. Every plan now has rates lower than those from two years ago without cutting benefits or significantly increasing member co-pays. Additionally, the "spread" between the lowest and highest enrollee premiums per income category is narrower than FY12. Based on current membership distribution, average FY13 enrollee premium will decrease relative to FY12.[59] Because members have the option to switch to lower premium health plans during open enrollment, actual average enrollee premiums in FY13 may be even lower.

Existing members have the full choice of health plans during open enrollment and all incoming members have at least two health plans to choose from, encompassing a broad array of hospitals and doctors. Incoming Plan Type 1 members without prior coverage history in an MCO through either Commonwealth Care or MassHealth in the past six months that is not currently a low cost MCO will be required to choose between the two "low-cost MCOs" in their service area. Further, all MCOs will cover either the same or expanded networks compared with FY12. The two lowest bidders, BMCHP and Network Health, collectively cover 66 out of the 73 acute hospitals in the state.

In April 2012, the Health Connector Board of Directors voted unanimously in favor of awarding the FY13

Commonwealth Care contracts to all health plans that bid for the period beginning July 1, 2012 and ending June 30, 2013: Boston Medical Center HealthNet Plan, CeltiCare Health Plan, Fallon Community Health Plan, Neighborhood Health Plan, and Network Health.

The Health Connector is grateful for the hard work and dedication of MCOs and providers to achieving cost savings without sacrificing member care.

3.6 Commonwealth Care Budget

As of fall 2012, the Commonwealth Care program is estimated to be $36.6 million under budget for FY12, primarily as a result of lower than projected enrollment due to the extension of unemployment benefits for MSP members announced in February 2012. Table 3a below compares the budgeted and actual expenditures for FY12.

Table 3a. Commonwealth Care Expenditures FY12 (Non-AWSS Members)

FY 2012 Budget and Actual	FY12 (Budget)	FY12 (Actual)[2]	FY12 (Variance)
Year End Membership	175,542	164,942	-10,600
Member Months	2,070,399	1,922,479	-147,920
Capitation Rate	$414.00	$408.15	($5.85)
Total Spending[1]	$784,681,221	$748,124,135	($36,557,086)

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

[2] FY12 Actual excludes AWSS members (new and waitlisted AWSS members and former Bridge members) reintegrated into CommCare beginning March 1, 2012.

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.

Notwithstanding the budget challenge, the Governor Patrick Administration and the Legislature have made an extraordinary commitment to Commonwealth Care with the FY13 final budget, which includes full funding for AWSS reintegration. Approximately 13,000 members of the Commonwealth Care Bridge program and over 24,000 waitlisted AWSS members became eligible for Commonwealth Care as of March 2012. The $905 million in FY13 funding includes $143 million for covering the AWSS population for a full year through Commonwealth Care. Relative to the $42 million funding for the Bridge program in FY12, this is an increase of $101 million in funding that is not eligible for federal reimbursement. This serves as an important solution that provides equal coverage for AWSS members before a more sustainable mechanism for funding AWSS coverage, namely, federal tax credit subsidies under national health care reform, become effective in 2014. Table 3b shows budgeted enrollment and expenses for FY13.[60]

Table 3b. Commonwealth Care FY13 Final Budget [2]

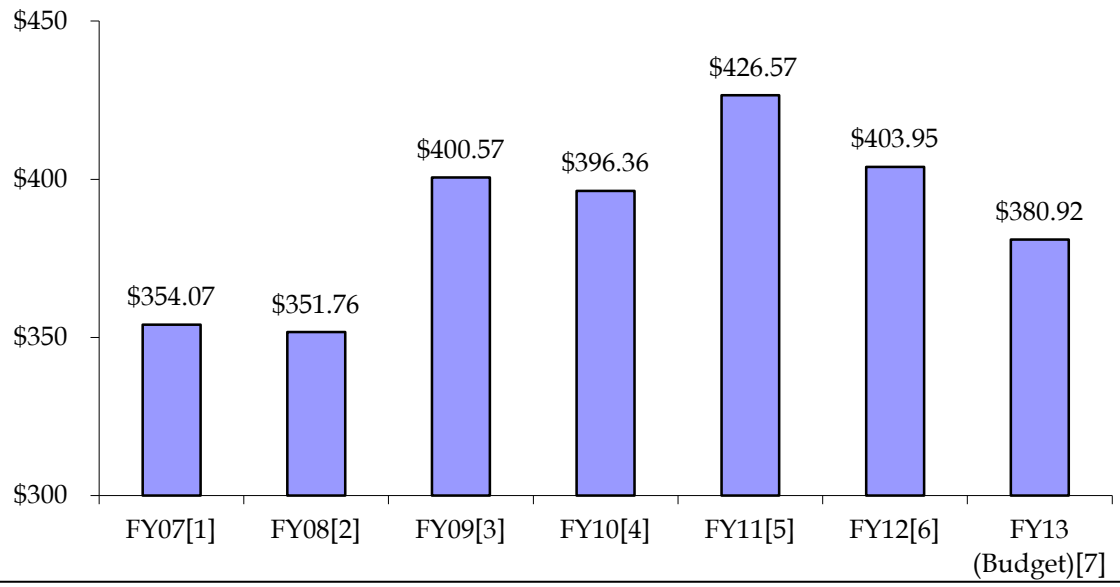
FY 2013 Budget	FY13 Final Budget
Year End Membership	208,948
Member Months	2,455,611
Capitation Rate	$380.92
Total Spending[1]	$904,540,930

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

[2] FY13 Final Budget includes AWSS & non-AWSS members.

As described in Section 3.5, the Health Connector was able to achieve significant cost savings for FY13 through an innovative procurement process that maintained covered benefits and ensures projected enrollment growth can

Figure 8. Average Commonwealth Care Capitation Rate (PMPM)
FY07 - FY13



[1] This figure reflects payments made for AWSS and non-AWSS members for the fifteen month period from 10/1/06 - 12/31/07.

[2] This figure reflects actual payments made for AWSS and non-AWSS members for the six month period from 1/1/08 - 6/30/08.

[3] This figure reflects payments made for AWSS and non-AWSS members for the twelve month period from 7/1/08 - 6/30/09.

[4] This figure reflects actual payments for the twelve month period from 7/1/09 - 6/30/10. This figure includes non-AWSS members for the twelve month period and AWSS members for the three month prerior from 7/1/09 - 9/30/09.

[5] This figure reflects payments made for non-AWSS members for the twelve month period from 7/1/10 - 6/30/11.

[6] This figure reflects payments made for the twelve month period from 7/1/11 - 6/30/12 and includes non-AWSS members and AWSS members (new and waitlisted AWSS members and former Bridge members) reintegrated into CommCare beginning March 1, 2012.

[7] This figure reflects the final budget for the twelve month period from 7/1/12 - 6/30/13 and includes non-AWSS members and AWSS members reintegrated into CommCare.

be sustained despite fiscal constraints. For the second year in a row, Commonwealth Care capitation rates are projected to be five percent lower than the previous year, with all capitation rates less than they were in FY11.

4.0 Commonwealth Care Bridge

4.1 Program Updates

The Commonwealth Care Bridge program (Bridge), which was in operation from October 2009 through February 2012, was established to provide low-cost health insurance coverage to certain legal immigrants, known as AWSS, who lost eligibility for coverage under Commonwealth Care in 2009. Legal immigrants were eligible to participate in the Bridge program if they (1) were enrolled in Commonwealth Care as of August 31, 2009, (2) lost Commonwealth Care coverage on August 31, 2009 due to changes in state law, and (3) met the eligibility requirements for Commonwealth Care except for immigration status. After review by the three administering agencies (ANF, EOHHS and the Health Connector), in FY10 the Governor accepted a proposal from CeltiCare for a fully-capitated coverage plan. Following a second competitive procurement, the Bridge program contract was again awarded to CeltiCare in FY11. The Bridge program contract with CeltiCare was extended for FY12. For a more detailed program description, please refer to the FY10 Annual Report.

In February 2010, immigration and health care advocacy groups filed a class action lawsuit, Finch v. Commonwealth Health Insurance Connector Authority, challenging the constitutionality of excluding legal immigrants from Commonwealth Care. On May 6, 2011, the Massachusetts Supreme Judicial Court (SJC) issued an interim ruling indicating that the Legislature's action to exclude the AWSS population from Commonwealth Care would be reviewed with the highest level of scrutiny reserved for state actions. After hearing oral arguments in the fall of 2011, on January 5, 2012 the SJC issued a decision finding that the law suspending AWSS eligibility for Commonwealth Care, first enacted in 2009, violated the Equal Protection Clause of the Massachusetts Constitution.

In late January 2012, the Patrick Administration, EOHHS and the Health Connector launched a process to reintegrate approximately 13,000 Bridge members and over 24,000 waitlisted AWSS members who became eligible for Commonwealth Care as a result of the SJC ruling as expeditiously and responsibly as possible. The guiding principle of the reintegration approach was to treat AWSS exactly as any other citizen of the Commonwealth, reflecting the principles of the SJC's decision.

