Report to the Massachusetts Legislature

Implementation of Health Care Reform

Fiscal Year 2011

November 2011

Table of Contents

List of Figures and Tables

Figures

Tables

1.0 Preface

Five years have passed since Chapter 58 was enacted, but this milestone anniversary does not mark the end of our health care reform efforts. A model for the nation, Massachusetts has made health care affordable for its poorest residents through expansions in subsidized health insurance coverage and offers individuals, families, and small businesses a simple, streamlined shopping experience to easily compare and purchase health insurance through the Health Connector, the state's Exchange. Residents of Massachusetts have some of the best health care providers in the world at their doorstep and, thanks to our reform efforts, hundreds of thousands more have access to coverage for those services. In fact, according to a recent state survey, over 98% of Massachusetts residents have health insurance, including nearly all Massachusetts children.[1]

While there is much to look back on with pride, the Commonwealth, not unlike the rest of the country, is focusing its attention on the challenge of unsustainable increases in health care costs. This challenge was not created by health reform. Rather, it is a longtime national and state challenge, rooted in the fundamentals of how we deliver and pay for care. Successful implementation of Chapter 58, the result of which is near universal health insurance coverage in the state, has allowed state leaders to shift their focus to identifying opportunities to address this issue and reign in health care costs. In February 2011, Governor Patrick introduced health care payment reform legislation entitled *An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments*. This bill aims to lower the cost of health care by promoting and providing a framework for the use of alternative payment methodologies and the widespread establishment of Accountable Care Organizations (ACOs). In the spring 2011, the Joint Committee on Health Care financing held a series of public hearings across the Commonwealth to ensure all stakeholders could offer testimony relevant to this legislation. In June, the state's Division of Health Care Finance and Policy (DHCFP) sponsored a separate set of hearings to discuss cost trends in the health care market in an effort to support progress on health care cost containment efforts.

In the meantime, both the public and private sectors have been charged with employing innovative strategies to address health care costs. For its part, the Health Connector and participating health plans have achieved great success in controlling costs within the subsidized Commonwealth Care (CommCare) program. In addition, the Health Connector continues to ensure that its unsubsidized Commonwealth Choice (CommChoice) shopping experience enables consumers to select those products that offer the best value for the dollar. Still, system-wide changes are necessary to control rising health care costs in Massachusetts. The Health Connector will continue to work with Governor Deval Patrick, other state agencies, the Legislature, health plan partners, and other stakeholders in our efforts to achieve real cost control for consumers and businesses in the Commonwealth.

The Health Connector is also working in concert with many state agencies and stakeholders in planning for implementation of historic national health reform legislation, the Patient Protection and Affordable Care Act (ACA). Though many elements of Massachusetts' health care reform are reflected in the ACA, there are differences between the state and national reform laws. Through its own planning efforts and as a contributor to the state's Inter-Agency Task Force on Implementation of (National) Health Care Reform, the Health Connector is committed to ensuring the Commonwealth fully avails itself and its residents of the opportunities presented by the ACA and preserves or improves the health care coverage gains made in our state. While planning is well underway, there is much work to be done in the months ahead.

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 (EOHHS), MassHealth, the Division of Insurance (DOI), the Group Insurance Commission (GIC), the Department of Revenue (DOR), the Division of Health Care Finance and Policy (DHCFP), the Department of Public Health (DPH), the Division of Unemployment Assistance (DUA), 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) 2011. In December 2010, Richard C. Lord, President and Chief Executive Officer of the Associated Industries of Massachusetts, resigned from his position on the Health Connector Board and, in January 2011, Andrés López, Principal of AJL Consultants, joined the Board. The Health Connector would like to thank Mr. Lord for his leadership and the time dedicated to ensuring the success of Massachusetts health reform. Thanks and gratitude are also extended to the following Directors of the Health Connector for their continued commitment to health reform in FY11: Secretary of the Executive Office of Administration and Finance Jay Gonzalez, Chair of the Board; Terry Dougherty, Medicaid Director; Ian Duncan, Founder and President of Solucia, Inc.; Jonathan Gruber, Professor of Economics at MIT; Andrés López, Principal of AJL Consultants; 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

Massachusetts continues to realize gains in insurance coverage, boasting the highest rate of coverage in the nation. Over 98 percent of residents had health insurance coverage in 2010, a significant accomplishment given the economic climate. 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 in the country. Of the nearly 6.5 million Massachusetts residents, only 120,000 were uninsured.[2,3] Adults (ages 19 to 65) comprise the vast majority of the Commonwealth's remaining uninsured.[4]

Massachusetts has significantly reduced racial and ethnic disparities in coverage rates. Specifically, among non-elderly adults, the uninsured rate for Hispanics has declined from almost 13 percent in 2008 to 7.3 percent in 2010.[5] Hispanic residents continue to be more likely to be uninsured than residents in other racial/ethnic groups with almost four percent of Hispanic residents uninsured in 2010, compared with 1.7 percent of white, non-Hispanic residents and 1.5 percent of other race, non-Hispanic residents.

Young adults have experienced some of the greatest gains in insurance coverage since the passage of health care reform in Massachusetts. According to a study published by the Robert Wood Johnson Foundation in August 2010, 21 percent of young adults ages 19-26 were uninsured pre-reform (2005-2006). This constituted the largest segment of the uninsured by age cohort. Thanks to dependent coverage expansions and Young Adult Plan (YAP) options available through the Health Connector, the uninsurance rate for young adults fell to 8.2 percent post-reform (2007-2008).[6]

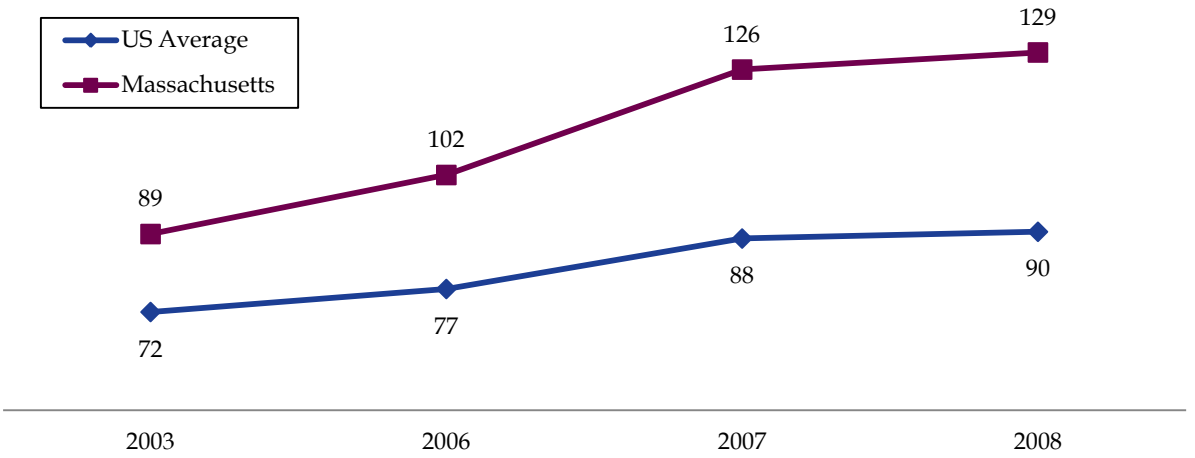
In contrast to national trends, the number of employers offering employer-sponsored insurance (ESI) continues to rise in Massachusetts. In 2010, 77 percent of employers offered health insurance to their workers[7] and ESI covered two-thirds of Massachusetts residents. While ESI represents the most common means for residents to access health insurance, the share of residents enrolled in ESI fell by almost two percent since 2009.[8] The decline in enrollment through ESI is likely attributable to the continued economic downturn and high unemployment rates, given the employer offer rate has continued to rise.[9]

Having health insurance coverage makes medical care more affordable, but does not guarantee access to services. Ensuring that residents are able to receive needed health care services in a timely fashion is an integral part of health care reform and critical to the health and well being of residents of the Commonwealth.

Massachusetts residents continued to indicate that they were able to access necessary health care services in 2010. In the 2008-2010 Massachusetts Health Insurance Survey, approximately 93 percent of residents had a usual source of care in 2010, an increase from 2009.[10] The majority of residents have visited a doctor in the past 12 months, with 79 percent reporting having received care from a primary care physician (PCP). In addition, the number of patients receiving care at Community Health Centers (CHCs) increased by 31.0 percent between 2005 and 2009, while the share of CHC patients who were uninsured fell from 35.5 to 19.9 percent over the same time period.[11]

The Commonwealth also boasts having the highest physician to population and the highest PCP to population ratios in the country, with the latter showing consistent improvement over time. Between 2006 and 2008, the rate of Massachusetts's residents without a PCP declined from 12.2 to 11.0 percent respectively, as reform expanded health insurance coverage to more residents.

Figure 1. MA Supply of Active PCPs* per Population on the Rise since 2003



*Active PCPs are physicians whose self-designated specialty is either internal medicine, family medicine, general practice, or pediatrics. It includes physicians who report providing direct patient care, as well as those who may be involved in administration, medical research, medical teaching, or other non-patient care activities.

Source: Association of American Medical Colleges; Office of Shortage Designation, Health Resources and Service Administration (HRSA). HRSA Data are derived from the 2006 American Medical Association Physician Master File (AMA MF).

Despite continued improvements, nearly a quarter of Massachusetts residents reported having difficulty accessing health care in 2010.[12] The Commonwealth is working to address a number of barriers that can limit access to care, including geographic variation in the availability of health care providers and services across the Commonwealth, long wait times, and decreases in the number of PCPs accepting new patients.[13]

Several approaches have been suggested for addressing PCP shortages and addressing geographic disparities in access to care. Recommendations include improving the primary care delivery system and reforming payment models through programs such as the Patient Centered Medical Home Initiative (PCMHI) described below.[14] In addition to these approaches, the ACA makes financial investments to strengthen the overall health care

workforce through loan repayment programs and public health workforce recruitment and retention programs. The ACA also provides for an enhanced reimbursement for defined primary care physician services.

In an effort to make improvements in access to and integration of care, EOHHS has coordinated an interagency PCMHI intended to promote comprehensive, coordinated, cost-effective care. As explained in the FY10 Annual Report,[15] the PCMHI strives toward a better patient experience by ensuring that all of an individual's health care needs are coordinated through a PCP. This strategy addresses a series of challenges that limit patient outcomes and contribute to rising health care costs, such as fragmented care and the increasing prevalence and suboptimal management of chronic disease. The Health Connector, as part of the PCMHI, has requested that CommCare Managed Care Organizations (MCOs) participate in this initiative and work with providers to better coordinate care for members.[16]

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 were required to obtain a health insurance policy that meets 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.

In TY09, compliance with the state's health insurance reporting requirements continued to be high, with 99% 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 96% of adults who filed a Schedule HC reporting having MCC-compliant coverage at least some point during the year and 92% of adults reporting having MCC-complaint coverage for the full-year (Table 1). Relatively few filers were assessed a penalty for TY09 (approximately 26,000 who were uninsured for the full year and 22,000 who were uninsured for part of the year, despite having affordable insurance available to them).

