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The 2006 Massachusetts Health Care Reform Law: Progress and Challenges After One Year of Implementation

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About the Blue Cross Blue Shield of Massachusetts Foundation

Since its inception in 2001, the Blue Cross Blue Shield of Massachusetts Foundation (www.bcbsmafoundation.org) has awarded grants of more than \$20 million to spark innovation and strengthen services for uninsured and low-income individuals and families in Massachusetts. The Foundation is governed by its own 17-member Board of Directors and operates separately from Blue Cross Blue Shield of Massachusetts. The Foundation has an endowment of nearly \$100 million making it one of the largest health philanthropies in New England.

About the Massachusetts Health Policy Forum

The Massachusetts Health Policy Forum is a non-profit, nonpartisan organization dedicated to improving the health care system in the Commonwealth by convening forums and presenting the highest quality research to legislators, stakeholders and the public.

About the Massachusetts Medicaid Policy Institute

The Massachusetts Medicaid Policy Institute is an independent and nonpartisan source for information and analysis about the Massachusetts Medicaid program (“MassHealth”). MMPI seeks broader understanding of MassHealth and public discussion of the program’s successes and challenges ahead.

Introduction

On April 12, 2007, exactly one year after former Massachusetts Governor Mitt Romney signed into law a comprehensive new approach to statewide health care reform, the last of the major complex policy decisions needed to implement the law was agreed upon. At the same time, supporters, including Governor Deval Patrick, who took office in January, were able to celebrate substantial, early progress toward the goal of providing access to health care coverage for virtually all citizens of the Commonwealth.

This report is an overview of the critical first year of Chapter 58 of 2006, “An act to provide access to affordable, quality, accountable health care.” It catalogs some of the most significant milestones and achievements and describes how policymakers, stakeholders and the new Commonwealth Health Insurance Connector Authority and its Board managed a host of potentially contentious issues and decisions. It also previews some of the difficult challenges still ahead, because, despite the progress so far, many of the key assumptions upon which the law is based are still untested.

The Massachusetts health care law is unusual in many ways, not the least of which is the fact that the implementation process has been open to public scrutiny at every step of the way. The most important issues have been discussed and voted on in public meetings; policy documents and presentations are readily available on the Web; the broad array of interest groups that support the law have kept up a spirited but civil dialogue about their viewpoints and concerns; and the “blogosphere” has become a rich source of information, opinions and musings about the law from health care leaders and interested citizens alike.

That is not to say that no important analysis, debate, cajoling, and old-fashioned, political horse-trading has gone on out of the public eye. But everyone got to play. None of the stakeholders — consumer advocates, business and labor groups, insurers, providers, politicians and policy experts — was shut out of the process or left without a voice. The rationale for policy decisions was clearly spelled out, and ultimately, the diverse membership of the Connector Board achieved near unanimity on every major policy decision they faced.

So, our report is a relatively brief synopsis of what is, for the most part, already in the public record. We hope that, by summarizing and documenting the early stages of Chapter 58, we can contribute to public understanding of this groundbreaking law — in Massachusetts, in other states considering health care reform, and in our nation’s capital, which is a source of laws, policies and taxpayer dollars that help make it possible.

Highlights

...from the First Year of Massachusetts Health Care Reform

The Law

On April 12, 2006, Chapter 58 of the Acts of 2006 became law, establishing ambitious goals for health care reform: that Massachusetts could achieve nearly universal coverage for its residents, that their care and coverage would be affordable and of high quality, and that the process of expanding coverage would be open to transparency, accountability and improvement.

Massachusetts Health Care Reform:

- Continues and expands upon employer sponsored health insurance as the primary source of coverage for Massachusetts residents,
- Creates new, lower-cost plans for individuals and small businesses, with more portability and flexibility for part-time and seasonal workers,
- Encourages pre-tax treatment of health insurance premiums for employees,
- Makes it easier for individuals and employers to participate in health care coverage and also introduces financial penalties for not participating,
- Creates standards of adequacy and affordability for new, state-endorsed insurance plans,
- Expands public programs for people without access to employer sponsored health insurance,
- Moves uninsured people from uncompensated care to insured care, and
- Maintains the health care safety net for uninsured people who cannot afford, or who are ineligible for, health insurance.

The Results So Far

The number of Massachusetts residents covered by MassHealth, the state's Medicaid program, and Commonwealth Care, a new, publicly subsidized insurance program for low-income residents, increased by 122,000 during the first year of health care reform, which is equal to almost one third of the 372,000 Massachusetts residents the state estimates were uninsured in June 2006.

- From the end of June 2006 to the end of March 2007, total MassHealth enrollment increased by almost 53,000.
- As of May 1, 2007, Commonwealth Care plans had enrolled more than 69,000 low income residents: 53,768 with incomes at or below 100 percent of the federal poverty level (FPL), and 15,560 earning between 100 and 300 percent of FPL.

Commonwealth Choice plans, which offer unsubsidized coverage for individuals, became available on May 1, 2007, with coverage to begin on July 1, 2007. These plans will be available for small businesses (up to 50 employees) as of October 1, 2007.

The new Commonwealth Health Insurance Connector Authority met a series of tight deadlines for the implementation of reform and its Board achieved near unanimity on critical issues that could have stalled progress. The Connector:

- Established Commonwealth Care coverage and subsidy levels for people under 300 percent of the federal poverty level,
- Decided which health plans should receive the Connector’s “seal of approval” for unsubsidized Commonwealth Choice coverage, and
- Defined “minimum creditable coverage” and determined what will be deemed “affordable” for compliance with the individual mandate.

The coalition of stakeholders — politicians, consumer advocacy groups, business associations, medical providers and organizations — that helped pass the legislation held together through a series of complex and potentially contentious implementation issues.

Implementation proceeded smoothly through a change of Administrations at the State House, from Republican Governor Mitt Romney to Democratic Governor Deval Patrick.

Future Challenges

Many provisions of Massachusetts health care reform break new ground, and while much has been accomplished, there are many potential pitfalls ahead:

- Outreach, education, promotion and public understanding of the law’s individual mandate, employer requirements and new insurance programs are critical to its success.
- A high rate of compliance with the individual mandate is needed in order to further reduce the number of uninsured, spread the insurance risk of expanded coverage among young and old and healthy and sick, and allow for the movement of funds from uncompensated care to subsidized insurance.
- Health care reform requires a continued commitment from the federal government and a stable state economy, because of its reliance on more than a billion dollars of federal financial participation and more than \$400 million from the state’s general fund. (See Appendix A for details.)
- Because the law is not yet fully implemented, it is not yet clear whether even this level of funding is adequate to support the law’s goals. What is certain, however, is that health care reform and universal access to coverage will become unaffordable — for individuals, employers and government — unless health care spending can be brought under control.

An Overview of Chapter 58

In mid-2006, a state survey estimated that 372,000 Massachusetts residents were uninsured, or about six percent of the total population. The goal of Chapter 58 is to reduce the percentage of uninsured to as close to zero as possible over the course of several years, and to sustain the reduction, long-term, by expanding access to both public and private insurance coverage.

By entitling the Massachusetts health care reform law, “An act to provide access to affordable, quality, accountable health care,” lawmakers established an ambitious set of goals — that the state could achieve nearly universal coverage for its residents, that their care and coverage would be affordable and of high quality, and that the process of expanding coverage would be open to transparency, accountability and improvement.

The new law was built on a series of earlier reforms that created “MassHealth,” which covers most of the non-elderly people in the state’s Medicaid program. MassHealth is designed to reduce the number of uninsured and the cost of their care, and to get federal funding for existing state health programs. Also, in the mid-1980s, the state created an Uncompensated Care Pool to reimburse hospitals and community health centers that provide “free care” to low-income uninsured and underinsured patients.

An essential element of these earlier reforms was a federal Medicaid waiver that allows Massachusetts to use hundreds of millions of dollars in federal matching funds to expand access and coverage in new and creative ways. A condition of the waiver is that the innovations must be “budget neutral,” meaning that federal spending for MassHealth under the waiver cannot be more than it would have been without the waiver. Medicaid waivers must be renewed, however, and the impending expiration of the Massachusetts waiver and potential loss of federal funds in mid-2006 was one of the major drivers of agreement on Chapter 58.

Finding the right balance

Like many significant laws, Chapter 58 was constructed on a series of grand compromises among politicians and other stakeholders with very strong, often divergent, beliefs about what could be achieved and how, especially when the question was asked, “Where will the revenue come from and where will it go?” Ultimately, agreement was reached on the broad principle of *shared responsibility* for expanding access to health coverage. This means that publicly funded state and federal programs will subsidize insurance for low-income residents; private sector assessments that now pay for “free care” will shift, in part, to subsidizing insurance coverage; employers will be obligated to make it easier for employees to purchase insurance and take on the additional cost of funding previously uninsured workers who are now more likely to enroll in employer sponsored plans; and individuals will be required to have, and pay for, health coverage at a level the state decides they can afford — the nation’s first “individual mandate.”

[Appendix A, at the end of this report, summarizes where the revenue for health care reform comes from and how it is spent.]