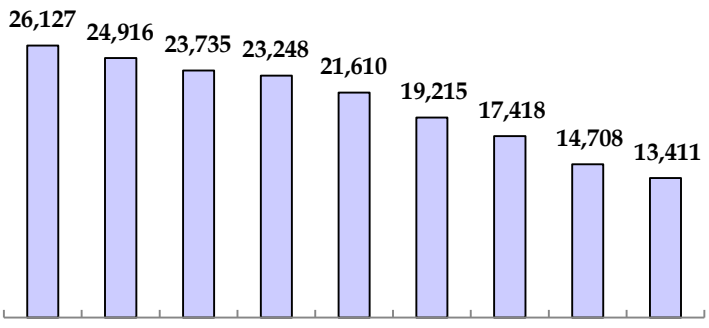
To that end, the Health Connector immediately began working to close the Bridge program and transition Bridge members into Commonwealth Care. In February 2012, the Health Connector held a special open enrollment period for Bridge members to choose from any of the Commonwealth Care health plans that they were eligible for in the event they wished to change their current health plan. All ~13,000 former Bridge members were then transitioned into Commonwealth Care effective March 1, 2012 – less than two months after the SJC issued its decision.

During the same period, the Health Connector and EOHHS staff worked closely together on the information technology and operational changes necessary to eliminate the AWSS waitlist for Bridge coverage and begin enrolling the population into Commonwealth Care. Under the program rules in effect for Commonwealth Care in FY12, formerly waitlisted AWSS members, and any other AWSS members newly applying for coverage, were able to enroll in Commonwealth Care as early as April 2012. All AWSS members enrolled as of June 1st had the opportunity to participate in the Open Enrollment for FY13 coverage, and as of the end of FY12, 22,454 total AWSS members were newly enrolled or re-enrolled in Commonwealth Care.

The Health Connector is grateful to the Patrick Administration and EOHHS for providing operational and budgetary support for AWSS reintegration. This support has served as an important means for providing full, equal coverage for AWSS members before a more sustainable mechanism for funding AWSS coverage, namely, federal tax credit subsidies under the ACA, becomes available in 2014.

4.2 Commonwealth Care Bridge Enrollment through February 2012

Figure 9. Commonwealth Care Bridge Enrollment



As of February 2012, the last month that the Bridge program was in operation, there were 12,474 members participating in the Bridge program, down from 17,418 at the end of FY11. The overall decline in Bridge enrollment figures during the program's life, as depicted in Figure 9, is attributable to natural attrition. This includes people opting out of the program, leaving the state, gaining access to employer sponsored insurance, or losing their AWSS status and becoming eligible for Commonwealth Care (*i.e.,* reaching the five year federal residency requirement necessary to be eligible for federal funding).

Reintegration of the AWSS population into Commonwealth Care began effective March 1st. As of the end of CY12, there were 27,312 AWSS members enrolled in Commonwealth Care.

5.0 Commonwealth Choice

5.1 Program Update

Commonwealth Choice, the Health Connector's unsubsidized health insurance program, offers individuals and small businesses high-quality, private health insurance. Commonwealth Choice is a valuable resource for non- and small-group shoppers, providing an easily accessible one-stop shopping experience for health insurance.

Eight health insurance carriers currently participate in the Commonwealth Choice program, with Boston Medical Center HealthNet Plan offering coverage through Commonwealth Choice for the first time effective January 1, 2012. Collectively, as of the end of FY12, the eight carriers provided health coverage to more than 40,000 members. Of the carriers with sufficient experience to be rated,[61] all receive an "Excellent" overall accreditation status according to NCQA's health plan report card.[62] A detailed program description can be found in the annual reports for 2006-2008 and FY09.[63]

To further enhance the consumer shopping experience, in July 2011 the Health Connector launched a provider search tool which allows shoppers to compare plans by doctors and hospitals. Previously, shoppers were required to navigate to individual carrier sites to search for providers and were unable to directly compare carrier networks. This new feature enables individuals and small businesses to easily shop for plans which include their preferred providers, simplifying the online shopping experience through Commonwealth Choice.

The Health Connector has significant responsibilities related to fashioning and implementing an ACA-compliant Exchange for individuals and small businesses. Planning efforts are well underway, and these changes will provide increased value for individuals and small businesses shopping through the Commonwealth Choice

program. Health Connector staff are working with Massachusetts health plans participating in the Commonwealth Choice program to design and operationalize the programmatic changes necessary for compliance with federal requirements under the ACA. For example, as of September 23, 2010, the ACA required health plans to waive cost-sharing requirements for certain preventive care office visits. All health plans sold through the Health Connector in FY12 comply with this requirement.

The ACA also required health plans to eliminate annual benefit limits. Young Adult Plans (YAPs) are the only Commonwealth Choice products that may include an annual limit. To mitigate potentially significant premium increases resulting from the removal of annual benefit limitation, existing members enrolled in a YAP with an annual limit will be able to remain in their plan with a limit through December 31, 2013. All new YAP enrollees are offered plans without any annual limit.

For coverage effective January 1, 2014, the Health Connector will also be required to effectuate a number of changes to ensure plan designs comply with ACA requirements, and planning for these changes is well underway. This includes aligning health insurance plans currently offered through the Health Connector with actuarial value requirements, Essential Health Benefits, and plan metal tiers (Platinum, Gold, Silver, Bronze). Additionally, the Health Connector will be required to offer a number of new plans to individuals and small businesses shopping through the Exchange, including Multi-State Plans,[64] Consumer Operated and Oriented Plans (COOPs), and catastrophic plans and child-only plans (only available to non-group purchasers) as required by ACA. As we work to implement these adjustments and improvements, the Health Connector is shaping and driving an implementation approach that will minimize disruption to carriers, employers and individuals already participating in the Exchange.

5.2 Helping Small Employers

Small businesses are an integral part of the Massachusetts economy, fostering job growth and innovation. As such, the Health Connector is demonstrating its commitment to supporting the health and well-being of small businesses and their employees by enhancing the tools and resources they need to identify and enroll in high-quality, affordable health insurance.

Figure 10. Business Express Shopping Experience

The Business Express (BE) program is the Health Connector's sole-source product for small businesses. Originally launched in 2010, BE was "re-launched" on February 10, 2012 with full carrier participation. Small employers can now choose from among 53 health insurance plans from eight leading insurance carriers. Additionally, to further its efforts to bring value to small businesses, those small businesses with one to five employees are no longer required to pay the $10 per subscriber per month supplemental fee and carriers enjoy a reduced administrative fee of 2.5 percent for BE.[65] Over 4,300 members are enrolled in a plan through BE as of July 2012.

The Health Connector continues to develop tools for small businesses and their employees that not only improve their health insurance shopping experience, but also promote health and wellness. As described in the next section, the re-launch of BE helps effectuate the Health Connector's wellness pilot program, "Wellness Track."

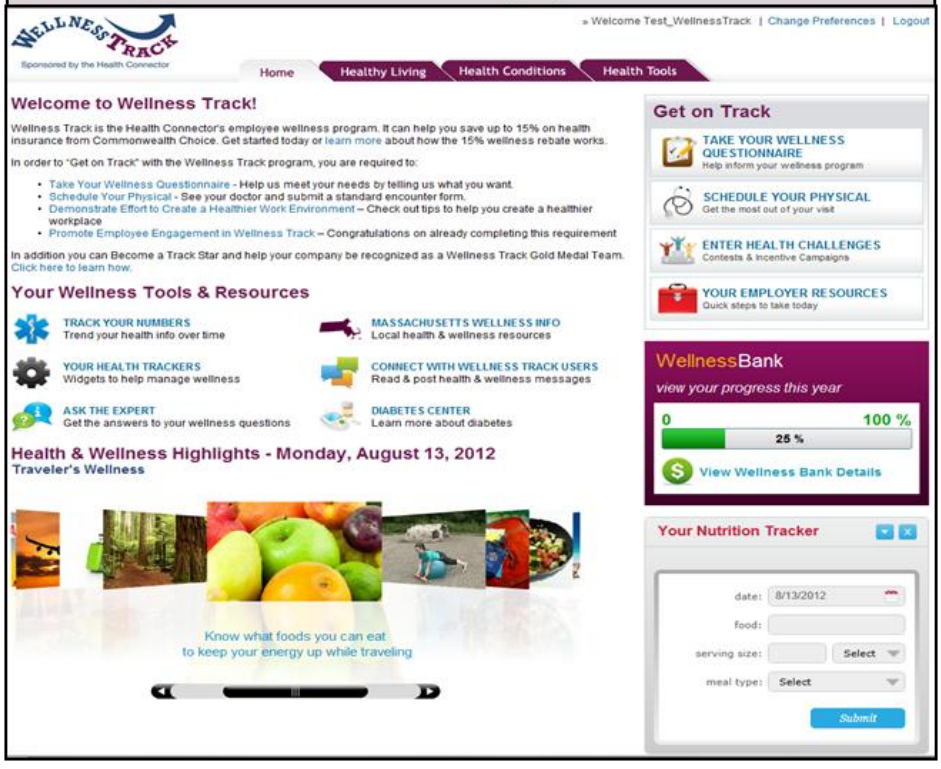
In addition to establishing Exchanges for the non-group market, the ACA calls on states to implement a Small Business Health Options Program (SHOP) Exchange to serve the small-group market. The ACA allows states to establish one Exchange serving both individuals and small groups or two Exchanges serving these populations. The Health Connector is using its ongoing experience serving small businesses to inform the development of the SHOP component of the Exchange that will go beyond federal requirements to meet the unique needs of Massachusetts employers and employees. To create a meaningful and innovative SHOP Exchange, the Health Connector has begun to collect and will continue to incorporate input from key customers and user groups, including small-group employers, small-group employees and brokers.