Table 1. Tax filers Insurance Data, Tax Year 2009[17]	
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)	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	~120,000 for full-year, ~55,000 for part-year
No penalty because affordable insurance was not available (based on the tax filer's application of the affordability schedule)	~22,000 for full-year, ~18,000 for part-year
No penalty because appeal was requested	~3,800 for full-year, ~3,000 for part-year
No penalty due to religious exemption	~5,300 for full-year, ~600 for part-year
No penalty due to Certificate of Exemption	~200 for full-year, ~70 for part-year
No penalty due to a permissible gap in coverage of three or fewer consecutive calendar months	~48,000
Penalty assessed since affordable insurance was available	~26,000 for full-year, ~22,000 for part-year

As explained in the FY10 report,[18] there was an increase in penalty appeal approvals from TY08 to TY09. This was due in large part to more appellants meeting the criteria for hardship waivers. Early receipts indicate that the state of the economy has continued to make hardship waiver requests prevalent, but with more than half of the appeals submitted to the Health Connector Appeals Unit by the end of FY11 pending, it is too early to determine how the appeals will trend for TY10.

2.3 Costs

Having largely tackled the issue of coverage, the Commonwealth continues its efforts to address rising health care costs and to promote access to affordable insurance. The Health Connector has tried to do its part in both the CommChoice and CommCare programs to address costs.

By facilitating apples-to-apples comparison of health plans, the CommChoice program has enabled shoppers in the small- and non-group markets to find and compare prices for high-quality private health insurance. Experience to date suggests this shopping experience has enabled consumers to more easily identify the health plan that best meets their needs and budgets than was possible in the past. In July of 2011, the Health Connector modified the CommChoice program to make it even easier for small businesses to find affordable coverage by eliminating all up front administrative fees (see Section 5.0 for further details) and offering up to a fifteen percent

premium subsidy for eligible small businesses that participate in the Health Connector's new wellness program, "Wellness Track."

Through careful purchasing strategies and competitive procurements, CommCare has been able to offer quality, affordable health insurance coverage to nearly 160,000 adult residents at an average annual premium trend of three to four percent, considerably lower than trends seen in commercial health insurance. In FY12, for example, the CommCare procurement achieved a projected net five percent *decrease* in aggregate rates paid to health plans.

But these savings alone cannot provide sufficient relief to individuals, families, and businesses in the Commonwealth struggling to balance the growing cost of health care with other family and economic needs. The Commonwealth will need to implement broad-reaching reforms in its efforts to rein in health care costs. These efforts are not complete, but are underway.

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).[19] 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. Additionally, legislation passed in August 2010, Chapter 288 of the Acts of 2010, introduced a number of state-wide market reforms intended to address certain cost-driving practices and encourage development of plans that might provide lower-priced options for consumers. For example, the new law established open enrollment periods limiting when individuals and families can purchase non-group health insurance;[20] this change was initiated in response to concerns that without defined enrollment periods consumers would wait to buy insurance until they needed care. Other provisions in the bill that promote cost containment include: a pilot program to foster the adoption of bundled payments;[21] the requirement that small group health carriers submit detailed information regarding medical loss ratios (MLR); administrative expenses, and other financial information;[22] and an increase in the MLR amount that triggers presumptive disapproval of a carrier's proposed rate.[23] The legislation also promotes the development of select or tiered network health plan designs, requiring carriers to offer these types of plans at rates at least 12% lower than full network products. [24]

The Patrick Administration is working with stakeholders to take further legislative action to address rising health costs. In February 2011, responding to evidence from various studies[25] which have found that the existing fee-for-service payment system rewards volume of services instead of quality of care, Governor Patrick filed a health care payment and delivery system reform bill to lower the cost of health care through integrated care organizations and valued-based payment methods.[26] The proposed legislation, House Bill 1849, "An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments," is intended to transition the Commonwealth's payment and delivery system over the next three years by encouraging providers to form integrated care organizations. Under the bill, fee-for-service payments will be significantly reduced by the end of 2015 in favor of alternative payment methodologies.[27] In the short term, the Governor's bill expands DOI's authority with respect to rate review in the small and non-group market. It also allows DOI to restrict the level of rate increases that carriers are permitted to include in provider contracts on an annual basis.

In addition to these initiatives, federal support has provided the Commonwealth further opportunities to promote state-level cost containment programs. In April 2011, Massachusetts' Executive Office of Health and Human Services was awarded a $1 million dollar grant from the Centers for Medicare and Medicaid Innovation (CMMI) to promote quality, coordinated, cost-effective care for residents eligible for both Medicare and Medicaid. These "dual eligibles" are among the sickest and poorest residents enrolled in state-subsidized health insurance and, consequently, constitute the largest share of health care costs. This funding will allow the state to create an integrated financing and care model to ensure this population receives both quality and cost-effective care.[28]

The ACA makes a significant investment in funding opportunities aimed at improving quality and reducing cost within the health care delivery system. More than $22 billion in new funding was authorized in the ACA to be directed toward demonstration projects, pilot programs, grants and other health care delivery initiatives that are

emerging within states across the country.[29] Specifically, the ACA directs federal dollars toward Medicaid payment reform, delivery system redesign, clinical workforce development, care coordination, quality measurement and improvement, wellness and prevention, and efforts to reduce racial and ethnic disparities in health care. These federal investments will complement the cost containment efforts currently underway in Massachusetts.

2.4 Supporting Value-Based Purchasing in the Commonwealth

Fiscal Year 2012 will be another challenging year for the Commonwealth. With health care programs already totaling nearly 40 percent of the state budget, current spending trends are neither fiscally permissible in FY12 nor sustainable in the long term.

In addition to our own programmatic cost control efforts, the Health Connector also collaborates with other state entities that are wrestling with the challenges of health care cost containment.

Since September of 1989, Massachusetts law, G.L. c.15A, § 18, has required every student 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. All QSHIP plans must offer "reasonably comprehensive" coverage, but schools have significant autonomy in the ultimate design of a student health plan.[30] Consequently, costs and coverage vary by institution. A 2009 study found that QSHP plans that have lower levels of coverage often have coverage gaps that can result in high out-of-pocket expenses.[31]

For the past two years, the Health Connector, in collaboration with the Board of Higher Education and DHCFP, has conducted competitive procurements on behalf of the state universities and community colleges to help them secure affordable health insurance for their students. In the first year of this partnership, the procurement yielded a 15 percent upgrade in benefits with only a 5 percent increase in premiums. The new student health plan, offered by Blue Cross Blue Shield of Massachusetts (BCBSMA), was announced in early April 2010. It was the first major overhaul of the system in over twenty years.

This year, through the power of competition, additional improvements in benefits were offered to students with continued restraint on premiums. For example, community colleges will offer prescription drug coverage for the first time this year for only a single-digit increase in premiums. Moreover, most other participating public college campuses renewed at below trend premium increases while also improving benefits for their students.

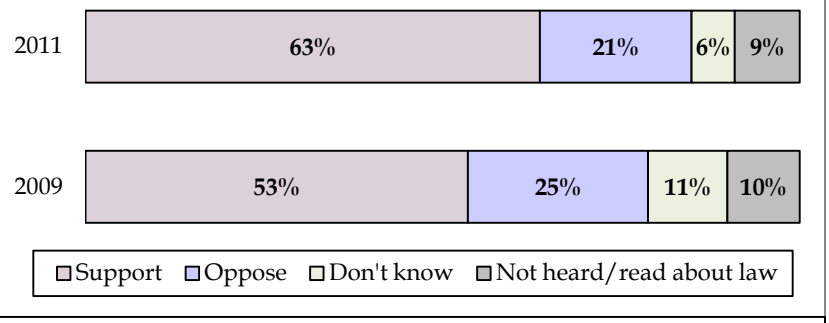
At the request of Governor Patrick, the Health Connector is also working with DUA to launch a competitive re-procurement for the Medical Security Program[32] (MSP) direct coverage program, a program offering subsidized health insurance for low-income Massachusetts residents receiving unemployment insurance benefits. The Medical Security Trust Fund, which finances MSP and is funded by employer contributions, is 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 the spring of 2011, with a target effective date for coverage in early 2012. The new program will be modeled after CommCare, offering comprehensive coverage with progressive cost-sharing. While the new approach will not eliminate the Medical Security Trust Fund deficit in the short term, the procurement offers an opportunity to materially improve the program's cost structure. MSP members will also see 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.

2.5 Public Support for Health Care Reform

Massachusetts residents continue to express strong approval of health care reform. Support for the Commonwealth's health care reform law has grown ten percent over the past two years, with two-thirds of households stating that they support the law. Sixty-eight percent of households feel that the law has been a success. [33]

Figure 2. Support for Massachusetts Health Reform Law: Given what you know about it, in general, do you support or oppose the Massachusetts Universal Health Insurance Law?



Sources: Harvard School of Public Health/Boston Globe Massachusetts Health Reform Poll (conducted May 24-26, 2011); Harvard School of Public Health/Boston Globe Massachusetts Health Reform Poll (conducted September 14-16, 2009).

In addition to support for the state's reform efforts, the majority of Massachusetts residents are supportive of national reform efforts. Seventy-three percent of households reported that they support the national reform bill passed by Congress in March of 2010.[34]

2.6 Planning for National Reform

While many aspects of national reform are broadly grounded in the elements of Massachusetts' health reform initiative, the Commonwealth has much work to do in evaluating the consistency of our current policies with new federal requirements and identifying areas where change is necessary. The passage of the ACA offers the Commonwealth a unique opportunity to evaluate and improve the programs already in place and has occurred at a time, five years into the lifecycle of state reform, where the state is naturally poised to evaluate its progress and identify opportunities for future improvements.

The Health Connector is one of twenty state agencies actively participating in the state's Inter-Agency Task Force on Implementation of (National) Health Care Reform. The Secretary of EOHHS chairs this Task Force and has established several work groups charged with assessing the implications of new ACA-related requirements on the state. This interagency task force has established several work groups, including the following: Private Insurance Market, Employer, Subsidized Insurance, Behavioral Health/Long Term Care, and Healthcare Workforce. Health Connector staff actively lead or participate in three of these five work groups.

Stakeholder involvement is critical to the Task Force's planning activities. Meetings are held quarterly to review issues associated with the implementation of national reform with all stakeholders. Key stakeholders include, but

are not limited to, consumer advocates, health plans, brokers, employers and providers. Several of the work groups mentioned above have also organized activities or public meetings designed to inform or seek feedback from these stakeholders.

For example, as an active member of the Employer work group, the Health Connector participated in a series of employer forums convened by DHCFP in collaboration with the Associated Industries of Massachusetts (AIM), an association of small and mid-size employers in Massachusetts. The purpose of these sessions was to discuss differences between employer-related provisions in the federal and state health reform laws and to solicit employer feedback as to how these might best be reconciled. The seven meetings held across the state exhibited strong attendance. The Health Connector also uses its public Board meetings as an opportunity to engage stakeholders and update and solicit feedback from Board members on Exchange-related health reform issues.

One of the primary components of the national reform bill is the creation and maintenance of American Health Benefit Exchanges (Exchange). While the Health Connector served as the model for this element of the ACA, there are some differences between the current model and that which is required under national reform. The Health Connector has already launched its planning efforts to ensure our Exchange meets these requirements and capitalizes on new opportunities presented by reform.

In September 2010, the Health Connector was awarded a $1 million Exchange Planning grant by the United States Department of Health and Human Services (HHS). This funding will assist the Health Connector, in collaboration with EOHHS, ANF, DOI, and other state and stakeholder partners, to develop a transition program that will allow for planning and implementation of Exchange-based aspects of federal reform, while continuing to implement and improve our current programs and responsibilities. The Health Connector's planning efforts will be supported by Manatt/Mercer, a multi-disciplinary consulting team selected via a rigorous procurement process and funded through a portion of the Exchange Planning grant. Manatt/Mercer will provide project management support and a strategic plan, considered and informed by: analysis of the major policy questions before the Health Connector and the Commonwealth, research and analysis relative to the populations impacted by the ACA, evaluation of the Information Technology (IT) and business operations infrastructure and needs (in collaboration with the Early Innovators grant vendor), product assessment and development needs, and review of existing and necessary financial, accounting and auditing models.