Another important principle in Chapter 58 is that it is not sufficient to make “affordable” coverage available to the uninsured; lower-cost coverage must also be adequate — “creditable” in the words of the law — with benefits that encourage preventive care and that offer enrollees a sufficient amount of financial security when they need medical care. Finding the right balance between *creditable coverage* and *affordable coverage* became one of the most difficult issues to resolve during the policy-making phase of implementation.

Creating an insurance “Connector”

The responsibility for finding the right balance in health care reform and for implementing many of the provisions of Chapter 58, including new insurance programs for the uninsured, is delegated to the Commonwealth Health Insurance Connector Authority. The Connector is a new, independent public authority that is governed by a 10-member board including state administrative officials and representatives of various interests appointed by the governor and attorney general. Its roles, as described elsewhere in this report, span a broad range of business and policy functions.

Expanding access to coverage

Adequate, continuous health insurance coverage is a major determinant of whether someone has access to needed health care services, including preventive care, screening for serious medical problems, and the treatment and management of chronic conditions. While most people without insurance are entitled to receive “uncompensated care” in Massachusetts, they may delay seeking care until a condition becomes serious, or they may get their care in an inappropriate or inefficient setting such as a hospital emergency room instead of a doctor’s office.

The goal of Chapter 58 is to cover as many uninsured people as possible, thereby giving them access to coordinated, preventive, well-managed care, accessible through health insurance plans, and to do so without a major infusion of new public funds. Chapter 58 expands access to coverage through a combination of public programs and subsidies and private requirements and incentives, with the expectation that much of the funding that has been used to provide uninsured people with uncompensated care will instead be used to provide low-income individuals and families with subsidized insurance coverage.

- *MassHealth* expanded income eligibility, lifted enrollment caps and restored benefits under the renewed, amended federal Medicaid waiver. Specifically, Chapter 58 expanded MassHealth eligibility for children and the Insurance Partnership, a program for low-income employees and their employers; removed caseload caps on MassHealth programs for the long-term unemployed, people living with HIV, and children and adults with disabilities; and restored MassHealth benefits that had been cut in 2002, including dental and vision services.
- *Commonwealth Care* offers publicly subsidized private insurance coverage through the Connector to individuals and families earning up to 300 percent of the federal poverty level (FPL) who are not eligible for MassHealth or employer sponsored coverage. Undocumented immigrants are not

eligible for Commonwealth Care. (See below for an explanation of FPL)

- *Commonwealth Choice* offers unsubsidized coverage from private insurance carriers to individuals and families and to small businesses. Commonwealth Choice plans are available through the Connector, from brokers, and directly from participating insurance carriers. Insurance products bearing the Connector’s “seal of approval” became available to individuals on May 1, 2007, with coverage to begin July 1, 2007. They will be available to small businesses as of October 1.
- *Young Adult Plans* offer unsubsidized, low-cost products through the Connector to residents 19-26 years of age who do not have access to MassHealth or employer health coverage (either their own or as a dependent). The law also requires health insurers to allow young adults to stay on their parents’ policies for up to two years after they are no longer dependent or until their 26th birthday, whichever comes first.

The federal poverty level (FPL) is the income threshold below which a family is considered to be poor. It is published each year by the U.S. Department of Health and Human Services, adjusted for the number of people in a family. For the purpose of Chapter 58, the FPL is revised on April 1st of each year. On April 1, 2007, the federal poverty level was set as follows:

Number in Family	Annual income level for 100% of FPL
1	\$10,210
2	\$13,690
3	\$17,170
4	\$20,650
5	\$24,130
More than 5	add \$3,480 per family member

Requiring employer participation

Chapter 58 includes new employer requirements that are intended to make all employers with 11 or more full-time-equivalent employees pay their “fair share” toward expanding access and coverage, and to encourage pre-tax premium payments, which can make coverage more affordable for employers and employees.

A “fair and reasonable” employer contribution

The law requires all employers with 11 or more full-time-equivalent employees to make a “fair and reasonable” contribution to their employees’ health insurance or to pay a “fair share” assessment of up to \$295 per uninsured employee per year into the Commonwealth Care Trust Fund. Fair and reasonable has been defined by regulation as having at least 25 percent of full-time employees (35 hours or more per week) enrolled in the employer’s health plan *or* having the employer offer to pay at least 33 percent of the employee insurance plan’s premium cost. (Most insurers require

higher participation and contribution levels for employers than those that meet the regulations' fair and reasonable standard.) The annual fair share assessment will be based on the amount of uncompensated care used by employees of firms that do not provide health coverage ("non-contributing" employers), and it is expected to go down as more people are insured.

Section 125 plans

Under Section 125 of the IRS code, employers can allow their employees to pay for health coverage and other benefits on a pre-tax basis, not subject to federal and state taxes. Average tax savings for employees range from 28 percent to 48 percent of their premium contribution, depending on their federal tax bracket, and employers generally save an additional 7.65% on their share of payroll taxes. To encourage this relatively simple cost-reduction device, Chapter 58 requires employers with 11 or more FTE employees to set up a Section 125 "cafeteria plan" for their employees by July 1, 2007.

An employer that fails to comply may be subject to a "free-rider surcharge" if its employees or their dependents make "excessive" use of uncompensated care. Specifically, if a non-complying company's employees or their dependents receive uncompensated care five or more times in a year, or if any employee or employee's dependent receives uncompensated care more than three times in a year, and if free care for its employees exceeds \$50,000 in a year, then the employer will be required to pay a percentage of the total free care used by its employees or their dependents into the Commonwealth Care Trust Fund.

Disclosure forms

Employers with 11 or more employees are required to complete Employer Health Insurance Responsibility Disclosure (HIRD) forms, which will be used to verify whether employers offer Section 125 plans and to collect other information related to employee coverage.

Non-discrimination rules

Employers must offer the same health benefits to all full-time employees who live in the Commonwealth and cannot make a higher premium contribution toward the coverage of a higher-paid employee than to a lower-paid employee. With certain limitations, the opposite *is* allowed: employers are permitted to make larger premium contributions for the coverage of lower-paid employees. Also, employers are permitted to provide different premium contributions for employees covered by collective bargaining agreements. The non-discrimination provisions are enforced by prohibiting insurers from entering into fully insured contracts with employers that fail to comply.

Mandating coverage for all

A key assumption behind Chapter 58 is that the continuation of a voluntary health insurance system will never get Massachusetts to the goal of near-universal coverage. Therefore, the law creates a first-in-the-nation individual mandate, starting July 1, 2007. It requires most residents over 18 to obtain

and maintain *creditable* health coverage, so long as *affordable* coverage is available to them, or face financial penalties. The Connector Board must approve standards for what is affordable at different income levels and also for what constitutes “minimum creditable coverage” — the minimum level of health insurance coverage that residents must have in order to satisfy the requirements of the individual mandate.

The Massachusetts Department of Revenue is responsible for enforcing the individual mandate through state income tax returns. With some exceptions, individuals who do not affirm that they had health insurance coverage that meets the standard of minimum creditable coverage by December 31, 2007, will lose their personal income tax exemption for 2007, which is \$219 for an individual. Failure to meet the individual mandate in 2008 will result in a fine for each month the individual does not have coverage. (Individuals are permitted to have up to a 63-day break in coverage without a penalty.) The fine will be not more than 50 percent of the premium for the least costly, available insurance plan that meets the standard for minimum creditable coverage.

Increasing hospital and physician payment rates

During the health care reform debate, MassHealth providers argued that the rates they were being paid for Medicaid patients were too low, which resulted in their having to shift costs to private-sector payers. In response, the law specifies that acute care hospitals and physicians will receive Medicaid rate increases totaling \$90 million in state fiscal year (SFY) 2007, \$180 million in SFY 2008 and \$270 million in SFY 2009, with not less than 15 percent allotted to physician rate increases. Starting in October 2007, the beginning of the 2008 hospital fiscal year, hospital rate increases will be tied to quality standards and the achievement of performance benchmarks. The law also creates the MassHealth Payment Policy Advisory Board, which is charged with examining the adequacy of Medicaid provider rates.

In recognition of the fact that a disproportionate number of uninsured and low-income patients will continue to be cared for by Boston Medical Center and Cambridge Health Alliance, Chapter 58 extends special, supplemental payments to these institutions for three years. Also, the state’s community health centers were granted a Medicaid rate increase of \$10 million in the SFY 2007 budget, based on the essential role they play in caring for low-income and uninsured patients.

Restructuring the private insurance market

In addition to creating new programs for the uninsured, Chapter 58 substantially restructures the private insurance market. The most dramatic change is the merger of the state’s non-group and small group insurance rules and markets, effective July 1, 2007. About 50,000 Massachusetts residents who do not have access to employer coverage are enrolled in non-group plans, paying the full premium amount directly to the insurance carrier. In general, they pay much higher rates than the over 700,000 people who are insured through small group plans, which are available to employers with one to 50

employees. (As a result of reforms passed a decade ago, Massachusetts insurers cannot use health screening or preexisting condition exclusions to refuse coverage to individuals or employer groups.)

Combining the two markets allows non-group enrollees to benefit from the wider product choice available through small group coverage and to join the much larger rating pool of people covered through small employer groups. The question this raised, however, was, “Will the merger accelerate premium rate increases for small businesses?” To try to answer this and other policy questions, a special commission was formed to estimate the impact of the merger prior to its implementation.