5.3 Wellness Track Update

Wellness Track, established by the Health Connector pursuant to chapter 288 of the Acts of 2010, is an innovative, web-based worksite wellness and subsidy program which became available to small businesses participating in BE in June 2011. Wellness Track provides small businesses with technical assistance to implement evidence-based employee health and wellness programs. Via the Health Connector website, participating employers and their employees have access to a user-friendly web interface that offers customized wellness programs and a library of health information. While all small businesses enrolled in a plan through BE may participate in Wellness Track, certain employers may also be eligible to receive a rebate of 15 percent of the employer's share of eligible employee health care costs.

Wellness Track's rebate eligibility guidelines have to date mirrored those governing the Federal Small Business Health Care Tax Credit. To be eligible for a rebate for participation in Wellness Track, small businesses must employ fewer than 25 full time equivalent employees with an average annual salary of less than $50,000 (excluding owners and family member-employees). The cost of coverage for employers and any family member-employees are not eligible for the tax credit.

Figure 11. Wellness Track Employer Welcome Screen



Given the narrow nature of the initial eligibility requirements enacted in 2010, the Legislature passed legislation in FY12 allowing

the Health Connector Board of Directors to determine the most appropriate minimum eligibility criteria and participation requirements to ensure broad access to wellness programs for small businesses in the Commonwealth. Health Connector staff are reviewing current guidelines and anticipate presenting a recommendation to the Board in FY13.

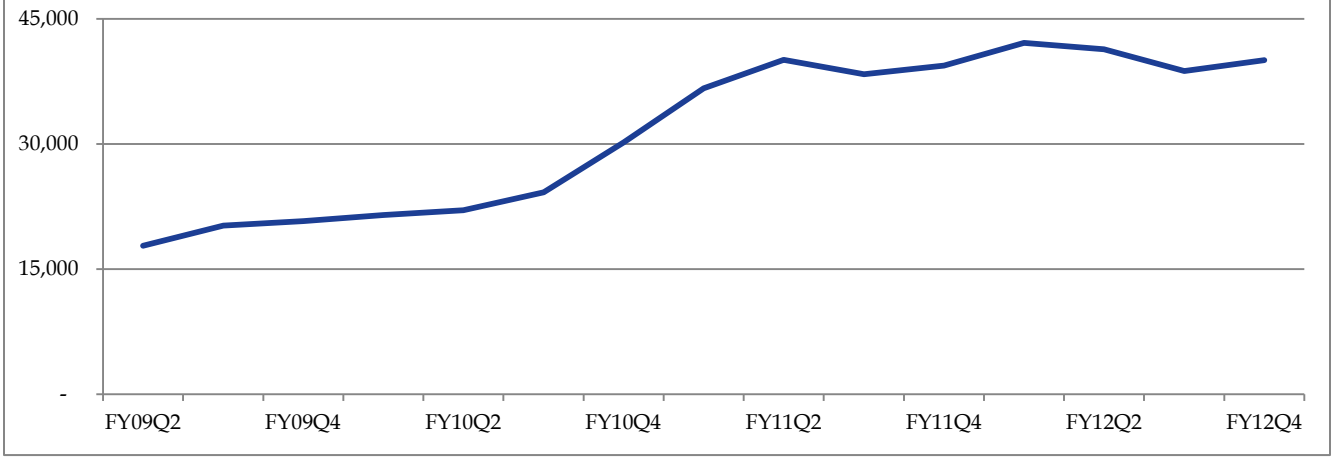
Wellness Track provides participating small employers and their employees with a suite of tools, such as health and nutrition trackers and exercise videos, to promote a healthier work environment. To qualify for the rebate, employers must encourage their employees to utilize these tools. Specifically, employees must complete a wellness questionnaire as well as submit a standard encounter form attesting to the fact that the employee has seen a medical professional within twelve months of the company's enrollment. In addition, the employer is encouraged to implement policies and procedures that foster a healthy work environment.

Wellness Track is an innovative product unique to the small-group market and the Health Connector is looking forward to leveraging lessons learned during its first year in operation to enhance the wellness program for FY13 and beyond.

5.4 Commonwealth Choice Enrollment

As of July 2012, there were 39,018 paid members enrolled in a health plan through Commonwealth Choice, 26,570 paid subscribers and 12,448 dependents. Commonwealth Choice enrollment peaked in September 2011 at 42,075 paid members. This can be attributed to the open enrollment period of the non-group market that was in effect from July 1 through August 15, 2011 for effective dates of August 1 and September 1, as non-group subscribers account for about 80 percent of total Commonwealth Choice enrollment.[66] Health Connector staff anticipates another increase in the growth of non-group membership following the FY13 open enrollment period which will run from July 1 through August 15, 2012.

Figure 12. Commonwealth Choice Enrollment (members)

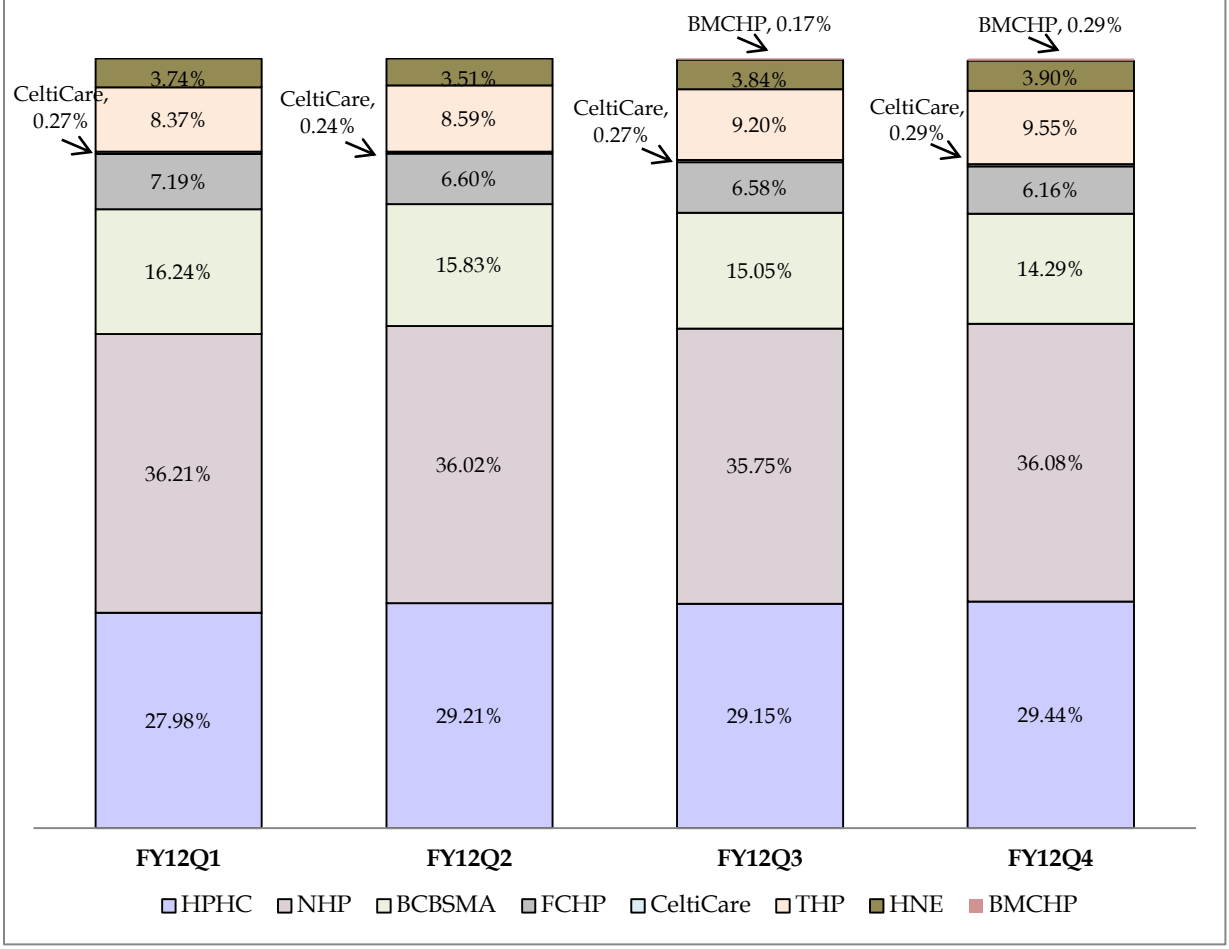


Of the four tiers of coverage (Gold, Silver, Bronze and YAP), Bronze-level products continue to attract the most customers, with enrollment in these products increasing by 13.5 percent (2,422 paid members) between July 2011 and July 2012. Nearly 34 percent of members (13,204 paid members) are enrolled in a Silver-level plan while only 7.7 percent of members (2,990 paid members) are enrolled in a Gold-level product. Similar to FY11, YAP enrollment has been decreasing throughout the fiscal year, likely as a result of the extension of dependent coverage provision in the ACA that enables young adults up to age 26 to enroll in their parent's coverage. Though Massachusetts's own reform initiative included a similar provision, it was only applicable to fully-

insured coverage; the ACA applies to both fully and self-insured plans, broadening the number of young adults who may benefit from this provision.