In February 2011, HHS awarded the University of Massachusetts (UMass) Medical School a $35.6 million Early Innovators grant. Massachusetts officials, specifically staff from UMass, the Health Connector and EOHHS, will work with other New England states to design and implement an IT infrastructure improving how individual consumers and small businesses shop for health insurance. The federal grant will largely be used to assist Massachusetts in creating a single entry portal for all individuals applying for Medicaid or for a federal tax credit through the Exchange and to develop and improve upon the existing eligibility and shopping IT infrastructure. Part of the project will also involve identifying opportunities for collaboration and reusability across the participating states as, starting in 2014, all states will be required to set up online health care Exchanges that offer "one-stop shopping" for health insurance. More information on this project can be found at www.nescso.org.

In the spring of 2011, a new grant opportunity was announced to assist states that are ready to move beyond the planning process and begin the task of building and implementing an Exchange. The Health Connector is in the process of developing an application for an Establishment Grant in an effort to secure funds to advance the development of an ACA-compliant health insurance Exchange by 2014.

3.0 Commonwealth Care

3.1 Commonwealth Care Enrollment

CommCare provides subsidized health insurance to adult residents earning up to 300 percent of the Federal Poverty Level (FPL) that do not have access to other health insurance. Members may choose from among the approved MCOs that serve their region. As in FY10, all of the MCOs that participate in CommCare with sufficient experience to be rated[35] received high rankings from the National Committee for Quality Assurance (NCQA), with four plans being ranked among the top five in the country.[36]

For a more detailed description of the CommCare program, please refer to the 2006-2008, FY09, and FY10 Annual Reports.[37]

Approximately 160,000 Massachusetts residents receive assistance with their health care costs through the CommCare program. Following a decline in enrollment between the last quarter of FY09 and the first quarter of FY10,[38] CommCare enrollment has stabilized (enrollment changed by only one percent between FY10 and FY11). Enrollment is expected to increase to nearly 175,000 members (a 9 percent increase) in FY12 primarily due to the transition of MSP enrollees to the CommCare program as the federal unemployment benefit extension phases out.

Depending on their income level, CommCare members may be responsible for paying a monthly premium. Eligible individuals earning up to 100 percent FPL (Plan Type[39] 1 members) are not required to pay 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. Between FY10 Q4 and FY11 Q1, the percentage of enrollees with a premium increased by nearly 10 percent. This change is due largely to CeltiCare becoming the only $0 health plan for Plan Type (PT) 2A[40] members, causing some members who chose to stay with their same health plan during the FY10 open enrollment to become premium payers. As shown below, the distribution by premium and non-premium paying members remained the same throughout the remainder of the fiscal year.

Figure 3. Total CommCare Enrollment for FY 2011

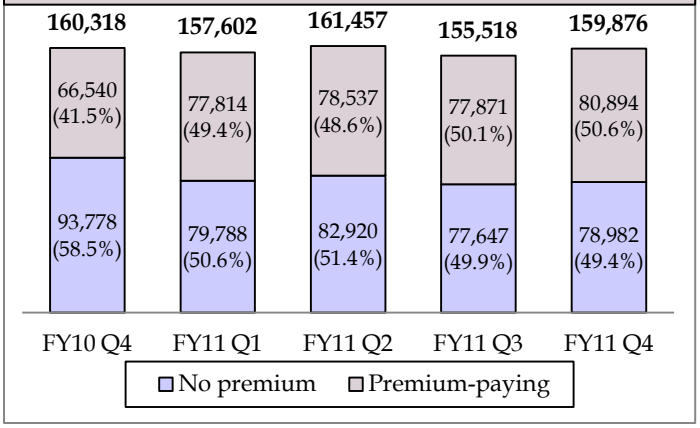
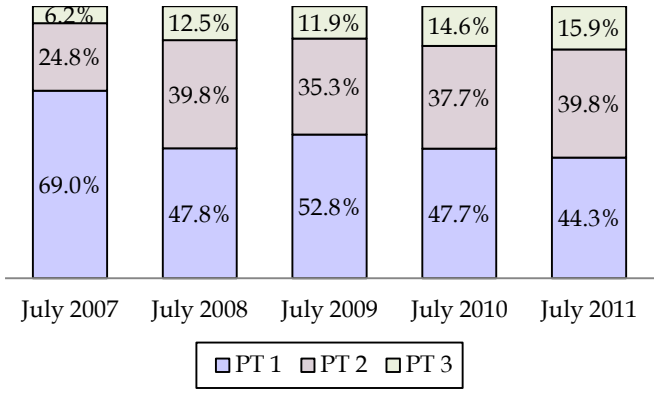
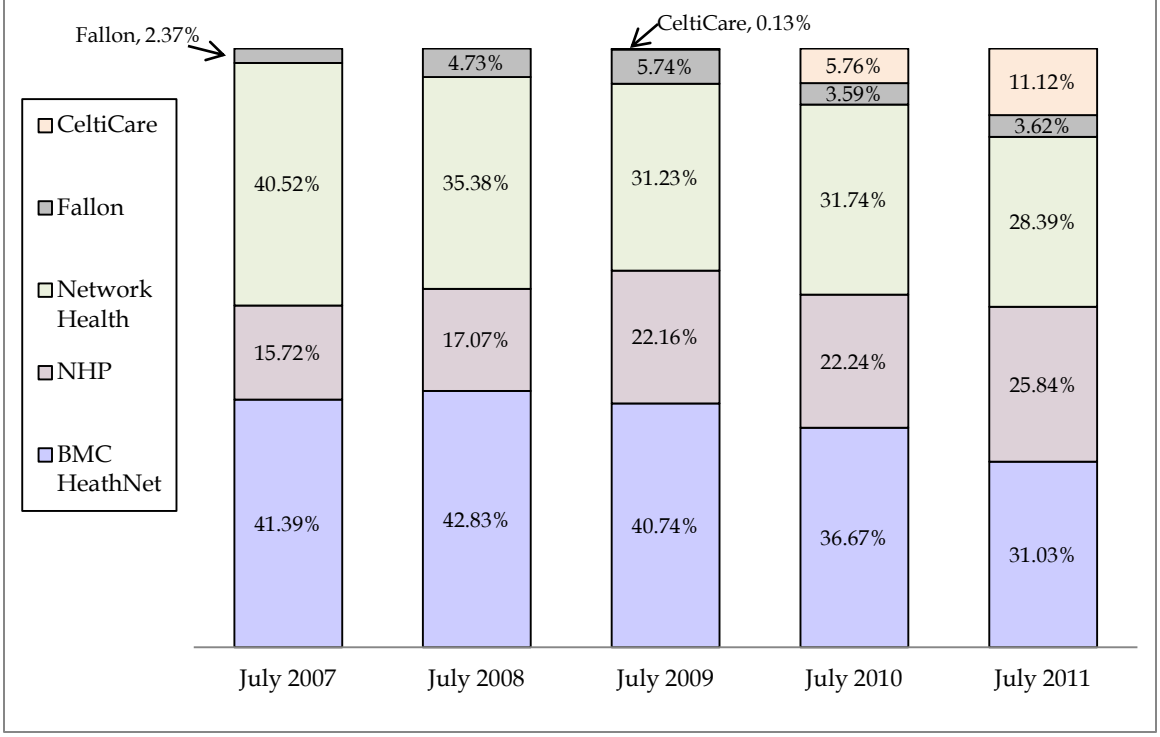


Figure 4. CommCare Enrollment by Plan Type



Network Health and CeltiCare experienced the most significant changes to their membership size, with Network Health enrollment declining by roughly three percent and CeltiCare enrollment increasing by more than five percent from July 2010 to July 2011. Neighborhood Health Plan (NHP) experienced a slight increase of just over three percent since July 2010. Fallon realized a small decline in membership due to reduced geographic coverage in the northern and southern regions of the state. BMC HealthNet continues to have the largest share of CommCare membership.

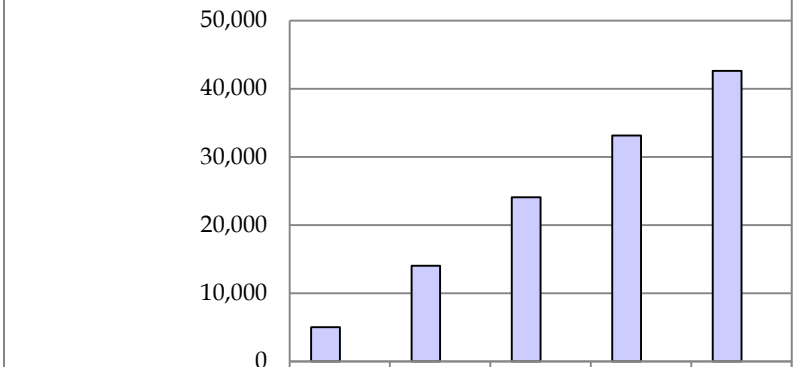
Figure 5. CommCare Enrollment by Health Plan



3.2 Program Updates

Due to budget constraints in FY11, as of July 1st, 2010, dental benefits for CommCare PT1 members (those at or below 100 percent FPL, the only CommCare members with dental benefits) were reduced. After that date, dentists who are CommCare providers will only be reimbursed for preventative and emergency care. If other services are needed, CommCare members may be able to access them through a Health Safety Net (HSN) provider.[41]

Figure 6. Commonwealth Care Web Portal Participation



	FY10 Q4	FY11 Q1	FY11 Q2	FY11 Q3	FY11 Q4
Currently Enrolled Members Registered	5,020	14,066	24,065	33,129	42,617
% of Membership Registered	3%	8%	13%	19%	24%

The operational improvements made to the CommCare member web portal in FY10 have proven to be a valuable tool for CommCare members with internet access (see the FY10 Annual Report for details on these enhancements). Twenty-four percent of current CommCare members have created an online member account and almost a quarter of all enrollment requests are made via the web portal.

3.3 Commonwealth Care Member Survey

In the fall of 2010, the Health Connector issued a Request for Proposals (RFP) for a vendor to perform a comprehensive survey of CommCare members. The survey research firm Market Decisions was selected to perform this survey and a complete report summarizing its findings.[42] The survey solicited input from enrollees on their:

- experiences with administrative processes, including application, eligibility determination, and enrollment,
- knowledge about CommCare as well as more general health and health insurance topics,
- satisfaction with the enrollment process and customer service,
- satisfaction with plan options,
- interest in and ability to use web-based resources, and
- enrollment and disenrollment experiences.