After actuarial and policy analysis, the commission reported that the market merger was likely to result in an average *decrease* in current non-group rates by 15 percent and an average *increase* in current small group rates by 1.0 to 1.5 percent. The pre-merger, non-group offerings will be closed to new enrollees on July 1, 2007; current enrollees will be allowed to remain in their non-group plans and add new dependents to their policies if they wish. In all likelihood, however, they will be able to find a less expensive plan in the merged market.

Maintaining the health safety net

As of October 1, 2007, the state’s Uncompensated Care Pool will be replaced by the Health Safety Net Trust Fund. The law anticipates that, as more of the uninsured are covered under health care reform, free care use will decline. In the meantime, however, the fund will be maintained through a continuation of hospital assessments, payer surcharges and government payments. A new Health Safety Net Office will administer a methodology for equitably allocating free care reimbursements from the Trust Fund to hospitals and community health centers. The current prospective, charges-based payment system for hospital reimbursements will be replaced by one incorporating Medicare payment principles, basing payments on actual claims of service, and applying measures to ensure appropriate payment for services. The Office will also administer eligibility and the services to be covered under the new Health Safety Net regulations.

The Health Safety Net Office will also be responsible for administering the Essential Community Provider Trust Fund, a program of grants to hospitals and community health centers to support improvements in their ability to provide “community-based care, clinical support, care coordination services, disease management services, primary care services, and pharmacy management services.”

Addressing racial and ethnic health disparities

The acute care hospital Medicaid rate increases in the law are made contingent upon providers meeting performance benchmarks, including for the reductions of racial and ethnic disparities. The law creates a study of a sustainable Community Health Outreach Worker Program to target vulnerable populations in an effort to eliminate health disparities and remove linguistic barriers to health access. Finally, the law creates a Health Disparities Council, which will make recommendations regarding the reduction and elimination of racial and ethnic disparities in

health care and outcomes, methods to increase diversity in the health care workforce, and other recommendations related to factors affecting health disparities, such as an individual's environment and housing.

Controlling costs and improving quality

While most of the provisions of Chapter 58 create mechanisms to expand access and coverage, the law also includes a number of provisions intended to address health care costs and quality of care. They include:

- A *Health Care Quality and Cost Council*, which will set health care cost and quality goals for the Commonwealth, establish performance benchmarks, publish information for consumers to use in making decisions about medical care and health care providers, and develop a consumer health information website providing comparative quality and cost information,
- An *infection prevention and control program* to increase adherence at all licensed health care facilities in the state to practices and protocols that prevent the transmission of infectious diseases, and
- A MassHealth *Wellness Program*, which will encourage enrollees to meet wellness goals in five clinical areas: diabetes and cancer screening for early detection, stroke education, smoking cessation, and teen pregnancy prevention.

Access and Coverage to Date

A look at the baseline numbers

Massachusetts has long had a relatively low rate of uninsured residents and a high rate of employer sponsored health insurance coverage. When implementation of Chapter 58 began in mid-2006, an estimated 372,000 Massachusetts residents, or about 6 percent of the total population of 6.35 million, were uninsured, according to a household survey conducted for the Massachusetts Division of Health Care Finance and Policy. This means that about 94 percent of Massachusetts residents of all ages had some form of coverage, through an employer, MassHealth, Medicare or non-group insurance. (Using a federal data source, the Urban Institute estimates the number of uninsured at around a half million.)

Among those not eligible for Medicare, 83 percent of the insured said they received coverage through an employer-sponsored plan. Of the 328,000 uninsured Massachusetts residents, ages 19 to 64, 70 percent, or about 228,000, were employed and two-thirds, or about 154,000, worked for firms with 50 or fewer employees. About one-third of the working uninsured adults, or about 83,000, reported that their employers offered health insurance, which means they either declined coverage or were ineligible to participate.

Adding up the newly insured

The number of Massachusetts residents covered by MassHealth and Commonwealth Care increased by 122,000 during the first year of health care reform, which is almost a third of the 372,000 people who were estimated to be uninsured in the June 2006 survey conducted for the Massachusetts Division of Health Care Finance and Policy.

MassHealth — 53,000

MassHealth covers about one out of every six Massachusetts residents, and 45 percent of MassHealth beneficiaries are children. Health care reform includes expanded income eligibility and the restoration of programs that had been reduced in prior years, along with more aggressive outreach to people who were already eligible. From the end of June 2006 to the end of March 2007, total MassHealth enrollment increased by almost 53,000.

Commonwealth Care — 69,000

Commonwealth Care, available only through the Connector, offers subsidized private coverage to uninsured people up to 300 percent of the federal poverty level who are not eligible for MassHealth or employer-sponsored coverage. Undocumented immigrants are not eligible for Commonwealth Care. As of May 1, 2007, Commonwealth Care had enrolled 53,768 low-income residents with incomes at or below 100 percent of FPL. They qualified for a full premium subsidy and many were automatically enrolled, having been known to the state because of their use of the Uncompensated Care Pool. With an estimated 60,000 uninsured people in this category when Commonwealth Care was launched in October 2006, this means enrollment has reached almost 90 percent of the total.

Starting in January 2007, Commonwealth Care began enrolling residents earning between 100 and 300 percent of FPL, for whom subsidies decline as income rises. The general expectation was that enrollment among this second group would not grow as quickly because automatic enrollment is not possible. (People must choose a health plan and pay the first month's premium). As of May 1, 2007, 15,560 of an estimated 80,000 uninsured people in this category had enrolled in Commonwealth Care, or about 19.4 percent of the total.

On April 12, 2007, the Connector Board approved new premium subsidy levels for people eligible for Commonwealth Care, raising the income eligibility limit for fully subsidized coverage to 150 percent of the federal poverty level and reducing premiums for those earning from 151 to 200 percent of FPL. These changes are scheduled to go into effect July 1, 2007.

Next up: Commonwealth Choice

The second major new program in health care reform is Commonwealth Choice, the unsubsidized coverage program for residents and for small businesses (up to 50 employees). Commonwealth Choice will offer coverage from private insurance carriers, both directly and through the Connector. Insurance products bearing the Connector's "seal of approval" became available for individuals on May 1, 2007, with coverage to begin July 1, 2007, and will be available to small businesses as of October 1.

The Health Insurance Connector

One of the groundbreaking concepts in Chapter 58 is the creation of the Commonwealth Health Insurance Connector Authority, which has broad statutory responsibilities for implementing health care reform and for making affordable health coverage available to the uninsured and small businesses.

While the provisions of Chapter 58 are comprehensive and detailed, the law leaves a number of potentially contentious decisions to the regulatory process. Lawmakers decided that complex policy issues such as defining *creditable coverage* and *affordable coverage* were best left to regulation by the Connector Board, subject to public hearings and the state's open meeting law. Therefore, they turned over to the Connector a detailed blueprint for reform and \$25 million in start-up funding, and left it to the Connector staff and its Board to complete the design and construction.

The Connector Staff: Building the infrastructure

The Connector is an independent, public authority with an unusual dual role: it must create a framework for implementation of reform and also a mechanism for selling health insurance to individuals and small businesses. It has broad statutory responsibilities and has to work in concert with multiple state agencies. Rather than fund it through a budget line item, lawmakers decided to capitalize the Connector with \$25 million and charge the staff to make it succeed as a self-sustaining entity within the legislative framework of what it can sell and how it can generate revenue.

Staffing

The Connector's first Executive Director, Jon Kingsdale, was hired in June 2006, to create and run the new authority. Kingsdale had been a senior executive at Tufts Health Plan for almost 20 years and had worked for Blue Cross Blue Shield of Massachusetts for 5 years, with experience in strategic planning, product development and public affairs. Kingsdale started building his senior management team by hiring a Chief Operating Officer and Chief Financial Officer, and within a year, the staff had grown to 35 people drawn from both the public and private sectors. In order to meet the law's tight deadlines and federal requirements that the Connector contract with Medicaid Managed Care Organizations at "financially sound" rates, independent legal and actuarial services were obtained through contractual arrangements. Subsequently, most legal services were brought in-house.

The Connector also entered into two major, multi-year outsourcing contracts to support its operations and customer service: Maximus, Inc. (which had an existing contract with MassHealth) to provide outreach, eligibility determination, enrollment, billing and customer service for Commonwealth Care; and the Small Business Service Bureau (SBSB), as a "sub-connector" to assist the Connector with the administration of Commonwealth Choice, including enrollment support, billing, payments to health plans and brokers, assistance to employers in setting up Section 125 plans, and customer service. In addition, the Connector has contracted with Computer Services Corporation (CSC) to develop the Connector's website strategy and online customer service

capabilities, and Weber Shandwick for an integrated marketing, advertising, outreach and public relations campaign.

Financing the Connector

The Connector projects that it will be self-financing, with revenue exceeding expenses, by state fiscal year (SFY) 2009. It was capitalized with \$25 million in start-up funding appropriated by the legislature in SFY2006, and projects that it will have depleted \$18 million of its start-up capital by the end of SFY2007, leaving a balance of \$7 million. Expenditures are projected to continue to exceed revenues through the second quarter of SFY2008, and its cash balance is projected to bottom out at approximately \$2 million in the third quarter of SFY2008. As this is a razor-thin cash balance for a self-supporting, start-up enterprise, the Connector has secured a line of credit from a commercial bank in the event of a short-term cash shortage.