Percentage enrollment by carrier remained consistent throughout FY12, with NHP and Harvard Pilgrim Health Care (HPHC) retaining roughly two thirds of total membership. Enrollment in Tufts Health Plan (THP) and Health New England (HNE) increased slightly, representing 9.6 percent and 3.9 percent of membership at the end of FY11 respectively. Blue Cross Blue Shield of Massachusetts (BCBSMA) membership decreased during the fiscal year, with enrollment remaining stable at roughly 15 percent for the second half of the fiscal year. Enrollment in CeltiCare has also remained stable throughout the fiscal year. BMCHP is a new entrant offering coverage through Commonwealth Choice with an initial effective date of January 1, 2012.

Figure 13. Commonwealth Choice enrollment by Health Carrier (members)



Individual (*i.e.*, subscriber only) coverage remains the top-selling rate basis type by far, constituting about half of total enrollment in both small and non-group products in June 2012. As noted above, young adult participation in Commonwealth Choice continues to decline. The number of members age 18-26 declined by about 57 percent between July 2010 and July 2012. Enrollment by gender has not changed significantly during FY12. Non-group membership constitutes 83 percent of Commonwealth Choice enrollment.

In addition to selling non-group products directly to individuals and families, the Health Connector also operates the Voluntary Plan (VP) and Business Express and offered the Contributory Plan (CP) on a pilot basis to facilitate the purchase of insurance for employees through the Commonwealth Choice program. VP allows employees without access to ESI to purchase a non-group Commonwealth Choice health insurance plan using pre-tax dollars if their employer established an Internal Revenue Code Section 125 plan with the Health Connector. As of July

2012, 2,516 members were enrolled in Commonwealth Choice through VP. The Health Connector piloted CP in January 2009 to increase flexibility in health insurance options for small employers. Enrollment was closed to new business in the CP pilot in March 2010 and, as of April 2012, employers and employees could no longer renew into CP and were referred to BE. The Health Connector is evaluating the CP program and will consider this model, among other potential options, that may be implemented in 2014 to comply with the "employee choice model" required by the ACA. BE is discussed in more detail in Section 5.2.

5.5 Procurement and Seal of Approval for Plans with Coverage Effective January 1, 2013

The Seal of Approval (SoA), as specified in M.G.L. chapter 176Q, is a designation awarded by the Health Connector, indicating that a health benefit plan meets certain standards regarding quality and value. This process ensures health insurance carriers are willing to work with the Health Connector to offer high value, cost-effective health benefit plans through the Commonwealth Choice program. Through the SoA process, the Health Connector is able to select and offer high value plans, align choice of plan designs and carriers with consumer demand, enhance simplicity of the consumer shopping experience, minimize risk selection inside and outside of the Health Connector among participating health plans, and maintain continuity of coverage for existing members.

In FY11, the Health Connector solicited two separate bids from carriers interested in participating in the Commonwealth Choice program. The first procurement and contract cycle was for the period from January 1 through June 30, 2011 and the second was from July 1, 2011 through December 31, 2012 with the option to extend for an additional year. The 18-month contract term of the second contract cycle provides the Health Connector and health plans stability while planning for changes required by national health reform. During this period, several improvements have been made to the Commonwealth Choice program. As described in more detail in Sections 5.1, 5.2 and 5.3, the Health Connector was able to achieve full health insurance carrier participation in Business Express, add a new carrier, implement Wellness Track, enhance the non-group shopping experience by launching a new Provider Search Tool, implement chapter 288 provisions (*i.e.,* non-group open enrollment), and remove the annual benefit maximum for all new YAPs.

To reduce the administrative workload for the Health Connector and existing Commonwealth Choice carriers while still allowing the opportunity for potential new carrier entrants to join, the Health Connector conducted a more limited bid process in FY12. Health Connector staff recommended exercising the option to extend existing carrier contracts for an additional twelve month term beginning January 1, 2013 through December 31, 2013, with an invitation to offer certain new products during this period, as discussed subsequently. Under the contract extension, existing carriers must continue to participate in all product offerings in both the non- and small-group markets and they must continue to provide products that meet the current standardized plan design specifications on all benefit tiers on the broadest commercial provider network offered by the carrier. For potential new carrier entrants or new plan offerings by existing carriers, the Health Connector issued an RFR in May 2012 inviting responses for the term beginning January 1, 2013 through December 31, 2013. Responses were due at the end of June 2012 and the Health Connector presented staff evaluations and recommendations to the Board of Directors in September 2012.

With consumer demand for plan designs that help lower costs and improve value growing in the non- and small-group markets, many insurers have launched new innovative products that are responsive to this demand that may not currently be available through the Health Connector's shelf. This includes select network products. Since the re-launch of Business Express, the Health Connector has received feedback from brokers and small businesses expressing a strong desire for more product choice, and several carriers have expressed an interest in offering non-standardized products through Commonwealth Choice. Consequently, in addition to offering standardized products on their broadest commercial network, carriers were invited to offer one or more of the following effective January 1, 2013:

- Narrower network products on all standardized plan designs for at least one benefit tier (*i.e.*, Gold, Silver, Bronze); and/or
- One or more other popular and/or innovative products (*i.e.,* need not meet standardization specifications)

This approach provides flexibility to carriers, allowing them to offer popular, innovative products in response to market innovation, and yet also allows shoppers who continue to be interested in standardized products to continue to compare "apples to apples." All proposed products were subject to the Health Connector's review and approval. Review criteria included non-discriminatory plans that meet MCC standards, meet federal and state mandated benefits, products that bring value to consumers by adding meaningful diversity to the Health Connector shelf and innovative plan designs that can help achieve premium cost savings for consumers.

Operating Commonwealth Choice for the last five years has provided the Health Connector with a solid foundation of plan management experience and a deep understanding of the small and non-group health insurance market. Similar to the SoA process, the ACA requires the Exchange to review carrier plan information across a number of criteria. While the majority of these criteria are assessed as part of the existing SoA process, new criteria are introduced by the ACA, including network adequacy and essential community provider participation standards, service area requirements, transparency reporting, quality requirements and a marketing standards review. In addition, plan certification, recertification, decertification and compliance monitoring processes are being redesigned to fully comply with the ACA. The Health Connector is working with other agencies, such as the DOI, to develop operational procedures of a coordinated plan certification that streamlines existing plan management processes to ensure they can support a broad and flexible carrier/product portfolio and stay responsive to the market.

6.0 Policy and Regulatory Responsibilities

6.1 Minimum Creditable Coverage

MCC requirements were established by the Health Connector Board of Directors to create a "floor" of benefits that adult tax filers must have in order to be considered insured and avoid tax penalties in Massachusetts. The regulation was first made effective July 1, 2007 and, beginning in TY09, individuals were required to obtain a health insurance policy that meets MCC standards, if an affordable plan is available to them. As explained in the FY10 report, for TY11 (*i.e.*, January 2011 through December 2011), fixed-dollar caps on prescription drug benefits are no longer allowed. Additionally, with regard to benefits for dependents, if dependent coverage is provided by the health benefit plan, the coverage must provide all core medical services and a broad range of medical services to all covered dependents, including maternity benefits for dependent children. The MCC requirements for TY10 and TY11 can be found on the Health Connector website.[67]

As part of the revised October 2008 MCC Regulation, the Health Connector's Board of Directors adopted a provision that would allow a health benefit plan that did not meet every element of the MCC Regulation to be submitted to the Health Connector for review. If the Health Connector, in its discretion, felt that the coverage was sufficiently comprehensive, the Health Connector could deem such health benefit plan as being actuarially equivalent to MCC standards despite its deviation(s) from the MCC standards.

This process, called "MCC Certification," is further described in Health Connector Administrative Bulletins (released in November 2008 and February 2010).[68] Many carriers and employers seeking MCC Certification involve national plans that are either self-insured or utilize a group insurance plan issued in another state that also covers Massachusetts residents.

As of June 2012, the Health Connector has reviewed 4,855 plans in FY12, more than the number of MCC certification requests received in FY11. This increase (20 percent) is likely attributable to allowing the electronic submission of a large number of plans at one time. Of the plans submitted to the Health Connector for MCC Certification, the vast majority (88.6 percent) were submitted in this new bulk format.

The majority (97 percent) of plans reviewed were granted MCC Certification by the Health Connector, signifying that coverage provided by the plan was deemed to be actuarially equivalent or greater than coverage provided by the Health Connector's Bronze-level plans. This high rate of approval reflects the Health Connector's flexibility in defining MCC to minimize unnecessary disruption to comprehensive employer-sponsored plans, while ensuring that Massachusetts residents have health insurance coverage options that provide sufficient levels of benefits. Also, public education relating to MCC requirements may have reduced the number of plans with significant deviations that would have been submitted for review only to fail the MCC Certification process. The Health Connector's website and the MCC Certification application itself make clear that there are certain plan design requirements that must be met and, if not, the plan will be denied MCC Certification.