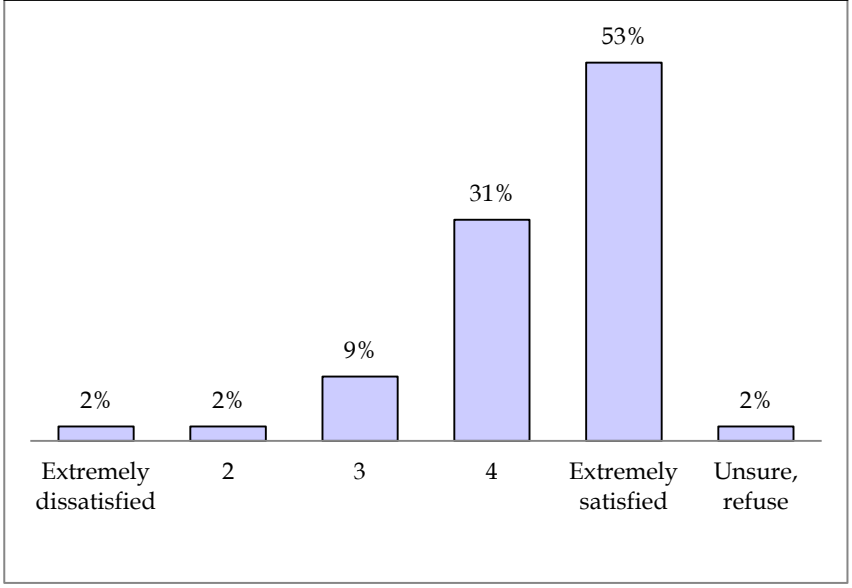
Other areas addressed by the survey included satisfaction with health care services, access to PCPs and specialists, utilization of emergency room care and other health care services, cost of care, need to delay or forego care for financial reasons, and comparison with prior health care experiences. In addition to building a foundation for longitudinal research of the CommCare population, the survey also looks at participants' experiences in order to identify opportunities for policy and programmatic improvements.

Based on the survey results, a large majority of members are pleased with the program experience and the care they have received as CommCare members, with 84 percent reporting that they were "extremely satisfied" or "satisfied" with CommCare overall.

Primary drivers of satisfaction with the program were satisfaction with the choice of health plans, perceived high quality of care, and the broad range of services covered. Only 4 percent of members indicated they were dissatisfied with the CommCare program.

Overall, members reported having a good understanding of their benefits and indicated that they are satisfied with their coverage, choice of providers, and the quality of care available under their plan. Eighty-six percent of respondents rate the range of services covered, and 86 percent rate the quality of care available under their current health insurance as excellent, very good, or good. Eighty-two percent rated the choice of providers available to them under their current plan as excellent, very good, or good.

Figure 7. CommCare Member Survey:
How satisfied are you with the Commonwealth Care program



Supporting the notion that CommCare has been successful in helping members to afford medical services, only four percent of members reported being unable to access care due to cost-sharing. Among those members who pay a monthly premium, 63 percent felt the price was reasonable. Monthly premiums at the time of the survey for premium paying members ranged from $10 to $151 per-month.

While overall the results were extremely positive, the survey did highlight areas where the Health Connector can improve the member experience. Areas of short-term program improvements include further clarifying plan benefits materials, increasing understanding of the renewal process, and improving the availability of web-based resources.

Like some other Massachusetts residents, provider workforce shortages are impacting the ability of some CommCare enrollees to access medical care. According to the survey, less than a third of CommCare members experienced difficulties trying to access health services during the past 12 months or since becoming a CommCare member. Among these members, the most common reasons for difficulty were that the provider was not accepting new patients or the provider did not accept the member's health insurance.

Despite some barriers to care outlined above, the vast majority of members surveyed, 81 percent, have a usual source of care and more than 80 percent of those surveyed reported seeing a doctor at least once during the year/since becoming a member.

An updated survey is scheduled to be conducted in the fall of FY12.

3.4 CommCare Waivers and Appeals

The Health Connector processes three types of waivers and appeals relating to the CommCare program: (1) a waiver or reduction of premiums or co-payments due to extreme financial hardship; (2) a request to change health plans at a time other than open enrollment; or (3) an appeal to challenge decisions related to CommCare. The Health Connector Appeals Unit, in operation since June 2007, processes all appeals relating to CommCare 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 increased by 26.8 percent between FY10 and FY11. This is likely a reflection of programmatic changes that have been implemented, increased member awareness of the waiver process, and the historic economic decline in the state during this time. In terms of programmatic changes, amendments were made to the waiver criteria in 2010 to account for additional financial stresses. For example, the regulations implemented at the end of April 2011 added filing for bankruptcy in the last 6 months as a new hardship.[43]

While there was a significant decrease in the number of health plan change requests received between FY10 and FY11, there were no programmatic or operational changes that can be directly attributed to this decline.

Table 2. CommCare Waivers, Change Requests, and Appeals								
	June 1, 2007 [1] - June 30, 2008		FY 2009		FY 2010		FY 2011	
	#	%	#	%	#	%	#	%
CommCare Waivers Requests (for premium or co-pay reduction)								
Total:	**722**		**1,780**		**1,714**		**2,173**	
# approved:	344	48%	939	53%	940	55%	1,240	57%
# denied:	221	31%	841	47%	774	45%	933	43%
# dismissed:	10	1%	0	0%	0	0%	0	0%
# pending:[2]	147	20%	0	0%	0	0%	0	0%
CommCare Health Plan Change Requests								
Total:	**507**		**227**		**554**		**362**	
# approved:	283	56%	204	90%	543	98%	259	72%
# denied:	209	41%	1	0%	11	2%	20	6%
# dismissed:	13	3%	19	8%	0	0%	83	23%
# pending:[2]	2	0%	3	1%	0	0%	0	0%
CommCare Appeals								
Total:	**1,193**		**5,668**		**5,389**		**4,723**	
# approved:	6	1%	80	1%	349	6%	354	7%
# denied:	6	1%	347	6%	861	16%	680	14%
# dismissed:	811	68%	4,315	76%	3,804	71%	3,210	68%
# pending:[2]	370	31%	926	16%	375	7%	479	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 appeal receipts have averaged 371 appeals per month in FY11. Average monthly receipts in FY10 were 374 appeals per month. The Health Connector Appeals Unit held 2,290 CommCare hearings in FY11.

3.5 CommCare FY12 Procurement Process

Over the last five years, the CommCare program has provided quality, affordable health insurance coverage to low- to moderate-income adults in Massachusetts at an average annual premium trend of three to four percent, considerably lower than trends seen in commercial health insurance.

In the winter of 2011, the Health Connector launched its annual procurement for the FY12 CommCare program. In light of an extremely challenging fiscal environment for the Commonwealth, but illustrative of the continued desire to invest in CommCare, the program received level funding of $822 million.

Given projected increases in enrollment (largely driven by MSP members transitioning off Unemployment Insurance and Fishing Partnership members becoming eligible for CommCare), and "normal" medical cost

trends, the Health Connector would estimate a program budget increase of about 10% or $82 million for FY12. Therefore, the prospect of a level funded budget required introduction of a new procurement strategy and bidding dynamics so as to avoid cutting benefits or capping program enrollment.

As in prior years, the CommCare procurement required health plans to provide bids within an Actuarially Sound Rate Range (ASRR). (Please see prior Annual Reports for more on the ASRR and prior procurements.) This was the first time, however, that sufficient experience existed to develop the ASRR based on member experience in all five health plans. Member experience in CeltiCare Health Plan, a low-cost, narrower network MCO, was included. This resulted in a lower bound than what was previously seen in the development of the ASRR.

For the FY12 procurement, the bidding rules allowed all health plans to bid at or below the bid ceiling, and the procurement continued to include membership incentives to encourage low bids. For example, as described in prior annual reports, PT 2 and 3 members who do not choose the lowest cost plan will continue to pay a premium differential. A new dynamic was also introduced to further encourage health plan innovation and to improve existing contractual arrangements, medical management, administrative efficiencies, and strategies to direct care to lower cost settings. Certain new PT 1 members who have not been enrolled with a CommCare MCO other than the lowest cost health plan or with a MassHealth MCO in the last 180 days would only have the option of choosing the lowest cost health plan(s). Finally, the procurement further encouraged competition across the plans by requiring an active open enrollment (i.e. 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) if at least three heath plans did not bid within $55 per member per month of the low end of the ASRR.

These bidding rules and dynamics proved largely successful. Four of the five participating health plans bid flat or lower rates than those in effect for FY11. As will be described in a later section of the report, the result was a net *decrease* in the average capitation rate from FY11 to FY12, enabling the CommCare program to maintain the scope of benefits provided to members and to continue to serve the projected population without enrollment caps. Consistent with the bidding rules described in the procurement, several programmatic changes will be implemented in CommCare for FY12.

The Health Connector will continue to work closely with MCOs and other stakeholders, and monitor the member experience, to ensure members are given robust information and support as they transition to the FY12 program.

3.6 CommCare Budget

As of July 2010, the CommCare program is estimated to be $52.7 million under budget for FY11, primarily as a result of lower than projected enrollment due to the extension of unemployment benefits for MSP members. Table 2 below compares the budgeted and actual expenditures for FY11. Table 2 also shows the projected enrollment and budgeted expenses for FY12.[44]

Table 3. CommCare Expenditures FY11

FY 2011 Budget and Actual	FY11 (Budget)	FY11 (Actual)[2]	FY11 (Variance)	FY12 (Budget)
Year End Membership	173,481	159,903	-13,578	174,310
Member Months	1,985,799	1,886,450	-99,349	2,075,773
Capitation Rate	$426.00	$426.57	$0.57	$417.00
Total Spending[1]	$838,709,765	$786,032,711	($52,677,054)	$822,690,748

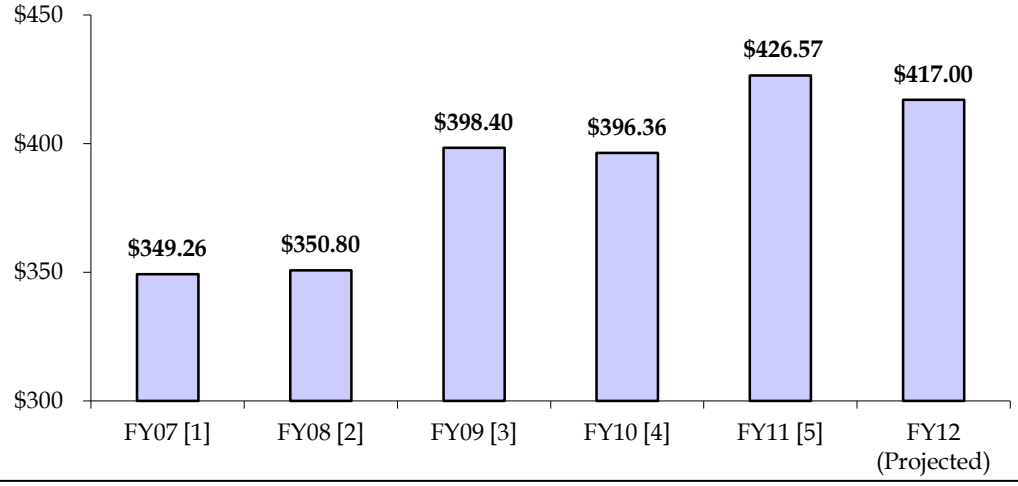
[1] Total spending is inclusive of administrative costs and net of enrollee contribution collections.

[2] FY11 Actual is based on June 2010 enrollment but due to timing total spending is not yet final due to enrollee contribution collections.

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.

As described in Section 3.5, the Health Connector was able to achieve significant cost savings for FY12 through an innovative procurement process that maintained covered benefits and should ensure projected enrollment growth can be sustained despite fiscal constraints. The Health Connector was able to recommend a lower capitation rate for FY12 largely as a result of aggressive contracting and case management strategies proposed by the participating MCOs. The capitation rates for FY12 range across MCOs from $359.98 to $446.63 per member per month, resulting in an average capitation rate of $417.

Figure 8. Average CommCare Capitation Rate (PMPM)
FY07 - FY12 (Projected)



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

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

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

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

[5] This figure reflects payments made for the twelve month period from 7/1/10 - 6/30/11. Due to timing differences and updated information the amount reflected may differ from figures previously released by the Health Connector.