The Connector's revenue will come primarily from administrative fees charged to health plans in both Commonwealth Care and Commonwealth Choice, calculated as a percentage of the per member per month payment to insurers. In SFY2008, for instance, the Connector will receive 4.5 percent for both its Commonwealth Care and Commonwealth Choice sales, and in SFY2009, hopes to reduce the fee to 4.0 percent. On the expense side, the Connector pays MassHealth for Commonwealth Care eligibility determination and administration of capitation payments through an Interagency Service Agreement; Maximus for enrollment, premium billing, collection and customer service; CSC for website development and administration; the Small Business Service Bureau as sub-connector for Commonwealth Choice enrollment, premium collection and customer service; and Weber Shandwick and others for marketing and outreach. In addition, when independent brokers sell a Commonwealth Choice product, the Connector pays a broker fee of \$10 per subscriber per month.

The Connector's revenue also supports its own policymaking, regulatory and adjudicatory functions, which include: acting as the primary portal for public information on reform; reviewing and analyzing policy issues for the Board as well as the results of the Board's decisions; overseeing major contracts and outsourcing relationships; conducting annual bid processes and re-contracting with health plans for both Commonwealth Care and Commonwealth Choice; managing appeals under both programs; and conducting an extensive waiver and appeals process each year related to affordability determinations.

The Connector Board: Tackling the tough policy decisions

The Connector Board was sworn in and held its first public meeting on June 7, 2006. From this first meeting, the Connector had only four months before the new Commonwealth Care program was to begin the first phase of enrollment. In short order, the Board needed to establish its identity and individual roles, set Board versus staff responsibilities and develop trust among members and with staff. These were no easy tasks — by statute, the Board was selected from different constituent groups, and most of the Board's work would be conducted in very public, well-attended meetings.

Board member Dolores Mitchell, Executive Director of the Commonwealth's Group Insurance Commission, summed up the group's challenge this way: "Most new governmental enterprises at least begin with a history. There are new players all the time, but the basic structures, procedures, rules and traditions are already in place...they usually don't have to build from scratch. That's what the Connector Authority had to do — and is doing." (March 4, 2007, WBUR CommonHealth blog)

The Board has relied on Connector staff for research, analysis and policy development, and has created sub-committees to receive information and recommendations from public individuals and organizations, design policy options and determine how the Board should conduct its business. These include sub-committees on policy, community outreach, governance, and administration and finance.

Defining adequate, affordable coverage, Round I

The Connector Board was immediately faced with the challenge of determining how much people on the low end of the income scale should pay for subsidized Commonwealth Care insurance and how extensive the coverage should be. Enrollees with family incomes between 100 and 300 percent of the federal poverty level would have to pay a portion of the total premium, with the rest publicly subsidized. The question, therefore, revolved around what is affordable, not only to individuals, but to the government and taxpayers. As a report from the Affordability Subcommittee of the Board put it, "The issues of benefit coverage, cost-sharing, financial incentives to seek care, and the affordability of insurance coverage — both to enrollees and to the state — are critically important to the eligible population, taxpayers, the health plans, medical care providers, and the citizens of the Commonwealth."

The Board held a well attended public hearing, received information and advice from legislators and advocates, and had the Connector staff collect data on what insured and uninsured people spend on health care at different levels of income. The Connector staff recommended that Commonwealth Care plans should have relatively standardized benefit designs, modeled after commercial HMO benefits and a comparable public program called MassHealth Essential. A month before the program went "live," the Board approved a variety of benefit designs and set enrollee contributions, based on income.

The Board decided that each Commonwealth Care managed care organization would offer four plan types with the same basic benefits but different enrollee contributions and out-of-pocket costs. As required by the law, individuals with earnings up to 100 percent of FPL would pay no premiums and make only very small copayments for prescription drugs and emergency care. The lowest cost plans for enrollees with family incomes between 100 and 300 percent of FPL would range from \$18 to \$106 a month. Enrollees with family incomes between 100 and 200 percent of FPL would pay a monthly premium and small copayments would apply to most types of care. Enrollees with family incomes between 200 and 300 percent of FPL would be able to choose from two plan types, one with lower monthly premiums and higher copayments, the other with higher monthly premiums

and lower copayments. (Commonwealth Care only covers individual adults, since MassHealth covers children in families earning up to 300 percent FPL).

As described elsewhere in this report, the Board came back to the affordability question seven months later in the context of the law's individual mandate, and decided to recalibrate Commonwealth Care enrollee contributions, including raising the threshold for fully subsidized premiums to 150 percent of the federal poverty level.

Launching Commonwealth Care

Chapter 58 specifies that four private, managed care organizations already under contract to cover MassHealth members will be able to participate in Commonwealth Care on an exclusive basis, at least for the first several years. The MCOs were required to submit proposals to the Connector, outlining the details of their benefit packages, enrollment systems, utilization management, information systems, grievance and appeals procedures, and, of course, their premium rates, which would have to be certified as actuarially sound.

The health plans had to make difficult business decisions about how much financial risk they could take. Would the uninsured bring pent-up demand for care? What kind of systems support, product development, marketing and customer service would be needed? The bidding took place in two rounds, and, according to Connector officials, the premium rate difference between the first and second bids resulted in substantial savings for the state. When the negotiations were completed, there was concern that some rates might have been set too low, so the Connector instituted stop-loss and other protections in case the plans significantly underestimated their costs.

The Connector decided that the fastest and most efficient way to establish an eligibility, screening and enrollment process for Commonwealth Care would be to adapt processes and systems used by MassHealth and to build on MassHealth's contract with Maximus for enrollment, billing and customer service. MassHealth already had contracts and capitation payment systems for the Commonwealth Care managed care organizations, as well as the MassHealth eligibility logic and "Virtual Gateway" enrollment systems to process applications and conversions from the Uncompensated Care Pool. MassHealth staff played a crucial role in getting the program up and running, and on October 1, 2006, the first phase of Commonwealth Care was launched as planned, starting with the automatic enrollment of adults whom had received care paid for by the Pool.

In less than four months, the Connector had specified Commonwealth Care benefits and enrollee contributions, developed bid specifications and a model contract for the four managed care organizations, completed negotiations and contracting with each of them, and worked in conjunction with MassHealth and Maximus staff to develop outreach, eligibility and enrollment procedures and materials, and to train customer service representatives.

Since Commonwealth Care enrollees earning more than 100 percent of the federal poverty level would have to pay premiums, Maximus had to develop a new billing and collection system for the

Connector before the program could be extended to this population. Once the program requirements were developed, October 1st was less than two months away, so the Connector decided to delay this next phase of Commonwealth Care until January 2007.

Preparing for the individual mandate

Beginning on July 1, 2007, Massachusetts residents are required to have minimum creditable coverage if an affordable health insurance plan is available to them. Failure to comply with the individual mandate will result in financial penalties imposed by the Massachusetts Department of Revenue. To make it easier for people to meet the individual mandate's requirements, Chapter 58 expands income eligibility for MassHealth, creates subsidized Commonwealth Care plans, and encourages the development of a whole new class of unsubsidized, lower-cost plans for uninsured people who are not eligible for MassHealth or Commonwealth Care. These latter classes of Commonwealth Choice plans are developed by the state's private insurance carriers and must be given a "seal of approval" by the Connector before they can be offered.

Starting in late 2006, the Connector Board and staff — and many of the law's stakeholders and advocates — were consumed by three major policy questions that still needed to be resolved: Which plans should get the seal of approval? How should minimum creditable coverage (MCC) be defined? And, what should be deemed "affordable" coverage for the upcoming individual mandate?

Choosing Commonwealth Choice plans

Chapter 58 states that the Connector seal of approval is intended to "indicate that a health benefit plan meets certain standards regarding quality and value." What those standards should be was a subject of considerable debate. On one side were those who argued that the objective of health care reform is to offer the uninsured the widest possible choice of options, and that insurers should be able to develop very low-cost, bare-bones options along with their higher-premium plans with very little cost sharing. Others argued that consumers neither want nor need too many choices, given the complexity of health care and coverage, and that the Connector should set a high standard of coverage to ensure that benefits meet people's needs, protect people from under-insurance, and protect both patients and providers from medical debt that could result from patients not being able to pay their out-of-pocket costs.

Before a Request for Responses (RFR) was issued in early December 2006, the Board's Policy Committee recommended general criteria for what kinds of coverage limitations should not be allowed and what kinds of benefit designs should be "preferred," but the final criteria were not agreed upon until the process for receiving bids, evaluating submissions and awarding the Connector seal of approval ended on March 8, 2007.

