

**Report to the Massachusetts Legislature
Implementation of the Health Care Reform Law, Chapter 58
2006-2008**

**The Massachusetts Health Insurance Connector Authority
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i. Preface

The first two years of the Commonwealth Connector's existence have witnessed many start-up and developmental activities. In contrast, the claims experience from programs which were only initiated during its first year and the opportunities for formal evaluation of these programs are still evolving. Therefore, this report is largely narrative, laying out a chronology and recapping the important steps taken to develop the Connector's programs and policies. While the report does evaluate some elements of reform's implementation, we expect that subsequent annual reports called for under the Connector's authorizing legislation will reflect a heavier balance of evaluation versus narrative.

For the benefit of the Massachusetts Legislature and the broader readership that follows the development of health reform in Massachusetts, we have synthesized the major progress points in chapter 1. Chapter 1 also forms the basis for a separate, stand-alone "Summary Report."

This document was prepared by staff of the Commonwealth Connector. Special thanks to Bob Carey, Kaitlyn Kenney, Michael Chin, Joan Fallon, Dick Powers, and Niki Conte for their fine work.

1.0 Summary

Two years after passage of Massachusetts' landmark Health Care Reform law, nearly 440,000 individuals are newly insured. Nearly half of the newly covered are enrolled in private plans with no government subsidies. To date, there is little evidence of crowd-out, or the shifting of enrollment from the private to the public sector. A report by the U.S. Census Bureau shows that gains made in enrollment in Massachusetts since the law was enacted have propelled the state from seventh place in the percentage of insured citizens to first place for the 2006 and 2007 period. The following report to the Massachusetts Legislature details the state's experience with Health Care Reform at its early stages.

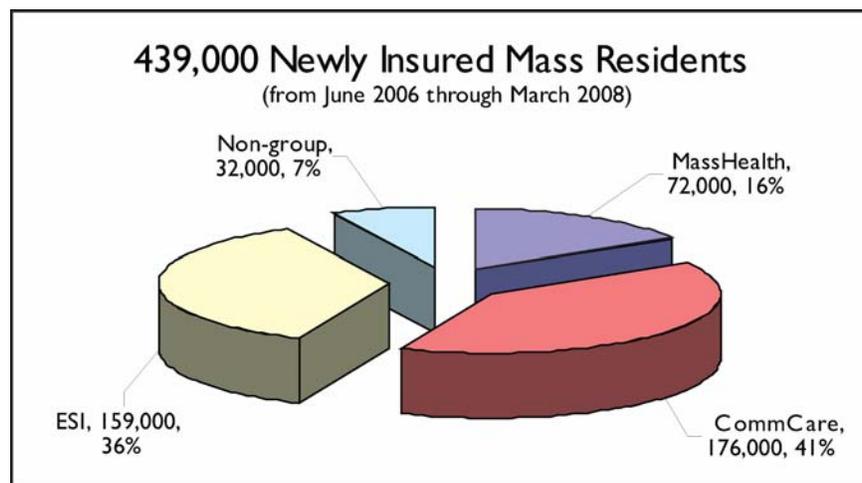
Implementation Begins

Chapter 58 of the Acts of 2006, was signed into law in April of 2006. Work on implementation began immediately with the expansion of MassHealth eligibility and the promulgation of the first set of emergency regulations from the Massachusetts Health Insurance Connector Authority.

The Health Connector first began to offer subsidized coverage for uninsured adults with the lowest incomes in October 2006 for a November 1 effective date, and three months later extended this offering to those from 100 to 300% of the federal poverty level (fpl). Commonwealth Choice, the Health Connector's program for individuals not eligible for subsidized coverage, opened in May 2007, for an effective date of July 2007.

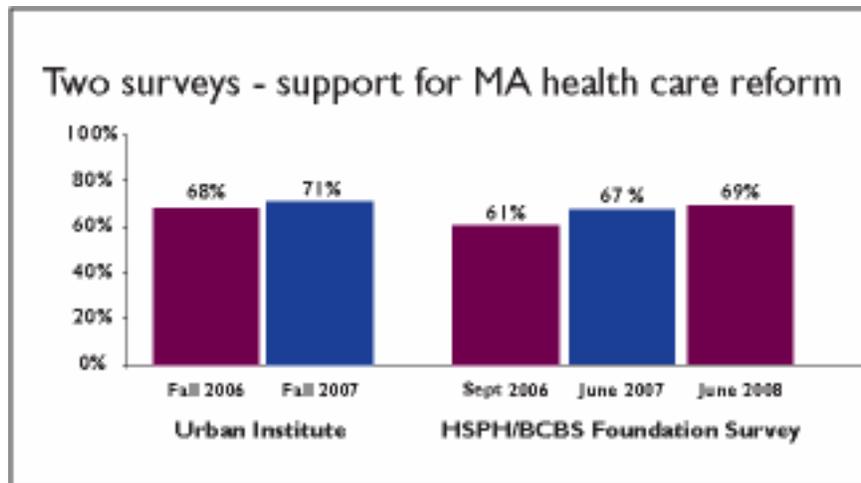
The three-year phase-in of Health Care Reform in Massachusetts continues with an increase in tax penalties for 2008 and implementation of new standards for Minimum Creditable Coverage in 2009. Also planned for early 2009 is the extension of the Commonwealth Choice program to small employers

Two years after beginning implementation and phase-in of the law, Massachusetts has passed a number of significant milestones. Most importantly, more Bay Staters now have health insurance. Based on information collected by the Division of Health Care Finance and Policy (DHCFP), 57% of the almost 440,000 newly insured are enrolled in Commonwealth Care or MassHealth and 43% are in private insurance. Well over half of the new enrollees contribute all or something significant to the premium cost of their coverage and incur co-payments and other cost-sharing in line with private employer-sponsored insurance. (This DHCFP data is from the first 21 months of the law's implementation, from June of 2006 through March of 2008.)



Based on data from fall of 2007 – both survey data and tax filings – the number of uninsured in Massachusetts has fallen substantially. A state survey of the uninsured due out at the end of 2008 will provide more definitive information on the remaining number of uninsured.

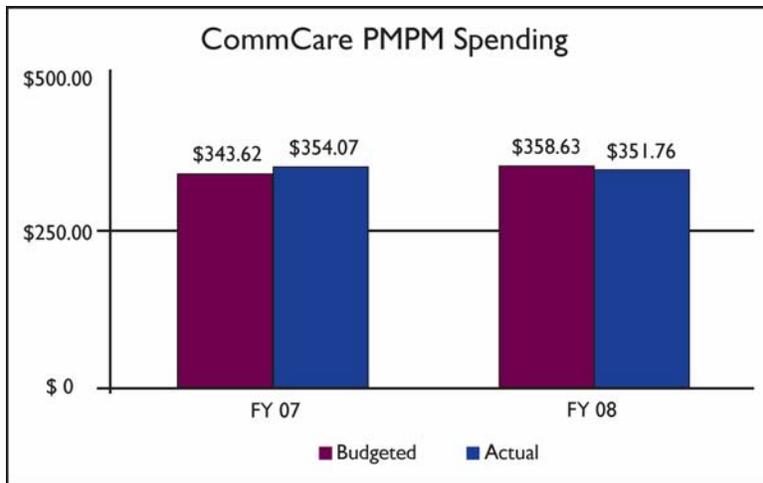
In addition to launching two major coverage programs in its first year – subsidized Commonwealth Care and unsubsidized Commonwealth Choice – the Health Connector’s Board of Directors met 25 times to wrestle with a number of critical and high profile policy decisions. Most of these matters were decided unanimously. The Board’s successful efforts to reach consensus are in keeping with the earnest efforts of many interested parties dedicated to implementation of the landmark legislation.



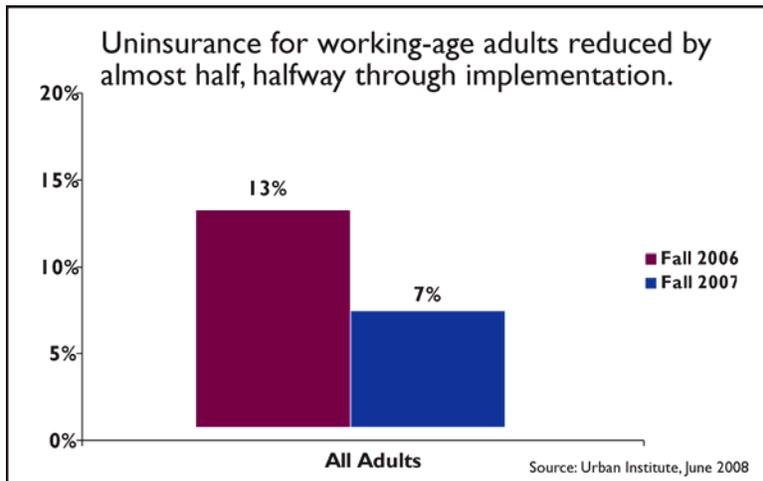
Soon after its enactment, popular support for Health Care Reform was already high. Remarkably, in the two years since, public support in Massachusetts has actually increased. And beyond our borders, this legislation is often examined as a possible model for national health reform.

Due in part to an aggressive public education program, enrollment growth in Commonwealth Care peaked just as the individual mandate penalties came into effect at the end of 2007. With the introduction of a comprehensive process for annually re-determining eligibility, enrollment in Commonwealth Care leveled off in March 2008 at approximately 176,000 while growth in MassHealth has reached about 72,000. The Health Connector projects that growth in the program will soon resume. The portion of premium-paying enrollees in Commonwealth Care continues to grow, as does enrollment in private, commercial insurance.

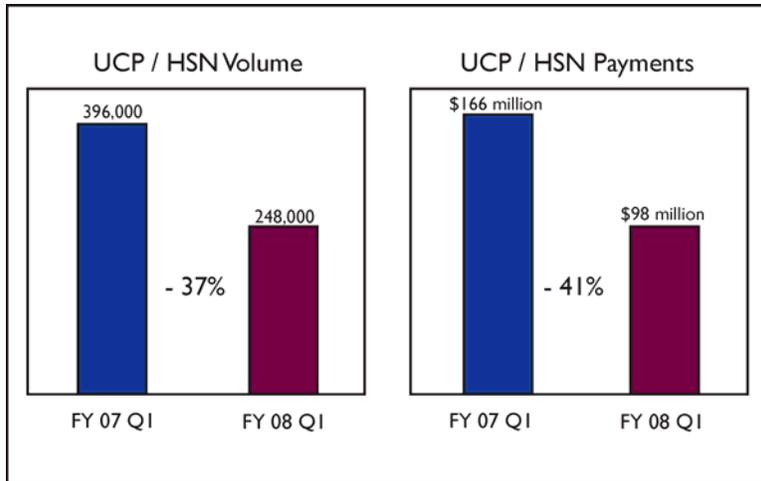
The rapid pace of the growth in Commonwealth Care has generated cost concerns. In fact, spending on Commonwealth Care exceeded early budget projections for FY 2008 by over \$150 million. However, as a relatively new program expected to grow at rates which can only be estimated in its early years, enrollment growth is more an indicator of need than anything else. On the basis of cost per member per month, Commonwealth Care has tracked close to budget for the past two years.



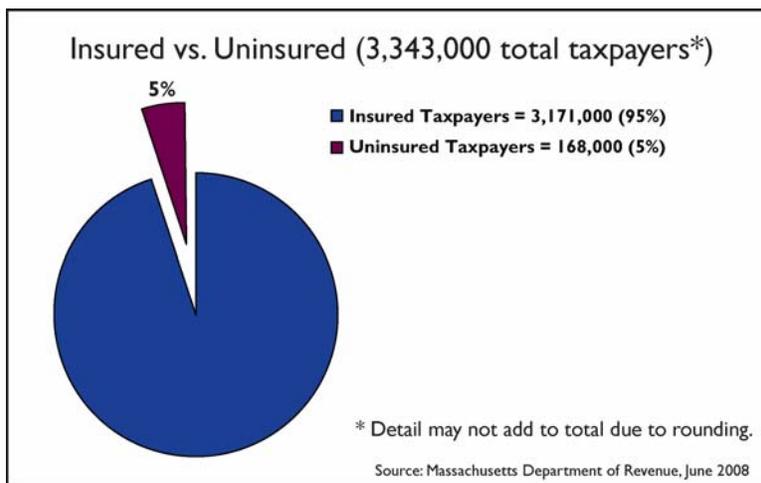
Meanwhile, a look at available data begins to paint a picture of initial success, not only in covering more individuals, but in improving access to routine care and reducing reliance on “free care.” A survey by the Urban Institute reports that from the fall of 2006 to the fall of 2007, the number of uninsured adults in Massachusetts dropped almost in half, from 13% to 7%. Because seniors and children were not included in the survey and have far higher rates of insurance than working-age adults, the overall percentage of uninsured was likely lower. Moreover, the survey was conducted in October and November of 2007, before penalties for complying with the new law went into effect, prompting a large surge in enrollment.



The Urban Institute findings are corroborated by the annual U.S. Census Bureau survey that showed the state’s average uninsured rate for the two-year period, 2006-2007, dropped to 7.9%, making Massachusetts the state with the lowest rate of uninsured residents in the country. As predicted, the use and cost of the Health Safety Net for the uninsured is falling. As reported by DHCFP, utilization of free care had declined by 37% and payments declined by 41%, in the first quarter of Health Safety Net fiscal year 2008 over the same quarter a year earlier. As intended under the new law, increasing subsidies for insurance and constricting eligibility for the Health Safety Net are moving cost from institutional subsidies to individual and comprehensive coverage.



The state Department of Revenue (DOR) has been a strong partner in the implementation of Health Care Reform. Communications to tax filers and employers explaining their responsibilities under the law have been undertaken through DOR, which is also responsible for implementing the schedule of tax penalties. DOR also serves as a source of important data about compliance. The department confirms a high level of coverage among adults through state income tax filings for 2007. Just 5% of some 3.3 million tax filers reported being adults through state income tax filings for 2007. Just 5% of some 3.3 million tax filers reported being uninsured as of Dec. 31, 2007, and compliance with the new tax filing requirements was overwhelmingly successful, with only 1.4% failing to file appropriately.



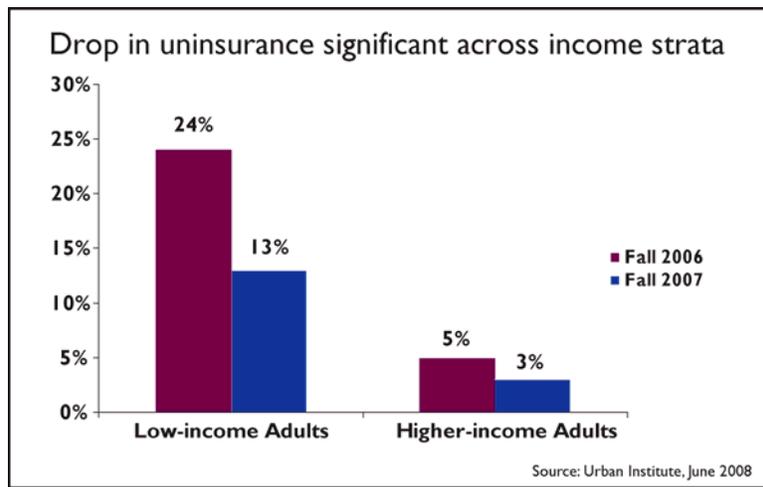
Of those Massachusetts taxpayers who reported not having health insurance, 3% (97,000) were deemed able to afford coverage, but self-assessed a penalty for not having it; the remaining 2% (71,000) were exempt from the requirement, either because they could not afford to purchase insurance, or because of their religious beliefs. As of August 2008, only 2,411 Massachusetts residents out of some 3.3 million filers had actually appealed the 2007 penalty decision.

Of the nearly 440,000 newly insured, as of March 2008, about 176,000 were enrolled in the Commonwealth Care program, 72,000 were receiving MassHealth, the state's Medicaid program, and 191,000 had enrolled in private insurance through their employers, the Commonwealth Choice program or because they purchased directly from a carrier.

The 43% who are enrolled in commercial health insurance plans represent the first significant increase in private, commercial insurance in Massachusetts in decades. Over half of the new enrollees contribute significantly toward their monthly premium, whether they pay all of it--as do some 32,000 new buyers of non-group insurance--or part, as do some 159,000 new enrollees who took up their employer's offer of insurance as well as more than 60,000 enrollees in government-subsidized Commonwealth Care. Among the 32,000 new buyers of non-group (individual) insurance, nearly 50% bought through the Health Connector, and 80% of that group utilized the Health Connector's award-winning web site for their purchases.

The Uninsured

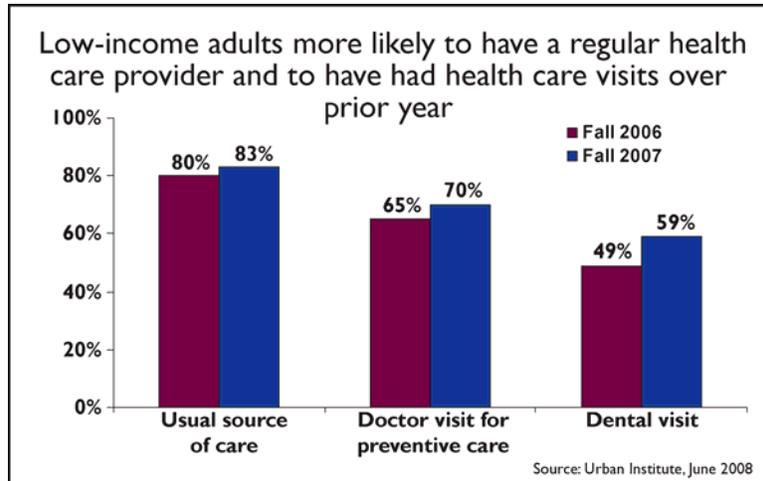
The uninsured are disproportionately poor, so they make up a large portion of the newly insured, but Health Care Reform is helping people in need of coverage across the income spectrum. In the Urban Institute study, a significant decline in the numbers of uninsured was evident from 2006 to 2007 for both middle class adults and those earning 300% or less of the federal poverty level.



It is important to note that market reforms generated as a result of the new law significantly increased the choice and value of non-group health insurance in Massachusetts. Before reform, a healthy 37-year-old living in Boston – the median age for uninsured adults in the Bay State – paid \$335 per month in premiums and had few market options. Post reform, that same 37-year old had a broad range of options, including at least one plan for a little over half the price, with twice the benefits. In just nine months following reform of the non-group market, enrollment in individual plans doubled from 36,000 to 72,000.

	Pre-reform	Post-reform
Monthly Premium	\$335	\$184
RX coverage	None	\$100 deductible
Deductible	\$5,000	\$2,000

Increased access to medical care is a key goal of health reform, and the Urban Institute study showed that adults across income categories in Massachusetts have not only experienced increases in access to medical care, but have also experienced reduced out-of-pocket spending and increased use of preventive care services. In other words, Massachusetts insured hundreds of thousands of people who are now able to address previously unmet medical needs in a more affordable way.