4.0 Commonwealth Care Bridge

4.1 Program Updates

The CommCare Bridge program (Bridge) provides low cost health insurance coverage to certain legal immigrants, known as Aliens with Special Status (AWSS), who lost eligibility for coverage under CommCare in 2009. Legal immigrants are eligible to participate in the Bridge program if they (1) were enrolled in CommCare as of August 31, 2009, (2) lost CommCare coverage on August 31, 2009 due to changes in state law, and (3) meet the eligibility requirements for CommCare except for immigration status. For a more detailed program description, please refer to the FY10 Annual Report.[45]

In FY10, each MCO participating in CommCare was invited to submit a proposal to provide coverage for this population within the appropriated budget. After review by the three administering agencies (ANF, EOHHS, and the Health Connector), the Governor accepted a proposal from CeltiCare for a fully-capitated coverage plan. The Bridge program contract with CeltiCare has been extended for FY12.

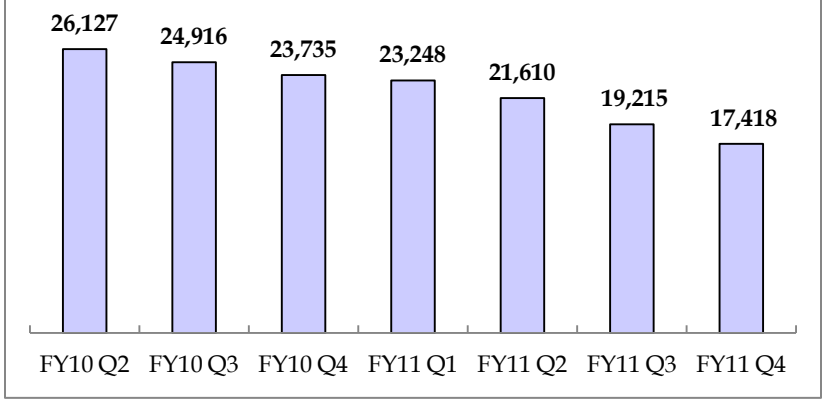
Continued coverage under the Bridge program for FY12 will be contingent on available funding. Under the ACA, federal funding for these immigrants' coverage will begin in 2014 in the form of premium tax credits.

In February 2010, immigration and health care advocacy groups filed a class action lawsuit, Finch v. Connector Authority, challenging the constitutionality of excluding legal immigrants from CommCare. 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 CommCare will be reviewed with the highest level of scrutiny reserved for state actions. In the event that the review of the decision to exclude legal immigrants from CommCare does not withstand this level of judicial scrutiny, then the AWSS population will again be eligible for CommCare. The SJC convened to hear oral arguments on this issue on October 6, 2011.

4.2 Commonwealth Care Bridge Enrollment

As of July 1, 2011, there are 16,521 members participating in the Bridge program, down from 23,593 members at the same time last year. The overall decline in Bridge enrollment figures, as depicted in Figure 9 below, is due 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 CommCare (i.e., reaching the five year federal residency requirement necessary to be eligible for federal funding).

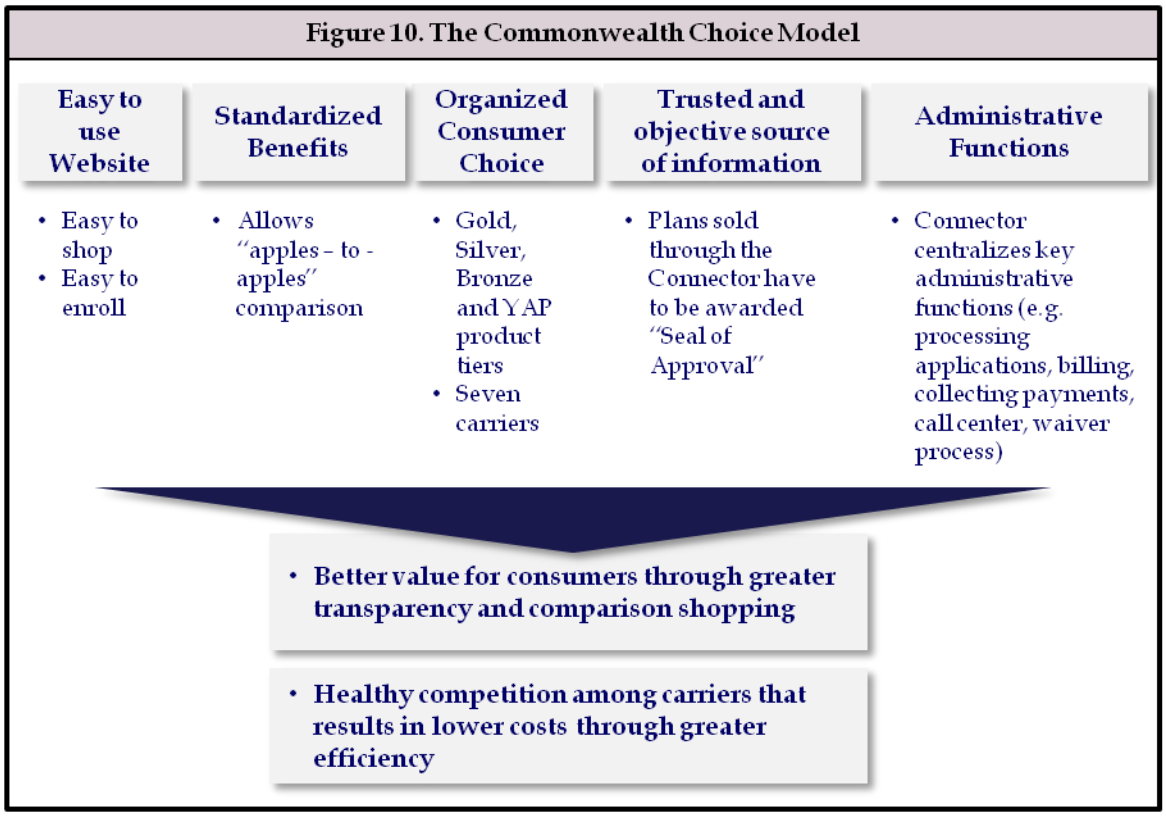
Figure 9. CommCare Bridge Enrollment



5.0 Commonwealth Choice

5.1 Program Update

Commonwealth Choice, the Connector's unsubsidized health insurance program, offers individuals and small businesses high-quality, private health insurance at more affordable prices. As the figure below illustrates, CommChoice is a valuable resource for non- and small-group shoppers, providing an easily accessible one-stop shopping experience for health insurance.



Seven health insurance carriers currently participate in the CommChoice program, with a new entrant, Boston Medical Center HealthNet Plan (BMCHP), offering coverage beginning in Calendar Year (CY) 2012. Collectively, as of the end of FY11 Q4, the carriers provided health coverage to more than 38,000 members. Of the six carriers with sufficient experience to be rated,[46] all receive an "excellent" accreditation status according to NCQA's health plan report card.[47] A detailed program description can be found in the annual reports for 2006-2008 and FY09.[48]

To further enhance the consumer shopping experience, the Health Connector implemented a provider search tool in July 2011. 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 consumers to narrow their plan options by providers, simplifying the online shopping experience through CommChoice.

Health Connector staff are also working with those health plans participating in the CommChoice program to implement 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 comply with this requirement.

The ACA also required health plans to begin the process of phasing out annual limits on essential health benefits. YAPs are the only CommChoice products that may include an annual limit. To mitigate potentially dramatic premium increases for current YAP enrollees, the Health Connector and those carriers with an annual limit on their YAPs sought and received a federal waiver of this requirement for FY11. As part of the Seal of Approval (SoA) process for FY12, carriers were given the option to implement the removal of the annual limit to new purchasers as of July 1, 2011 or October 1, 2011. The Health Connector and those carriers that continue to offer plans to renewing members with an annual limit recently received a federal waiver for those renewing YAP enrollees through December 2013.

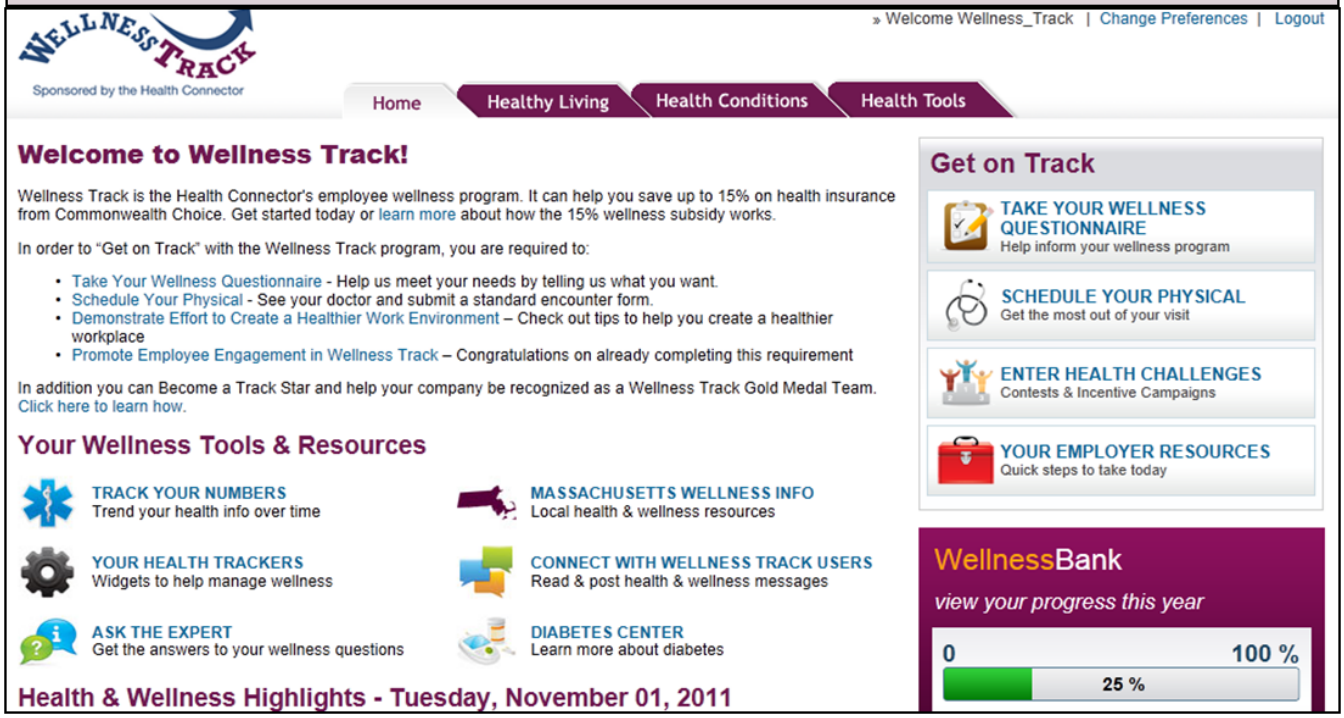
5.2 Helping Small Employers

Recognizing the financial strain small business owners are feeling as the cost of small-group health benefits continues to climb, the Health Connector is renewing its commitment to the business community by improving its small-group offering.

Beginning in FY12, the Health Connector is adding new features to the Business Express (BE) program that will make it even easier for small businesses to find affordable coverage. As part of the FY12 procurement process, all health plans awarded the Seal of Approval agreed to participate in BE. Consequently, employers will be able to choose from among a broader array of health plan options. Additionally, small businesses with one to five employees will no longer be required to pay the $10 per subscriber per month supplemental fee and once all health plans are participating, carriers will enjoy a reduced administrative fee of 2.5 percent for BE.[49] Over 4,000 members are enrolled in a plan through BE as of July 1, 2011.