The RFR required bidders to submit five coverage options: one *premier* plan, two *value* plans, one *basic* plan and one *young adult plan*. All plans provide similar benefits (with the exception of the

young adult plan, which would not have to meet MCC standards). The premier options were to have the highest monthly premiums but very limited cost sharing with no deductibles; design of the value plans, with mid-level premiums, was left to the plans' discretion, although it was assumed that some combination of network selection, cost-sharing and aggressive medical management would be required to reach the target actuarial value prescribed by the Board (72.5 percent to 87.5 percent of the value of Premier plans); and the basic plans, targeted at 60 percent of actuarial value, would offer the lowest premiums and the highest out-of-pocket costs.

Ten carriers responded with proposals, which were first discussed in general terms at a public meeting of the Board's Policy Committee in January. Reports emerged from the meeting that the average cost of a Commonwealth Choice plan would be \$380 per month for an individual, compared with estimates during the legislative debate ranging from as low as \$200 to about \$320 a month. This set off a firestorm of concern that the plans were going to be unaffordable. Although the Connector staff pointed out that \$380 per month was a composite number for all of the bids, with many bids well below that number, the Board and Governor Patrick asked the insurers to "sharpen their pencils" and come back with revised bids. At the time, the Board was also debating whether or not minimum creditable coverage should require drug coverage, so they asked that the revised bids include two plan designs, one that included prescription drug coverage and one that did not, pending the Board's final decision on MCC regulations, scheduled for March.

The resubmissions, with revised premiums and plan designs, were evaluated and scored by the Connector staff based on member premiums and cost-sharing, plan design, marketing plans, provider network, geographical coverage, and other key program elements. In early March, the Connector Board gave its seal of approval to plans offered by seven of the state's health insurers — Blue Cross Blue Shield of Massachusetts, ConnectiCare, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan and Tufts Health Plan. The Connector later reached agreement on contract terms with all of the plans except ConnectiCare.

While this was the first time that premium rates for individual plans had been made public, it was apparent that coverage would be less expensive than in the first-round bids — most of the carriers reduced their bids by 5 to 10 percent, and one plan cut its proposal by 18 percent. Rates vary by plan type (renamed Bronze, Silver and Gold), number of insured (one person, two people, a family), age and geography, but, in general, the premium rates for Commonwealth Choice plans will be significantly lower than those currently available in the non-group market.

For a single individual at the average age of the uninsured in Massachusetts — 37 years old — premiums for plans that include prescription drug coverage range from \$175 to \$288 per month in the most expensive, eastern region. If purchased on a pre-tax basis through an employer's Section 125 plan, the average net cost of the \$175 plan is reduced to \$109 for a single individual earning \$50,000 per year. These rates were based on bids effective April 1, 2007 and will be adjusted for the July effective date.

Finalizing minimum creditable coverage, almost

The Board's decision on the minimum benefit levels that would qualify for its seal of approval had moved it closer to defining standards for minimum creditable coverage, but the Board could still choose to set MCC standards at a lower or higher level than it had established for Commonwealth Choice seal of approval plans. Chapter 58 requires that seal of approval plans and minimum creditable coverage must include all current state-mandated benefits, but leaves the definition of MCC up to the Connector Board.

Minimum creditable coverage is not an employer requirement, per se; it is a standard that applies to adult residents through the individual mandate. Employers may voluntarily choose to offer MCC-compliant plans to ensure that their employees will be able to comply with the individual mandate, but they are not required to do so. However, health insurers and business groups strongly objected to the Connector's proposed MCC regulations, especially the requirement for drug coverage, the proposed limits on deductibles, and the prohibition of lifetime benefit limits. They asserted that hundreds of thousands of people who were insured by employer-sponsored or non-group plans that did not comply with MCC would face the prospect of having to buy more costly coverage in order to meet the requirements of the individual mandate.

Consumer advocates countered that prescription drugs are essential to "adequate" coverage, both because of their role in modern medicine and their potential to drive up patients' out-of-pocket costs. Similarly, they argued that high deductible plans simply trade low premiums for out-of-pocket costs that people cannot afford when they need expensive medical care.

In the end, the Board unanimously approved a delay in the enforcement of the new MCC requirements, including mandatory drug coverage, until January 2009, to give employers and consumers time to adjust their coverage. In recognition of the added cost of prescription coverage, the Board directed the Connector staff to consult with actuaries and plans in an effort to develop alternative minimum drug benefits that can meet the MCC requirement in January 2009, without substantially increasing premiums.

The Board defined Minimum Creditable Coverage as "comprehensive health plans that include preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services, mental health services and prescription drug coverage." More specifically, the MCC standards require that:

- No annual or per-sickness benefit maximum is allowed
- No benefits can be based on an indemnity fee schedule
- Annual deductibles are capped at \$2,000 for individual coverage and \$4,000 for family coverage
- All products with upfront deductibles are required to cover a certain number of preventive care visits prior to the deductible (a minimum of 3 visits for individual policies, 6 for family coverage)
- For those plans with deductibles or co-insurance on core services, the maximum out-of-pocket

spending for in-network services is capped at \$5,000 individual/\$10,000 family per year

- Any out-of-pocket maximum must include the upfront deductible, most co-insurance, and any service that requires a copayment of \$100 or more
- Any separate deductible for drug coverage may not exceed \$250 for individual and \$500 for family coverage

Individuals will have to enroll in MCC-compliant plans starting with plan effective dates of February 2008 in order to satisfy the new January 2009 deadline.

Defining affordable coverage, Round II

The final major piece of the individual mandate policy puzzle was to determine the limits of how much the uninsured should be expected to pay for minimum creditable coverage and at what premium levels they should be exempt from the mandate. This was another hotly debated topic. Some consumer advocacy groups that had strong reservations about the individual mandate presented data and case studies of what they called “real people with real budgets” to support a broad exemption from the mandate. An opposing point of view was that too loose a standard of affordability might erode employer-based coverage, and drive up government spending for subsidies.

Once again, a compromise was developed among stakeholders and, in mid-April, the Board unanimously approved an “affordability schedule” to be used to determine whether minimum creditable coverage is affordable for most uninsured people in various income brackets, and a waiver and appeals process that allows people to demonstrate that their individual circumstances should exempt them from the mandate even if the schedule indicates they should not be exempt. At the same time, to make the government-subsidized plan more “affordable” for the lowest income uninsured, the Board voted to eliminate premiums in the Commonwealth Care health insurance program for an estimated 29,000 low-income Massachusetts residents and reduce premiums for another 23,000 who do not qualify for employer-sponsored insurance. Specifically:

- The income limit for enrollees eligible to receive a full premium subsidy for Commonwealth Care was raised from 100 percent to 150 percent of FPL, reducing the monthly enrollee contribution from \$18 to \$0.
- Commonwealth Care enrollee contributions for individuals earning between 151 and 200 percent of FPL were recalculated and reduced from \$40 to \$35. (Contributions for those earning from 201 to 250 percent of FPL remain at \$70, and for 251 to 300 percent of FPL, they were reduced by one dollar to \$105 per month.
- The same affordability schedule will apply to people earning up to 300 percent of the federal poverty level who are eligible for employer-sponsored insurance and are therefore ineligible for Commonwealth Care. Although Commonwealth Care offers a richer benefit package than MCC, employees will generally be able to use pre-tax payroll deductions to buy coverage, making their real premium costs lower.

Those earning more than the Commonwealth Care income threshold of 300 percent of FPL are deemed able to purchase affordable insurance if they have an opportunity to purchase employer-sponsored insurance, or purchase insurance from the Connector or directly from an insurer, for an amount that does not exceed the “Monthly Premium” amount for their income bracket in the following affordability schedule:

Single		Couple		Family with children	
Income bracket	Monthly premium	Income bracket	Monthly premium	Income bracket	Monthly premium
\$0–\$15,315	\$0	\$0–\$20,535	\$0	\$0–\$25,755	\$0
\$15,316–\$20,420	\$35	\$20,536–\$27,380	\$70	\$25,756–\$34,340	\$70
\$20,421–\$25,525	\$70	\$27,381–\$34,225	\$140	\$34,341–\$42,925	\$140
\$25,526–\$30,630	\$105	\$34,225–\$41,070	\$210	\$42,926–\$51,510	\$210
\$30,631–\$35,000	\$150	\$41,071–\$50,000	\$270	\$51,511–\$70,000	\$320
\$35,001–\$40,000	\$200	\$50,001–\$60,000	\$360	\$70,001–\$90,000	\$500
\$40,001–\$50,000	\$300	\$60,001–\$80,000	\$500	\$90,001–\$110,000	\$720
> \$50,000	affordable	> \$90,000	affordable	> \$110,000	affordable

Single individuals, couples and families with incomes higher than the upper limits of the affordability schedule are deemed by the Connector to be able to afford health insurance at any price. Like anyone else, however, they are still entitled to appeal for a waiver of the mandate based on financial hardship or other individual circumstances. The Connector also approved the staff’s recommendation to develop “a generous and constructive” process for both prospective waivers of the individual mandate and retrospective appeals of the penalty for non-compliance — a process “that will not penalize those who, given their individual circumstances, truly cannot afford coverage or did not understand their obligation to participate.”

At the newly reduced Commonwealth Care enrollee contribution rates, health insurance will be considered affordable for all of the approximately 140,000 eligible adults unless they are granted individual hardship exemptions through appeals. Overall, the Connector has estimated that minimum creditable coverage will be considered affordable for all but one to two percent the state’s total population.