6.2 Individual Mandate and the Affordability Schedule

The Health Connector Board is required on an annual basis to devise a schedule that defines the percentage of income an individual could be expected to contribute towards the purchase of an MCC-compliant health insurance plan.[69] An adult is considered able to purchase affordable health insurance if his or her monthly contribution to subsidized insurance or the lowest cost insurance plan available through the Health Connector does not exceed the corresponding maximum monthly premium for his or her income bracket.

The ACA also includes a health insurance coverage mandate effective in 2014, and an affordability standard to identify those subject to the mandate. Under the ACA, a taxpayer is exempt from the individual mandate if the individual's required contribution for coverage exceeds 8 percent of household income.

In March 2010, a working group consisting of four Board members was established by Secretary Gonzalez, Chair of the Health Connector Board of Directors, to review the existing affordability schedule and the process for updating it annually. After considerable deliberation, the working group recommended maintaining the 2010 affordability schedule for 2011. This approach was designed to provide stability while the Health Connector and the Board assess other changes that may need to occur to address differences between the state and federal standards by 2014 as a result of national health reform.

In developing a recommendation for 2012, the following factors were considered: the lack of increase to the affordability schedule maximum monthly premium contributions over the past couple years (since 2008 for those with incomes below 300 percent FPL) despite evidence of some income growth, and the likely increase in the upper bounds of an income bracket of approximately 3 percent following FPL and Massachusetts Cost of Living Adjustments (COLA) (the latter are finalized in March). In light of these factors, Health Connector staff recommended a 1.5 percent increase in the maximum allowable premium contribution amounts across all income categories. This represents about half of the expected inflation in the schedule due to FPL and Massachusetts COLA.

The tables below illustrate the affordability schedules for Calendar Year (CY) 2012. The lower and upper income bounds have been increased consistent with the increase in guidelines from 2011 to 2012 for individuals, couples and families. Since these increases are very modest, the maximum amount one would be required to contribute to a health insurance premium remains largely the same in 2012 as compared to 2011 when measured as a percentage of income.

Table 4. Affordability Schedule for INDIVIDUALS				
Income Bracket (% of FPL)	Annual Gross Income	Maximum Monthly Premium		
		2011	2012	Increase from 2011
0 - 100%	$0 - $11,172	$0	$0	$0
100.1 - 150%	$11,173 - $16,764	$0	$0	$0
150.1 - 200%	$16,765 - $22,344	$39	$40	$1
200.1 - 250%	$22,345 - $27,936	$77	$78	$1
250.1 - 300%	$27,937 - $33,516	$116	$118	$2
300.1 - 360%	$33,517 - $40,195	$175	$178	$3
360.1 - 408%	$40,196 - $45,554	$235	$239	$4
408.1 - 504%	$45,555 - $56,273	$354	$359	$5
Above 504%	above $56,274	n/a	n/a	n/a

Table 5. Affordability Schedule for COUPLES				
Income Bracket (% of FPL)	Annual Gross Income	Maximum Monthly Premium		
		2011	2012	Increase from 2011
0 - 100%	$0 - $15,132	$0	$0	$0
100.1 - 150%	$15,133 - $22,704	$0	$0	$0
150.1 - 200%	$22,705 - $30,264	$78	$80	$2
200.1 - 250%	$30,265 - $37,836	$154	$156	$2
250.1 - 300%	$37,837 - $45,396	$232	$236	$4
300.1 - 374%	$45,397 - $56,656	$315	$320	$5
374.1 - 446%	$56,657 - $67,448	$422	$428	$6
446.1 - 588%	$67,449 - $89,032	$589	$598	$9
Above 588%	above $89,033	n/a	n/a	n/a

Table 6. Affordability Schedule for FAMILIES				
Income Bracket (% of FPL)	Annual Gross Income	Maximum Monthly Premium		
		2011	2012	Increase from 2011
0 - 100%	$0 - $19,092	$0	$0	$0
100.1 - 150%	$19,093 - $28,644	$0	$0	$0
150.1 - 200%	$28,645 - $38,184	$78	$80	$2
200.1 - 250%	$38,185 - $47,736	$154	$156	$2
250.1 - 300%	$47,737 - $57,276	$232	$236	$4
300.1 - 398%	$57,277 - $75,899	$373	$379	$6
398.1 - 511%	$75,900 - $97,584	$586	$595	$9
511.1 - 625%	$97,585 - $119,270	$849	$862	$13
Above 625%	above $119,271	n/a	n/a	n/a

As described in the FY09 Annual Report,[70] Massachusetts adult residents must maintain affordable health insurance that meets MCC standards, if an affordable plan is available to them. Individuals who are deemed able to afford health insurance but fail to comply are subject to a tax penalty. The penalty is assessed when an individual files a tax return. Statute sets the penalty as equal to no more than half of the lowest cost insurance premium for coverage available through the Health Connector. For those with income below 300 percent FPL, the penalty schedule is based on the lowest cost premium contributions for enrollment in a Commonwealth Care plan. Since individuals with income at or below 150 percent FPL are not required to make a premium contribution, there is no penalty for individuals in this income cohort. For those with income above 300 percent FPL, the schedule is based on half of the premium of the lowest cost Bronze plan in January 2011, or half of the premium of the lowest cost YAP plan for adults up to age 26. The penalties for 2012 are shown in Table 7.[71]

Table 7. Penalty Schedule for Failure to Comply with the Individual Mandate, 2009 - 2012

	2009		2010		2011		2012	
	per month	per year*	per month	per year*	per month	per year*	per month	per year*
150.1 - 200% FPL	$17	$204	$19	$228	$19	$228	$19	$228
200.1 - 250% FPL	$35	$420	$38	$456	$38	$456	$38	$456
250.1 - 300% FPL	$52	$624	$58	$696	$58	$696	$58	$696
Above 300% FPL. Age 18-26	$52	$624	$66	$792	$72	$864	$83	$996
Above 300% FPL. Age 27+	$89	$1,068	$93	$1,116	$101	$1,212	$105	$1,260

*If the individual is without insurance for all twelve months of the year.

The Individual Mandate Workgroup, co-chaired by DOR and the Health Connector, has been convened to address the need for policy analysis and recommendations around differences between the Massachusetts individual mandate and the mandate included in the ACA. This includes policy related to affordability schedules, coverage standards and penalties. The Workgroup has begun to engage stakeholders and will continue to solicit feedback on policy questions relating to the intersection of the Federal and State mandates.

7.0 National Health Care Reform

Chapter 58 enabled Massachusetts to achieve the highest insured rate in the nation, expanding eligibility for subsidized insurance, making it easier for those not eligible for subsidized coverage to find and maintain affordable coverage, and instituting a first-in-the-nation adult health insurance coverage mandate. Despite the coverage gains made under Massachusetts reform, the Commonwealth continues to look for opportunities for improvement.

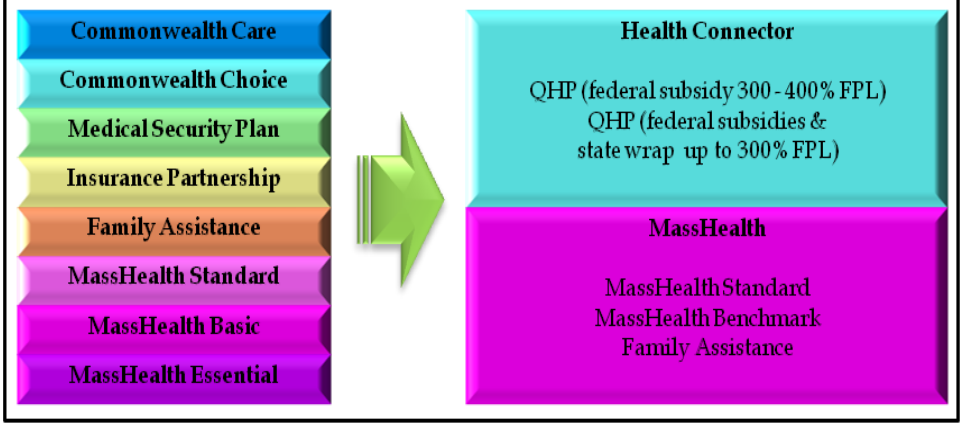
Eligibility for the Commonwealth's subsidized health insurance programs is complicated and, as individuals and families have changes in status and income, they can experience gaps in coverage when attempting to move among different subsidized programs. The ACA largely adopts the model for coverage gains achieved in Massachusetts but with simplified eligibility rules and additional consumer protections that provide a clear framework for achieving expanded coverage. Beginning in 2014, these changes include:

- **An individual mandate.** As in Massachusetts, national reform requires most US citizens to purchase health insurance coverage.
- **Affordable health insurance options to help low and middle- income people afford health insurance.** Eligibility for Medicaid will be expanded to individuals earning up to 133 percent FPL, and federal tax credits will be available to eligible individuals earning up to 400 percent FPL, with eligible individuals up to 300 percent FPL receiving additional state subsidies. This will allow a greater number of Massachusetts residents to access some form of subsidized coverage, as

Commonwealth Care subsidies are not available to individuals with a total household income above 300 percent FPL.