The Health Connector implemented an innovative new worksite wellness and subsidy program, "Wellness Track," which became available to small businesses on June 6, 2011 (for coverage effective July 1, 2011), offering a unique opportunity to both improve employee health and decrease employer health costs. The program, authorized by Chapter 288 of the Acts of 2010, provides eligible small groups[50] 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.[51] Participating eligible employers will receive a subsidy of up to fifteen percent of eligible employer health care costs at the end of the state fiscal year.[52] Figure 11 below depicts the "Welcome" screen for participating employers.

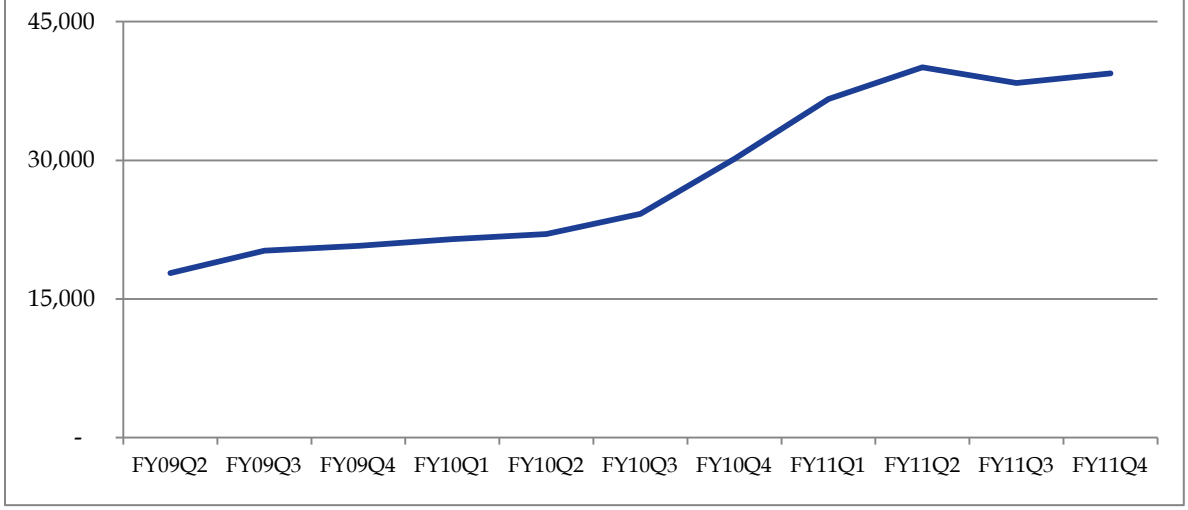
Figure 11. Wellness Track Employer Welcome Screen



5.3 CommChoice Enrollment

As of July 2011, there were 38,107 paid members enrolled in a health plan through CommChoice, 26,561 paid subscribers and 11,545 dependents. Due to a number of factors, including new open enrollment periods[53] and declining YAP enrollment, CommChoice enrollment peaked in December 2010 at 40,075 paid members. Health Connector staff anticipates an increase in the growth of non-group membership following the FY12 open enrollment period which will run from July 1 through August 15, 2011 for effective dates of August 1 and September 1.

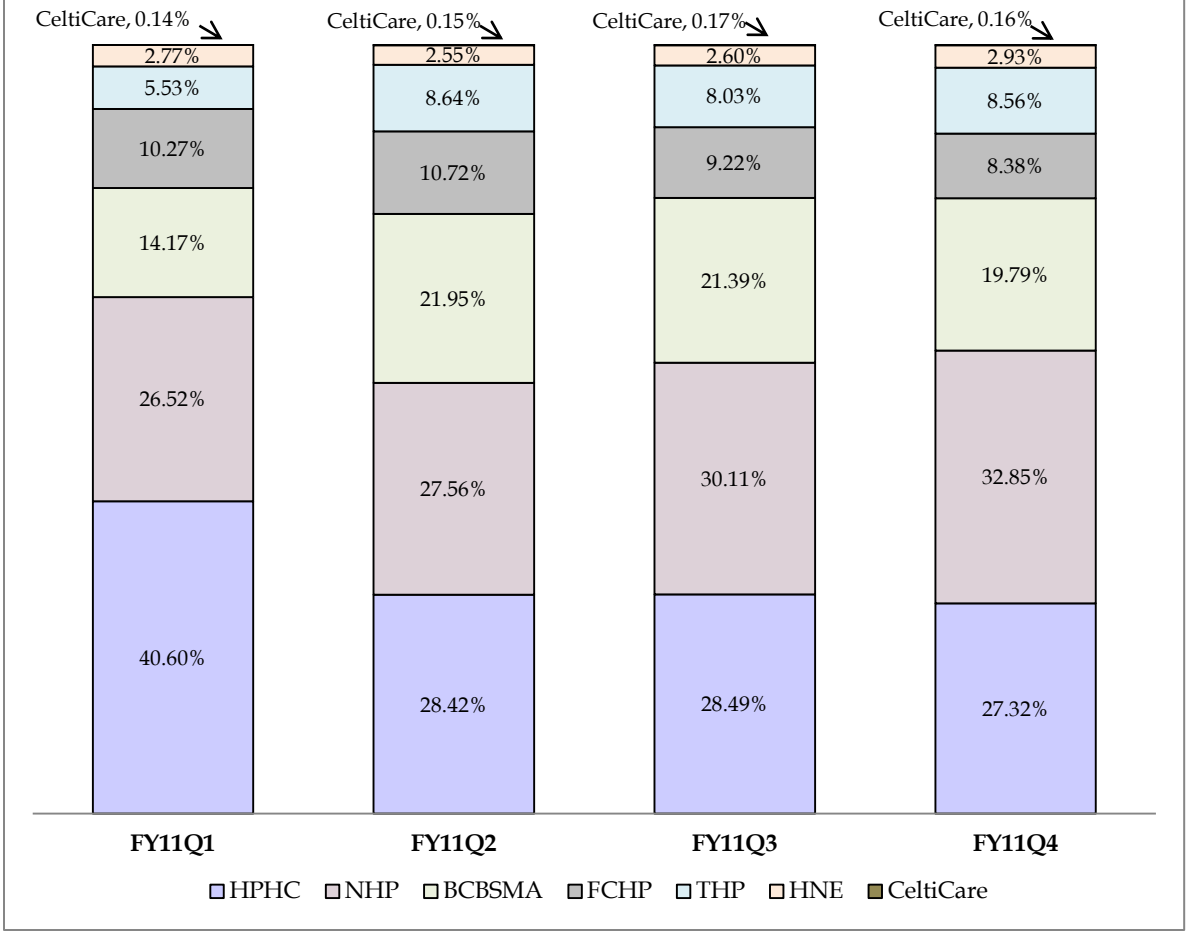
Figure 12. CommChoice Enrollment (members)



Bronze-level products continue to attract the most customers, with enrollment in these products increasing by 21.7 percent (3,134 paid members) between July 2010 and July 2011. Over 36 percent of members (13,743 paid members) are enrolled in a Silver-level plan while only 8.1% of members (3,066 paid members) are enrolled in a Gold-level product. As noted above, 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.[54] Though Massachusetts' 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.

The percentage of individuals enrolled in Neighborhood Health Plan grew to 33 percent of total membership by the end of FY11. Enrollment in Tufts Health Plan also increased, representing 27 percent of membership at the end of FY11. BCBSMA membership grew during the first quarter of the fiscal year, with enrollment remaining stable at roughly 20 percent for the remainder of the fiscal year. Harvard Pilgrim Health Care saw a 10 percent reduction in enrollment between FY11 Q1 and FY11 Q2.

Figue 13. CommChoice enrollment by Health Carrier (members)



Individual coverage remains the highest selling rate basis by far, constituting 80 percent of subscribers in June 2011. As noted above, young adult participation in CommChoice has declined. The percentage of subscribers age 18-26 declined by almost six percent between July 2010 and July 2011. Enrollment by gender has not changed significantly during FY11. Non-group membership constitutes 83 percent of CommChoice enrollment.

In addition to selling non-group products directly to individuals and families, the Health Connector also operates the Voluntary Plan (VP), Business Express (BE), and offered the Contributory Plan (CP) on a pilot basis to facilitate the purchase of insurance for employees through the CommChoice program. VP allows employees without access to ESI to purchase a CommChoice health insurance plan using pre-tax dollars if their employer established an Internal Revenue Service (IRS) Section 125 plan with the Health Connector. As of July 2011, 2,228 members were enrolled in CommChoice through VP. The Health Connector piloted CP in January 2009 to increase flexibility in health insurance options for small employers. Enrollment was closed to new business in the CP pilot in March 2010. During the closing, the Health Connector will more fully evaluate the program and consider this model, among other potential options, that may be implemented come 2014 to comply with the concept of an "employee choice model" required by the ACA. Current CP subscribers may continue to renew their plan. As of July 2010, 180 members were enrolled in CommChoice through the CP pilot program. BE is discussed in more detail in Section 5.2.

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

The Seal of Approval is an important designation awarded by the Health Connector, as it indicates that health insurance carriers selected meet certain standards regarding quality and value and are willing to work with the Health Connector to offer high value, cost-effective health benefit plans through the CommChoice program. In FY11, the Health Connector solicited two separate bids from carriers interested in participating in the CommChoice program. The first procurement and contract cycle was for the period from January 1 –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 six month contract period was intended to allow the Health Connector to maintain a steady state while refining the small group insurance program, developing the wellness subsidy program, and updating the standardized benefit designs available through the Health Connector. Carriers were given the flexibility to participate in both the non- and small-group programs, or just the non-group program during this period. The Health Connector accepted responses from the seven health insurance carriers already participating in the CommChoice program.

The second Request for Responses (RFR) was issued in January 2011 for coverage effective July 1, 2011 through December 31, 2012. The 18-month contract term provides the Health Connector and health plans stability while we engage in planning for changes required by national health reform.

During the six-month contract period, the Health Connector worked with the health plans and consumers to identify enhancements to the standardization model. Based on this stakeholder input, the Health Connector developed three broad objectives: (1) maintain standardized benefit designs that allow for price transparency and simplify the shopping experience, (2) streamline the number of benefit designs, while continuing to provide the level of choice expected by consumers and small businesses, and (3) minimize member disruption and health plan administrative costs by offering benefit designs that match our current offerings. To streamline the CommChoice product portfolio, the Silver Medium benefit package was eliminated for all new business beginning in July 2011. Additionally, cost-sharing for inpatient Skilled Nursing Facility (SNF) care, outpatient mental health visits, routine vision, and ambulance was removed from the standardization specifications.

The goals of the July 2011 SoA were: (1) robust carrier participation in BE (and continued participation in the non-group program), (2) an enhanced shopping experience for individuals and small businesses, (3) a balance between the need for choice and the desire for a streamlined shopping experience and product portfolio, (4) initiation of the transition to compliance with ACA requirements, and (5) stability while the Health Connector plans for changes required by national health reform. The contract required health plans to participate in all product offerings, including individual/non-group, YAPs, BE, VP and CP renewals. Additionally, carriers were required to continue to offer products that meet the standardized plan design specifications in all benefit tiers and offer the standardized products on their broadest provider network. In addition, carriers were encouraged to also offer "select or limited" network product(s) that also met the plan design parameters.