Note: The Connector Board’s recommendations on minimum creditable coverage and affordability, as well as regulations governing Section 125 plans, are draft regulations subject to public hearings and possible revisions by the Board prior to their July 1, 2007, effective dates. Further, they are subject to change by the Board in future state fiscal years.

Outreach, Education and Enrollment

Achieving the goal of near-universal health care coverage will require aggressive, successful outreach and education. The general public needs to understand its individual responsibilities under the law, as well as the new plans and services that are available and how to gain access to coverage. Convincing low income, uninsured people to begin paying monthly health insurance premiums and finding uninsured individuals not previously known to the system will be especially challenging. Outreach and education for employers regarding their new responsibilities is also critical. During the first year, most of the effort focused on supporting community-based efforts to match eligible, low-income uninsured residents with MassHealth and Commonwealth Care, and informing employers of their obligations. As the effective date of Commonwealth Choice and the individual mandate approached, a much broader public information and marketing effort got underway.

Community outreach

Chapter 58 appropriated \$3 million for community groups to provide outreach and education activities and enrollment assistance to consumers who may be eligible for MassHealth or Commonwealth Care. Twenty-four agencies received an average of \$50,000 in “Model A” grants for traditional community-based outreach and enrollment assistance, and seven agencies received “Model B” grants for integrated outreach and marketing campaigns. In one such collaborative effort, the Massachusetts Hospital Association, Health Care For All and the Massachusetts League of Community Health Centers have developed multi-lingual, community outreach materials and a website — www.gethealthcoverage.net — with resources for patients, providers and small businesses.

Another major source of funding for outreach has been the Blue Cross Blue Shield of Massachusetts Foundation, which awarded over a half a million dollars in grants to 29 community health centers and other community-based organizations to help low-income patients apply for MassHealth, Commonwealth Care and the Uncompensated Care Pool, and also to help patients to select a health plan and find a primary care physician. During most of the first year of implementation, individuals were required to submit applications for MassHealth, Commonwealth Care and the Uncompensated Care Pool through authorized health provider or community based organizations, so the organizations funded by the state and the Foundation functioned as the primary points of contact for most people seeking to obtain health care coverage.

Training and education

MassHealth and the Connector held Commonwealth Care training sessions throughout the state for providers and outreach and enrollment workers. These highly attended trainings provided eligibility information, details of the implementation process and communication strategies, and uncovered numerous unanswered questions and kinks that needed to be worked out. In response, the Connector developed Frequently Asked Questions (FAQs) that are posted on its website.

MassHealth and Commonwealth Care staff meet monthly with outreach workers and other recipients of the state grants to share best practices, monitor progress in reaching the grantees’ goals,

and review materials in advance of publication. The senior staff of Commonwealth Care also meets regularly with advocacy groups to keep them informed of operational and policy developments and to gather their input.

The Blue Cross Blue Shield of Massachusetts Foundation held three technical assistance sessions for its outreach and enrollment grantees which detailed the law and provided an opportunity for outreach workers to have a dialogue with staff from the Connector and MassHealth. Health Access Network meetings, convened by Community Partners, bring front-line health access workers together monthly to exchange information, network with peers, and share best practices.

In January, Community Partners published “Making Outreach Work,” a guide of effective outreach strategies collected from workers across the state. Health Care for All has created, distributed, and presented information that simplifies the legislation and the Commonwealth Care program. They also have hosted the ACT!! Coalition (Affordable Care Today) Outreach Working Group, which meets monthly to share outreach materials and practices and discuss issues and concerns.

Employer outreach and education

In early 2007, Associated Industries of Massachusetts (AIM) collaborated with the Connector to hold ten three-hour information sessions for employers around the state. The sessions included detailed information on employer requirements, information on the Connector as a health insurance purchasing vehicle for small employers (up to 50 employees), and the role of the sub-connector in providing administrative support to the Connector and its Commonwealth Choice product offerings. The sessions explored numerous “real company” scenarios and allowed ample time for questions and answers. The Connector also published an Employer Handbook that is available on the Connector website along with frequently asked questions for employers and brokers.

AIM and the Connector plan to continue these and other educational sessions in an effort to reach as many of the state’s 193,000 employers as possible. AIM will hold its own, even more detailed workshops for employers; the Connector is initiating another statewide educational series for employers, jointly sponsored with the Massachusetts Retailers’ Association and the National Federation of Independent Business; the Connector and sub-connector (SBSB) will begin an ongoing series of educational and accrediting sessions for over 600 health insurance brokers across the state; and letters will go out from the Connector to all Massachusetts employers, providing them a brief summary of the law and directing them to the Connector’s newly enhanced website portal for employers.

The Connector’s public information and marketing

The Connector staff has worked with stakeholder groups to develop strategies to maximize enrollment in Commonwealth Care and to increase understanding of the individual mandate and Commonwealth Choice. Two websites were launched: www.mass.gov/connector provides information

about the Connector, the Board of Directors and all public meetings, Chapter 58, coverage plan types, enrollment, news and updates about reform, and other resources; and www.macommonwealthcare.com provides information about the Commonwealth Care program — how to apply, who is eligible, what the plans cost and entail, and how to choose and enroll in a plan. A new website for Commonwealth Choice products and services sold by the Connector, www.mahealthconnector.org, will be launched in May.

The Connector identified and mailed eligibility information and enrollment packets to users of the Uncompensated Care Pool with incomes below 300 percent of FPL who were likely to be eligible for Commonwealth Care. Individuals under 100 percent of FPL who did not enroll on their own were automatically enrolled in plans. The Connector's Customer Service Center (1-877-MA-ENROLL) helps potential enrollees through the entire process, and also refers individuals to organizations that can help them fill out applications. Callers are asked about their family size, income and other pertinent facts, and are then directed to the appropriate services.

Marketing

The Connector has a significant marketing and communications challenge to reach and educate uninsured individuals and small businesses affected by the health care reform law. The Connector's overall marketing goal is to enroll uninsured individuals in appropriate health insurance plans, directly or through brokers or small businesses. The Connector has partnered with CVS, Shaw's, Market Basket, Price Chopper and 40 small businesses through the Retailers Association of Massachusetts to distribute information on Commonwealth Care eligibility. As part of a broad-based public education effort, an integrated advertising campaign will be launched in May to raise awareness of the law and brand the Connector. The campaign, developed in conjunction with Weber Shandwick, will use television, radio and print placements, as well as web applications and direct mail, and will target key prospects for Connector products, including college students.

In addition, the insurers that are selling Commonwealth Care and Commonwealth Choice plans are conducting product-related marketing and promotional campaigns using both traditional advertising media and their websites.

Future Issues and Challenges

The speed with which major provisions of Chapter 58 were put into place and the complex policy decisions agreed upon during the first year of implementation are impressive, especially given the intense level of scrutiny by stakeholders and the public transparency of the process. No state has attempted what Massachusetts has set out to achieve, and much of it had to be built from scratch. The journey has really just begun, however, and many of the assumptions upon which the goal of achieving near-universal coverage is based are still untested. There are many skeptics who believe it will unravel in future years, and even the law's most ardent supporters acknowledge that significant challenges lie ahead and warn against assuming that the Massachusetts approach can be replicated elsewhere. We conclude this report with an overview of some of the key issues and challenges that will face health care reform in the second year of implementation and beyond.

Helping the uninsured achieve compliance, coverage and access to care

The success of health care reform requires that uninsured individuals — healthy and sick, young and old, employed and unemployed — will comply with the individual mandate if plans that the state deems to be affordable at their income level is available to them. It will take outreach, promotion, persuasion, education, decision support and outstanding customer service to increase awareness, acceptance and compliance and to ward off backlash. The success of reform also requires that people who do become newly insured will understand their coverage, especially if there is cost sharing with deductibles and coinsurance; that they will have access to primary care providers and specialists; that they will take advantage of the coordinated, care management that health insurance provides; and that they will not rely on getting episodic care at emergency rooms.

In focus groups held by the Connector, uninsured people made it very clear that they not only want information in writing, they want to talk to a person who is able to help them through the complex decision-making and enrollment processes. Community organizations conducting outreach and enrollment with support from the Blue Cross Blue Shield of Massachusetts Foundation have been reporting their progress monthly, and they have found that, of the 6,000 uninsured individuals served during the early months of Commonwealth Care, three quarters of those who were deemed eligible required additional assistance, which illustrates the program's complexity and need for an adequate number of outreach and enrollment workers.

The Foundation's grantees have also identified significant challenges resulting from the operational overlap between the Connector and MassHealth. MassHealth has the systems and structure needed to process Commonwealth Care applications, so the Connector entered into an Interagency Service Agreement to pay MassHealth for these services. (This function cannot be contracted out because Commonwealth Care is regarded as a Medicaid program under the terms of the state's waiver, and federal regulations require that state employees conduct eligibility determinations for Medicaid.) MassHealth has not, however, increased staffing at the MassHealth Enrollment Centers (MECs) to accommodate the greatly increased volume, and this has resulted in reduced hours of phone operation

and significant backlogs. This critically affects the overall success of the program and could become even more problematic when the individual mandate takes effect.