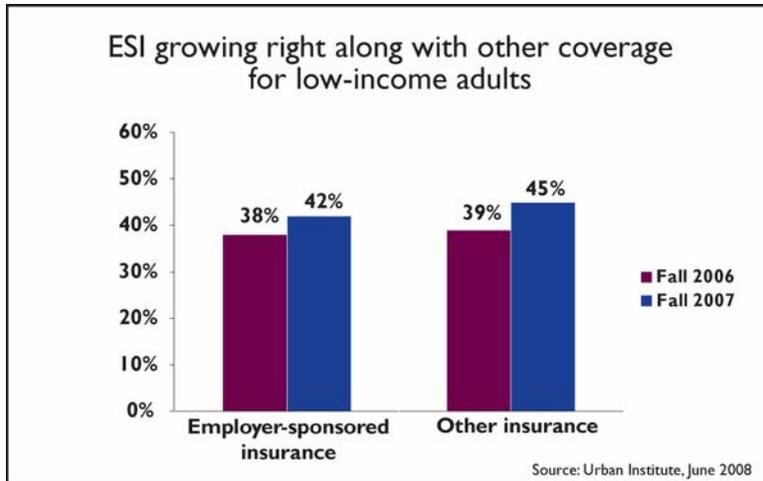


Shared Responsibility

The reform law in Massachusetts has been an effort borne of shared responsibility among individuals, business and government. It's a formula that has proved attractive to voters. A survey by the Harvard School of Public Health and the Blue Cross Blue Shield of Massachusetts Foundation (HSPH/BCBSMA Foundation) showed that of the 93% of Massachusetts residents who say they know about the law, 69% support it. That support is up from 61% in September of 2006. Similarly, Urban Institute surveys in the fall of 2006 and fall of 2007 show a rise in favorable opinion among working-age adults from 68% to 71%, and those favorability ratings were similar for low-income and higher income respondents. When asked in the HSPH/BCBSMA Foundation study about repeal of the new law, only 12% of residents said they would like to see it repealed.

Support for the requirement that businesses with 11 or more employees provide health insurance or pay an assessment of up to \$295 per employee per year is also growing, with the HSPH/BCBSMA Foundation survey showing support at 75% in June of 2008, up from 70% in September 2008. Additionally the study showed that 77% of Massachusetts residents supported providing subsidized health insurance to low-income residents.

The cost of the program has grown in response to enrollment growth. And, just as Commonwealth Care has grown, so has employer-sponsored insurance and private, non-group insurance. To date, there is no evidence of significant "crowd-out," or behavior changes from employers or employees that would shift enrollment from the private to the public sector.



None of this is to suggest that cost is not a concern. It is the major concern in any successful effort to significantly expand health coverage. By embracing the moral imperative to cover the uninsured, Massachusetts can no longer respond to medical cost increases by rationing financial access to care; instead, the challenge of moderating annual increases in the cost of medical care and health insurance must be squarely confronted. Legislation to do just that has recently been enacted and cost containment will continue to be a priority in the years ahead.

2.0 Introduction

2.1 Overview of Health Care Reform

The cornerstone of Massachusetts health reform is shared responsibility, meaning that government (taxpayers), individuals, employers, providers and health insurers are all shouldering new responsibilities. A unique feature of reform in Massachusetts is the statutory mandate that adult residents who can afford insurance maintain a minimum standard of coverage.

One of the primary responsibilities assumed by government as a result of reform is the provision of subsidized medical coverage to an expanded set of eligible individuals through the Massachusetts Medicaid program (MassHealth) and through a new insurance program, Commonwealth Care (CommCare)¹. In addition, chapter 58 authorized the development of an independent state agency known as Connector Authority to lead many elements of the implementation of reform.

Employers also have new responsibilities intended to facilitate and expand access to health insurance for their employees. Employers with 11 or more full-time equivalent (FTE) employees are required to establish Section 125 plans, enabling employees to purchase health insurance on a pre-tax basis. Employers must provide Section 125 plans even if the employer does not offer employer-sponsored insurance (ESI) to their employees. Use of Section 125 plans can greatly reduce the cost of health insurance for workers by avoiding federal and state income and payroll taxes on the “wages” used to pay health insurance premiums. Employees may use Section 125 dollars to purchase health insurance directly through a carrier, through the Connector’s Commonwealth Choice (CommChoice) program, or through a third party. Employers who are required to set up a Section 125 plan and fail to do so risk imposition of a “free rider” surcharge².

In addition, the Fair Share Contribution (FSC) requirement included in the health reform law, which also applies to employers with 11 or more FTEs, requires them to make a “fair and reasonable contribution” to their employees’ health insurance costs or pay an assessment to the state. If an employer does not meet the FSC requirement, it may be required to make an FSC payment of up to \$295 per employee per year.³ These funds are used to help offset the cost of the subsidized health insurance programs provided by the Commonwealth.

¹ Commonwealth Care is a subsidized insurance program that was established by chapter 58. It is described in greater detail in Section 3.0 Commonwealth Care.

² An employer may be subject to the free rider surcharge if it is required to set up a Section 125 plan, has failed to do so, and if one of its employees (or the dependents of an employee) receives health care services paid for as free care on three or more occasions during any hospital fiscal year, or if there are five or more occurrences of health care services paid for as free care by all employees in aggregate during any fiscal year. To be assessed a surcharge, the total costs of such free care must be \$50,000 or more. More information on the free rider surcharge is available at, <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/Employer/Overview/Employer%2520Handbook.pdf>

³ For more information on Fair and Reasonable Contribution requirements, see page 6 of the following document, <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/Employer/Overview/Employer%2520Handbook.pdf>

Chapter 58 also included an important change in the insurance laws of the state by merging the small⁴ and non-group health insurance markets. The merger of these markets, coupled with the development of the CommChoice program through the Connector, successfully and significantly lowered the cost of health insurance in the non-group market. It also improved consumer choice among health plans, thereby promoting increased coverage. Of equal importance, the newly merged small and non-group market has not had a noticeable adverse effect on the rates charged small group employers.

Other important elements of reform include restructuring of the Uncompensated Care Pool (UCP), now called the Health Safety Net (HSN), which shifted its payment method from a block grant to a claims based system of reimbursement. As a result of this change and the expansion of other state insurance programs, the eligibility requirements for the pool were also modified. Recognizing the importance of addressing health care costs, policymakers also established a Health Care Quality and Cost Council and included a provision to increase Medicaid reimbursement rates to hospitals and providers in chapter 58.

In two years, Massachusetts has made tremendous progress toward the goal of providing near universal health insurance coverage for its residents. While the coming years will undoubtedly be very challenging, the state's remarkable progress to date contrasts sharply with the failure across most of the rest of the country to insure the uninsured.

2.2 Mission and Structure of the Connector

The Connector is an independent state authority created by chapter 58 of the acts of 2006 to implement key elements of health reform. As manager of the CommCare and CommChoice programs, the Connector serves as an intermediary that assists individuals in acquiring health coverage. CommCare is a subsidized insurance program available to Massachusetts adults earning up to 300% of the Federal Poverty Level (FPL) who do not have access to ESI or other subsidized insurance and who meet certain eligibility guidelines. CommChoice is a commercial (non-subsidized) insurance program currently available to individuals and (in the near future) to small employers.

In addition to managing these two programs, the Connector is charged under chapter 58 with developing several policy and regulatory components of reform. Among the most important policy tasks completed by the Connector since passage of reform are: establishment of the benefits packages and premium contribution schedules for the CommCare program; development of regulations defining what constitutes Minimum Creditable Coverage (MCC); and construction of an Affordability Schedule. (Discussion of the Connector's policy decisions can be found in Section 6.0 of this report.)

The Connector works in tandem with many state agencies. For example, the Connector contracts with MassHealth to conduct eligibility screening and much of the enrollment process for CommCare applicants. The Connector works with the Division of Insurance (DOI) on a range of health insurance regulatory issues and with the Department of Revenue (DOR) on interpreting and enforcing chapter 58's requirement that adults have health insurance. In addition, the Connector works closely with the Division of Unemployment Assistance (DUA), the Executive Office of Health and Human Services (EOHHS), the Executive Office for Administration and Finance (EOAF), and the Division of Health Care Finance and Policy (DHCFP), among others, on a broad variety of initiatives.

Another responsibility that the Connector has taken on is to inform the public and other interested and affected parties of the new insurance options and requirements associated with health reform. The

⁴ Prior to health reform, the small group market in Massachusetts included self-employed individuals and employers with 50 or fewer employees.

Connector has launched numerous outreach, marketing, and public information activities, most of which have greatly benefited from the assistance and participation of various state agencies and other civic partners committed to health reform. (Section 7.0 of this report provides a more detailed description of these activities.)

The Connector operates on a hybrid model, incorporating some features which are typical of public agencies and others associated with private organizations. Moreover, to implement CommCare and CommChoice, the Connector contracts with other state agencies as well as private businesses. Financially, the Connector is a mixed business model as well: the state appropriated start-up funds to develop an infrastructure and operations, but thereafter the Connector is expected to generate its own revenues.

The Connector employs approximately 50 people and is led by a team of ten senior staff members, some of whom are dedicated to CommCare, some to CommChoice, and others who have cross-cutting responsibilities that include both programs as well as regulatory and policy development. The Connector is governed by the Board of the Commonwealth Health Insurance Connector Authority (the Board), chaired by the Secretary for Administration and Finance. The Board is composed of ten members with diverse backgrounds and areas of expertise, which allows for a broad range of perspectives to be represented. The Board approves all major policy, regulatory and programmatic decisions, and generally meets on a monthly basis in a public forum.

3.0 Commonwealth Care

3.1 Program Description

Eligibility and enrollment

CommCare is designed to provide health insurance coverage to adults who are uninsured and meet specific statutorily-defined eligibility requirements. These requirements include⁵:

- U.S. citizen/national, qualified alien, or alien with special status;
- resident of the Commonwealth for the previous six months⁶;
- ineligible for any MassHealth program or for Medicare;
- age 19 or older;
- not offered health insurance coverage through an employer in the last six months for which he is eligible and for which the employer covers 20% of the annual premium cost for a family insurance plan or at least 33% of the cost for an individual insurance plan;
- not accepted a financial incentive from his employer to decline ESI; and
- family income at or below 300% FPL.

In addition to these criteria, the Board approved additional eligibility regulations in setting up the CommCare program. These guidelines specify that individuals eligible for TriCare⁷; the Massachusetts

⁵ M.G.L. c. 118H § 3(a).

⁶ Though this is an eligibility criterion by statute, it is not enforced due to its inconsistency with federal laws.

⁷ TriCare is the managed care component of the United States Department of Defense Military Health System. TriCare provides civilian health benefits for military personnel, military retirees, and their dependents, including some members of the Reserve Component.

Fishermen's Partnership; Qualifying Student Health Insurance Programs (QSHIP); or the Massachusetts Division of Unemployment Assistance's Medical Security Program are not eligible for CommCare⁸.

While the Connector manages the CommCare program, MassHealth fulfills a fundamental role in the eligibility and enrollment process. Operating under severe time constraints to get CommCare up and running less than four months after the Connector's directors first met and hired their first employee, the Connector amended MassHealth's existing contract with Maximus to assist the Connector with various administrative functions, such as enrollment, customer service support and premium billing. Subsequently, the Connector went through a formal bid process and selected Perot Systems to replace Maximus. It is now in the process of transitioning these functions from Maximus to Perot Systems.

Plan Types and Cost-Sharing

The health plans offered through the CommCare program provide comprehensive medical coverage comparable to, or more generous than, typical ESI in Massachusetts. All plans include coverage for inpatient services, outpatient services and preventive care services, inpatient and outpatient mental health and substance abuse services, and prescription drugs. For members earning up to 100% FPL, dental services are also covered (as required by chapter 58).

CommCare is designed as a mixed Medicaid/commercial model of insurance. For those enrollees earning 100% FPL or less, coverage resembles a Medicaid program: by statute, the cost-sharing schedule is tied to MassHealth and these enrollees do not pay any monthly premium. Using a progressive scale of increasing cost-sharing for those enrollees earning above 100% FPL, the Connector developed the benefit package, co-payments, and enrollee premium contributions at the top of the income eligibility scale (200% - 300% FPL) to approximate a fairly generous standard of ESI.

If determined eligible and enrolled in CommCare, members are assigned a Plan Type. Initially, the program was structured with four different Plan Types and with four corresponding cost-sharing structures. Assignment to Plan Type 1 (\leq 100% FPL) and Plan Type 2 (100.1% - 200% FPL) was based solely on income, while enrollees with incomes between 200.1 - 300% FPL were given a choice of either Plan Types 3 or 4. Plan Type 3 was structured to allow members' lower premium contributions with higher co-payments at the point-of-service, while Plan Type 4 required higher premium contributions with lower co-payments at the point-of-service.

⁸ For more information, see 956 CMR 3.09 § 2. Available online at <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Regulations/documents/CommCareRegs956CMR3000408Revision.pdf>

Table 1. Description of Enrollee Premium Contributions (lowest cost plan) and Cost-Sharing by Plan Type

Plan Type (PT)	Household income (as % of FPL)	Description of enrollee cost-sharing	Lowest Premium Available		
			10/1/06 – 6/30/07	7/1/07 – 6/30/08	7/1/2008
1	0% - 100%	There are co-pays only for Rx*	\$0	\$0	\$0
2A	100.1% - 150%	There are co-pays for Rx and all medical services	\$18	\$0	\$0
2B	150.1% - 200%	There are co-pays for Rx and all medical services	\$40	\$35	\$39
3	200.1% - 300%	There are co-pays for Rx and all medical services (Lower premium, higher co-pays compared to PT 4)	200.1 - 250% FPL: \$70 250.1 - 300% FPL: \$106	200.1 - 250% FPL: \$70 250.1 - 300% FPL: \$105	200.1 - 250% FPL: \$77 250.1 - 300% FPL: \$116
4	200.1% - 300%	There are co-pays for Rx and all medical services (Higher premium, lower co-pays compared to PT 3)	200.1 - 250% FPL: \$92-96** 250.1 - 300% FPL: \$128-130**	200.1 - 250% FPL: \$92 - 96** 250.1 - 300% FPL: \$127 - 131**	(eliminated in July '08)

* For emergency room visits, there is no co-payment for an emergency condition, but there is a \$3 co-payment for a non-emergency condition.
 ** The lowest premium available depends on the region within Massachusetts where the enrollee lives.

Over time, however, modifications were made to the cost-sharing structures associated with Plan Types 2, 3, and 4. In July 2007, the premium contributions of those individuals with earnings of 100.1-150% FPL (classified as Plan Type 2A) were eliminated⁹. As of July 2008, Plan Type 4 was eliminated and premium contributions and some co-payments for those in Plan Types 2 and 3 were increased. Table 1 lists enrollee contributions for the lowest cost plan for each of the contract periods and tables 2 & 3 detail co-payments for health care services before and after they were increased (July 1, 2008).

Table 2. CommCare Co-payments by Plan Type. October 1, 2006 – June 30, 2008

Benefit	Plan Type 1	Plan Type 2	Plan Type 3	Plan Type 4
	0-100% FPL	100.1-200% FPL	200.1-300% FPL	200.1-300% FPL
			lower premiums higher co-pays	higher premiums lower co-pays
Office Visit (PCP/Specialist)	\$0	\$5/\$10	\$10/\$20	\$5/\$10
Hospital Inpatient Admission	\$0	\$50	\$250	\$50
Emergency Room (no admit)	\$3	\$50	\$75	\$50
Prescription Drugs	\$1/\$3	\$5/\$10/\$30	\$10/\$20/\$40	\$5/\$10/\$30
Outpatient Surgery	\$0	\$50	\$100	\$50
Annual Out of Pocket Max (Pharmacy)	\$200	\$250	\$500	\$250
Vision (exam + glasses every 24 mo)	\$0	\$10	\$20	\$10
Dental (preventive + restorative)	\$0	Not covered	Not covered	Not covered

⁹ The premium contributions for this cohort were dropped from \$18 per month to \$0 per month, if the enrollee selects the lowest cost plan available in his or her region.

Benefit	Plan Type 1	Plan Type 2	Plan Type 3
	0-100% FPL	100.1-200% FPL	200.1-300% FPL
Office Visit (PCP/Specialist)	\$0	\$10 / \$18	\$15 / \$22
Hospital Inpatient Admission	\$0	\$50	\$250
Emergency Room (no admit)	\$3	\$50	\$100
Prescription Drugs	\$1/\$3	\$10 / \$20 / \$40	\$12.50 / \$25 / \$50
Outpatient Surgery	\$0	\$50	\$125
Annual Out of Pocket Max (Pharmacy)	\$200	\$500	\$800
Vision (exam + glasses every 24 mo)	\$0	\$10	\$20
Dental (preventive + restorative)	\$0	Not covered	Not covered

Note: co-payments that are highlighted were modified effective 7/1/08.

MMCO Selection

After an individual's Plan Type is verified, the next step is for an individual to select an MMCO. A number of factors influence this selection. For individuals with income at or below 100% FPL who were previous users of the UCP and who were identified as eligible for enrollment in CommCare as a Plan Type 1 member, an auto conversion method facilitated the enrollment process¹⁰. These individuals were mailed an enrollment package informing them of their eligibility for the program. They then had 14 days from the date their enrollment package was mailed to select an MMCO.

If an individual did not select an MMCO within this 14-day period, he was automatically enrolled into one of the four MMCOs. If an individual had a previous relationship with one of the MMCOs available in his service area, he was enrolled in that MMCO. Otherwise, the MMCO to which the individual is assigned depends on an auto assignment method that gives preference to the lowest cost¹¹ MMCO available in his service area. While the auto conversion and auto assignment process certainly expedited the enrollment process for those who were previous users of the UCP, the majority of enrollees in the CommCare program self-select the MMCO in which they enroll. As of August 2008, among Plan Type 1 enrollees, 55% had selected an MMCO on their own, 18% were assigned to an MMCO with which they had a previous relationship, and 27% were automatically assigned to an MMCO.

¹⁰ This auto conversion process was applied to any individual who had previously used the UCP if the data currently available to MassHealth indicated the individual was eligible for CommCare as a Plan Type 1 enrollee. In July 2007, the premium contribution for individuals earning 100.1 - 150% FPL, or classified as Plan Type 2A, was eliminated. To help individuals enroll before the individual mandate deadline of December 31, 2007, an auto conversion process was utilized in October, November, and December of 2007 to enroll individuals in this income category who were previous users of the UCP.