- **New responsibilities and opportunities for employers.** Similar to Massachusetts, certain employers may face penalties starting in 2014 if they fail to make affordable coverage available to employees.
- **Health insurance Exchanges like the Massachusetts Health Connector.** The ACA calls for the creation of state Exchanges to facilitate shopping and ensure those eligible for new and existing subsidies are able to access them. Small businesses will also be able to purchase coverage through these new Exchanges and, beginning in 2014, those small businesses eligible for Federal small business tax credits will be required to purchase through the Exchange to maintain the Federal small business tax credits first introduced in 2010.
- **New minimum benefits.** Plans offered in the individual and small-group markets, both inside and outside of the Exchange, will be required to offer a comprehensive package of items and services, known as Essential Health Benefits (EHBs), effective January 1, 2014.

Figure 14. Subsidized coverage options in 2014



As Figure 14 demonstrates, this new model for providing affordable health insurance will collapse a number of different subsidized programs together to simplify and expand access to affordable health insurance. The ACA expands eligibility for MassHealth such that most legal residents at or below 133 percent FPL are eligible (*i.e.*, eliminates categorical eligibility) and provides other affordable coverage options for uninsured residents up to 400 percent FPL through advanceable premium tax credits and cost-sharing subsidies. People between 300 and 400 percent FPL will be newly eligible for subsidies through the Exchange. Additionally, real-time eligibility determinations, achievable through new technology tools and access to federal databases, will provide streamlined access to coverage and significantly reduce gaps in coverage.

Maintaining affordability of coverage for lower-income populations is critical to maintaining health reform coverage gains in Massachusetts. Federal subsidies under the ACA go a long way towards making coverage affordable, expanding subsidies across-the-board up to 400 percent FPL, but enrollee premiums and point-of-service cost-sharing will be significantly higher than those currently required through Commonwealth Care (for individuals up to 300 percent FPL). In June 2012, Governor Patrick signed legislation, §§ 8, 38, 42 and 43 of chapter 118 of the Acts of 2012,[72] authorizing the Health Connector, if funding is made available, to provide additional state subsidies to individuals receiving federal premium and cost sharing subsidies through the Exchange. These additional subsidies could help to mitigate enrollee cost increases for a population historically served through Commonwealth Care.

In addition to these changes, several health insurance market reforms (many of which were introduced by the ACA) have been identified and implemented by the Commonwealth. These include:

- **Elimination of annual limits.** The state's MCC rules require that a plan cannot have an annual limit with certain exceptions, including YAPs sold through the Health Connector. The Health Connector has phased out annual limits for all new YAPs.

- **Elimination of lifetime limits.** The state's MCC rules did not preclude lifetime limits. This is a new requirement effective with plan years beginning on or after September 23, 2010.
- **Coverage of preventive health services.** Health plans in Massachusetts have eliminated co-pays for preventive care consistent with ACA requirements.
- **Extension of dependent coverage.** A young adult may now remain on their parent's insurance policy up to age 26, without regard to dependent status. In addition, the federal provision applies to both fully and self-insured plans, whereas a similar state provision in effect previously was only applicable to the fully-insured market.
- **MLR requirements and premium rebates.** Massachusetts enacted legislation that requires health plans to provide MLR information to the DOI. The MLR requirements in state law exceed those prescribed in the ACA.
- **Fair health insurance premiums.** DOI has an active rate review process in place and regularly disseminates information regarding this process. In addition, DOI has been awarded two federal Premium Review grants to support the state's premium rate review process.

8.0 Concluding Comments

In 2006, Massachusetts enacted landmark health reform legislation, chapter 58 of the Acts of 2006, and created the Health Connector to promote access to affordable health insurance for the Commonwealth's residents and small businesses. Collaboration proved critical to the successful implementation of state-level health care reform and the creation and growth of the Health Connector. The Commonwealth's success, and the Health Connector's transformative impacts on the health care coverage landscape of the state are testaments to the importance of working in partnership across agencies and alongside consumers and key stakeholders to successfully plan, build and implement thoughtful health care policies and programs. This proven approach is being utilized once again as the Commonwealth continues to lead in health care reform, now with the benefits and opportunities afforded by the ACA. In that vein, the Health Connector staff lead or actively participate in a number of inter-agency workgroups to ensure a timely and coordinated approach to implementation of national health reform in Massachusetts. These workgroups regularly engage stakeholders through open meetings and ongoing dialogue and exchanges of ideas. Through the HIX/IES project, the Health Connector is working closely with MassHealth and UMMS to design and implement a single, streamlined eligibility and enrollment process that will support real time eligibility determinations for both subsidized and non-subsidized populations. Thanks to federal technical and financial support, the Health Connector is able to continue developing an Exchange that meets not only the ACA requirements, but also excels at addressing and responding to the unique needs of individuals and small businesses in Massachusetts, in turn bringing transformation and value to the health care market.

The Commonwealth has made substantial progress implementing national health care reform in FY12, but there is remaining work ahead, especially as the Health Connector works to transition into an ACA-compliant Exchange by 2014. Using insights from the Commonwealth's own experiences, the Exchange is being designed to improve access to high-quality health care and transform the health care system by serving as the leading-edge marketplace for Massachusetts's residents and small businesses to pool together and easily find and enroll in affordable health insurance.

While transition planning activities are well underway, the Health Connector continues to focus on meeting the needs of existing Commonwealth Care and Commonwealth Choice members. The Health Connector already serves over 215,000 members, and expects to grow to almost 250,000 within the next year. In 2012 and 2013, Health Connector staff are continuing to build and refine the existing model to continue to bring value to individuals and small businesses in Massachusetts. In addition, the Commonwealth maintains its commitment to "bending the cost curve," and continues to deliver meaningful cost-savings results with state-level cost

containment initiatives such as the promotion of value-based purchasing for public health insurance programs, the PCMHI and the enactment of cost control legislation.

Appendix I: Abbreviations

3Rs	Risk Adjustment, Reinsurance and Risk Corridors
ACA	Patient Protection and Affordable Care Act
ANF	Executive Office for Administration and Finance
ASRR	Actuarially Sound Rate Range
AWSS	Alien with Special Status
BCBSMA	Blue Cross Blue Shield of Massachusetts
BE	Business Express
BHP	Basic Health Plan Option
BMCHP	Boston Medical Center HealthNet Plan
Bridge	Commonwealth Care Bridge Program
CCIIO	Center for Consumer Information and Insurance Oversight
CHC	Community Health Center
CHIA	Center for Health Information and Analysis
CMR	Code of Massachusetts Regulations
CMS	Centers for Medicare and Medicaid Services
CP	Contributory Plan
CY	Calendar Year
DHCFP	Division of Health Care Finance and Policy
DHE	Department of Higher Education
DOI	Division of Insurance
DOR	Department of Revenue
DPH	Department of Public Health
DUA	Division of Unemployment Assistance
EHB	Essential Health Benefit
EOHHS	Executive Office of Health and Human Services
ESI	Employer-Sponsored Insurance
Exchange	American Health Benefit Exchange
FFP	Federal Financial Participation
FPL	Federal Poverty Level
FY	Fiscal Year
GIC	Group Insurance Commission
GSP	Gross State Product
Health Connector	Commonwealth Health Insurance Connector Authority
HHS	United States Department of Health and Human Services
HIX/IES	Health Insurance Exchange/Integrated Eligibility System
HNE	Health New England
HPHC	Harvard Pilgrim Health Care
HSN	Health Safety Net
IT	Information Technology
MCC	Minimum Creditable Coverage
MCO	Managed Care Organization
M.G.L.	Massachusetts General Law
MLR	Medical Loss Ratio
MSP	Medical Security Program
NCQA	National Committee for Quality Assurance
NHP	Neighborhood Health Plan
PCMHI	Patient Centered Medical Home Initiative
PCP	Primary Care Physician
PMPM	Per Member Per Month

Q ..... Quarter
QSHIP ..... Qualified Student Health Insurance Plan
RFR ..... Request for Responses
SHOP ..... Small Business Health Options Program
SJC ..... Supreme Judicial Court
SoA ..... Seal of Approval
Task Force ..... Inter-Agency Task Force on Implementation of Health Care Reform
THP ..... Tufts Health Plan
TY ..... Tax Year
UMass ..... University of Massachusetts
UMMS ..... University of Massachusetts Medical School
VP ..... Voluntary Plan
YAP ..... Young Adult Plan

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[1] §42 of chapter 288 of the Acts of 2010 requires the appointment of a member of the Massachusetts chapter of the National Association of Health Underwriters to the Health Connector Board.