Advocates believe that ongoing funding for community outreach at the \$3 million level committed to under Chapter 58 is necessary given the complexity of the enrollment process for Commonwealth Care and the affordability standards of the individual mandate, but it currently appears that funding for community outreach could be dramatically reduced, based on preliminary budget proposals for the 2008 state fiscal year, which begins on July 1, 2007.

The Connector has developed an affordability schedule and waiver process that it hopes will maximize compliance with the individual mandate and keep its staff from being overwhelmed by appeals of the mandate. At the same time, they recognize that there is enormous variability in individuals' financial circumstances and an enormous communications challenge — to get the uninsured to understand, in advance, why there is a mandate and how it works so they will have the time they need to sign up for insurance. The penalty for non-compliance with the individual mandate is modest the first year, and uninsured people who are in a financial squeeze may choose either to forgo coverage in 2007 or delay signing up until the end of the year. The real test will come in 2008 and beyond, when individuals will face a financial penalty for every month they are uninsured.

Longer term, the issue of individual affordability will have to be constantly revisited and viewed from a broader perspective than simply the cost of Commonwealth Care premiums. Will lower-cost, high deductible and/or coinsurance plans reduce the unnecessary utilization of services and reduce personal health care expenses as some hope, or will enrollees in these plans delay or avoid needed care, or be burdened by unaffordable out-of-pocket costs, as others fear?

Then there is the problem of the Massachusetts residents who will be exempt from the individual mandate because creditable health coverage is not affordable for them, or who are not eligible to enroll in public programs that would be affordable (e.g., people who are undocumented immigrants). They will have access to the new, lower-cost insurance products, but not be required to purchase them. How many of them will voluntarily buy insurance? What effect will being uninsured have on the health and well being of those who remain uninsured, and what will it cost to provide them with safety net care when they need it?

Keeping small businesses healthy

While the employer provisions of Chapter 58 apply to all companies with 11 or more employees, the larger companies — those with more than 50 employees — are more likely to be already in compliance with the law's requirements than small businesses, and more of their employees are already insured. About 235,000 of the uninsured adults in Massachusetts are employed, and, of those, two-thirds work for small businesses. The obligations of compliance, both administrative and financial, will therefore fall disproportionately on small companies that do not offer coverage at all,

those that offer employee coverage but without making a “fair and reasonable contribution,” and those that do not yet have Section 125 plans in place.

Even businesses that already offer coverage with a fair and reasonable contribution could be affected financially if a significant number of employees have, until now, chosen to opt out of their employer’s health insurance plans. Small businesses are more likely to require their employees to pay a higher percentage of the premium than large companies, which can result in fewer employees signing up for coverage (the “take-up rate”). As a higher percentage of their employees accept coverage in order to comply with the law’s individual mandate, their health benefit costs will increase.

The burden on small employers will be exacerbated if factors like the merger of the small-group and non-group markets drive up small-group rates more than anticipated. And, although standards of minimum creditable coverage such as mandatory drug coverage and limits on deductibles have been delayed until January 2009, they will motivate many small businesses to consider buying richer benefit plans than they do currently. Even employers that already offer generous benefits, with a high rate of employee participation, will need to draw on human resource and legal support to comply with new non-discrimination rules, newly applicable (multiple) definitions of full-time versus part-time employees, Section 125 requirements for certain part-time and temporary employees, and annual filing and record-retention requirements.

Finally, many of the state’s uninsured work for state’s very small companies, with fewer than 10 employees, that are not subject to the employer provisions of the law. Depending on their incomes, the workers themselves may be required to comply with the individual mandate, and they would get some premium relief if their employers could be convinced to set up Section 125 payroll deduction plans even though they are not required to do so.

Testing the Connector’s operations and sales roles

The Connector staff and Board have received high marks for building the foundation for reform and developing policies and regulations that will allow it to move ahead on schedule. It is too early to judge, however, whether the Connector can efficiently and effectively sell insurance products and whether it will become financially self-sustaining. As discussed earlier, the Connector will receive an administrative fee from all Commonwealth Care sales, which are exclusive to the Connector, and from sales of Commonwealth Choice plans that it makes directly. In many cases, however, individuals and employers will be able to buy the same Commonwealth Choice plans at the same price outside the Connector, so the Connector will have to find ways to add value to the sale. The Connector has identified four key prospect groups for its Commonwealth Choice sales:

- People seeking non-group insurance will be able to buy any of the Commonwealth Choice plans either from the Connector or directly from the carriers.
- People whose employers offer Section 125 plans but who do not receive subsidized insurance (part-time and seasonal workers, for instance) will be able to buy non-group insurance from the

Connector with pre-tax dollars, if the employer designates the Connector for its Section 125 payroll deductions.

- Small employers will be able to offer their employees “group insurance with individual choice” through the Connector. Employees will be able to choose a Commonwealth Choice plan from any carrier as long as it is within the tier (Bronze, Silver or Gold) chosen by their employer. (Connector sales of Commonwealth Choice products to small businesses will be phased in starting in October 2007.)
- Qualified individuals, aged 19-26, will be able to buy Young Adults Plans, which are only available from the Connector.

Some concerns have been raised about the effect the Connector will have on the existing small group market and on the health plans, brokers and intermediaries that serve that market. Will the Connector have an unfair advantage competing in a highly regulated market, using state-subsidized sales and marketing? Does it have a conflict of interest in both setting important rules of the market and competing in that market? Longer term, will the Connector control the direction of the overall insurance market too much and keep the state from adapting to changes in the national insurance market? Or will it become a driver of innovation in the health insurance market, encouraging the development of products with strong incentives for improving quality and controlling costs? Given the track record so far, none of these and other questions about the Connector’s role are likely to play out behind closed doors.

Managing the cost of Commonwealth Care

The four managed care organizations enrolling low-income people through Commonwealth Care — thus far, mostly people who are not paying premiums — are having their first experience with insuring new segments of the previously uninsured. Early, incomplete data on Commonwealth Care indicate that those with incomes between 101 and 300 percent of the federal poverty level may be higher utilizers of health services than expected. This could be due to pent-up demand by people who have put off getting needed care, or they may be sicker than anticipated. If this year’s enrollees turn out to be more in need of costly medical services than was predicted, if the plans do not attract a balanced pool of both sick and healthy people, or if the plans’ costs are driven up by their provider contracts, they are likely to come back with substantial rate increase requests for the second year. This could be exacerbated if health plans were overly aggressive with their initial pricing. (The Commonwealth Care contribution formula favors plans with lower prices, since an enrollee pays, in addition to the scheduled contribution, any difference between the lowest priced plan and the plan they select.) If the Commonwealth Care plans demonstrate that they require significantly higher capitation payments for the coming year, the Connector will have to consider three unpleasant options – reduced benefits, higher enrollee contributions, or increased government subsidies, each of which would reopen the issue of balancing public and individual affordability.

Maintaining the health safety net

Changing the name of the Uncompensated Care Pool to the Health Care Safety Net Trust Fund signifies a new approach to the uninsured — moving them out of “free care” into insured care — but it also makes it clear that the safety net will still be available. The organizations receiving grants from the Blue Cross Blue Shield of Massachusetts Foundation for community outreach have reported that, while 2,600 of the first 6,000 people they served were deemed eligible for MassHealth or Commonwealth Care, over 900 were only eligible for, or chose coverage through, the Uncompensated Care Pool. One group excluded from coverage under health care reform, for instance, is undocumented immigrants.

There are many risks and unanswered questions for the safety net providers that have traditionally provided a high level of free care to uninsured patients, particularly Boston Medical Center and Cambridge Health Alliance and the State’s community health centers. Will they be able to adjust to the movement from free care to an insured population; how will new eligibility and reimbursement rules affect them; will they lose revenue when they are paid contracted payment rates for Commonwealth Care patients rather than “free care” rates; how much free care will they still need to provide to uninsured who are ineligible for or waived from the provisions of the law; will low income people who are newly insured actually stop using emergency rooms at safety net hospitals for routine care; and what will happen when the hospitals’ supplemental payments expire after three years?

Controlling government spending for health care reform

As described earlier, Massachusetts is financing a large part of health care reform through a special waiver of normal federal Medicaid rules granted by the Centers for Medicare and Medicaid Services (CMS), and the Commonwealth must demonstrate that spending on health care reform will be “budget neutral” through the waiver’s current term. The MassHealth waiver amendment that was approved by CMS in 2006 explicitly quantified the budget neutrality “cushion” at \$82 million over the first 11 years of the waiver, from July 1997 to June 2008, when it will have to be renewed once again. If it appears that spending will exceed the budget neutrality cap, the state can choose to fund the amount in excess of the cap at full state cost or take corrective actions to scale back projected spending on the program.

The overall health care reform budget relies on estimates of health care inflation trends and the number and demographics of the uninsured. If health care costs rise too fast or if the number of very-low-income uninsured was underestimated, program costs will be pushed up faster than anticipated. Other risks include an underestimation of the cost of MassHealth benefit restorations and an overestimation of how much “free care” spending will be reduced as uninsured people move to insurance coverage. On the other side of the equation, Chapter 58 is built on assumptions that the economy will stay strong enough to keep employment at a high level and produce needed tax revenues so that state and federal funds will be available and sufficient to subsidize premiums. [See

Appendix A for a summary of where the revenue for health care reform comes from and how it is spent.]