¹¹ Since Plan Type 1 individuals do not pay a monthly premium, the "lowest cost" plan refers to the MMCO that is the lowest cost for the Commonwealth. According to the auto assignment method, a composite capitation rate is calculated based on the proposals provided by each of the MMCOs. If an MMCO has a composite capitation rate that is more than 3% lower than the bids provided by all other MMCOs, that MMCO receives all of the enrollees subject to auto assignment. If one or more bids from the MMCOs are within three percentage points of the lowest bidder, then enrollees will be auto assigned on a percentage basis to each of the MMCOs, with a majority of enrollees assigned into the MMCO with the lowest composite capitation rate. If an enrollee is auto-assigned, he is able to switch to another MMCO during the first 60 days after his initial enrollment.

The MMCO selection process is different for premium paying individuals. Premium paying enrollees select an MMCO and provide the first month's premium payment in order to become enrolled in CommCare. There is no auto assignment for these individuals. Eligible members select among MMCOs available in their region, as not all MMCOs are available in every region. The premium contribution for an individual with income between 100.1 - 150% FPL who does not select the lowest cost plan in his region is half of the cost difference between the lowest cost plan and the plan he selects¹². The premium contribution for an individual with income between 150.1 - 300% FPL who selects an MMCO that is not the lowest cost plan available is equal to the contribution for the lowest cost plan plus the full difference between the lowest cost plan and the plan the member selects.

As is typical with commercial insurance, enrollees stay in their MMCO for a year or until they have an open enrollment period to switch plans. One year after CommCare enrollment began, the Connector sponsored an open enrollment period, allowing all CommCare members to change plans. This period ran from November 1, 2007 through December 15, 2007. Plan changes requested were effective January 1, 2008 and remained in effect through at least June 30, 2008. From May 1, 2008 through June 13, 2008 the Connector hosted a second open enrollment period, again allowing members to change plans. This second open enrollment was held to allow enrollees to change plans in response to changes in premium contributions and the elimination of Plan Type 4, approved by the Board for the plan year starting July 1, 2008.

3.2 MMCO Procurement Process

Pursuant to section 123 of chapter 58 of the acts of 2006, from July 1, 2006 through June 30, 2009 the Connector may only contract with MMCOs under contract with MassHealth for the delivery of managed care services to individuals enrolled in the CommCare program. Therefore, in the summer of 2006, the Connector issued a Request for Responses (RFR) to the four MMCOs to solicit bids for the CommCare program. All four MMCOs responded to the RFR and all four were selected to participate¹³. The initial contracts with these MMCOs were effective from October 1, 2006 through December 31, 2007. (These contracts were eventually extended for six months, to June 30, 2008.)

In October 2006, the Connector launched enrollment in CommCare for eligible adults earning 100% FPL or less. As described above, the auto conversion process facilitated enrollment for individuals in this income category who were previous users of the UCP and identified as eligible for the CommCare program. Subsequently, in January of 2007, enrollment was opened to eligible individuals earning 300% FPL or less.

In early 2008, a full contract renewal process was undertaken with the four MMCOs, which was completed in the spring of 2008 for Fiscal Year (FY) 2009. At the conclusion of this contract period (i.e., June 30, 2009), the Connector will not be statutorily restricted to contract exclusively with these four MMCOs and may open up the program to other health insurers.

Exclusivity presented the Connector with a difficult negotiating situation in the summer of 2006. By setting up a competitive pricing dynamic for CommCare members who contribute toward their

¹² Within every region there is always at least one plan that requires no premium contribution for individuals in this income category.

¹³ The four MMCOs participating in the CommCare program are: Boston Medical Center Health Net, Cambridge Health Alliance's Network Health, Fallon Community Health Plan, and Neighborhood Health Plan.

premiums (originally those between 100.1% and 300% of FPL), and deciding to auto-assign non-contributing eligibles ($\leq 100\%$ FPL) who did not select a plan to the lowest bidder, the Connector succeeded in bringing price discipline to the original bidding process. As a result, the original MMCO bids came down by some 15% before being finalized, saving the program some \$50 million in its first full year. As it turned out, this was both financially prudent and fair: in aggregate, the MMCOs actually realized a small margin on their CommCare membership in the first year, even at this far reduced level of capitation.

At the end of this initial contract period, December 31, 2007, CommCare negotiated a 6-month extension of the original contracts and bid rates (with a 4% trend factor), thereby (a) extending the savings achieved in the original bid process; (b) avoiding the need for “price shopping” by enrollees facing different premiums as of January 1, 2008; (c) allowing time to accumulate a credible claims base for developing new MMCO capitation rates; and (d) synchronizing the CommCare contract year with the state’s fiscal year.

CommCare faced its most challenging re-procurement for FY09. This would be the last year of exclusive reliance on the original four MMCOs, as required by chapter 58, so the incentives for competitive bidding were weak. In fact, the Connector went through protracted negotiations with the four MMCOs, and increased co-payments and enrollee contributions in order to bring the aggregate increase in MMCO capitation rates (FY08 to FY09) down by six percentage points, from an aggregate trend of 15.4% to 9.4%. One lesson learned is the need for a more controlled MMCO procurement process going forward.

3.3 Program Integrity

The Connector has instituted a variety of practices in its efforts to ensure the integrity of the CommCare program. The objective of these activities is to validate that the CommCare program is satisfying the customer service needs of enrollees, serving the intended target population, and minimizing crowd-out (i.e., the substitution of publicly subsidized coverage in cases where private insurance is available).

Beginning in late 2007, the Connector initiated annual eligibility re-determinations. Under this process, information that impacts a member’s eligibility is updated (e.g., income, household size, the availability of other health insurance, etc.). In addition to annual re-determinations, eligibility checks are triggered at any time during the year by a change in member circumstances. This process is critical to ensure that the program is meeting state and federal requirements, and to ensure that individuals are enrolled in the most appropriate health insurance program for their circumstances.

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

In an effort to minimize crowd-out, the eligibility process for CommCare requires individuals to indicate if they currently have ESI or had access to ESI in the last six months. If an individual provides a

positive response to this question, or provides information that suggests this possibility, the Connector follows up directly with the applicant to obtain additional information to verify if ESI is available, and if so, if there is an exception under which they might still be eligible for CommCare. Specifically, the health reform law states that if ESI is offered, and the employer covers at least 20% of the annual premium cost for a family insurance plan or at least 33% of the cost for an individual insurance plan, then the applicant is not eligible for CommCare.

The Connector recently contracted with Health Management Systems (HMS) for further assistance with program integrity. HMS performs data matching to determine if an individual enrolled in CommCare is currently enrolled in alternative commercial insurance or has access to ESI. HMS then verifies the policy information (premium levels, effective dates, coverage types, etc.) to determine whether the applicant/member is still eligible for CommCare. Based on this review, the Connector will then make a determination as to the applicant/member's (continued) eligibility for CommCare.

Finally, during the summer of 2008, the Connector issued a Request for Proposals (RFP) to solicit bids for an operational audit of the CommCare MMCOs. Specifically, the RFP requested that respondents complete the following activities for the Connector: an audit of claims adjudication, payment accuracy and reporting; an assessment of the adequacy and competitiveness of the provider networks; and an evaluation of the effectiveness of care management programs and other operational and administrative activities provided by the MMCOs. The Connector contracted with Navigant to conduct this audit, the results of which will be used by the Connector to guide future discussions with the MMCOs and by the MMCOs to improve their care management programs and administrative practices.

3.4 Enrollment

In August 2008 there were approximately 173,000 adults enrolled in the CommCare program. Enrollment in CommCare began in October 2006 and steadily increased through October 2007. It spiked in November and December 2007, with a spurt of promotion and the advent of tax penalties for not being covered. In March 2008, the impact of the re-determination process (begun at the end of 2007) resulted in essentially flat (even slightly declining) enrollment for the first time since the program's inception. Nonetheless, enrollment still exceeds initial projections.

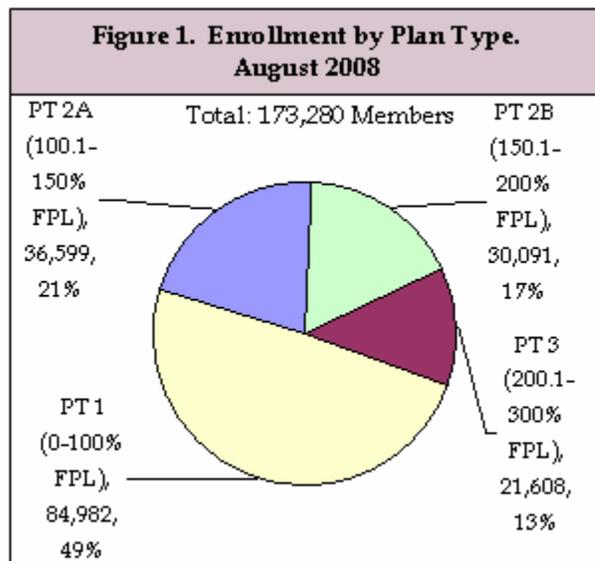
While CommCare enrollment climbed quickly and significantly throughout 2007, including a surge at year end, it has leveled off since early 2008. Preliminary analysis of this recent trend suggests that it is due to two main elements of the program. First and foremost, as CommCare membership increased, the absolute number of members who leave the program due to a "change in status"¹⁴ has increased, even though the rate or percentage of members leaving the program has remained relatively constant. For example, in June 2008 there were 4.7 percent of CommCare members who had their cases closed due to a change in status, a rate that was less than one percentage point higher than the June 2007 closure rate of 3.9 percent. However, because the membership base upon which the two closure rates are calculated had grown so significantly -- from 79,800 in June 2007 to 175,617 in June 2008 -- the actual number of closures due to a change in status rose from 2,672 in June 2007 to 8,323 in June 2008. During these same two months, gross additions to the CommCare program were comparable, with 13,144 members added to the rolls in June 2007 compared with 15,162 in June 2008.

The second main reason for the leveling off of enrollment in the CommCare program relates to the Connector initiating a formal process of re-determining eligibility for existing enrollees, which started

¹⁴ A "change in status" includes, for example, a member's income level changing, a member gaining access to employer-sponsored insurance or other subsidized insurance (e.g., MassHealth, Medicare, TriCare), and a change in the member's family status (e.g., married, divorced, children leaving the household, etc.).

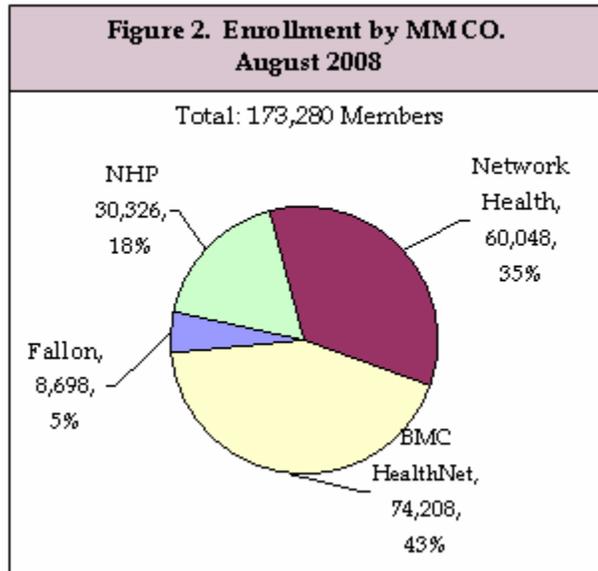
in November 2007, one year after coverage began. Like MassHealth’s eligibility re-determination process, CommCare re-determines eligibility for all enrollees who remain in the program at the member’s annual anniversary date of their enrollment. Because of lag times in communications, appeals, etc., the results of last November’s re-determination process first started to affect the caseload in March 2008. Since March 2008, these re-determination-related dis-enrollments have been running at about 5,000 per month (on top of the 8,000 to 10,000 monthly change in status closures noted above). As a result, total dis-enrollments of roughly 15,000 members per month have approximated gross additions to the program, resulting in virtually flat membership in CommCare since March 2008. Because many of those who were re-determined in the first nine months of this process had previously been in the UCP and had not been re-determined before joining CommCare, the rate of re-determination-related closures may soon begin to decline, at which point CommCare membership is likely to begin to grow again.

Not surprisingly, enrollment in Plan Type 1 is higher than all other plan types. This is likely due to both the auto conversion process and the fact that there is no monthly premium for members in this income category. In July 2007, the premium contribution for individuals eligible for Plan Type 2A (those with incomes of 100.1 - 150% FPL) was eliminated. This change and the imposition of the individual mandate that same month resulted in increased enrollment for individuals in this income category. The auto conversion process utilized in October through December 2007 for eligible but un-enrolled individuals with incomes between 100.1 - 150% FPL (Plan Type 2As) also contributed to the increased enrollment. In addition, the individual mandate prompted an increase in enrollment in Plan Types 2, 3 and 4 as well. As of August 2008, there are approximately 85,000 members in Plan Type 1 (49% of all CommCare enrollees), 37,000 members in Plan Type 2A (21% of all CommCare enrollees), 31,000 members in Plan Type 2B (17% of all CommCare enrollees) and 22,000 members in Plan Type 3 (13% of all CommCare enrollees) (see Figure 1 below). Collectively, premium paying members represent about 35% of enrollees, up from 20% in August 2007.

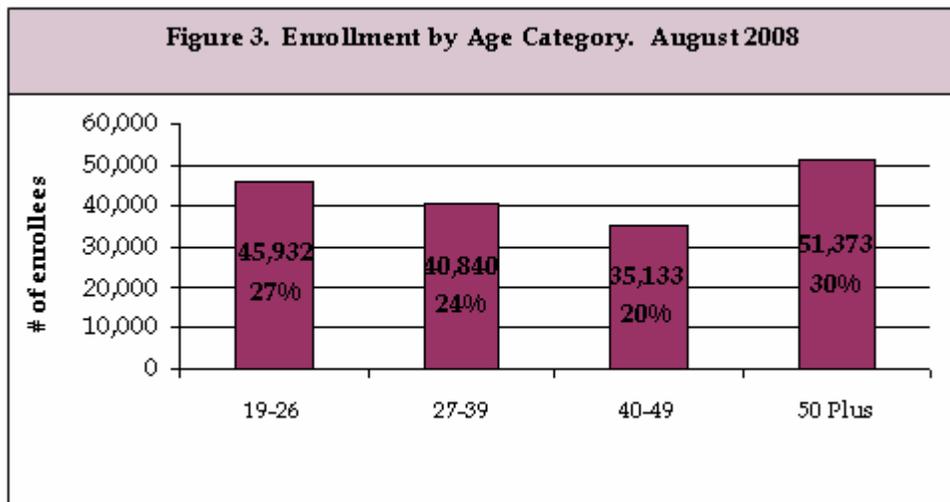


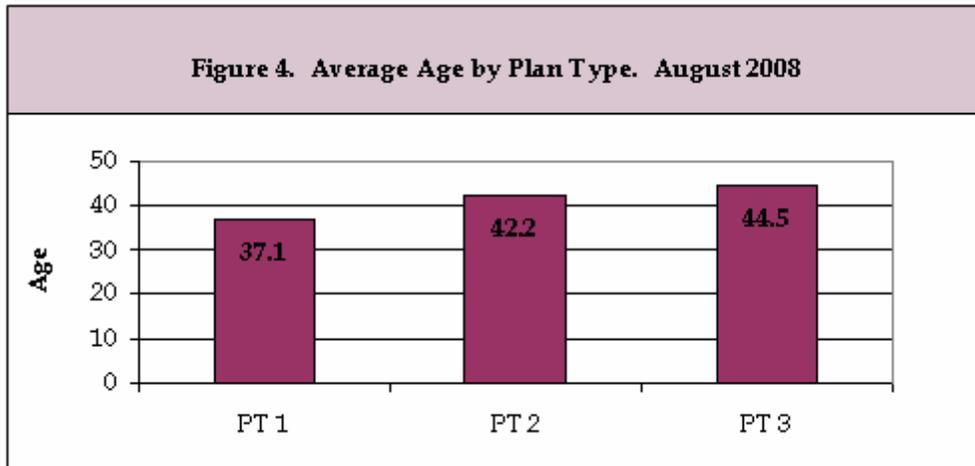
As described in the section addressing MMCO selection, there are a number of factors including the auto assignment process, region of residence, and personal preference that can impact enrollment in each MMCO. These are important to consider when analyzing enrollment trends, as there is considerable variation in enrollment by MMCO. As of August 2008, Boston Medical Center (BMC) HealthNet and Cambridge Health Alliance’s Network Health enroll the largest percentage of members; 74,208 enrollees (43% of all CommCare members) are members of HealthNet, while 60,048 enrollees (35% of all CommCare members) are members of Network Health. Neighborhood Health Plan (NHP) has enrolled

30,326 members (18% of all CommCare members), while Fallon Community Health Plan (FCHP) has enrolled 8,698 members (5% of all CommCare members) (see Figure 2 below). There are two main reasons for the high enrollment in BMC HealthNet and Network Health: geography (i.e., they are available in the greatest number of regions) and cost (i.e., they were generally the lowest cost MMCOs for Plan Type 1 and Plan Type 2A and therefore received a higher percentage of those members subject to the auto-assignment process).



As is evident in Figure 3, individuals in the youngest and oldest age cohorts represent the greatest proportion of total enrollment. As of August 2008, the average (mean) age of CommCare enrollees was 40.0 years old, up from 39.1 in September 2007 and 36.7 in December 2006. This reflects the gradual growth in enrollment among members in Plan Types 2 and 3, since the average age of CommCare enrollees increases with income level and, consequently, member premium cost (see Figure 4 below). The correlations probably reflect two underlying dynamics: (1) age and income tend to be related, and (2) older people have more medical needs, value coverage more, and therefore are more likely to contribute to buying it.