[2] Division of Health Care Finance and Policy (2011, June). *Key Indicators: Quarterly Enrollment Update*. Available online at, http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/12/2011-june-key-indicators.pdf

[3] Division of Health Care Finance and Policy (2010, December). *Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys*. Boston, MA: Author. Available online at, http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/10/mhis-report-12-2010.pdf

[4] The number of uninsured found by the 2010 DHCFP survey differs from the number of adult tax filers without MCC-compliant insurance in 2009 that is mentioned in Section 2.2 of this report. There are several reasons for the difference, including: the time periods are different (*i.e.*, the DHCFP survey captured information for 2010, whereas the Schedule HC captured information for 2009); the duration is different (*i.e.*, the DHCFP survey asked if people were uninsured at a single point in time, whereas the Schedule HC asked if people where uninsured for each month of the year); the methodology is different (*i.e.*, the DCHFP survey is a phone survey done on a representative sample of Massachusetts residents, whereas the tax filers data is taken from Schedule HC forms submitted to DOR); and the definition of insurance is different (*i.e.*, the DHCFP survey asked if individuals had any type of insurance, whereas the Schedule HC asked if individuals had MCC-compliant insurance).

[5] Division of Health Care Finance and Policy (2011, June). *Key Indicators: Quarterly Enrollment Update*. Available online at, http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/12/2011-june-key-indicators.pdf

[6] Division of Health Care Finance and Policy (2011, May). *Health Care in Massachusetts: Key Indicators.* Available online at, http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/11/2011-key-indicators-may.pdf

[7] Division of Health Care Finance and Policy (2010, December). *Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys*. Boston, MA: Author. Available online at, http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/10/mhis-report-12-2010.pdf

[8] *Patient Protection and Affordable Care Act*. Pub. L. no. 111-148&111-152, 124 STAT. 119 (2010).

[9] Division of Health Care Finance and Policy (2010, December). *Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys*. Boston, MA: Author. Available online at, http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/10/mhis-report-12-2010.pdf

[10] Long, S., Stockley, K., Dahlen, H. (2012, January) *Health Reform in Massachusetts as Of Fall 2010: Getting Ready For The Affordable Care Act & Addressing Affordability*. Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. Available online at, http://www.urban.org/uploadedpdf/412491-Health-Reform-in-Massachusetts-as-of-Fall-2010.pdf

[11] The Commonwealth Health Insurance Connector Authority (2011, November). *Report to the Massachusetts Legislature. Implementation of Health Care Reform. Fiscal Year 2011.* Boston, MA: Author. Available online at,

https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/ConnectorAnnualReport2011.pdf

[12] Division of Health Care Finance and Policy (2011, April). *Access to Health Care in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys for All Residents*. Boston, MA: Author. Available online at, http://archives.lib.state.ma.us/bitstream/handle/2452/109939/ocn725895010.pdf?sequence=1

[13] Long, S., Stockley, K., Dahlen, H. (2012, January) *Health Reform In Massachusetts As Of Fall 2010: Getting Ready For The Affordable Care Act & Addressing Affordability.* Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. Available online at, http://www.urban.org/uploadedpdf/412491-Health-Reform-in-Massachusetts-as-of-Fall-2010.pdf

[14] Long, S., Stockley, K., Dahlen, H. (2012, January) *Health Reform In Massachusetts As Of Fall 2010: Getting Ready For The Affordable Care Act & Addressing Affordability.* Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. Available online at, http://www.urban.org/uploadedpdf/412491-Health-Reform-in-Massachusetts-as-of-Fall-2010.pdf

[15] Long, S., and Phadera, L. (2010, November). *Health Insurance Coverage and Access to Care in Massachusetts: Detailed Tabulations Based on the 2010 Massachusetts Health Insurance Survey.* Boston, MA: Division of Health Care Finance and Policy. Available online at, http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/11/2010-mhis-detailed-tables.pdf

[16] Long, S., Stockley, K., Dahlen, H. (2012, January) *Health Reform In Massachusetts As Of Fall 2010: Getting Ready For The Affordable Care Act & Addressing Affordability.* Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. Available online at, http://www.urban.org/uploadedpdf/412491-Health-Reform-in-Massachusetts-as-of-Fall-2010.pdf

[17] U.S. Department of Health & Human Services. (May, 2012). *Health care law helps community health centers build, renovate facilities, serve more patients* [Press release]. Retrieved from http://www.hhs.gov/news/press/2012pres/05/20120501a.html

[18] The Commonwealth Health Insurance Connector Authority (2010, October). *Report to the Massachusetts Legislature. Implementation of Health Care Reform. Fiscal Year 2010.* Boston, MA: Author. Available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/ConnectorAnnualReport2010.pdf

[19] Details regarding Massachusetts Patient-Centered Medical Home Initiative may be accessed via http://www.mass.gov/hhs/medicalhome

[20] Details regarding the Integrated Care model for Dual Eligible adults may be accessed via http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/overview.html

[21] Massachusetts Health Connector and Department of Revenue, Data on the Individual Mandate. Tax Year 2010, June 2012. Available on-line at, http://tinyurl.com/report-TaxYear2010

[22] The number of adult tax filers without MCC-compliant insurance in 2009 differs from the number of uninsured found by the 2010 DHCFP survey that is mentioned in Section 2.1 of this report. There are several reasons for the difference, including: the time periods are different (*i.e.*, the DHCFP survey captured information for 2010, whereas the Schedule HC captured information for 2009); the duration is different (*i.e.*, the DHCFP survey asked if people were uninsured at a single point in time, whereas the Schedule HC asked if people where uninsured for each month of the year); the methodology is different (*i.e.*, the DCHFP survey is a phone survey done on a representative sample of Massachusetts residents, whereas the tax filers data is taken from Schedule HC forms submitted to DOR); and the definition of insurance is different (*i.e.*, the DHCFP survey asked if individuals had any type of insurance, whereas the Schedule HC asked if individuals had MCC-compliant insurance).

[23] Massachusetts Health Connector and Department of Revenue, Data on the Individual Mandate. Tax Year 2010, June 2012. Available on-line at: http://tinyurl.com/report-TaxYear2010

[24] The Health Connector's Annual Report to the Legislature is a retrospective of the work performed during the previous State Fiscal Year (July 1 through June 30). Individual mandate appeals, however, are reviewed and reported on a Tax Year basis.

[25] Massachusetts Taxpayers Foundation. (2012, April). *Massachusetts Health Reform Spending, 2006-2011: An Update on the "Budget Buster"* Myth. Boston, MA: Author. Available online at, http://www.masstaxpayers.org/sites/masstaxpayers.org/files/Health%20Reform%20Report.pdf

[26] Massachusetts Taxpayers Foundation. (2012, April). *Massachusetts Health Reform Spending, 2006-2011: An Update on the "Budget Buster" Myth.* Boston, MA: Author. Available online at, http://www.masstaxpayers.org/sites/masstaxpayers.org/files/Health%20Reform%20Report.pdf

[27] The Commonwealth Health Insurance Connector Authority (2010, October). *Report to the Massachusetts Legislature. Implementation of Health Care Reform. Fiscal Year 2010.* Boston, MA: Author. Available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/ConnectorAnnualReport2010.pdf

[28] C. Schoen, A. Fryer, S. Collins, and D. Radley, *Realizing Health Reform's Potential*, The Commonwealth Fund, November 2011, and MTF analysis of data from the Agency for Healthcare Research and Quality.

[29] Additional details on the grant submission and award is available at, http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html

[30] *Patient Protection and Affordable Care Act*. Pub. L. no. 111-148&111-152, 124 STAT. 119 (2010).

[31] "*Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act*," 45 CFR Part 158. Available online at, https://www.federalregister.gov/articles/2012/05/16/2012-11753/medical-loss-ratio-requirements-under-the-patient-protection-and-affordable-care-act.

[32] Division of Health Care Finance and Policy. (2011, July). *Massachusetts Employer Survey 2010.* Boston, MA: Author. Available online at, http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/11/mes-results-2010.pdf

[33] Division of Health Care Finance and Policy (2012, May). *Massachusetts Health Care Cost Trends: Premiums and Expenditures*. Boston, MA: Author. Available online at, http://www.mass.gov/eohhs/docs/dhcfp/cost-trend-docs/cost-trends-docs-2012/premiums-and-expenditures.pdf

[34] Division of Health Care Finance and Policy. (2011, July). *Massachusetts Employer Survey 2010.* Boston, MA: Author. Available online at, http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/11/mes-results-2010.pdf

[35] Division of Health Care Finance and Policy. (2009, November). *Massachusetts Health Care Cost Trends Historical (1991-2004) and Projected (2004–2020).* Boston, MA: Author. Available online at, http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/09/cost-trends-nov-2009.ppt

[36] MSP provides health insurance options for persons eligible for unemployment compensation in Massachusetts, or residents who either receive or are eligible to receive state unemployment benefits with a total household income under 400 percent FPL. MSP offers two different options to eligible persons: (1) the Premium Assistance Plan which pays for part of COBRA or other insurance costs and (2) the Direct Coverage Plan.

[37] Long, S., Stockley, K., Dahlen, H. (2012, January) *Health Reform In Massachusetts As Of Fall 2010: Getting Ready For The Affordable Care Act & Addressing Affordability.* Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation. Available online at, http://www.urban.org/uploadedpdf/412491-Health-Reform-in-Massachusetts-as-of-Fall-2010.pdf

[38] Gabel JR, et. al.; "After the Mandates: Massachusetts Employers Continue to Support Health Reform as More Firms Offer Coverage;" Health Affairs; web exclusive; October 28, 2008.