Eight of the nine health plans that submitted responses were awarded an SoA: Blue Cross Blue Shield of Massachusetts, BMCHP, CeltiCare Health Plan, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, and Tufts Health Plan. BMCHP is a new entrant and is targeting an initial implementation date of January 1, 2012. Fallon will continue to offer a limited network (in conjunction with their broad network) for all Silver and Bronze plans. Harvard Pilgrim has indicated that they may also offer a limited network product in 2012.

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 will no longer be allowed. Additionally, benefits for dependents, if dependents are covered, must include coverage for core medical services and a broad range of medical services. The MCC requirements for TY10 and TY11 can be found on the Health Connector website.[55]

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 meeting MCC despite its deviation from the MCC standards.

This process, called "MCC Certification" is further described in a Health Connector Administrative Bulletins (released in November, 2008 and February 2010). 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 2011, the Health Connector has reviewed 3,884 plans in FY11, significantly fewer than the number of MCC certification requests received in FY10. This reduction is attributable to process improvements implemented for carriers that have 50 or more applications for MCC certification. Additionally, if there were no material changes to a plan that received an MCC certification in FY10, the carrier was permitted to use the certification for FY11 and would not need to request a new one.

The majority (93.3 percent) of plans reviewed were granted MCC certification by the Health Connector, signifying that coverage provided by the plan was equivalent or more robust than coverage provided by the Health Connector's Bronze level plans. This high rate of approval reflects the Health Connector's flexibility in defining MCC to minimize unnecessary disruption to comprehensive employer-sponsored plans, while ensuring that Massachusetts residents have health insurance coverage options that provide sufficient levels of benefits.

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.[56] 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.

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. The group reviewed several sources of data to inform their deliberations, including analyses

of tax-filer data pertaining to insurance coverage as well as Health Connector Board member Jon Gruber's analysis of Consumer Expenditure Survey data designed to assess whether individuals have "room" in their budgets to afford health insurance after spending on other necessities.

The group also concentrated on understanding the relationship between the state and federal affordability standards. Despite different standards, analysis of existing data suggests that the aggregate number of people in groups that may become newly subject to or newly exempt from a mandate under federal standards (as compared to current state standards) is relatively small. [57]

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 February 2011, the Board voted on a "draft" schedule that was then issued for public comment. In March, the public comment was reviewed with the Board and the final schedule for the calendar year was adopted.

The tables below illustrate the proposed affordability schedules for CY11. Updated FPL guidelines were announced in January requiring modest changes to the income brackets used in the affordability schedule. For income brackets above 300 percent FPL, the lower and upper income bounds have been increased consistent with the increase in guidelines from 2010 to 2011 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 2011 as compared to 2010 when measured as a percentage of income.

Table 4. Affordability Schedule for INDIVIDUALS

Income Bracket (% of FPL)	Annual Gross Income	Maximum Monthly Premium		
		2010	2011	Increase from 2010
0 - 100%	$0 - $10,896	$0	$0	$0
100.1 - 150%	$10,897 - $16,344	$0	$0	$0
150.1 - 200%	$16,345 - $21,780	$39	$39	$0
200.1 - 250%	$21,781 - $27,228	$77	$77	$0
250.1 - 300%	$27,229 - $32,676	$116	$116	$0
300.1 - 360%	$32,677 - $39,215	$175	$175	$0
360.1 - 408%	$39,216 - $44,443	$235	$235	$0
408.1 - 504%	$44,444 - $54,900	$354	$354	$0
Above 504%	above $54,901	n/a	n/a	n/a

Table 5. Affordability Schedule for COUPLES				
Income Bracket (% of FPL)	Annual Gross Income	Maximum Monthly Premium		
		2010	2011	Increase from 2010
0 - 100%	$0 - $14,712	$0	$0	$0
100.1 - 150%	$14,713 - $22,068	$0	$0	$0
150.1 - 200%	$22,069 - $29,424	$78	$78	$0
200.1 - 250%	$29,425 - $36,780	$154	$154	$0
250.1 - 300%	$36,781 - $44,136	$232	$232	$0
300.1 - 374%	$44,137 - $55,113	$315	$315	$0
374.1 - 446%	$55,114 - $65,611	$422	$422	$0
446.1 - 588%	$65,612 - $86,607	$589	$589	$0
Above 588%	above $86,608	n/a	n/a	n/a
Table 6. Affordability Schedule for FAMILIES				
Income Bracket (% of FPL)	Annual Gross Income	Maximum Monthly Premium		
		2010	2011	Increase from 2010
0 - 100%	$0 - $18,540	$0	$0	$0
100.1 - 150%	$18,541 - $27,804	$0	$0	$0
150.1 - 200%	$27,805 - $37,068	$78	$78	$0
200.1 - 250%	$37,069 - $46,332	$154	$154	$0
250.1 - 300%	$46,333 - $55,596	$232	$232	$0
300.1 - 398%	$55,597 - $73,688	$373	$373	$0
398.1 - 511%	$73,689 - $94,742	$586	$586	$0
511.1 - 625%	$94,743 - $115,796	$849	$849	$0
Above 625%	above $115,797	n/a	n/a	n/a

As described in the FY09 report, 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 CommCare 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 2011 are shown in Table 7.[58]

Table 7. Penalty Schedule for Failure to Comply with the Individual Mandate. 2009, 2010						
	2009		2010		2011	
	per month	per year*	per month	per year*	per month	per year*
150.1 - 200% FPL	$17	$204	$19	$228	$19	$228
200.1 - 250% FPL	$35	$420	$38	$456	$38	$456
250.1 - 300% FPL	$52	$624	$58	$696	$58	$696
Above 300% FPL. Age 18-26	$52	$624	$66	$792	$72	$864
Above 300% FPL. Age 27+	$89	$1,068	$93	$1,116	$101	$1,212
*If the individual is without insurance for all twelve months of the year.						

7.0 National Health Care Reform

The ACA was signed into law on March 23, 2010. This represents the first comprehensive overhaul of the United States healthcare system in over 40 years. Modeled largely after the Commonwealth's own health reform efforts, the ACA puts into place a number of provisions to increase access to care, reduce costs, and improve quality of care. Beginning in 2014, states will be required to have established an Exchange that will facilitate shopping and ensure those eligible for new and existing subsidies are able to access them. Eligibility for Medicaid will be expanded to individuals earning up to 133 percent FPL and federal tax credits will be available to individuals earning up to 400 percent FPL (note that this will allow a greater number of Massachusetts residents to access some form of subsidized coverage as CommCare subsidies are not available to individuals with a total household income above 300 percent FPL). Small businesses will also be able to purchase coverage through these new Exchanges and come 2014 those eligible for tax credits will be required to do so to maintain the tax credits first introduced in 2010. As in Massachusetts, the national reform bill will require most US citizens to purchase health insurance coverage beginning in 2014.

The table below highlights some of the provisions that have already gone into effect and what they mean for Massachusetts.

Table 8. Selected Provisions of the ACA Effective as of FY 2011

Provision	Effective Date	Impact	What it means for Massachusetts residents
Federal Small Business Tax Credits	January 1, 2010	Provides tax credits to small employers (up to 25 employees) with average annual wages of less than $50,000 that provide health insurance for employees.	Offers a new financial resource for small businesses.
Minimum MLR for Insurers	January, 2011	Requires all plans, including grandfathered plans, to provide a rebate to enrollees if the MLR exceeds a certain threshold (85 percent for the large group market and 80 percent for the individual and small group market).	Most health plans in Massachusetts have MLRs that exceed these limits, though some consumers, such as student health plan enrollees, will benefit from this new requirement.
Dependent coverage up to age 26	Sept. 23, 2010	In most circumstances, insurance plans that provide dependent coverage must extend coverage to children until the child turns 26.	The federal requirement is more expansive than Massachusetts law,[59] further expanding eligibility for dependent coverage.
Preventive care coverage	Sept. 23, 2010	All new plans must cover preventive services at no charge. These benefits must be exempted from cost-sharing obligations.	The Massachusetts MCC standards require a compliant plan to cover preventive care services, but the federal requirement will allow certain preventive services to now be acquired at no cost to members at the point of service.

Much of the work for implementing the ACA still lies ahead. In addition to new tax credits and easier shopping for non-group and small-group coverage through the Exchange, the national reform bill expands access to Medicaid, and calls for a number of changes to the insurance market as well as more stringent consumer protections. Though the Health Connector and the state have already done a significant amount of work to implement key components of the ACA, there is still much to do to ensure a smooth transition to full implementation of the ACA and its associated requirements by 2014.

8.0 Concluding Comments

In the five years since Chapter 58 became law, Massachusetts has remained a leader in providing access to affordable health insurance. Moving beyond the initial implementation phase, the Health Connector has been able to focus efforts on enhancing our current programs. CommCare members, for example, have seen dramatic improvements to their online experience through the member web portal, while employers who offer coverage through BE can now participate in the Health Connector's innovative new wellness program and receive up to a 15 percent subsidy on their annual premium. As the Health Connector works with the Patrick Administration, the Legislature, and other state agencies to move forward with implementation of the ACA, we look forward to taking advantage of the many benefits the national law offers the Commonwealth to further improve our existing programs.

While the Health Connector continues to identify and implement improvements for the members it serves, consideration must be given to the issue of rising health care costs. State and federal policy makers are focused on containing costs in the health care industry, and addressing this issue will require innovation and collaboration with key stakeholders. The Health Connector is currently working on a number of important initiatives that expand upon our core functions in an effort to reduce costs and make health care more affordable. For example, the Health Connector is currently assisting the Board of Higher Education with a competitive procurement for obtaining more cost-effective and comprehensive health insurance as part of our collaborative Student Health Insurance Initiative. The Health Connector will continue to look for opportunities to support any payment reform initiatives passed by the Legislature this Session, and is already collaborating with the Executive Office of Health and Human Services on its Patient-Centered Medical Home Initiative.

As described in this report, the Health Connector is working closely with state agencies to ensure implementation of the ACA yields benefits for Massachusetts. The changes brought on by the federal law require state policymakers to consider refinements to programmatic and operational aspects of providing health coverage to Massachusetts' residents and the success of this effort will again rely on the involvement of key stakeholders. The Health Connector has also played an important role in securing funding under the federal Exchange Planning and Early Innovators grants to help implement national health reform in Massachusetts. Collectively, these grants exceed $35 million in additional federal monies devoted to enhancing and developing the infrastructure needed to move forward under the national health reform acts.

As we proceed, we are confident that, with the continued support of the Legislature, our Board, the Administration, and the health care stakeholder community, the "next iteration" of the Health Connector can and will be a continued force in facilitating access to affordable health insurance for all the citizens of the Commonwealth.