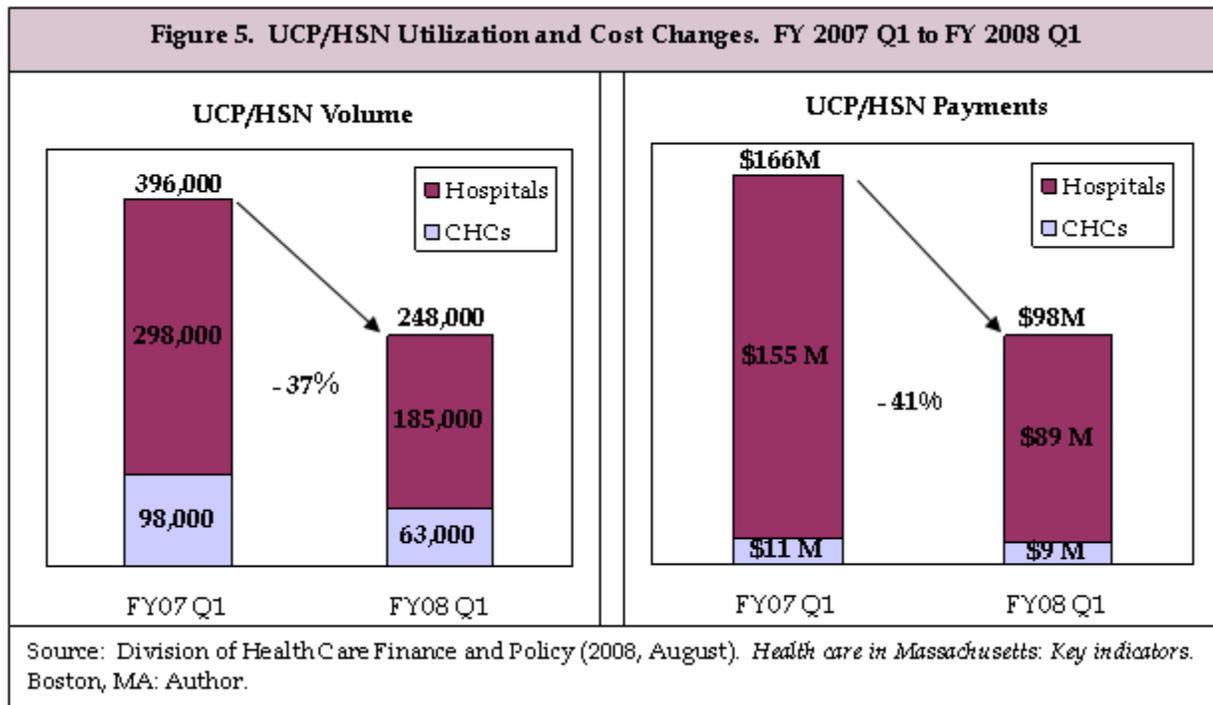


3.5 Decreased Utilization of the UCP/HSN

Formerly known as the UCP and now referred to as the HSN, this state subsidy program finances emergency, inpatient acute, and other selected medical services for residents with income at or below 400% FPL who do not qualify for other coverage or cannot afford CommCare. One of the fundamental purposes of health reform was to minimize the number of individuals accessing health care through the UCP/HSN by transferring those who had previously accessed health care through the UCP into new insurance programs. The health benefits provided to CommCare members are much more comprehensive than the episodic acute care that was generally provided through the UCP/HSN. As of July 2008, nearly 70% of CommCare enrollees had been either UCP eligible or had used the UCP at some point in 2004 – 2007.

DHCFP monitors and reports on utilization and costs associated with the UCP/HSN. Comparing the costs and utilization of the UCP/HSN from the first quarter of Pool Fiscal Year (PFY) 2008 to first quarter of PFY07 indicates that utilization of the UCP/HSN has declined rapidly¹⁵. As the figure below shows, in the first quarter of PFY08 (i.e., October 1, 2007 – December 31, 2007), the volume of UCP/HSN services dropped 37 percent, while UCP/HSN payments to community health centers (CHCs) and hospitals plunged 41 percent, generating a savings to the state and federal governments of \$68 million in the first quarter alone. These data provide striking evidence of health reform’s success in transitioning individuals from the UCP/HSN to health insurance programs.

¹⁵ The Pool Fiscal Year (PFY) runs from 10/1 through 9/30 of the following year. For example, PFY07 ran from 10/1/06 through 9/30/07.



3.6 CommCare Waivers and Appeals¹⁶

As statutorily required, the Connector has developed a fully operational waivers and appeals unit¹⁷. As explained in *Administrative Bulletin 01-07: Notice Regarding Commonwealth Care Procedures*¹⁸, an enrollee in CommCare may make any one of the following three requests or appeals:

- request a waiver or reduction of premiums or a waiver of co-payments due to extreme financial hardship¹⁹;
- request a change of health plans during the plan year (i.e., at a time other than open enrollment); or
- file an appeal to challenge decisions related to CommCare²⁰.

¹⁶ This section addresses waivers and appeals related to the Commonwealth Care program, specifically. A later section of the report, Section 6.5, addresses appeals related to the individual mandate.

¹⁷ M.G.L. c. 176Q § 3.

¹⁸ The Bulletin is available online at, <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Regulations/documents/Admin%2520Bulletin%252001-07.pdf>

¹⁹ The circumstances defining what constitutes a “hardship” are detailed in 956 CMR 3.11(5). This is available online at, <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/Current/Connector%2520board%2520meeting%2520June%252005%2520C%25202007/956%2520CMR%25203.00%2520Final%2520060507.pdf>

The specific details about the rules and procedures governing the process for filing requests and appeals are explained in 956 CMR 3.11(5)(a). Since issuing *Administrative Bulletin 01-07* on May 31st, 2007, the Connector has been reviewing and tracking requests and appeals and has adopted a robust and generous review process.

From June 1, 2007 through August 1, 2008, among the over 200,000 individuals who have been enrolled in CommCare at some point during this time period, fewer than 800 have submitted waiver requests for a co-pay or premium reduction. Among those who have filed requests with the Connector Review and Appeals Unit, the majority have been approved. Among those that have been denied, the majority were denied because the enrollee failed to provide appropriate documentation or evidence of a hardship.

During this same time period, about 500 health plan change requests have been filed. The majority have been approved. In most cases, the change was requested because the individual was subject to the auto assignment process and wished to change MMCOs at a time other than open enrollment.

Finally, there have been approximately 1,600 appeals submitted to the Connector from June 1, 2007 through August 1, 2008. In most cases, individuals appealed the determination that they were ineligible for the program based on the availability of ESI. These individuals were sent a letter from MassHealth (which conducts eligibility determinations for the Connector), requesting additional information about the ESI available to them. Based on the information provided to MassHealth, in most cases it was determined that the individual was not able to acquire health insurance through their employer and was therefore eligible for CommCare or other subsidized insurance. As a result, almost all of the appeals filed were “dismissed” because they were resolved prior to a formal review by the Connector’s appeals unit.

Table 4 summarizes the number, type, and outcomes of requests and appeals related to CommCare that have been submitted to the Connector as of August 1, 2008.

²⁰ It is important to note that the Connector does not hear any appeals related to eligibility determinations. All eligibility determinations are handled by MassHealth. Therefore, any appeals of this nature are handled by the MassHealth Appeals Unit. Enrollee appeal rights are detailed in full in 956 CMR 3.14 and 956 CMR 3.17. Some examples of decisions that an enrollee may file an appeal to challenge include: the Connector’s termination of an enrollee for failure to pay enrollee premium contributions, the Connector’s denial of a financial hardship waiver or renewal of a financial hardship waiver, dis-enrollments of enrollees based upon the discretion of the Connector, among others.

Table 4. CommCare Waivers and Appeals. June 1, 2007 - August 1, 2008			
	Waiver Requests (for premium or co-pay reduction)	Health Plan Change Requests ^[1] (i.e. requests to change MMCOs off-cycle)	Appeals
Total:	<ul style="list-style-type: none"> ● 745 waiver requests 	<ul style="list-style-type: none"> ● 508 health plan change requests 	<ul style="list-style-type: none"> ● 1605 appeals
Action:	Of the 745 waiver requests: <ul style="list-style-type: none"> ● 413 were approved ● 247 were denied ● 10 were dismissed^[2] ● remainder are pending 	Of the 508 health plan change requests: <ul style="list-style-type: none"> ● 284 were approved ● 211 were denied ● 13 were dismissed^[3] 	Of the 1605 appeals: <ul style="list-style-type: none"> ● 10 were approved ● 14 were denied ● 1128 were dismissed^[4] ● remainder are pending
<p>1. The number of health plan change requests that the Appeals Unit handles is only a portion of the total number of changes between MMCOs. This is because the majority of requests to change to a new MMCO are granted by the Customer Service Center, without sending the request to the appeals unit.</p> <p>2. The majority of "waiver request" dismissals are because the person no longer is in a premium-paying health plan.</p> <p>3. The majority of "health plan change request" dismissals are because the person has already changed MMCOs.</p> <p>4. The majority of appeals dismissals are because the person has become eligible for state subsidized insurance pending an appeal. Thus, the appeal was "dismissed" because it was resolved prior to a formal review by the Connector's appeals unit.</p>			

3.7 Claims Experience

The Connector included several innovative provisions in its contracts with the MMCOs in order to account for the uncertainty surrounding actual claims experience of CommCare enrollees. The initial contracts negotiated with the MMCOs included an aggregate risk-sharing program for all Plan Types. Based on this provision, the Connector will share half of an MMCO's costs if actual medical expenditures are more than 5% above total capitation payments to the MMCO. Conversely, actual medical expenditures between 50-95% of an MMCO's total capitation revenue require the MMCO to share the savings with the Commonwealth. This provision of the contract enabled the Connector to control program costs without exposing the state or the participating MMCOs to severe financial risk. In addition to the aggregate risk sharing arrangement, the Connector also included a specific stop loss element. Under this arrangement, each MMCO pays 1.25% of the monthly capitation payment to the Connector for the stop-loss pool. If the costs for a specific enrollee exceed \$150,000, the rest of the cost is covered by the stop-loss pool.

Despite some initial concerns by the MMCOs that the capitation rates were not sufficient to cover the program's costs, two of the four MMCOs total claims costs were positive (i.e., total claims costs were less than total capitation payments), and three out of four were within five percent of capitation revenue (see Table 5 below). Overall, MMCO margins on medical capitation for the first full year of the program (ending December 31, 2007) were just over two percent. Risk-sharing between the Connector and the MMCOs allowed the Connector to reduce capitation rates while providing a measure of security to both the MMCOs and the Connector. Ultimately, the risk-sharing cost the Connector very little and will bring a modicum of relief to the one MMCO, FCHP, which did experience losses beyond the risk sharing

threshold. (However, with relatively small CommCare membership, FCHP's total loss after risk sharing was less than one million dollars.)

Table 5. Preliminary Risk Sharing Settlement, Contract Year 2007. October 1, 2006 - December 31, 2007

Source: MMCO Provided Financial Statements Submitted May 30, 2008^[1]

	Boston Medical Center HealthNet		Cambridge Network Health		Neighborhood Health Plan		Fallon Community Health Plan		Total	
Member Months	448,368		441,898		178,369		27,297		1,095,932	
Physician	23,218,809	17%	26,202,046	20%	13,851,138	22%	2,252,121	20%	65,524,113	19%
Behavioral Health	10,516,058	8%	9,299,326	7%	4,356,506	7%	477,496	4%	24,649,386	7%
Inpatient	24,498,071	18%	25,465,187	20%	12,938,072	20%	2,459,782	22%	65,361,112	19%
ER	11,117,404	8%	11,512,839	9%	5,525,547	9%	409,709	4%	28,565,499	8%
Other Outpatient Facility	22,089,189	17%	17,699,796	14%	2,959,030	5%	1,509,347	13%	44,257,362	13%
Prescription Drug	20,676,647	16%	17,066,717	13%	9,852,770	16%	1,308,316	12%	48,904,450	15%
Other Medical	20,817,161	16%	22,464,265	17%	13,659,126	22%	2,901,735	26%	59,842,287	18%
Total Medical (Without IBNR)	132,933,339		129,710,177		63,142,189		11,318,505		337,104,210	
IBNR ^[2]	890,653		869,058		423,053		75,834		2,258,598	
Total Medical (With IBNR)	133,823,992		130,579,235		63,565,242		11,394,339		339,362,808	
Recoveries from Stop Loss Pool	(544,981)		(1,708,843)		(1,033,510)		(588,437)		(3,875,771)	
Adjusted Total Medical Expenditures	133,279,012		128,870,392		62,531,732		10,805,902		335,487,037	
Capitation Revenue	154,322,711		148,818,192		68,753,293		10,875,555		382,769,752	
Stop Loss Contribution	(1,936,686)		(1,864,871)		(864,684)		(136,358)		(4,802,598)	
Distribution of the Stop Loss Pool										
Surplus/(Deficit)	373,750		359,891		166,871		26,315		926,827	
Capitation Revenue Net of Stop Loss Pool	152,759,776		147,313,213		68,055,480		10,765,512		378,893,981	
Administrative Fee ^[3]	(15,692,880)		(15,466,430)		(6,242,915)		(955,395)		(38,357,620)	
Total Medical Capitation Revenue	137,066,896		131,846,783		61,812,565		9,810,117		340,536,361	
Est. Profit/(Loss) Before Risk Share	3,787,884		2,976,391		(719,167)		(995,784)		5,049,324	
Est. Aggregate Risk Share ^[4]	-		-		-		252,639		252,639	
Profit/(Loss) After Risk Share	3,787,884		2,976,391		(719,167)		(743,145)		5,301,963	
	3%		2%		-1%		-8%		2%	

Notes:

1. Claims incurred through Dec. 31, 2007 and paid through June 30, 2008.
2. IBNR refers to claims incurred during the contract period but not reported by the report submission date.
3. Administrative fee for risk sharing held to \$35.00 per CY2007 Commonwealth Care contracts.
4. Connector shares 50% of risk for medical costs above/below 5% of medical portion of capitation rate.

As the table below illustrates, preliminary claims data provided by the MMCOs show significant variation in costs per member per month (PMPM). These data have not been adjusted for the relative age, health conditions, and service needs of members within each of the four MMCOs. This process, known as case mix adjustment or risk adjustment, is critical to thoroughly understanding health care utilization patterns of the CommCare populations covered by each MMCO; when completed, it will provide insight into the cost, service utilization and profitability variations from one MMCO to the next. Nonetheless, it is interesting to note that the total PMPM costs are almost identical for BMC HealthNet and Cambridge Network Health, the two MMCOs with the greatest number of members.

Table 6. Estimated Per Member Per Month Profit/(Loss) For Risk Share Settlement, Contract Year 2007. October 1, 2006 - December 31, 2007										
Source: MMCO Provided Financial Statements Submitted May 30, 2008 ^[1]										
	Boston Medical Center HealthNet		Cambridge Network Health		Neighborhood Health Plan		Fallon Community Health Plan		Total	
Member Months	448,368		441,898		178,369		27,297		1,095,932	
Physician	51.79	17%	59.29	20%	77.65	22%	82.50	20%	59.79	19%
Behavioral Health	23.45	8%	21.04	7%	24.42	7%	17.49	4%	22.49	7%
Inpatient	54.64	18%	57.63	20%	72.54	20%	90.11	22%	59.64	19%
ER	24.80	8%	26.05	9%	30.98	9%	15.01	4%	26.07	8%
Other Outpatient Facility	49.27	17%	40.05	14%	16.59	5%	55.29	13%	40.38	13%
Prescription Drug	46.12	16%	38.62	13%	55.24	16%	47.93	12%	44.62	15%
Other Medical	46.43	16%	50.84	17%	76.58	22%	106.30	26%	54.60	18%
Total Medical (Without IBNR)	296.48		293.53		354.00		414.64		307.60	
IBNR ^[2]	1.99		1.97		2.37		2.78		2.06	
Total Medical (With IBNR)	298.47		295.50		356.37		417.42		309.66	
Recoveries from Stop Loss Pool	(1.22)		(3.87)		(5.79)		(21.56)		(3.54)	
Adjusted Total Medical Expenditures	297.25		291.63		350.58		395.86		306.12	
Capitation Revenue	344.19		336.77		385.46		398.42		349.26	
Stop Loss Contribution	(4.32)		(4.22)		(4.85)		(5.00)		(4.38)	
Distribution of the Stop Loss Pool Surplus/(Deficit)	0.83		0.81		0.94		0.96		0.85	
Capitation Revenue Net of Stop Loss Pool	340.70		333.36		381.54		394.38		345.73	
Administrative Fee ^[3]	(35.00)		(35.00)		(35.00)		(35.00)		(35.00)	
Total Medical Capitation Revenue	305.70		298.36		346.54		359.38		310.73	
Est. Profit/(Loss) Before Risk Share	8.45		6.74		(4.03)		(36.48)		4.61	
Est. Aggregate Risk Share ^[4]	-		-		-		9.26		0.23	
Profit/(Loss) After Risk Share	8.45	3%	6.74	2%	(4.03)	-1%	(27.22)	-8%	4.84	2%

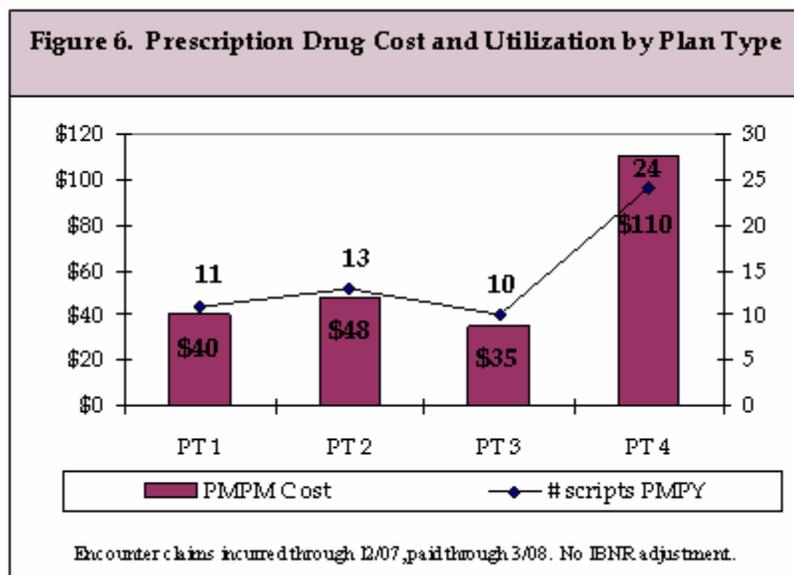
Notes:

1. Claims incurred through Dec. 31, 2007 and paid through June 30, 2008.
2. IBNR refers to claims incurred during the contract period but not reported by the report submission date.
3. Administrative fee for risk sharing held to \$35.00 per CY2007 Commonwealth Care contracts.
4. Connector shares 50% of risk for medical costs above/below 5% of medical portion of capitation rate.

Preliminary claims data indicate considerable variation in PMPM cost and utilization by Plan Type, which is best exemplified by the fact that PMPM costs for Plan Type 4 members (\$646 PMPM) were more than double those of members in Plan Type 1 (\$289 PMPM) and Plan Type 3 (\$273 PMPM), and nearly double that of Plan Type 2 members (\$324 PMPM). Greater utilization of prescription drugs and a higher number of inpatient hospital admission days per member per year (PMPY) were the major contributors to the higher PMPM costs associated with Plan Type 4 enrollees. It is worth noting, however, that when CommCare was initially launched, enrollees with income between 200.1 – 300% FPL were eligible for both Plan Type 3 and Plan Type 4 and could select which Plan Type they preferred. As described in section 3.1, Plan Type 3 was structured to allow members' lower premium contributions with higher co-payments at the point-of-service, while Plan Type 4 required higher premium

contributions with lower co-payments at the point-of-service. This option resulted in adverse risk selection as Plan Type 4 attracted older and presumably sicker individuals, driving up costs for this Plan Type.