Improving systems of care

Massachusetts is known as a center for medical excellence, but there is also an acknowledged need to improve quality-of-care and reduce medical errors. The state also has a traditionally high level of overall health care costs, a fact that will play a major role in the long-term success of health care reform. Whether there will be enough money to pay for coverage in future years is highly dependent on the trend in insurance premiums, and since most premium dollars in Massachusetts (roughly 88 percent) pay for medical claims, keeping insurance for all affordable will require better management of the costs of delivering medical care.

Chapter 58 has provisions to address these issues, including the creation of a Quality and Cost Council, but, fundamentally, the law is focused on expanding access to insurance. So far, the Quality and Cost Council has hired an executive director, solicited suggestions on how to control costs and improve quality, and developed a list of “policy levers” that might be used to influence systemic change, including:

- Patient choice (educating and/or providing incentives to patients to choose low cost and high quality care)
- Malpractice insurance (regulation or legislation to reduce the cost and possibly improve quality)
- System capacity (addressing overuse and under-use of health care services)
- Payment systems and methods
- Clinical decision making (online prescribing and other technologies to decrease or eliminate medical errors and hospital infections)
- Promoting prevention and chronic disease management

Any effort to improve health care quality and manage costs in a systemic way will have to be devised in the context of Chapter 58’s many other provisions, including increased government subsidies, increased provider payments and increased individual and employer responsibility.

The Coalition of Support

Although there were strong, clear differences of opinion over most of the major policy decisions faced by the Connector Board during the first year of implementation, the interest groups that supported the law a year ago, even those that were most reluctant, still support it today. Those that opposed it — including advocates for a government-run, single payer system on one end of the spectrum and advocates for an exclusively market-based approach on the other — still oppose it.

All of the groups that had helped fashion Chapter 58 in the spring of 2006 continued to be involved in its implementation. The members of the ACT!! Coalition (Affordable Care Today) worked individually and collectively to forge consensus among community and religious organizations, labor unions, doctors, hospitals, community health centers, public health advocates and consumers. The Greater Boston Interfaith Organization, Health Care For All and other consumer groups played especially crucial roles in the debate over minimum creditable coverage standards and the affordability schedule and in advocating for expanded subsidies for low-income uninsured residents.

Business groups, public policy organizations and associations representing providers and health plans all weighed in on issues affecting their constituents. Despite growing recognition among employers that reform creates significant new reporting, compliance and financial responsibilities, their trade associations have championed reform and devoted considerable resources to promoting it and informing their constituencies.

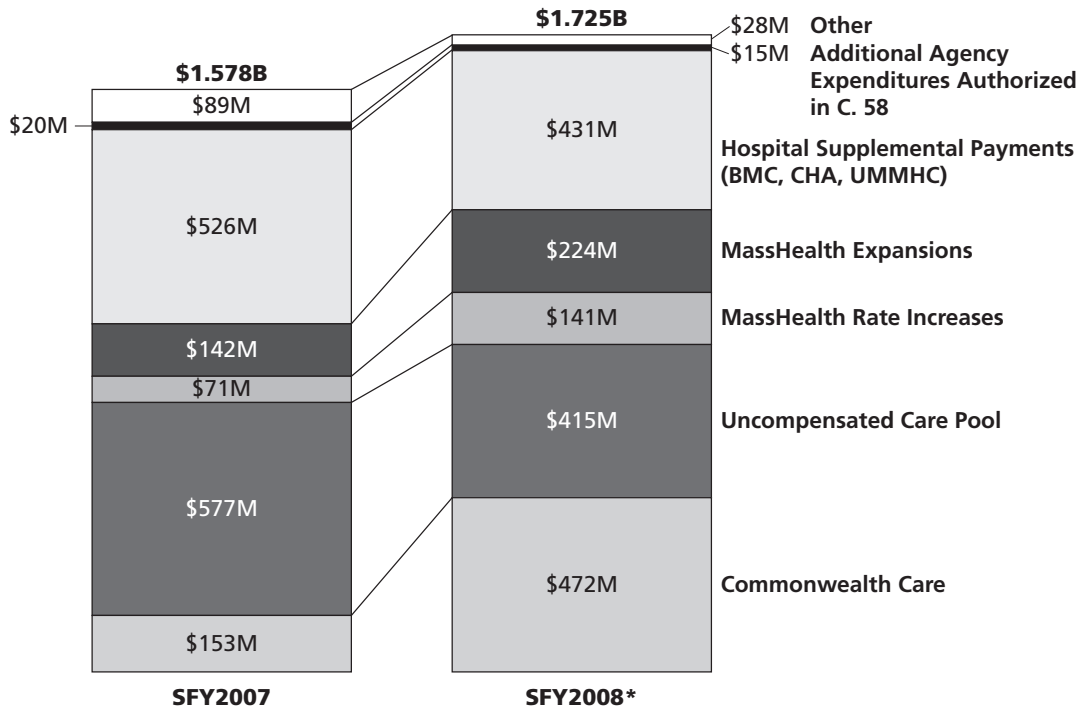
It is also notable that year one of Chapter 58 was split by a political upheaval at the State House, as Republican Governor Mitt Romney declined to run for reelection and Deval Patrick, a Democrat, was elected to replace him. This brought not only a change in political orientation, but also a change of Executive Office personnel in key positions such as the Secretary of Administration and Finance, who chairs the Connector Board, the Secretary of Health and Human Services, whose office oversees MassHealth, and among leaders of other state agencies that share responsibility with the Connector for implementing the law. The executive director and all of the Board's "stakeholder" members remained in place, however, and the process continued to move ahead on schedule.

So, how did the Connector Board manage to reach agreement on every major policy issue? Trust in the process is one factor that is often cited. Also, the extensive analysis and support provided by the Connector staff and others. And, perhaps most important has been the resiliency of the stakeholders — their willingness, when faced with a divisive issue, to slow down, take a deep breath, listen to other points of view, and keep coming back to the table to find a reasonable compromise.

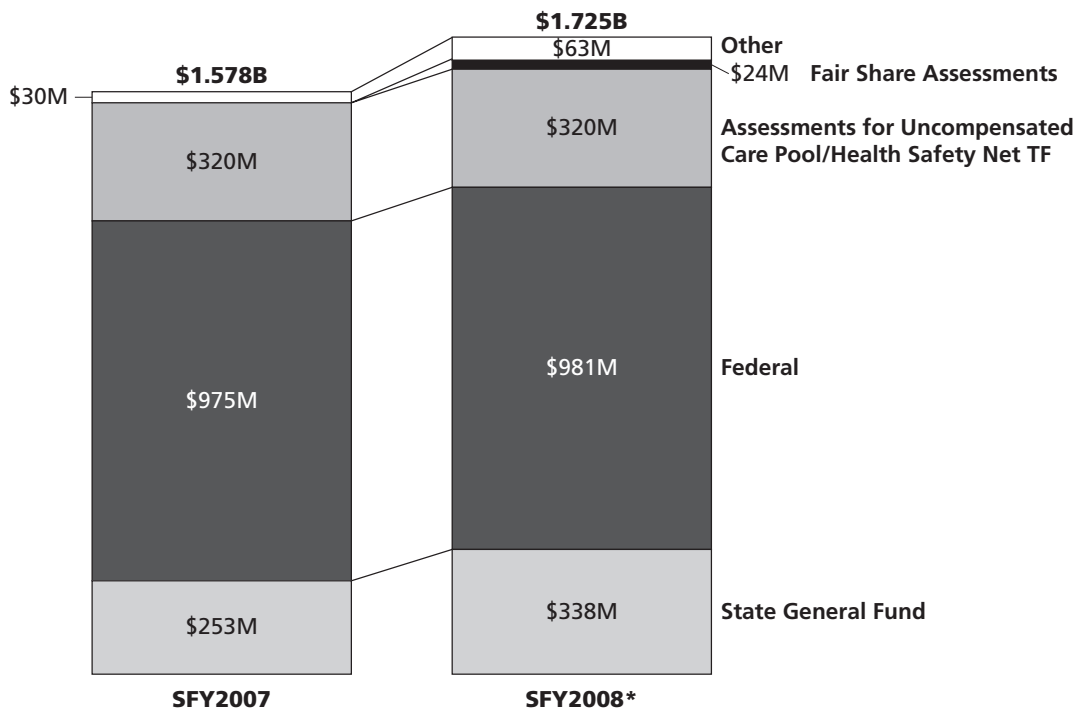
The challenges mentioned in the previous section, in particular the individual mandate and questions surrounding affordability of insurance coverage — to individuals, businesses and the state — will continue to test the commitment of political and community stakeholders and will create new opportunities for the law's opponents to predict failure. The challenges will also demonstrate whether the stakeholders can continue to adapt to changing circumstances and design solutions that will help achieve Chapter 58's ambitious and admirable goals.

Appendix A

Health Reform Spending, State Fiscal Year 2007-08



Revenue Sources for Health Reform, State Fiscal Year 2007-08



*FY 2008 figures based on Governor Patrick's budget recommendations, as filed 2/28/07.

Source: Executive Office of Administration and Finance

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