[39] SteeleFisher, GK, et. al.; "Physicians' Views of the Massachusetts Health Care Reform Law —A Poll;" NEJM; Oct 21, 2009.

[40] M.G.L. c. 96 of the Acts of 2012. Available online at http://www.malegislature.gov/Laws/SessionLaws/Acts/2012/chapter96

[41] Similar to the Health Connector, the ACA, under §1311, establishes state-based Affordable Health Insurance Exchanges to provide a competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges, which will become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses more resources. States have flexibility in the design and operation of their Exchange to best meet the unique needs of their citizens and their marketplace.

[42] The ACA provides states the option to implement a BHP. The BHP, authorized under §1331 of the ACA, gives states the opportunity to design a health insurance program for certain uninsured individuals, by contracting with health plans or providers, in lieu of those individuals receiving a federal premium tax credit. If a state elects to administer a BHP, that state would receive 95 percent of what the federal government would have spent on premium tax credits and subsidies for out-of-pocket costs. In a state that offers a BHP, non-elderly adult residents with income between 133 and 200 percent FPL and legally resident immigrants with incomes below 133 percent FPL whose immigration status disqualifies them from federally matched Medicaid would be eligible to participate.

[43] M.G.L. c. 118 of the Acts of 2012. Available online at http://www.malegislature.gov/Laws/SessionLaws/Acts/2012/chapter118.

[44] The Commonwealth Health Insurance Connector Authority (2011, November). *Report to the Massachusetts Legislature. Implementation of Health Care Reform. Fiscal Year 2011.* Boston, MA: Author. Available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/ConnectorAnnualReport2011.pdf

[45] The Establishment grant is a federal funding opportunity designed to give States multiple opportunities to apply for funding to assist in building an ACA-compliant Exchange. Structured as a cooperative agreement, there are two levels of funding for which a state could apply. A level one application would award a state with funds for one year. A level two application would provide states with federal dollars through December 2014.

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

[47] NCQA posts their NCQA Health Plan Rankings online at, www.ncqa.org/rankings

[48] The Commonwealth Health Insurance Connector Authority (2008, October). *Report to the Massachusetts Legislature. Implementation of the Health Care Reform Law, chapter 58.* Boston, MA: Author. Available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/Current/Week%2520Beginning%2520September%252028%252C%25202008/Connector%2520and%2520Health%2520Reform%2520Evaluation.pdf

The Commonwealth Health Insurance Connector Authority (2009, October). *Report to the Massachusetts Legislature. Implementation of Health Care Reform. Fiscal Year 2009.* Boston, MA: Author. Available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Executive%2520Director%2520Message/Connector%2520Annual%2520Report%25202009.pdf

[49] A member's Plan Type defines the set of benefits for which an individual is eligible for based on their total household income. Plan Type 1 members, for example, would not be required to pay a premium and only have limited co-pays.

[50] The Commonwealth Health Insurance Connector Authority (2011, November). *Report to the Massachusetts Legislature. Implementation of Health Care Reform. Fiscal Year 2011.* Boston, MA: Author. Available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/ConnectorAnnualReport2011.pdf

[51] As of July 1, 2012, Commonwealth Care is offering coverage for tobacco cessation consistent with the benefits offered through MassHealth.

[52] The survey was based on telephone interviews and mail surveys conducted between November 1 and December 15, 2011. Participants were selected from a list of existing members who had been enrolled at least three months and were stratified by health plan and Plan Type to ensure a representative sample of the entire Commonwealth Care population. There were three areas of oversampling: (1) new Plan Type I members with limited health plan choice, (2) members who changed their health plan during Open Enrollment, and (3) members who were enrolled in Network Health prior to the open enrollment period. The survey did not include members enrolled in the Commonwealth Care Bridge program. The overall response rate for was high at 31 percent (767 members completed the survey) and had a sampling error of plus or minus 3.5 percent at 95 percent confidence.

[53] The Commonwealth Health Insurance Connector Authority (2011, November). *Report to the Massachusetts Legislature. Implementation of Health Care Reform. Fiscal Year 2011.* Boston, MA: Author. Available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/ConnectorAnnualReport2011.pdf

[54] The Commonwealth Health Insurance Connector Authority (2011, November). *Report to the Massachusetts Legislature. Implementation of Health Care Reform. Fiscal Year 2011.* Boston, MA: Author. Available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/ConnectorAnnualReport2011.pdf

[55] Commonwealth Care members requesting to change MCOs outside of Open Enrollment must meet one of the following Qualifying Events as outlined in 956 CMR 3.11(6):

A. Moved to a service area where current MCO is not available
B. Member has a medical condition and continued enrollment will result in a lack of continuity of care

C. Member's PCP is no longer part of their MCO network
D. Member's health care is adversely affected by a significant change in the MCO's provider network
E. Member has had a Plan Type change within the past 90 days
F. Member is homeless, and homelessness is verified in MA21
G. Member has not received enrollment materials and returned mail is logged in the CRM

[56] Division of Health Care Finance and Policy (2012, May). *Massachusetts Health Care Cost Trends: Premiums and Expenditures*. Boston, MA: Author. Available online at, http://www.mass.gov/eohhs/docs/dhcfp/cost-trend-docs/cost-trends-docs-2012/premiums-and-expenditures.pdf

[57] The Commonwealth Health Insurance Connector Authority (2011, November). *Report to the Massachusetts Legislature. Implementation of Health Care Reform. Fiscal Year 2011.* Boston, MA: Author. Available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/ConnectorAnnualReport2011.pdf

[58] In an active open enrollment, members would have to proactively respond to enrollment materials, indicating their plan choice; a failure to respond would result in auto-enrollment into the lowest cost plan

[59] Base enrollee premiums for members with income greater than 150 percent FPL will increase by 1.5 percent ($1-2 PMPM), consistent with the Health Connector's recommendation for the 2012 Affordability Schedule. See Section 6.2 for additional information on the 2012 Affordability Schedule.

[60] Please refer to the FY10 annual report for the budgeted and actual expenditures for the Commonwealth Care program for FY10 and to the FY09 annual report for the budgeted and actual expenditures for FY07, FY08, and FY09.

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

[62] NCQA posts their NCQA Health Plan Rankings online at, www.ncqa.org/rankings

[63] The Commonwealth Health Insurance Connector Authority (2008, October). *Report to the Massachusetts Legislature. Implementation of the Health Care Reform Law, chapter 58.* Boston, MA: Author. Available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/Current/Week%2520Beginning%2520September%252028%252C%25202008/Connector%2520and%2520Health%2520Reform%2520Evaluation.pdf

The Commonwealth Health Insurance Connector Authority (2009, October). *Report to the Massachusetts Legislature. Implementation of Health Care Reform. Fiscal Year 2009.* Boston, MA: Author. Available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Executive%2520Director%2520Message/Connector%2520Annual%2520Report%25202009.pdf

[64] The ACA authorizes the Office of Personnel Management to establish and monitor the performance of two Multi-State Plans to be offered on a nationwide bases through state Exchanges. Multi-State Plans must meet the same federal requirements as other plans offered through the Exchange and individuals enrolled in a Multi-State Plan may receive premium tax credits and cost sharing reductions if they are deemed eligible.

[65] Business Express is described in more detail in the FY10 Annual Report which is available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/Connector%2520Annual%2520Report%25202010.pdf

[66] A new law went into effect limiting when individuals and families can purchase non-group coverage. In 2011, enrollment was open from July 1 to August 15, 2011. The next open enrollment period will be from July 1 to August 15, 2012. During closed enrollment, individuals and families can purchase coverage only if they meet special considerations as defined by DOI regulations.

[67] Details regarding the Minimum Creditable Coverage requirements may be accessed via http://tinyurl.com/mccbackground.

[68] Administrative bulletins issued by the Health Connector are available online at, https://www.mahealthconnector.org/portal/site/connector/template.MAXIMIZE/menuitem.3ef8fb03b7fa1ae4a7ca7738e6468a0c/?javax.portlet.tpst=2fdfb140904d489c8781176033468a0c_ws_MX&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_viewID=content&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_docName=Bulletins%20and%20Policies&javax.portle

t.prp_2fdfb140904d489c8781176033468a0c_folderPath=/Health%20Care%20Reform/Regulations/&javax.portlet.begCacheTok=com.vignette.cachetoken&javax.portlet.endCacheTok=com.vignette.cachetoken.

[69] M.G.L. 176Q §3.

[70] The Commonwealth Health Insurance Connector Authority (2009, October). *Report to the Massachusetts Legislature. Implementation of Health Care Reform. Fiscal Year 2009.* Boston, MA: Author. Available online at, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Executive%2520Director%2520Message/Connector%2520Annual%2520Report%25202009.pdf

[71] In February 2012 the Department of Revenue issued *Technical Information Release 12-2: Individual Mandate Penalties for Tax Year 2012.* The release is available at, http://www.mass.gov/dor/businesses/help-and-resources/legal-library/tirs/tirs-by-years/2012-releases/tir-12-2.html

[72] M.G.L. c. 118 of the Acts of 2012. Available online at http://www.malegislature.gov/Laws/SessionLaws/Acts/2012/chapter118.