For example, Plan Type 4 enrollees used approximately 24 prescriptions PMPY, while the number of prescription drugs used by Plan Type 1, 2, and 3 members was roughly half that at 11, 13, and ten prescriptions PMPY, respectively (see Figure 6 below). In addition, while Plan Type 1 members average 174 inpatient hospital days per 1,000 members per year and Plan Type 3 members average 172 inpatient days per 1,000 members per year, inpatient hospitalization days for Plan Type 4 members are two times this rate at 348 inpatient days per 1,000 members per year. The Plan Type 4 rate of inpatient hospitalization days per 1,000 members per year is also more than one and a half times that of Plan Type 2 (at 217 inpatient days per 1,000 members per year).

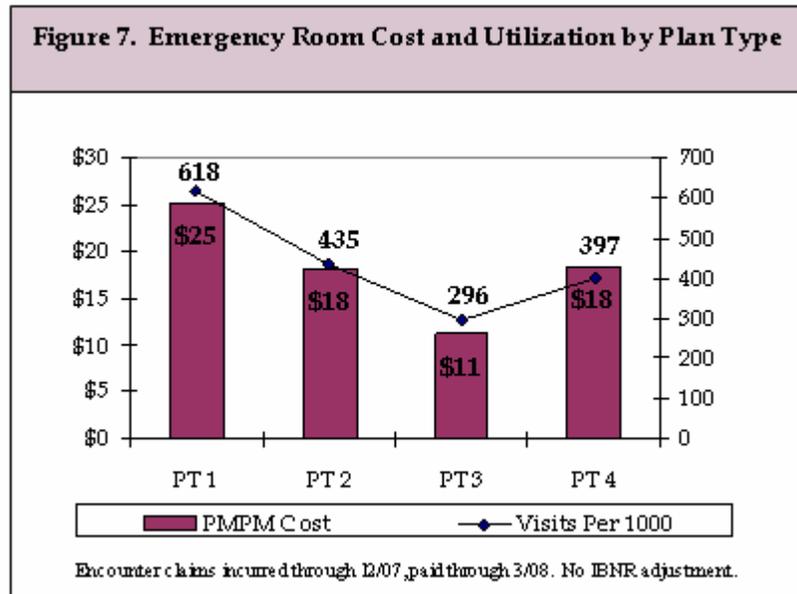


While prescription drug and inpatient costs for Plan Type 1 members were comparable to Plan Types 2 and 3, emergency room (ER) use among Plan Type 1 members was significantly higher than all other Plan Types. From October 1, 2006 through December 31, 2007, the ER costs for Plan Type 1 enrollees was \$25 PMPM compared to \$18 PMPM for Plan Type 2 and Plan Type 4, and \$11 PMPM for Plan Type 3 (see Figure 7 below). There are three likely reasons for the relatively high ER costs associated with Plan Type 1 enrollees. First, many Plan Type 1 members were previously users of the UCP/HSN and the ER may have been the typical access point when health care services were needed. Therefore, some Plan Type 1 members may be in the habit of using the ER for non-emergent health care needs. Second, Plan Type 1 members have no or a very low co-payment for utilization of ER services²¹, while members in Plan Types 2, 3, and 4 have co-payments ranging from \$50 to \$100, if they seek non-emergency care at the ER.²² Third, Plan Type 1 enrollees also had considerably higher costs due to hospital stays for mental health and substance abuse. From October 1, 2006 through December 31, 2007, inpatient mental health and substance abuse services cost \$22 PMPM for Plan Type 1 enrollees versus \$14

²¹ The benefit design and cost-sharing schedule for Plan Type 1 members is statutorily tied to that of MassHealth enrollees in the same income bracket (0 - 100% FPL). There is no co-payment for an emergency condition, and a \$3 co-payment for a non-emergency condition.

²² The co-payment is waived if the member is subsequently admitted to the hospital.

for Plan Type 2 enrollees, \$11 for Plan Type 3 enrollees, and \$17 for Plan Type 4 enrollees. A higher prevalence of MH/SA conditions among Plan Type 1 enrollees may also contribute to higher ER use.



As mentioned above, the Connector will be conducting case-mix analyses of the CommCare population and part of the MMCO audit will include an analysis of claims filings by the MMCOs. Together, the information from these projects will help the Connector to better understand the health care utilization patterns and health care status of the CommCare population. Ultimately, the Connector will share this information with the MMCOs and work to improve care management programs and help members access care at the most appropriate setting.

3.8 CommCare Budget

Establishing budget projections for a new health insurance program was particularly challenging due to a number of variables that have a direct impact on the cost of the program, most notably the total number of enrollees that would sign up once the program started, the demographic mix of those enrollees (i.e., age and sex of CommCare members) and the pace of that enrollment (i.e., how quickly people would sign up for insurance). For example, actual enrollment levels have an obviously large impact on program costs, but developing an accurate prediction of enrollment has been difficult given the wide range of estimates of the uninsured in Massachusetts, ranging from fewer than 400,000 to more than 650,000. In recent months, the re-determination process has also made it difficult to predict enrollment.

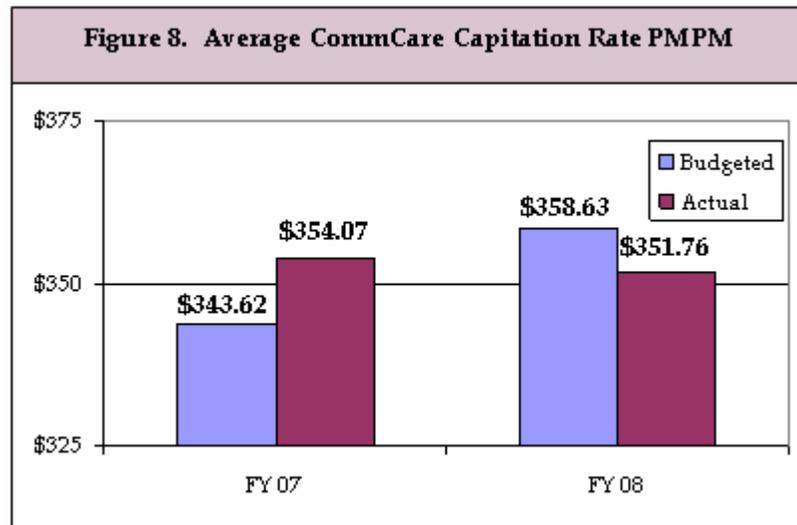
In addition to the number of enrollees and the pace of enrollment, the claims experience of enrollees and their demographic mix also influenced program costs. Lack of experience with the population eligible for CommCare made it difficult to determine health care utilization patterns and made it challenging to establish an appropriate capitation rate. Even after developing a base capitation rate, the Connector still faced the uncertainty of what the characteristics would be of those who enrolled in CommCare. The actual capitation rate paid to each MMCO per enrollee varies based on the age, gender, and residence of the member, as well as the Plan Type. As described in section 3.7 Claims Experience, to account for this uncertainty, the Connector used a number of innovative provisions designed to provide both the Commonwealth and the MMCOs with some financial protection.

For FY08, the CommCare program is expected to cost \$627.7 M, about \$155.7 M above initially budgeted amounts (see Table 7 below). This variance is due entirely to higher than anticipated enrollment, suggesting the number of the uninsured in Massachusetts was likely nearer to the higher range of the initial estimates. The pace of enrollment was also considerably faster than expected, due in large measure to aggressive outreach efforts, leading to higher than projected program costs.

Table 7. Commonwealth Care Expenditures for SFY 2008			
SFY 2008 Budget and Actuals	SFY08 (Budget)	SFY08 (Actual)	SFY08 (Var)
Year End Membership	147,774	175,617	27,843
Member Months	1,327,267	1,779,967	452,700
Capitation Rate	\$358.64	\$351.76	(\$6.88)
Total Spending ^[1]	\$463,937,546	\$627,406,104	\$163,468,558
Aggregate Risk Share ^[2]	\$8,000,000	\$252,639	(\$7,747,361)
Total Spending Including Risk Sharing	\$471,937,546	\$627,658,743	\$155,721,197

1. Total spending is net of administrative costs and enrollee contribution collections.
 2. Risk share figure for FY08 Actual is CCA best estimate pending final settlement.

As shown in Figure 8 below, the average PMPM capitation rate paid to the MMCOs for CommCare enrollees actually declined from FY07 to FY08, due to a larger than expected proportion of younger people enrolling in the program. The Connector is still in the process of “settling” with the MMCOs for the full FY08 and lacks the fully “matured” claims data necessary to know how the MMCOs fared financially in the last six months of FY08 (since December 31, 2007). This settlement process will be completed by December 2008.



4.0 Commonwealth Choice

4.1 Program Description

Pursuant to section two of chapter 176Q of the Massachusetts General Laws, the Connector is to facilitate the availability, choice, and purchase of health insurance products for eligible individuals and small groups. CommChoice is the program the Connector established in response to this legislative charge.

In December 2006, the Connector issued an RFR to solicit responses from locally governed and incorporated agencies with experience in the health insurance industry for the purpose of serving as a sub-Connector²³. In February 2007, Connector staff recommended and the Board approved a contract with the Small Business Service Bureau (SBSB). Similar to Maximus's role with respect to the CommCare program, SBSB is primarily responsible for administrative functions associated with the CommChoice program. More specifically, SBSB provides eligibility and enrollment assistance; customer support services; and premium billing, collection and remittance services for CommChoice. In addition, SBSB provides Section 125 support to employers and works with brokers selling insurance through the CommChoice program.

Bid process and plan benefits

The Connector issued an RFR in December 2006 to insurers interested in offering health insurance plans through the Connector. The bid specifications requested proposals that included a collection of benefit plans with premiums and co-payment structures that aligned with the plan requirements and actuarial value ranges requested by the Connector. Respondents were also invited to develop and submit products designed specifically for the young adult population, those ages 19-26²⁴.

In January 2007, the Connector received responses from ten insurance carriers. Connector staff reviewed the submissions and recommended that the Board approve contracts with six carriers. These carriers are: Blue Cross Blue Shield of Massachusetts (BCBS-MA), Fallon Community Health Plan (FCHP), Harvard Pilgrim Health Care (HPHC), Health New England (HNE), Neighborhood Health Plan (NHP), and Tufts Health Plan (Tufts). The Board awarded the Connector Seal of Approval (SOA) to seven plans offered by each of these carriers. The SOA confirms that these health benefit plans offer consumers good quality and value. To help consumers navigate the various insurance options available for purchase through the Connector, the products were grouped into four levels: Gold, Silver, Bronze, and Young Adult Plans (YAPs). The first three levels are based on the actuarial value of the plans; the fourth level, representing a somewhat slimmer benefit level, is available only to young adults, ages 18-26. Below, Table 8 illustrates the range in monthly premium rates for each of these plan levels as of August 2008.

²³ M.G.L. c. 176Q, § 1.

²⁴ Chapter 205 § 40 of the Acts of 2007, "An Act Further Regulating Health Care Access," which was approved by the Massachusetts General Court on November 20, 2007 and signed by the Governor on November 29, 2007, expanded eligibility for Young Adults Plans to age 18, down from the original limit of 19 years of age. Individuals ages 18 to 26 without access to ESI are now eligible to purchase Young Adults Plans through the Connector.

Table 8. Commonwealth Choice Monthly Premium Ranges by Plan Level. August 2008	
	August 2008 Monthly Premium Range*
Gold	\$337 - \$551
Silver	\$269 - \$415
Bronze	\$193 - \$287
Young Adult Plan (with Rx)	\$158 - \$196
Young Adult Plan (without Rx)	\$133 - \$176
*The premium range reflected here represents the range in monthly premium costs among those plans available to a single 35-year-old living in the Boston area. For Young Adult Plans, the premium range represents the range in monthly premium rates among those plans available to a single 25-year-old living in the Boston area. Rates are rounded to the nearest whole dollar.	

Plan levels and cost-sharing

Though 42 different plans were made available for purchase through the Connector, not all plans were available in all regions. Only two of the six insurers have service areas that cover the entire state (BCBS-MA and HPHC). The plans available through CommChoice offer consumers a wide variety of plan designs and features. For example, some plans offer a large network while others offer a tiered or select network of doctors and hospitals; some plans provide first dollar coverage for health services subject to a co-payment or co-insurance, while others include an up-front deductible; and a few plans include a separate deductible applied to prescription drugs. This variation in plan options was designed to provide consumers (and eventually employers and employees) meaningful choice in selecting a health insurance plan with a premium cost and plan design that best meets their individual needs and preferences.

4.2 Program Launch

Focus groups

During winter 2007, prior to the launch of the CommChoice program, the Connector conducted a series of focus groups to help identify consumer preferences among the target population of the CommChoice program. The Connector sponsored 12 focus groups in three locations across the state with approximately 120 participants. Attendees were from diverse backgrounds, but particular emphasis was placed on ensuring representation of the uninsured, young adults, and small business owners. Focus group participants emphasized the importance of keeping the shopping experience and enrollment process simple. In addition, attendees indicated their preference to have choice among an array of health plans, suggesting an ideal arrangement would be the ability to choose among three to four plan designs offered by four to six carriers. As noted above, the range of options available through CommChoice reflects the preferences of the focus group participants.

Consistent with the timeline specified in the authorizing legislation, by May 2007, individuals (non-group purchasers) were able to shop for health insurance products from the Connector. Consumers were able to acquire plan information and shop for insurance online at www.MAhealthconnector.org, or they could contact the call center, 1.877.MA.ENROLL. Coverage took effect starting on July 1, 2007.

In September 2007, the Connector began offering a Voluntary (non-contributory) insurance program. This program enables employees without access to ESI to purchase a CommChoice health insurance plan with pre-tax dollars. Under this arrangement, the employer does not contribute to the purchase of health insurance, but does create a "Section 125 plan" for part-time, contract, or other

employees not eligible for ESI²⁵. Eligible employees can then use a Section 125 plan to purchase a health insurance plan of their choice through the CommChoice program.

In December 2007, the Connector began a renewal process for those health insurance products awarded the Connector SOA. The primary objectives of the renewal specifications were to: promote cost-effective, affordable health insurance options for Commonwealth residents and businesses; simplify and improve consumer choice and member experience; and provide program stability and continuity of coverage for thousands of CommChoice enrollees.

The renewal specifications issued by the Connector explicitly acknowledged the importance of cost control to the success of health reform in Massachusetts, and the Connector promoted strategies to control costs, not simply to shift costs from the member's monthly premiums to greater point-of-service cost-sharing. For example, one of the preferred plan design features identified in the CommChoice renewal specifications was the inclusion of an alternative prescription drug benefit designed to encourage greater use of lower-cost generics. Carriers were encouraged to offer a prescription drug benefit that excluded from the drug deductible those drugs typically placed in Tier one of a three-tier formulary (i.e., generic drugs). While a co-payment or co-insurance for Tier one drugs would apply, members in these plans would receive prescription drug coverage for these relatively high value drugs without having to satisfy a separate drug deductible. Two carriers responded by developing and offering this benefit design, which is the first time this type of benefit design has been offered in the Commonwealth.

Another preferred plan design feature was the utilization of select or tiered networks. If properly designed, limited provider networks can reduce monthly premiums without sacrificing benefits, increasing cost-sharing or restricting access. Therefore, the Connector strongly encouraged carriers to offer health benefit plans with a provider network that rewards members for using cost-efficient, quality providers. Four carriers offer select network designs through the Connector.

The carriers were also encouraged to submit plans that would meet a premium target of no more than a 5% annual increase in the base premium rate. After negotiations between the health carriers and the Connector staff, the products approved by the Board in April 2008 resulted in a 5.1% average increase in CommChoice premiums. This increase is markedly lower than the rate of increase in ESI premiums in Massachusetts over the past several years, which average 12 percent per year from 2000 to 2006.²⁶

Later this year, the Connector plans to launch the Contributory Plan, which will allow small employers (50 employees or fewer) to subsidize the purchase of health insurance by their employees through the CommChoice program.

²⁵ A Section 125 plan, sometimes called a "cafeteria plan" or a "premium only plan," refers to the section of the federal tax code that allows employers to offer employees a choice between taxable income and certain benefits, like health insurance. These benefits are then paid for without subjecting the income to taxation and FICA contributions. Massachusetts' health reform requires employers with 11 or more full-time equivalent employees to provide a Section 125 plan that allows employees to pay their health insurance premiums using pre-tax wages. This requirement applies whether or not the employer contributes to health insurance. Section 6.6 of this report discusses Section 125 plans in greater detail.

²⁶ Mercer Human Resources (2007, July). *A special analysis of Mercer's National Survey of Employer-Sponsored Health Plans for the Massachusetts Division of Insurance*.

4.3 Enrollment

Enrollment: Descriptive statistics

As of August 2008, over 18,000 members were covered by insurance policies purchased through CommChoice. The greatest increase in enrollment was seen in the month of December, when enrollment grew by more than 50%. This likely reflected responsiveness to the individual mandate, which required most Massachusetts adults to obtain health insurance by December 31, 2007.

Among CommChoice subscribers, the most popular plan tier is Bronze. Enrollment in this tier has consistently represented 40-45% of enrollment in the CommChoice program. YAPs have the second highest number of enrollees, constituting between 25-30% of enrollment, followed by Silver (20-24%), and Gold (7-10%) plans. Within the Bronze and YAP plan levels, plans were initially available both with and without prescription drug coverage. The percentage of subscribers in plans with prescription drug coverage has increased over time from 66% in July 2007 to 81% in August 2008. This is largely due to the decline in enrollment in Bronze plans without prescription drug coverage (which will not be compliant with MCC standards effective January 2009 and are no longer sold by the Connector). Among those in YAPs, 68% of subscribers chose plans with prescription drug coverage, and 32% of subscribers prefer plans without prescription drug coverage.

There is considerable variation in enrollment by carrier. The most popular carrier selected is BCBS-MA, which enrolls over one-third (34%) of CommChoice subscribers. HPHC is the second most popular carrier, enrolling nearly a quarter of CommChoice subscribers (23%), followed closely by NHP (22%), FCHP (13%), Tufts (5%), and HNE (3%).

In contrast to enrollment in the CommCare program, there are more male subscribers than female subscribers in the CommChoice program²⁷. This differential has increased over time. Currently, 55% of CommChoice subscribers are male, while 45% are female. Given the fact that men were more likely to be uninsured prior to health reform, this distribution of members is consistent with the Connector's original expectations.