Appendix I: Abbreviations

ACA	Patient Protection and Affordable Care Act
ACO	Accountable Care Organization
AIM	Associated Industries of Massachusetts
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
BMCHP	Boston Medical Center HealthNet Plan
Bridge	Commonwealth Care Bridge Program
CHC	Community Health Center
CMMI	Center for Medicare and Medicaid Innovation
CMR	Code of Massachusetts Regulations
CommCare	Commonwealth Care
CommChoice	CommChoice
CP	Contributory Plan
CY	Calendar Year
DHCFP	Division of Health Care Finance and Policy
DOI	Division of Insurance
DOR	Department of Revenue
DPH	Department of Public Health
DUA	Division of Unemployment Assistance
EOHHS	Executive Office of Health and Human Services
ESI	Employer-Sponsored Insurance
Exchange	American Health Benefit Exchange
FPL	Federal Poverty Level
FY	Fiscal Year
GIC	Group Insurance Commission
HCQCC	Health Care Quality and Cost Council
Health Connector	Commonwealth Health Insurance Connector Authority
HHS	United States Department of Health and Human Services
HNE	Health New England
HSN	Health Safety Net
IT	Information Technology
MCC	Minimum Creditable Coverage
MCO	Managed Care Organization
MLR	Medical Loss Ratio
MSP	Medical Security Program
NCQA	National Committee for Quality Assurance
NESCIES	New England States Collaborative Insurance Exchange Systems
PCMHI	Patient Centered Medical Home Initiative
PCP	Primary Care Physician
PMPM	Per Member Per Month
PT	Plan Type
Q	Quarter
QSHIP	Qualified Student Health Insurance Plan
RFP	Request for Proposals
RFR	Request for Responses
Roadmap	Roadmap to Cost Containment

SJC ..... Supreme Judicial Court
SNF ..... Skilled Nursing Facility
SoA ..... Seal of Approval
TY ..... Tax Year
UMass ..... University of Massachusetts
VP ..... Voluntary Plan
YAP ..... Young Adult Plan

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[1] 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/Eeohhs2/docs/dhcfp/r/pubs/10/mhis_report_12-2010.pdf

[2] 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/Eeohhs2/docs/dhcfp/r/pubs/10/mhis_report_12-2010.pdf

[3] 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).

[4] 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/Eeohhs2/docs/dhcfp/r/pubs/10/mhis_report_12-2010.pdf

[5] 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/Eeohhs2/docs/dhcfp/r/pubs/10/mhis_report_12-2010.pdf

[6] Long, S., Yemane, A., and Stockley, K. (2010, August). *Disentangling the Effects of Health Reform in Massachusetts: How Important Are the Special Provisions for Young Adults?* American Economic Review, 100(2): 297–302. Available online at, http://pubs.aeaweb.org/doi/pdfplus/10.1257/aer.100.2.297

[7] Division of Health Care Finance and Policy (2011, July). *Massachusetts Employer Survey 2010*. Boston, MA: Author. Available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/11/mes_results_2010.pdf.

[8] 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/Eeohhs2/docs/dhcfp/r/pubs/10/mhis_report_12-2010.pdf

[9] Long, S., and Phadera, L. (2011, May). *Estimates of Health Insurance Coverage in Massachusetts from the Massachusetts Health Insurance Survey: An Update for 2010*. Boston, MA: Division of Health Care Finance and Policy. Available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/11/MHIS_Policy_Brief_5_2011.pdf

[10] 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://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/11/his_access_chartbook_2010_all%20ages.pdf

[11] Byrne, F. R.; Jones, E; Shin, P.; Ku, L.; Long, S.K. *Safety-Net Providers After Health Care Reform: Lessons From Massachusetts.* Arch Intern Med. 2011; 171(15):1379-1384.

[12] 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/Eeohhs2/docs/dhcfp/r/pubs/11/2010_MHIS_detailed_tables.pdf

[13] Division of Health Care Finance and Policy (2010, July). *Primary Care in Massachusetts: An Overview of Trends and Opportunities*. Boston, MA: Author. Available online at, http://www.google.com/url?sa=t&source=web&cd=2&ved=0CB8QFjAB&url=http%3A%2F%2Fwww.mass.gov%2FEeohhs2%2Fdocs%2Fdhcfp%2Fr%2Fpubs%2F10%2Fprimary_care_report_in_massachusetts.ppt&ei=yLj4TY6KKqnw0gH4xd2yCw&usg=AFQjCNF-puAJcgTQysiygpAhDrcl-Y_nvQ&sig2=PO9QmQvX54jrQ0txSYak1Q

[14] Division of Health Care Finance and Policy (2010, July). *Primary Care in Massachusetts: An Overview of Trends and Opportunities*. Boston, MA: Author. Available online at, http://www.google.com/url?sa=t&source=web&cd=2&ved=0CB8QFjAB&url=http%3A%2F%2Fwww.mass.gov%2FEeohhs2%2Fdocs%2Fdhcfp%2Fr%2Fpubs%2F10%2Fprimary_care_report_in_massachusetts.ppt&ei=yLj4TY6KKqnw0gH4xd2yCw&usg=AFQjCNF-puAJcgTQysiygpAhDrcl-Y_nvQ&sig2=PO9QmQvX54jrQ0txSYak1Q

[15] 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/Connector%2520Annual%2520Report%25202010.pdf

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

[17] 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).

[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/Connector%2520Annual%2520Report%25202010.pdf

[19] 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/Connector%2520Annual%2520Report%25202010.pdf

[20] Chapter 288 of the Session Laws of 2010, § 26 and § 27 (August 10, 2010). *An Act To Promote Cost Containment, Transparency And Efficiency In The Provision Of Quality Health Insurance For Individuals And Small Businesses*.

[21] Chapter 288 of the Session Laws of 2010, § 64 (August 10, 2010). *An Act To Promote Cost Containment, Transparency And Efficiency In The Provision Of Quality Health Insurance For Individuals And Small Businesses*.

[22] Chapter 288 of the Session Laws of 2010, § 29 (August 10, 2010). *An Act To Promote Cost Containment, Transparency And Efficiency In The Provision Of Quality Health Insurance For Individuals And Small Businesses*.

[23] Chapter 288 of the Session Laws of 2010, § 30 (August 10, 2010). *An Act To Promote Cost Containment, Transparency And Efficiency In The Provision Of Quality Health Insurance For Individuals And Small Businesses*.

[24] Chapter 288 of the Session Laws of 2010, § 32 (August 10, 2010). *An Act To Promote Cost Containment, Transparency And Efficiency In The Provision Of Quality Health Insurance For Individuals And Small Businesses*.

[25]As mentioned in prior annual reports, in 2009, in order to begin to address this issue, the state's Health Care Quality and Cost Council (HCQCC), a public entity responsible for setting quality and cost targets for the Commonwealth, issued the "Roadmap to Cost Containment" (Roadmap). This report serves as a comprehensive review of the Commonwealth's healthcare system that outlines key strategies for containing health care cost growth. The Roadmap identifies four components of comprehensive payment reform: (1) increase use of payment methodologies that support health care delivery redesign, (2) encourage global payments, (3) monitor cost growth, and (4) continue system redesign initiatives for Medicare and Medicaid eligible residents.

In response to the Roadmap report, in August 2010 the HCQCC formed a Committee on the Status of Payment Reform Legislation. The objective of the Committee is to develop and make recommendations that would serve to inform comprehensive health care payment and system delivery reform legislation. Using the Roadmap as a basis, the multi-stakeholder Payment Reform Commission found that cost control required improved provider payment methodologies promoting integrated, "whole person" care.

[26] HB 1849, "An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments." (2011). Available online at, http://www.malegislature.gov/Bills/187/House/H01849

[27] Martin, D. (2011, March). *Governor Patrick's Payment and Delivery Reform Bill.* Boston, MA: Executive Office of Health and Human Services. Available online at, http://www.malegislature.gov/Bills/187/House/H01849 http://www.mass.gov/Ihqcc/docs/meetings/2011_03_16%20payment_reform_bill_presentation.pdf

[28] U.S. Department of Health and Human Services (2011, April 14). *New flexibility for states to improve Medicaid and implement innovative practice.* Washington D.C.: Author. Available online at, https://www.cms.gov/medicare-medicaid-coordination/downloads/MedicaidAnnouncement4_11.pdf

[29] Seifert, R. & Cohen, A. (2010, June). *Re-forming Reform: What the Patient Protection and Affordable Care Act Means for Massachusetts.* Boston, MA: Center for Health Law and Economics, University of Massachusetts Medical School. Available online at, http://bluecrossfoundation.org/~/media/Files/Publications/Policy%20Publications/062110NHRReportFINAL.pdf

[30] 114.6 CMR 3.00: Student Health Insurance Program. Available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_6_3.pdf

[31] Division of Health Care Finance and Policy (2009, November). *Student Health Program, Academic Years 2005-2006 through 2007-2008 Baseline Report.* Boston, MA: Author. Available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/student_health_program_report_nov-2009.ppt

[32] 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.

[33] Blendon, R., Gil, G., SteelFisher, G., Mailhot, J., Weldon, K. (2011 June) *Massachusetts Health Reform Poll (conducted May 24-26, 2011)*. Boston, MA: Harvard School of Public Health/*Boston Globe.*

[34] Blendon, R., Gil, G., SteelFisher, G., Mailhot, J., Weldon, K. (2011 June) *Massachusetts Health Reform Poll (conducted May 24-26, 2011)*. Boston, MA: Harvard School of Public Health/*Boston Globe.*

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

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

[37] 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

[38] CommCare enrollment decreased between FY09 and FY10 due to changes to the determination of eligibility for some legal immigrants, referred to as Aliens with Special Status (AWSS) beginning in September 2009. Further information on these eligibility changes is available in the FY10 Annual Report.

[39] 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.

[40] PT2A members have the option of a $0 dollar plan, but may select a plan with a monthly premium.

[41] In July 2010, the Executive Office of Health and Human Services issued *Administrative Bulletin 10-13: 114.6 CMR 13.00: Health Safety Net Dental Services MassHealth and Commonwealth Care Members*. The Administrative Bulletin is available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/g/ab/hsn_dental_ab_07-01-10.pdf

[42] The survey was based on telephone interviews and mail surveys conducted between October 19 and November 30, 2010. 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 CommCare population. The survey did not include members enrolled in the CommCare Bridge program. The overall response rate for was very high at 40 percent (695 members participated in the survey) and had a sampling error of plus or minus 3.7 percent at 95 percent confidence.

[43] 956 CMR 3.12(4)(a)(5)

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

[45] 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/Connector%2520Annual%2520Report%25202010.pdf

[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] 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

[50] To be eligible to participate, a small business employer must purchase small-group health care coverage through the Connector, be eligible for federal health care tax credits under the ACA, offer an evidence-based employee wellness program that meets certain minimum criteria, and the program must meet minimum employee participation requirements.

[51] In December 2010, the Connector issued an RFP for a comprehensive wellness program for small businesses. The contract was awarded to PayFlex Systems USA along with their subcontractor LiveHealthier. More information on the contract may be found on the Connector website: https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2011/2011-4-14/2%2520-%2520Minutes%2520-%25203.10.11.pdf

[52] Eligible employer health care costs as calculated by the employer for purposes of eligibility for federal tax credits under the ACA.

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

[54] PL 111-148 & 111-15, § 2714(a).

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

[56] M.G.L. 176Q § 3.

[57] A more detailed explanation of the differences between state and federal affordability standards can be found in the Board materials from the February 10, 2011 Connector Board meeting. These materials may be accessed via, http://tinyurl.com/4464ute

[58] In December 2010 the Department of Revenue issued *Technical Information Release 10-25: Individual Mandate Penalties for Tax Year 2011.* The release is available at, http://www.mass.gov/?pageID=dorterminal&L=4&L0=Home&L1=Individuals+and+Families&L2=Health+Care+Reform+Information&L3=Health+Care+Reform+Regulations+and+TIRs&sid=Ador&b=terminalcontent&f=dor_rul_reg_tir_tir_10_25&csid=Ador

[59] Federal reform allows parents to include adult children on a health plan until age 26 regardless of dependency status, whereas under the Massachusetts law adult children could only remain on a parent's health plan for two years after loss of dependent care status for tax purposes or age 26, whichever came first. Additionally, Massachusetts' law only applied to fully-insured plans. The federal law applies to all fully- and self-insured plans.