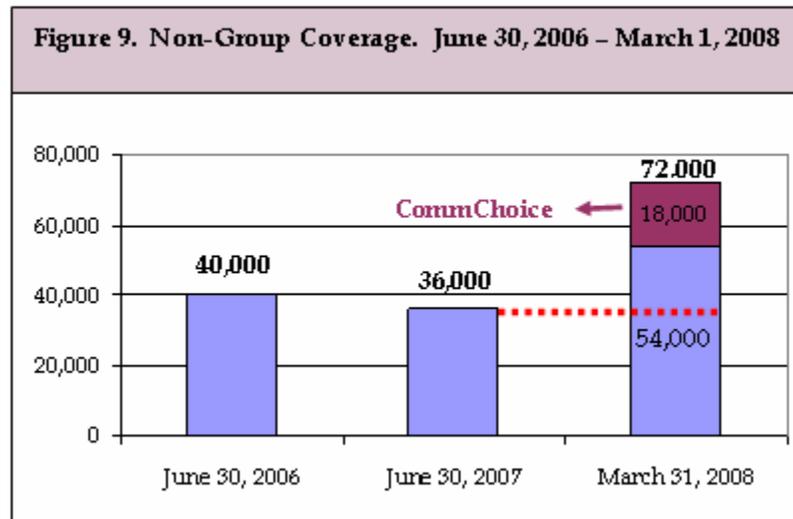
The largest cohort (33%) of subscribers enrolled in the CommChoice program is between the ages of 18-26, and the majority of these individuals are enrolled in YAPs (84%). Chapter 58 authorized the development of YAPs in an effort to provide individuals in this age cohort without access to ESI with a more affordable insurance option than had been available prior to reform in the non-group market. The relatively high rate of enrollment in CommChoice among the 18-26 year-old age cohort, and the high selection of YAPs among those eligible, suggests the appeal of this product to the young adult population. Finally, subscribers age 27-39 represent 28% of CommChoice subscribers, followed by those ages 50 and over (21%), and 40-49 (18%). As of August 2008, the average age of CommChoice subscribers was 37 years old, which is consistent with the profile of the "typical" uninsured person in Massachusetts prior to health reform.

Enrollment: Compared to change in non-group coverage

Comparison of enrollment in the CommChoice program to the change in enrollment in the overall non-group insurance market since implementation of reform suggests the Connector has been successful in selling the CommChoice program to this market. While approximately 18,000 people have coverage through the CommChoice program during this time period, recent data indicate that the non-group market has expanded by approximately 36,000 since June 30, 2007 (when CommChoice began),

²⁷ This is not directly comparable as this is a comparison of CommCare *members* to CommChoice *subscribers*. However, the vast majority (85%) of CommChoice subscribers purchase individual policies.

which means that 50% of net new non-group members are purchasing coverage through the CommChoice program (see Figure 9 below).



4.4 CommChoice Member Surveys

In winter 2008 the Connector conducted a web-based survey among young adult subscribers, those ages 18-26, in the CommChoice program. The purpose of this survey was to acquire information on the experience of these individuals in using the Connector and insight into purchasing behaviors and preferences of these subscribers.

With respect to consumer experience with the Connector, 98% of respondents reported that it was somewhat easy or very easy to shop for insurance through the Connector. This was a particular objective of the Connector in designing its website, based on the feedback received in initial focus groups. The results suggested the public education and outreach campaign had successfully reached those responding to the survey. Nearly 100% indicated they were aware of the individual mandate, and 75% reported they were purchasing insurance because it was required by law. Interestingly, this survey highlighted the importance of parental influence in plan selection among young adults, as over 40% of respondents indicated parents had the largest influence on their selection of a health carrier and plan. The cost of insurance premiums was cited by nearly 90% of respondents as another important criterion in selecting a health plan. However, less than 20% of respondents indicated that they purchased a plan with limited benefits because it was offered at a more affordable price. Finally, survey respondents indicated that one of the key reasons for purchasing through the Connector was the ability to choose among a variety of products and health plans.

5.0 Other Insurance Program Changes

The changes brought about by health reform have affected enrollment in other insurance programs and plans, both public and private. Since the passage of health reform in April 2006, there has been substantial growth in the number of individuals covered. As of March 2008, enrollment in MassHealth had increased by over 72,000 members, while enrollment in employer-based coverage increased by roughly 159,000 (see Table 9 below).

Table 9. Health Insurance Enrollment. June 30, 2006 – March 31, 2008.			
Non-Medicare Enrollment	June 30, 2006	March 31, 2008	Net Change
MassHealth	705,179	777,265	72,086
Commonwealth Care	n/a	176,298	176,298
Commercial Group Insurance (ESI)	4,274,159	4,432,827	158,668
Commercial Non-Group Insurance	40,184	72,466	32,282
Total	5,019,522	5,458,856	439,334

Finally, the merger of the small and non-group insurance markets has greatly increased access to more affordable health insurance products for those purchasing in the non-group market. Many more product options are now available, and the non-group market doubled in size between June 30, 2007 and March 31, 2008. Though the impact of this merger was uncertain, experience thus far suggests it has dramatically reduced premiums in the non-group market, with little to no reported impact on premiums for small group purchasers.

As an example, the merger has provided individuals purchasing coverage on their own and not through an employer a dramatic expansion in the number and range of options available at lower costs. Prior to health reform, the premium for a 37-year-old living in Boston – the prototypical uninsured person in Massachusetts – purchasing through the non-group market was roughly \$335. This plan had a \$5,000 deductible and did not include prescription drug coverage. After reform, the insurance premium for this same individual was \$184, for a plan with a \$2,000 deductible and prescription drug coverage and physicians’ office visits covered before the deductible (see Table 10 below).

Table 10. Example of Impact of Health Reform on Non-Group Market		
	Pre- reform	Post-reform
Monthly Premium	\$335	\$184
Prescription Drug Coverage	None	\$100 deductible
Deductible	\$5,000	\$2,000

6.0 Policy and Regulatory Responsibilities

6.1 CommCare Eligibility Guidelines, Benefit Packages, and Premium Contribution Schedule

In addition to administration of the CommCare and CommChoice programs, many policy and regulatory details associated with reform were delegated by the Legislature to the Connector. As indicated above, in addition to the statutorily defined eligibility criteria, the Board approved additional eligibility rules in setting up the CommCare program. These guidelines specified, for example, that individuals eligible for TriCare, the Massachusetts Fishermen’s Partnership; QSHIP; or the Medical

Security Program were not eligible for CommCare²⁸. Inclusion of these eligibility criteria was designed to minimize crowd-out and not undermine existing health insurance options.

In order to implement CommCare, the Connector had to establish the benefits packages and premium contribution schedules for those with income above 100% FPL²⁹. The Connector voted progressive benefit and cost-sharing schedules that considered concerns raised by diverse stakeholders, while also minimizing incentives for crowd-out and taking into account the costs to government and individuals. In September 2006, the Board approved the benefits packages and enrollee contribution schedules for the CommCare program, enabling program enrollment to begin on October 1, 2006 (see Appendix 2 for a summary of benefits). Under these schedules, co-payments and monthly premium contributions start low and increase with income. Above 200% FPL, where 80% of residents obtain insurance through ESI, CommCare approximates typical ESI contributions and co-payments. The premiums and benefits package were subsequently adjusted, effective July 1, 2008.

6.2 Minimum Creditable Coverage

The health reform law requires most Massachusetts adults to be covered by an insurance policy that meets Minimum Creditable Coverage (MCC), a particular level of value or standard of benefits. While the statute designates certain health coverage types as meeting creditable coverage (e.g., MassHealth, Medicare Parts A or B, TriCare, QSHIP, etc.), the statute also directs the Connector Board to define what constitutes MCC for the majority of people that are covered by commercial insurance. The definition of MCC establishes the floor below which insurance products will not satisfy the individual mandate. The underlying principles that guided the Connector in the development of a definition of MCC included: balance between premium affordability and potential out-of-pocket costs, encouragement of preventive care, coverage of a broad range of medical services, and maintenance of a broad array of choices among insurance products. In March 2007, the Board approved Connector staff's draft proposal of these regulations. During May 2007, hearings on the draft regulations were held throughout Massachusetts, and in June 2007, final regulations defining MCC were adopted by the Board. These regulations stipulate that to comply with MCC standards a health insurance plan must include a "broad range of medical services", including:

- inpatient acute care, physician services, diagnostic tests and procedures, outpatient care, and prescription drugs;
- deductibles that are capped at \$2,000 for an individual or \$4,000 for a family each year;
- visits to the doctor for preventive care covered prior to a deductible;
- an annual cap on out-of-pocket spending of \$5,000 for an individual or \$10,000 for a family (for plans with up-front-deductibles or co-insurance on core services);
- no cap on total benefits for a particular sickness or for a single year.

In November 2007, the Connector issued *Administrative Information Bulletin 04-07: Guidance regarding the implementation of minimum creditable coverage standards*³⁰, to provide additional clarification regarding other plans or policies that meet MCC standards.

²⁸ For more information, see 956 CMR 3.09 § 2. Available online at, <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Regulations/documents/CommCareRegs956CMR3000408Revision.pdf>

²⁹ Benefits and cost-sharing for those earning up to 100% FPL are statutorily tied to those of MassHealth.

³⁰ The Administrative Bulletin is available online at, <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Regulations/documents/CommCareRegs956CMR3000408Revision.pdf>

Though MCC standards were adopted in June 2007, the Connector Board approved a phased-in approach for application of the MCC requirements. Prior to January 1, 2009, an individual will be considered enrolled in an MCC compliant health plan so long as the individual is enrolled in a plan that meets state licensure requirements or a self-insured plan offered by an employer that meets federal ERISA requirements. The purpose of a phased-in approach was to minimize unnecessary disruption to ESI and to provide employers, employees, and individuals sufficient time to transition to plans that meet the new benefits requirements. Effective January 1, 2009, an individual must be enrolled in a plan that meets the standards described above for MCC compliance, or be covered by one of the statutorily-defined “creditable coverage” plans. The Board realized that because health insurance is typically a one-year contract, large employers generally decide on benefits six months or more prior to their anniversary dates, and such anniversary dates fall throughout the year. It actually requires a full 18 months of advance notice to allow most employers to adjust their benefits to new parameters, if necessary.

6.3 Individual Mandate and the Affordability Schedule

Another regulatory task delegated to the Connector is the establishment and annual update of an affordability schedule, which specifies maximum affordable monthly premiums (for an MCC compliant plan) for individuals, couples and families based on a progressive, sliding scale of income³¹. The affordability schedule is used to determine application of the individual mandate. Under this schedule, an adult will be considered able to purchase affordable health insurance if the monthly contribution to ESI or the monthly premium for the lowest cost insurance plan available through the Connector does not exceed the corresponding maximum monthly premium for his or her income bracket.

Connector staff recommended a draft affordability schedule to the Board in April 2007, and then held a series of statewide hearings in May 2007. In June 2007, the Board approved the affordability schedule for use in determining application of the individual mandate for those filing taxes for calendar year 2007 (see Table 11, Table 12, Table 13 below). In April 2008, the Board updated the affordability schedule for calendar year 2008 (see Table 11, Table 12, Table 13 below). The schedule adopted in 2008 included changes to both the income ranges and the maximum monthly premium contributions. The Connector website also offers an interactive affordability tool to assist individuals in determining if an affordable plan is available to them.

[vlet/FindInsurance/Employer/Overview/Administrative%2520Information%2520Bulletin%2520final%252004-07.pdf](#)

³¹ M.G.L. c. 176Q, § 3.

Table 11. Affordability schedule for INDIVIDUALS				
2007		2008		
Annual Gross Income	Maximum Monthly Premium	Annual Gross Income	Maximum Monthly Premium	Amount increase from 2007
\$0 - \$15,315	\$0	\$0 - \$15,612	\$0	\$0
\$15,316 - \$20,420	\$35	\$15,613 - \$20,808	\$39	\$4
\$20,421 - \$25,525	\$70	\$20,809 - \$26,016	\$77	\$7
\$25,526 - \$30,630	\$105	\$26,017 - \$31,212	\$116	\$11
\$30,631 - \$35,000	\$150	\$31,213 - \$37,500	\$165	\$15
\$35,001 - \$40,000	\$200	\$37,501 - \$42,500	\$220	\$20
\$40,001 - \$50,000	\$300	\$42,501 - \$52,500	\$330	\$30
\$50,001	n/a	>\$52,501	n/a	n/a

Table 12. Affordability schedule for COUPLES				
2007		2008		
Annual Gross Income	Maximum Monthly Premium	Annual Gross Income	Maximum Monthly Premium	Amount increase from 2007
\$0 - \$20,535	\$0	\$0 - \$21,012	\$0	\$0
\$20,536 - \$27,380	\$70	\$21,013 - \$28,008	\$78	\$8
\$27,381 - \$34,225	\$140	\$28,009 - \$35,016	\$154	\$14
\$34,226 - \$41,070	\$210	\$35,017 - \$42,012	\$232	\$22
\$41,071 - \$50,000	\$270	\$42,013 - \$52,500	\$297	\$27
\$50,001 - \$60,000	\$360	\$52,501 - \$62,500	\$396	\$36
\$60,001 - \$80,000	\$500	\$62,501 - \$82,500	\$550	\$50
\$80,001	n/a	>\$82,501	n/a	n/a

Table 13. Affordability schedule for FAMILIES				
2007		2008		
Annual Gross Income	Maximum Monthly Premium	Annual Gross Income	Maximum Monthly Premium	Amount increase from 2007
\$0 - \$25,755	\$0	\$0 - \$26,412	\$0	\$0
\$25,756 - \$34,340	\$70	\$26,413 - \$35,208	\$78	\$8
\$34,341 - \$42,925	\$140	\$35,209 - \$44,016	\$154	\$14
\$42,926 - \$51,510	\$210	\$44,017 - \$52,812	\$232	\$22
\$51,511 - \$70,000	\$320	\$52,813 - \$70,000	\$352	\$32
\$70,001 - \$90,000	\$500	\$70,001 - \$90,000	\$550	\$50
\$90,001 - \$110,000	\$720	\$90,001 - \$110,000	\$792	\$72
\$110,001	n/a	>\$110,001	n/a	n/a

6.4 Penalties

Effective July 1, 2007, most adult residents of Massachusetts were required to have minimum creditable health insurance coverage. If it is determined that an individual has access to an affordable insurance plan but does not obtain it, then a penalty is assessed when the individual files a tax return³². In the first year of the mandate, individuals were required to indicate if they had insurance as of December 31, 2007 (rather than July 1, 2007)³³. As was defined in statute, the penalty for noncompliance with the individual mandate in 2007 was the loss of one's personal income tax exemption, or \$219.

The reform legislation authorized a more stringent penalty starting in January 2008 of up to 50% of the insurance premium for creditable coverage for every month the individual fails to comply with the mandate³⁴. In filing 2008 tax returns, individuals will be required to indicate whether they had coverage in each month of 2008. For individuals not complying with the mandate, the DOR, in consultation with the Connector, established a penalty schedule (see Table 14 below). For adults earning 300% FPL or less, the penalty is equal to half of the premium for the lowest priced CommCare plan. In assessing penalties for 2008, individuals earning up to 150% FPL will not be penalized because the premium contribution for CommCare for people in this income bracket is \$0. For those earning 150.1 – 200% FPL, the penalty is \$17.50 per month (or up to \$210 for a full year without coverage), while the penalty for those earning 200.1 – 250% FPL is \$35 per month (or up to \$420 for a full year without coverage), and \$52.50 per month (or up to \$630 for a full year without coverage) for those earning 250.1% -300% FPL.

For adults up to age 26 whose income is above 300% FPL, the penalty is equal to half the premium of the lowest cost Young Adult Plan without prescription drug coverage (using January 2008 premium rates) offered through the Connector's CommChoice program. Since the lowest cost health plan for individuals ages 18-26 is \$112, those in this age group with access to affordable health insurance but failing to purchase it could be fined one half of that cost, or \$56, for each month they lack health insurance. Lacking health insurance for a full year could result in a penalty of \$672.

For adults 27 and older whose income is above 300% FPL, the penalty is equal to half of the premium for the lowest cost Bronze plan without prescription drug coverage (using January 2008 premium rates). Since the lowest cost health plan for individuals 27 and older in January of 2008 was \$152, individuals in this age group with access to affordable insurance but failing to purchase it could be fined one half of that cost, or \$76, for each month they lack health insurance. Failure to purchase affordable coverage for all of 2008 would therefore result in a fine of \$912.

³² M.G.L. c. 111M, § 2.

³³ In December 2007, the Connector issued *Administrative Bulletin 05-07: Guidance regarding the implementation of individual mandate penalties for 2007*, to provide clarification on imposition of the mandate for those individuals enrolled in CommCare or a Young Adult Plan through the CommChoice program with a plan effective date of January 1, 2008. The Administrative Bulletin is available online at, <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Regulations/documents/Administrative%2520Information%2520Bulletin%252005-07.pdf>

³⁴ M.G.L. c. 111M, § 2.

Table 14. Penalties for Failure to Comply with the Mandate. 2008		
Income	Penalty	
	per month	per year*
150.1-200% FPL	\$17.50	\$210
200.1-250% FPL	\$35.00	\$420
250.1-300% FPL	\$52.50	\$630
Above 300% FPL Age 18-26	\$56.00	\$672
Above 300% FPL Age 27+	\$76.00	\$912
<i>*If the individual is without insurance for all twelve months of the year.</i>		

6.5 The Individual Mandate: Certificate of Exemption & Appeals

The Connector and DOR worked collaboratively to develop a process to handle waiver requests and appeals filed by Massachusetts residents related to the individual mandate and the tax penalty. Together, these two state entities developed a unique system (i.e., there was no existing model that the state could rely upon for consultation in developing this process) that operated particularly smoothly in its first application.

For example, data from 2007 tax filings processed to date (representing about 86% of total expected filers) indicate that 98.6% of tax filers correctly completed the tax filing process, including the new questions pertaining to health insurance coverage. In addition, these filings indicate that 95% of Massachusetts tax filers had health insurance in calendar year 2007. Among those that did not have health insurance, approximately 58% (97,000) were deemed able to afford insurance, and approximately 37% (about 62,000) were deemed unable to afford health insurance. Thus far among over three million tax filers, only about 6,000 have appealed the penalty for failure to have health insurance (see Table 15 below). About 9,000 (5.5%) of those without insurance indicated they had a religious exemption. A more detailed breakdown of the preliminary data compiled by the DOR is included in Appendix 3.

The table below summarizes appeals filed by Massachusetts residents related to the individual mandate and the tax penalty from January 1, 2008 through August 1, 2008. If the affordability schedule indicates that an affordable plan was available, but an individual feels that because of a hardship or extenuating circumstances that insurance was not affordable, he or she can file an appeal to request a waiver of the mandate based on a hardship.

In addition, as mentioned above, a religious exemption from the individual mandate is available for individuals who have a sincerely-held religious belief that is the basis of refusal to obtain and maintain health insurance coverage. However, an individual claiming a religious exemption who has received medical care in the past year will not be entitled to a religious exemption³⁵.

³⁵ M.G.L. c. 111M § 3.

Table 15. Individual Mandate Penalty Appeals. January 1, 2008 - August 1, 2008	
Total	6,322
Action	Of the 6,322 penalty appeals:
	1,223 approved ^[1]
	4,259 dismissed ^[2]
	24 backlog ^[3]
	816 pending
<p>1. An appeal is approved if an appellant indicates he had insurance or if he proves he met grounds for appeal based on hardship.</p> <p>2. An individual may appeal the penalty on their taxes and then has 30 days to submit a Statement of Grounds to the Connector Appeals Unit. A significant majority of these appeals were dismissed because they were not perfected within 30 days.</p> <p>3. Backlog indicates that an individual has appealed the penalty but the Connector has not yet received the Statement of Grounds (and it has not yet been more than 30 days since the individual has filed taxes so the appeal has not been dismissed).</p>	

The Connector has also developed a system that allows individuals to acquire a Certificate of Exemption (COE) or waiver prior to filing their taxes. For example, in some instances use of the affordability tool may reveal that an “affordable” plan is not available to a given individual. In this case, an individual may apply prospectively (i.e., before taxes are filed) to the Connector for a COE. Individuals may also apply for a COE if they have suffered a hardship³⁶ which prevents them from affording the lowest cost health insurance plan available. If granted a COE, the individual receives a letter with a certificate number that he or she can provide to DOR when filing his Massachusetts income tax to indicate exemption from the mandate.

6.6 Section 125

The health reform law also charged the Connector with developing regulations to implement the statutory requirement that employers with 11 or more FTEs establish a Section 125 plan for all of their workers. A Section 125 plan, sometimes called a “cafeteria plan,” refers to the section of the federal tax code that allows employers to offer employees a choice between taxable income and certain benefits, like health insurance, which are then paid for without subjecting the income to taxation and FICA contributions. The requirement uses the benefit of pre-tax payment of premiums to reduce the net cost of health insurance, thereby making it more affordable. Because of the avoided taxes, using a Section 125 plan can reduce the effective cost of health insurance in Massachusetts by 28% to 48%, depending on the subscriber’s tax bracket. Based on the average tax bracket for Massachusetts filers, savings average 41%.³⁷

³⁶ The circumstances defining what constitutes a “hardship” are detailed in 956 CMR 6.08. This is available online at, <http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/Current/Connector%2520board%2520meeting%2520December%252013%2520C%25202007/4%2520-%2520Affordability%2520Regs%2520-%2520Emergency%252012%252007%2520Amendment.doc>

³⁷ Assuming 28% marginal federal income tax rate (the average marginal rate in the Commonwealth), 5.3% Massachusetts state income tax and 7.65% FICA tax. In addition, employers can save their share of the FICA tax (7.65%).

Table 16. Example of Savings Available through a Section 125 Plan		
	Without Section 125 Plan	With Section 125 Plan
Adjusted Gross Income	\$50,000	\$50,000
Annual Pre-Tax Health Insurance Contribution	\$0	\$2,100
Taxable Income	\$50,000	\$47,900
Estimated Taxes	\$12,676	\$11,880
Annual After-Tax Health Insurance Contribution	\$2,100	\$0
Net Take Home Pay	\$35,224	\$36,020
Savings from Use of Section 125	N/A	\$796

As a way to make complying with the Section 125 requirement as administratively simple as possible, the Connector set up the “Commonwealth Choice Voluntary Plan” for employers’ non-benefits-eligible employees. The CommChoice Voluntary Plan allows non-benefits-eligible employees to select a carrier and a health benefit plan that works best for them without burdening the employer with the administrative challenge of dealing with multiple health insurers. The employee may chose from a variety of carriers at different benefit levels, but the employer only needs to submit payments to one entity (the Connector).

In the first year of the program, over 3,300 employers established Section 125 plans with the Connector. While initial employee sign-up was slower than expected, as of August 2008 over 1,000 employees were taking advantage of the tax savings and purchasing health insurance through their employer’s CommChoice Voluntary Plan.

Section 125 Survey/Report

In an effort to better understand employers’ responses to the new Section 125 requirement, the Connector conducted a survey in early 2008 of the 2,800+ employers that designated the Connector in their Section 125 plan. In addition to the survey, Connector staff interviewed six employers representing small, mid-sized and large employers on their experience to date complying with the new requirement and their interactions with the Connector. The survey and case studies led to five key findings:

- 1 Low level of uninsured in Massachusetts -- which is due to high rate of ESI and relatively generous public insurance programs -- is likely a major reason for relatively low take-up rate, to date, of Section 125 plans by purchasers of individual coverage;
- 2 Affordability remains a significant barrier for employees to purchase health insurance, even when they have access to a Section 125 plan;
- 3 Part-time worker population can be difficult for employers to outreach to, as a result of staggered and irregular work schedules, language barriers, and difficulty in understanding complicated information about benefits, taxes and insurance;
- 4 Employers’ active engagement, armed with the right information that’s easily understood, can positively influence employees’ take-up rates; and
- 5 Consistent and correct information with regard to Section 125 requirement, in particular, and health reform, in general, is crucial to employers’ satisfaction.

Our findings suggest a wide range of employer responses to the new Section 125 plan requirement, ranging from the many employers who took only the minimal steps to comply with the law to those who committed considerable time and effort to engage in extensive employee outreach, making sure

employees understood their options, and encouraging sign-up among their non-benefits-eligible employees. Among employers who put in greater effort and engaged in “hand-to-hand combat,” greater take-up among employees was found. Some level of confusion among employers regarding details about Section 125 plans and insurance in general was pervasive. The perceived technical complexity of how a Section 125 plan works and how to explain the benefit to employees in layman’s terms was likely exacerbated by information gaps. In instances in which the lines of accurate communication broke down, employer frustration and confusion was likely to occur, leading to low levels of investment in educating employees and facilitating enrollment. Conversely, for employers who felt well-informed and supported in their handling of Section 125 plan set-up, administration, and employee-outreach, the requirement has been relatively easy and take-up rates have been better.

The Connector undertook the Section 125 assessment to gain a better understanding of the initial roll-out of this new employer responsibility and to glean information on how best to communicate this new benefit to employees in order to increase the take-up rate. Since the conclusion of the initial assessment in March 2008, the Connector has simplified the enrollment process, developed more user-friendly Section 125 plan communications materials for employers and employees, and has experienced a steady increase in the number of employees taking advantage of the significant tax savings associated with this means of paying for health insurance. While tax rules are often arcane and not easily digestible, the Connector is focused on simplifying the message and providing an efficient administrative mechanism for employers to help their employees pay for health insurance.

7.0 Outreach, Marketing, Public Information Unit Activities, & Customer Service

The health reform law, especially the mandate that nearly all Massachusetts adults have health insurance and the new requirements for employers, necessitated an aggressive marketing, public education and outreach campaign. Over six million residents and 193,000 employers needed to be informed of the benefits associated with having health insurance, tax penalties for failure to acquire and maintain health insurance, and the new requirements affecting the business community. In November 2006, as questions, concerns and confusion about the law mounted, the Connector was asked by the Secretaries of Health and Human Services and Administration and Finance to lead and coordinate communications about the many facets of reform to the public as well as to insurers, employers, and brokers.

The Connector promptly established its own Public Information Unit (PIU) designed to respond to inquiries regarding health reform from the public and employers. In addition, the Connector executed its public education and outreach campaign, collaborating with community organizations, state agencies, and corporate and civic organizations. A few examples are described in greater detail below. Included in Appendix 4 is a list of many of the Connector’s outreach partnerships. It should be noted that in addition to the many outreach and marketing activities mentioned below, insurance carriers -- MMCOs and commercial insurers -- launched advertising campaigns to raise awareness about the health reform law.

7.1 Outreach & Marketing Partnerships and Activities

Collaboration with community organizations

In October 2007, the Connector launched a series of statewide enrollment forums known as Connect-to-Health events. As part of this outreach initiative, the Connector sponsored 30 events in 20 communities across the state in conjunction with state legislators, municipal officials, local hospitals,

CHCs, and community groups³⁸. The primary purpose of these events was to provide a forum for potentially eligible individuals to acquire information and eligibility guidelines for the CommCare program, and for those ineligible, to receive guidance on other insurance options (e.g., CommChoice). In many instances, workers from the partnering sites worked with Connector staff to immediately determine eligibility of attendees and begin the enrollment process in CommCare, via the Virtual Gateway system, or CommChoice, via the Connector's website (www.MAhealthconnector.org). Following the enactment of health reform, Connector outreach workers also regularly presented to the MassHealth Training Forum.

Partnerships with state agencies and organizations

The DOR assisted the Connector in the development of a postcard that was mailed to nearly three million Massachusetts taxpayers. The card informed residents of the requirements of the new law and the opportunities for accessing insurance through the Connector. The timing of the postcard, sent in May 2007, aligned with the availability of CommChoice plans. In November 2007, the Connector and DOR mailed an additional three million postcards to tax filers. Letters were distributed to Massachusetts employers in the spring and fall of 2007, outlining ways in which they or their employees might be impacted by health reform. The Connector also worked with DOR in drafting a letter to taxpayers who indicated they were uninsured on their 2007 tax return and who, according to the affordability schedule, could have afforded health insurance. These taxpayers have been notified of the increased penalties for being uninsured in 2008, and the opportunities for accessing health insurance.

Pursuant to the authorizing legislation, funding was allocated to EOHHS for outreach purposes. EOHHS, approximately 40 organizations that received funding from them for outreach and enrollment assistance, and the Connector have worked together to coordinate outreach and enrollment events across the Commonwealth.

The Connector also worked with the Massachusetts Bay Transportation Authority (MBTA) to provide public messaging about health reform. MBTA cars display posters addressing the law, and provide tear-away note cards for passengers who wish to follow up with the Connector to get additional information on health insurance programs.

In 2008, the Registry of Motor Vehicles (RMV) joined the Connector's public outreach campaign. The RMV was a particularly helpful and important partner since many Massachusetts adults visit the RMV at some point during the year and many new Massachusetts residents visit the RMV. RMV locations display Connector posters and brochures and use LED screens to display a message on the requirement that most Massachusetts adults need to be insured. Additionally, the Driver's Manual distributed by the RMV now includes an excerpt on the health reform law and provides contact information for the Connector. In the future, the Connector and the RMV hope to develop a system that will deploy a letter on the health reform law to any individual converting an out-of-state license to a Massachusetts license.

Partnerships with other corporate and civic organizations

Throughout 2007 the Connector forged partnerships with several corporate and civic organizations. These partnerships enabled the Connector to disseminate information on the Connector and health reform to the public at no cost to the Connector. A few partnerships and activities are described below, but this is not an exhaustive list of all Connector partnerships.

³⁸ Connect-to-Health events were held in the following communities: Chicopee, Chinatown (Boston), Dorchester (seven locations), East Boston, Greenfield, Hyannis, Lawrence, Lowell, Lynn, Methuen, New Bedford, Newburyport, Norwood, Pittsfield, Plymouth, Quincy (two locations), Somerville, Southbridge, Weymouth, and Worcester (two locations).

CVS assisted the Connector in the summer of 2007 with a flier distribution campaign. The Connector supplied CVS stores throughout the state with fliers and brochures that CVS employees placed in the bag with a customer's purchase. In the fall of 2007, CVS sponsored a public service announcement in their stores for the Connector, informing individuals of the Massachusetts mandate requiring adult residents of the Commonwealth to have health insurance. The voiceover also directed consumers to call the Connector or to log onto the Connector's website to find information on health reform or to sign up for health insurance. Finally, as December 2007 approached, CVS stores displayed signs informing individuals of the mandate and tax penalties associated with non-compliance.

Adherence to the individual mandate is monitored through the tax system and resulted in some additional tax preparation requirements. The Connector assisted tax preparers in understanding the implications of health reform and the requirements for effectively completing the section of the income tax return associated with the individual mandate. With the assistance of DOR, the Connector was able to identify and proactively outreach to tax preparation agencies. Tax preparation organizations were provided the opportunity to participate in training sessions offered by the Connector. As part of this initiative, one organization the Connector worked with was the Earned Income Tax Credit Campaign, which is sponsored by the City of Boston. This group consists of 22 organizations that offer free tax preparation assistance for low-income individuals. In part due to this aggressive education campaign, compliance with the new tax filing requirement exceeded 98%.

The Connector's outreach and education initiative has also been aided by the work of several advocacy organizations including the Greater Boston Interfaith Organization (GBIO), Health Care for All (HCFA), and Community Partners. Each of these organizations has been invested in disseminating information about health care reform and working to increase insurance coverage of uninsured individuals. For example, GBIO held enrollment sessions after religious services and organized a grassroots door-to-door outreach campaign.

The Massachusetts Health Care Reform Coalition is a nonprofit coalition of organizations representing business groups, hospitals and providers, insurers, and advocates that has also been dedicated to promoting public education and awareness of new requirements and opportunities as a result of health reform. This coalition includes: Partners HealthCare, BCBS-MA and its Foundation, the Associated Industries of Massachusetts (AIM), the Massachusetts Business Roundtable, the Massachusetts Taxpayers Foundation, the Greater Boston Chamber of Commerce, HCFA, the Massachusetts Hospital Association, the Massachusetts League of Community Health Centers, HPHC, Tufts, NHP, Children's Hospital, Boston, Massachusetts Eye and Ear Infirmary, and Tufts Medical Center. As part of its commitment to reform, the Coalition raised funding to launch an advertising campaign that complemented the Connector's advertising campaign. The Massachusetts Health Care Reform Coalition also worked with the Connector on an array of outreach events.

The Connector has also developed a partnership with the Massachusetts Realtors Association. Like the partnership with the RMV, the target population of this partnership is new Massachusetts residents who may be unaware of the mandate requiring most adults to have health insurance. An online kit addressing health reform is available to realtors for dissemination to clients.

Paid advertising

The Connector's outreach strategy also relied on paid advertising. Television, radio, and print advertisements have all been utilized by the Connector. As part of the television marketing and advertising campaign, New England Sports Network (NESN) displayed the Connector logo during televised Red Sox home games in 2007. In addition, a sports broadcaster announced the partnership and the "cover your bases campaign" during the game. This informed the public of the need to obtain health insurance and directed individuals to the Connector for further information. Interviews with Governor

Deval Patrick and U.S. Senator Edward M. Kennedy addressing the importance of health reform were also televised during Red Sox games.

Given the potency of the Red Sox in garnering media attention, and data indicating the average uninsured individual in Massachusetts is a 37-year-old male, this partnership was particularly notable. The partnership included many different marketing and advertising opportunities for the Connector. In addition to the paid advertising purchased by the Connector, the Red Sox also offered additional pro bono advertising opportunities. For example, throughout the 2007 season, a health insurance information booth was situated at Fenway Park and administered by Connector staff at all home games. Brochures and pamphlets describing health reform and insurance plans available through the Connector were available at the booth.

In addition to NESN, the television marketing and advertising campaign included a contract with Univision, a Hispanic media network. Television commercials aired on Univision, and in May of this year, Univision sponsored a telethon allowing individuals to call in with questions about health reform.

Radio advertisements have been placed with regionally and ethnically diverse stations, with young adult listeners as the target audience. Print advertisements appeared in *The Metro*, *Boston Phoenix*, and *Bay State Planner*, while digital advertisements appeared on www.boston.com, www.bostonherald.com, www.facebook.com, and www.myspace.com.

7.2 Public Information Unit Activities

The Connector established the PIU to respond to questions pertaining to health reform. The PIU receives emails, letters, and calls. There is a direct line that the public can use to contact the PIU (1.617.933.3140). In addition, callers who have phoned the call center at 1.877.MA.ENROLL may be directly transferred to the PIU. Many of the inquiries addressed by the PIU pertain to the mandate, employer requirements under health reform, and MCC. However, the majority of calls received by the PIU are from CommCare members who have questions about their benefits or their plans. The PIU is able to directly transfer these individuals to CommCare customer service representatives.

The PIU also serves a legislative liaison function, responding to health reform issues and questions raised by state legislators and their staffs. Frequently, legislative offices request a representative from the Connector to conduct a presentation on health reform. Prior to implementation of the mandate (i.e., before December 31, 2007), the Connector was conducting approximately two to three presentations per week in response to legislative requests. Since the mandate has been in effect, legislative requests for presentations have declined to approximately one to two per month. On occasion, legislators or legislative staff may also contact the Connector to raise questions or issues from their constituents. In these instances, the Connector relies on an established protocol for efficiently responding to questions and resolving issues.

In addition to legislative requests for presentations on health reform, the Connector has received requests to conduct presentations from an array of other organizations. Presentations on the CommCare program and health reform have been provided at CHCs and advocacy, stakeholder and community organizations and institutions including HCFA, the Massachusetts Hospital Association, and human resource groups and organizations such as the New England Employee Benefits Council (NEEBC). Throughout 2007 business organizations were a particularly prominent audience of presentations by Connector staff. To date, Connector staff has delivered nearly 200 presentations at locations across the state.

7.3 Customer Service

Call centers

The Connector has established a system to streamline the process for responding to the customer service needs of individuals interested or enrolled in either the CommCare or CommChoice programs. By dialing 1.877.MA.ENROLL, individuals enter basic information and are automatically directed to a customer service representative for CommCare or CommChoice.

Website

The Connector has also contracted with Computer Sciences Corporation Consulting (CSC) to aid the development and management of the Connector's website. The website, www.MAhealthconnector.org, serves as a portal to assist individuals and other stakeholders in acquiring information on the new options and responsibilities associated with health reform. In November 2007, the Connector website received one of InfoWorld's top 100 awards for the most innovative corporate IT solutions for 2007.

The website provides consumers with information about the CommCare and CommChoice programs. Moreover, the website allows individuals and members of small groups to shop and compare among the health insurance plans available to them. CommChoice subscribers can purchase and enroll in plans through this website. Since CommCare is a subsidized program and eligibility screening must be conducted by MassHealth to determine if an individual is eligible to enroll, individuals cannot enroll directly in CommCare via this website. However, the website does provide tools and information to assist individuals in determining eligibility for CommCare as well as instructions for completing the application process.

7.4 Outreach to Employers & Brokers

In addition to outreach to the general public about health reform, the Connector has also worked extensively to ensure that employers are aware of their new options and responsibilities. While some aspects of the Massachusetts health reform law affect all employers, many employers (e.g., employers with fewer than 11 full-time employees) are exempt from some or most of the law. To provide employers guidance in identifying those pieces of the health reform law that pertain to them, the Connector has created both an Employer Handbook and a Section 125 Handbook, which can be downloaded from the Connector's website.

In the spring of 2007 the Connector partnered with AIM to present a series of ten health reform programs in conjunction with regional chambers of commerce to explain how the new law affects local businesses. The program was designed to foster an interactive discussion of the law's practical implications for Massachusetts employers, and to provide instruction as to where employers should look for additional information.

The Connector also worked with the Retailers Association of Massachusetts (RAM) in cooperation with the National Federation of Independent Businesses (NFIB) to sponsor informational forums on health reform. Six sessions were held with a more specific focus on the questions and concerns of smaller businesses. In addition to these formal sessions, the Connector also held a number of sessions in response to ad-hoc requests for information and assistance from various employer organizations.

8.0 Connector Administrative Budget

In June 2006, the Connector was provided an initial appropriation of \$25 million from the Commonwealth, which was expected to cover start-up costs and operating expenses until the Connector could generate revenue. Pursuant to section 12 of chapter 176Q of the General Laws, the Connector is authorized to apply an administrative fee on all health benefit plans, based on a percentage of the capitation payments for the CommCare program and monthly premiums for the CommChoice program.

The CommCare program began generating revenue in November 2006 for the population that is at or below 100% FPL and February 2007 for the population that is above 100% but at or below 300% FPL. The CommChoice program began generating revenue in July 2007 (FY08), the first effective date of enrollment. The administrative fee applied to CommCare in FY07 was 5%. In FY08, the administrative fee for both programs was 4.5%. For FY09, the administrative fee applied to CommCare has been further reduced to 4%, and remains at 4.5% for CommChoice.

As illustrated in Table 17, the Connector ran a significant operating loss in its first full fiscal year. This was expected, as the agency needed to hire staff, procure outside assistance and launch programs, while building initial enrollment; nonetheless, the actual loss was less than projected.

Table 17. Fiscal Year 2007 Administrative Budget

	SFY07 Original	SFY07 Year-End	Variance	
	Budget	Actual	\$	%
<u>Total Operating Revenues:</u>	\$6,163,243	\$7,425,402	\$1,262,159	20%
<u>Operating Expenses:</u>				
Salaries, Benefits & Payroll Taxes	\$3,393,917	\$2,352,096	\$1,041,821	44%
Appeals Program	\$1,003,103	\$0	\$1,003,103	NA
General & Administrative	\$70,920	\$97,654	(\$26,734)	-27%
Marketing & Advertising	\$5,050,000	\$2,364,618	\$2,685,382	114%
CommCare Customer Service & Premium Billing	\$4,364,968	\$5,426,548	(\$1,061,580)	-20%
CommCare Enrollment & Eligibility Services	\$5,910,592	\$5,940,269	(\$29,677)	0%
CSC Consulting (Website)	\$700,000	\$670,150	\$29,850	4%
CommChoice Intermediary	\$0	\$6,524	(\$6,524)	100%
Consulting & Professional Support	\$2,056,091	\$2,103,917	(\$47,826)	-2%
Facility & Related	\$330,862	\$140,139	\$190,723	136%
IT & Communications	\$1,299,820	\$377,454	\$922,366	244%
Total Operating Expenses	\$24,180,273	\$19,479,369	\$4,700,904	24%
Net Operating Gain/ (Loss)	(\$18,017,030)	(\$12,053,967)	\$5,963,063	33%

Table 18 shows the Connector's FY08 original administrative budget compared to FY08 year-end estimates. (The Connector's audited financial report for FY08 will be completed in November.) The Connector exceeded its budgetary goal of breaking even at the end of FY08, and is expecting a modest net

surplus for the entire FY08. As shown in more detail in Table 16 below, total FY08 year-end operating revenues are estimated at \$29.9 million, resulting in a \$4.2 million favorable variance or 16% more than FY08 original estimates. This variance is due primarily to higher than expected enrollment in CommCare, coupled with a small decrease in the average capitation rate. This is somewhat offset by lower than expected volume in CommChoice. Naturally, the significant increase over budget in total enrollment generated pressure on expenses, but the Connector managed total operating costs to within two percent of the original budget.

Table 18. Fiscal Year 2008 Administrative Budget

	SFY08 Original Budget	SFY08 Estimated Year-End	Variance	
			\$	%
<u>Total Operating Revenues:</u>	\$25,779,574	\$29,930,581	\$4,151,007	16%
<u>Operating Expenses:</u>				
Salaries, Benefits & Payroll Taxes	\$5,861,248	\$5,072,937	\$788,311	16%
Appeals Program	\$685,500	\$77,212	\$608,288	788%
General & Administrative	\$182,840	\$138,165	\$44,675	32%
Marketing & Advertising	\$4,857,770	\$3,710,006	\$1,147,764	31%
CommCare Customer Service & Premium Billing	\$5,639,195	\$8,300,000	(\$2,660,805)	-32%
Premium Billing Enhancements	\$226,762	\$750,000	(\$523,238)	-70%
CommCare Enrollment & Eligibility Services	\$5,814,875	\$4,440,745	\$1,374,130	31%
HMS (CommCare Program Integrity)	\$200,000	\$200,000	\$ -	0%
CSC Consulting (Website)	\$670,150	\$1,409,000	(\$738,850)	-52%
CommChoice Intermediary	\$1,587,360	\$1,602,609	(\$15,249)	-1%
Consulting & Professional Support	\$1,795,000	\$2,631,931	(\$836,931)	-32%
Facility & Related	\$824,012	\$608,430	\$215,582	35%
IT & Communications	\$388,217	\$434,311	(\$46,094)	-11%
Total Operating Expenses	\$28,732,929	\$29,375,346	(\$642,417)	-2%
Net Operating Gain / (Loss)	(\$2,953,355)	\$555,235	\$3,508,590	-632%

9.0 Concluding Comments

The Commonwealth Connector has achieved much in its first two years and health reform has helped hundreds of thousands of Bay State residents. The single largest piece of unfinished business in the Connector's start-up plan is bringing a valued-added offering to the small group market. An innovative "choice" offering is now being rolled out for implementation in the late fall of 2008. It is designed to provide broad choice of health plans to the employees of small employers and to facilitate easy annual renewal for those employers. Using competition and transparency, this offering is intended to encourage more employees to enroll by allowing them to select the plan that best fits their preferences and pocketbook.

There are many more challenges to come. The most pressing issue for the success of health reform is reducing the rate of growth in the cost of health care. And while the Connector continues to work with the MMCOs and the commercial insurers to identify opportunities to slow the rise in health care costs, the root causes for the continued increase in health care costs are much larger and far more complicated than anything under the Connector's purview. Health reform II must focus on setting a more sustainable rate of growth in the cost of health care.

In fact, the Legislature has begun to grapple with the issue of health care costs, as evident by passage of chapter 305 of the acts of 2008, *An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Health Care*. In addition, the Healthy Massachusetts Compact is illustrative of the Administration's commitment to this objective. By reducing rates of obesity and diabetes through disease management programs, developing new ways to pay for care that holds providers accountable for outcomes, and cutting administrative waste through more use of technology, the Administration hopes this initiative will assist in slowing the rise in health care costs.

For its part, the Connector is conducting an audit of the four MMCOs participating in the CommCare program in FY09. This audit includes an investigation of care management practices and programs. The Connector hopes to identify "best practices" for management of certain illnesses and conditions that might be implemented (if not already in place) or improved in each of these health plans, with the objective of improving the care provided to CommCare members and ultimately controlling health care spending through more efficient and effective care management programs.

As mentioned in a previous section of this report, the renewal process for CommChoice plans encouraged carriers to develop select or tiered networks that favor more cost-efficient, high quality providers and to develop new chronic disease prevention and care management initiatives. Renewal specifications also set a target of no more than five percent for annual premium increases across all CommChoice products. In fact, the weighted average premium increase in CommChoice plans was 5% from July 2007 to July 2008. And in the few months since July 2008, some of the CommChoice premiums have actually come down!

Nevertheless, cost control and affordability are critical challenges to the viability of health reform. Fundamental reform of provider reimbursement and financial incentives in health care, will be necessary to sustain near-universal coverage.

APPENDIX 1: Abbreviations

The following abbreviations are used in this report:

AIM	Associated Industries of Massachusetts
BCBS-MA	Blue Cross Blue Shield of Massachusetts
BMC	Boston Medical Center
Board.....	Board of the Commonwealth Health Insurance Connector Authority
COE.....	Certificate of Exemption
CommCare	Commonwealth Care
CommChoice	Commonwealth Choice
Connector	Commonwealth Health Insurance Connector Authority
CHC.....	Community Health Center
CSC	Computer Sciences Corporation Consulting
DOR	Department of Revenue
DHCFP	Division of Health Care Finance & Policy
DOI.....	Division of Insurance
DUA	Division of Unemployment Assistance
ER	Emergency Room
EOAF	Executive Office of Administration and Finance
EOHHS	Executive Office of Health and Human Services
ESI	Employer-Sponsored Insurance
FSC	Fair Share Contribution
FCHP.....	Fallon Community Health Plan
FPL	Federal Poverty Level
FY	Fiscal Year
FTE	Full Time Equivalent
GBIO	Greater Boston Interfaith Organization
HPHC	Harvard Pilgrim Health Care
HCFA.....	Health Care For All
HMS	Health Management Services
HNE	Health New England
HEDIS	Health Plan Employer Data and Information Set
HSN.....	Health Safety Net Fund
MBTA.....	Massachusetts Bay Transportation Authority
MMCO	Medicaid Managed Care Organizations
MCC.....	Minimum Creditable Coverage
NFIB.....	National Federation of Independent Businesses
NHP	Neighborhood Health Plan
NEEBC.....	New England Employee Benefits Council
NESN	New England Sports Network
PMPM.....	Per Member Per Month
PMPY	Per Member Per Year
PFY	Pool Fiscal Year
PIU	Public Information Unit
QSHIP	Qualifying Student Health Insurance Plan
RAM.....	Retailers Association of Massachusetts
RMV	Registry of Motor Vehicles
RFP	Request for Proposals
RFR	Request for Responses

SOA Seal of Approval
SBSB Small Business Service Bureau
Tufts Tufts Health Plan
UCP Uncompensated Care Pool
YAP Young Adult Plan

APPENDIX 2: CommCare Member Benefits and Co-Payments

Health Benefits and Copays - Plan Type I effective 7/1/08	
Benefit	Copay
Outpatient care	
Office visit to your primary care provider (PCP)	\$0
Office visit to a specialist	\$0
Radiology, imaging (x-rays), lab work	\$0
Outpatient surgery at a hospital or ambulatory surgery center	\$0
Abortion	\$0
Inpatient care	
Hospital stay, may include surgery, x-rays, lab services, and room and board (copay is per stay)	\$0
Emergency care	
Emergency room visit	\$0
Prescription drugs	
30 day supply from a pharmacy	
• Generic drug	\$1
• Drug on your plan's preferred list	\$3
• Drug not on your plan's preferred list	\$3
Alcohol, drug abuse and mental health care	
Outpatient or office visit	\$0
Inpatient care (copay is per stay)	\$0
Methadone maintenance (dosing, counseling, screens)	\$0
Dental	
Check-ups/cleanings/fillings/X-rays/restorations	\$0
Vision	
Eye exam every 24 months	\$0
Free glasses every 24 months	\$0
Diabetes care	
Office visit to PCP or podiatrist for routine foot care (may include foot orthotics)	\$0
Visit to specialist (may include foot orthotics)	\$0
Rehabilitation services	
Extended inpatient care (100 total days per year)	\$0
• In a skilled nursing facility	\$0
• In a rehabilitation hospital or chronic disease hospital (copay is per stay)	\$0
Physical therapy, speech or hearing therapy, pulmonary or occupational therapy (need plan approval for more than 20 visits)	\$0
Cardiac rehabilitation	\$0
Home health care	\$0
Maternity and family planning	
Outpatient office visit	\$0
Other benefits	
Ambulance (emergency only)	\$0
Prosthetics, oxygen and respiratory therapy equipment, other durable medical equipment	\$0
Hospice	\$0
Maximum copays	
Maximum amount a member will need to pay for all prescriptions in a benefit year *	\$200
Maximum amount a member will need to pay for services excluding prescription drugs in a benefit year *	\$0

* The benefit year is from July 1, 2008 – June 30, 2009.

Health Benefits and Copays - Plan Type 2 effective 7/1/08

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

* Copay waived if transferred from another inpatient unit

** The benefit year is from July 1, 2008 – June 30, 2009.

APPENDIX 3: Preliminary DOR Data on 2008 Tax Filers

Preliminary Data from Department of Revenue: For tax year 2007. (Released on June 2, 2008)			
Notes:			
Section 1. "Schedule HC filers" vs. "Schedule HC non-filers":			
Total # of "Schedule HC filers" ^[1]	3,343,000	86%	See Section 2 for details
Total # of "Schedule HC non-filers"	538,000	14%	See Section 3 for details
Total # of tax return filers (processed to date)	3,881,000	100%	
Section 2. Details about "Schedule HC filers":			
Have health insurance (as of December 31, 2007)	3,171,000	95%	See Section 4 for details
Do not have health insurance (as of December 31, 2007)	168,000	5%	See Section 5 for details
Total # of Schedule HC filers	3,343,000	100%	*
Section 3. Details about "Schedule HC non-filers":			
Non-residents	348,000	65%	
under 18 years old	77,000	14%	
certain part-year residents	47,000	9%	
part-year non residents	8,000	1%	
deceased	6,000	1%	
missing Schedule HC ^[2]	41,000	8%	
incomplete Schedule HC ^[2]	7,000	1%	
manual review ^[3]	4,000	1%	
Total # of "Schedule HC non-filers"	538,000	100%	
Section 4. Details about those who have health insurance:			
Private		78%	
Government		20%	
Both		2%	
Section 5. Details about those who do not have health insurance:			
deemed able to afford health insurance (based on affordability schedule)	97,000	57.7%	See Section 6 for details
deemed unable to afford health insurance (based on affordability schedule)	62,000	36.9%	
religious exemption ^[4]	9,000	5.4%	
obtained a Certificate of Exemption from the Connector	200	0.1%	
Total # who do not have health insurance (as of December 31, 2007)	168,000	100.0%	*

Section 6. Details about those who do not have health insurance AND were deemed able to afford it using the affordability schedule:			
self-assessed (i.e. taxpayers self-assessed the penalty)	86,000	89%	
appealed (i.e. taxpayers submitted a Schedule HC-A form to appeal the loss of their personal exemption)	6,000	6%	See Section 7+8 for details
appeal no-tax status ^[5]	5,000	5%	
errors	800	1%	
DOR removed exemption	30	0%	
Total	97,000	100%	*
Section 7. Details about those who filed an appeal (using the Schedule HC-A form) against losing their personal exemption on their 2007 Tax return: As of June 11, 2008			
homeless	477		
shut off of essential utilities	460		
high out-of-pocket medical / dental expenses	260		
buying health insurance would have caused deprivation of food, shelter, clothing, etc.	2,712		
fire, flood, natural disaster	74		
domestic violence, death of spouse, etc.	610		
other	2,457		
Total ^[6]	7,050		
Section 8. Results of the appeals that were submitted using the Schedule HC-A form. As of June 11, 2008			
# of appeals approved	573	10%	
# of appeals denied	437	7%	
# of appeals dismissed	2,008	33%	
# of appeals pending	3,000	50%	
Total ^[7]	6,018	100%	
<p>* numbers may not add to total due to rounding.</p> <ol style="list-style-type: none"> 1. This is the # of taxpayers who both: filed a complete Schedule HC and are subject to the individual mandate 2. DOR is currently seeking more information from these individuals 3. DOR will do a manual review of these tax returns in order to determine health insurance status 4. 634 of the 9,000 indicated that they had received medical health care in the previous year, and consequently are not eligible to claim a religious exemption 5. These taxpayers submitted a Schedule HC-A form to appeal the loss of their personal exemption, but this appeal was not processed since the taxpayer's adjusted gross income was below certain thresholds so that they qualified for "No Tax Status" and is not required to pay Massachusetts income tax. 6. The total is greater than the approximate 6,000 people who submitted a Schedule HC-A because an individual can select more than one reason for claiming a hardship. 7. There is a small difference between the 6,000 number in Section 6 and the 6,018 number in Section 7 due to rounding and minor time differences <p>Limitations:</p> <ul style="list-style-type: none"> • The data are preliminary results since they reflect about 86% of the total filings. • This does not include the estimated 450,000 returns that have yet to be processed or those expected through October from taxpayers who requested tax filing extensions. • Filers only (roughly 600,000 residents and their dependents do not file) • Only adults – most children are insured • Self-reported (though DOR will do additional verification of some results) 			

APPENDIX 4: Outreach Partnerships

Associated Industries of Massachusetts

- Conducted regional trainings
- Published regular newsletter updates
- Mailed Health Reform information to members

Bank of America

- Trained small business unit staff on Health Connector options for employers and employees

Boston Red Sox

- Provided *pro bono* advertising
- Broadcast announcements on the public address system and Jumbotron at Fenway Park
- Provided guest spots for Health Care Reform voices in the broadcast booth
- Hosted a Health Connector outreach booth on the Fenway Park concourse
- Hosted a major Health Care Reform press conference at Fenway Park
- Provided the 2007 World Series Trophy for a State House event
- Published a Health Care Reform feature in the official program book
- Hosted a “Connector Day” at Fenway

Comcast

- Provided *pro bono* advertising

CVS

- Ran in-store “radio” announcements
- Displayed window and stanchion posters
- Provided flyers at check-out locations.

Demoula’s Marketbasket

- Provided informational flyers at checkout

Greater Boston Interfaith Organization

- Conducted 50 in-congregation info sessions
- Performed door-to-door outreach in Boston.

H&R Block

- Displayed pamphlets and posters
- Conducted public outreach and education at local libraries and community centers
- Provided Health Connector contact information to uninsured clients
- Participated in Connect to Health events

IBEW

- Provided *pro bono* ads on I-93 (Dorchester) sign

Massachusetts Association of Patient Account Managers

- Hosted trainings
- Distributed flyers and brochures

Massachusetts Association of Realtors

- Published newsletter articles
- Provided brochures and posters to realtors

MBTA

- Provided *pro bono* advertising on subway lines

Massachusetts Board of Higher Education

- Assisted with the distribution of Health Care Reform information to graduating seniors.

Massachusetts Department of Public Health

- Conducted statewide Health Care Reform trainings

Massachusetts Hospital Association

- Supplied enrollment specialists at Connect to Health events.

Massachusetts League of Community Health Centers

- Supplied enrollment specialists at Connect to Health events.

Massachusetts Registry of Motor Vehicles

- Posters at RMV locations
- “Silent radio” (LED screen) and video announcements at RMV locations
- Pamphlets distributed at RMV locations
- Health Reform message in the “new residents” section of the driver’s manual
- Planned mailing to new residents (people who convert out-of-state licenses)

National Federation of Independent Business

- Conducted regional trainings
- Published newsletter updates
- Mailed handbooks and fact sheets to members.

PriceChopper

- Provided informational flyers at checkout

Retailers Association of Massachusetts

Conducted a series of regional trainings for employers

Published newsletter updates

Mailed employer handbooks and fact sheets to members

Shaw’s and Star Supermarkets

- Published Health Care Reform messages on newspaper inserts
- Printed Health Care Reform messages on register receipts
- Display Health Connector posters in stores

Zipcar

- “Connect to Health” events listed in Zipcar’s monthly newsletter,
- Posted Health Reform messages and a Health Connector link in “partners” section of the website