

HEALTH CARE PAYMENT REFORM CONFERENCE COMMITTEE REPORT

Health Policy Commission (HPC)

Governed by an 11 member board within but not subject to the control of A&F (similar to GIC).

Administers the Health Care Payment Reform Fund; conducts annual cost trend hearings; develops best practices and standards for development of alternative payment methodologies (APMs); certifies provider organizations, ACOs, and patient-centered medical homes; establishes and reviews health care cost growth benchmarks; oversees performance improvement plans; conducts market impact reviews; includes the Office of Patient Protection (moved from DPH).

Center for Health Information and Analysis (CHIA)

Governed by an executive director appointed by majority vote of Governor, Attorney General, and State Auditor (similar to IG).

Collects provider cost data and information from private and public health care payers; develops uniform reporting of a standard set of quality measures; conducts annual report on quality and provider and payer cost trends; participates in and supports the Commission's cost trend hearings; analyzes data to identify payers and providers whose increases in health status adjusted total medical expense is excessive; maintains consumer health information website; includes the Betsy Lehman Center for Patient Safety and Medical Error Reduction (moved from HHS).

Health Care Cost Growth Benchmark

The Commission shall establish the statewide health care cost growth goal for the health care industry, pegged at an amount no greater than the potential growth of the state economy, as follows:

- Years 2013 through 2017: Potential GSP
- Years 2018 through 2022: -0.5% below potential GSP
- Years 2023 and beyond: Potential GSP

Estimated Savings: \$200 billion over 15 years

One-Time Provider/Insurer Assessment of \$225 million

The Commission shall assess a surcharge on providers (\$60 million) and insurers (\$165 million), to be paid in a single payment or in four annual, equal installments.

Distribution of assessment funds:

- 1) \$135 million to the Distressed Hospital Trust Fund to enhance the ability of community hospitals to serve patients more effectively. Provides for a competitive grant process, to be developed by the Commission, for awards to distressed hospitals.
- 2) \$60 million to the Prevention and Wellness Trust Fund to fund grants for preventative health activities at the community level. DPH to administer fund.
- 3) \$30 million to the e-Health Institute Fund to fund the Massachusetts eHealth Institute (MeHI). MeHI will conduct the regional extension center program, run the electronic health records incentive program, and develop a plan to complete the implementation of electronic health records with all providers in Massachusetts.

Health Care Payment Reform Fund

Previously established to collect one-time gaming revenue from gaming facilities; funded by 5% administrative surcharge on assessments. The Commission shall create a competitive bid process to provide incentives, grants, or technical assistance to health care entities trying to develop payment or delivery system changes.

Medicaid Reform

- Provides an increase of 2% to Medicaid rates, not to exceed \$20 million, paid to providers that transition to new payment methodologies. Creates a special commission to review rates paid by public payers.
- Directs HHS, in collaboration with the Dept. of Veterans' Services and MassHealth, to investigate methods to improve access to Department of Veterans' Affairs benefits for qualified veterans, survivors, and dependents currently enrolled in the MassHealth program.
- Requires Medicaid, the GIC, and all other state funded health care programs to pay for health care based on alternative payment methodologies for 25%, 50%, and 80% of its enrollees by July of 2013, 2014 and 2015, respectively.

Provider Organizations and Accountable Care Organizations (ACOs)

- Provider organizations are health care providers that cover 15,000 lives or more and contract with insurance carriers for payment for health care services; can choose to organize as an ACO.
- Creates a certification process for provider organizations and ACOs and directs DOI to review reserves to ensure their ability to handle risk arrangements.
- Certified ACOs are responsible for care coordination, and the delivery, management, quality, and cost of all services provided under the ACO; they must integrate physical and behavioral health care services and accept alternative payment methodologies.
- Establishes a new "Cost and Market Impact Review" to examine provider organizations to determine whether any provider's market concentration exceeds certain federally-established parameters. If the Commission determines, based on its review, that actions of a provider constitute unfair practices or unfair methods of competition or other violations of law, the Commission must refer the matter to the Attorney General for further action.
- Requires ACOs, patient-centered medical homes, and provider organizations that receive a risk-based payment to set up a system of internal appeals. The appeals process may last no longer than 14 days.
- Requires certified ACOs to guarantee access to all medically necessary services for patients, either internally or through providers outside of the ACO.
- Model ACOs, as designated by the Commission, will receive preference in state contracting.

Medical Malpractice Reform

- Creates a new 182-day cooling off period for medical malpractice claims while both sides try to negotiate a settlement. Requires the exchange of information between the plaintiff and defendant to promote early settlement.
- Allows a health care provider or facility to admit a mistake or error. The admission cannot be used in a court as an admission of liability. However, if a provider lies under oath about the error or mistake, then the statement can be used as an admission of liability.
- Reduces the interest rate for medical malpractice from +4% to +2%.
- Raises the non-profit damage cap from \$20k to \$100k.
- Creates a task force to study defensive medicine and medical overutilization.

Workforce Development and Innovate Incentives

- Establishes the Health Care Workforce Transformation Fund to fund programs such as medical and nursing school loan forgiveness grants, health care job training and placement services, primary care residencies, and rural health rotation programs at medical and nursing schools.
- Establishes a new wellness tax credit for businesses that implement recognized workplace wellness programs, up to \$10,000 per employer (up to 25% of the cost of implementation).
- Requires that DPH develop a "model guide" for wellness programs for businesses and to provide stipends to help businesses establish programs.

- Requires health insurance companies to provide a premium adjustment for small businesses that adopt approved workplace wellness programs.
- Establishes the Health Information Technology (HIT) Revolving Loan Fund for making grants to providers for the costs associated with implementation of health care IT required under state and federal law. Provides for zero interest loans to providers and agreements with outside lending institutions to process applications and loans.
- Bans the use of mandatory overtime for nurses in a hospital setting unless patient safety requires it in an emergency situation. The Commission is directed to determine what constitutes an “emergency situation.” Nurses are not allowed to exceed 16 hours of worked time in a 24 hour period and must be given 8 hours off immediately after working a consecutive 16 hours.
- Directs state agencies responsible for the purchase of prescription drugs to form a uniform procurement unit to negotiate for bulk purchases.
- Raises the full-time equivalent (FTE) threshold for fair share contributions from 11 to 21 employees.
- Expands an existing workforce loan forgiveness program to include providers of behavioral, substance abuse, and mental health services.

Consumer Protections and Patient Access

- Develops a process to track price variation among different health care providers over time and establishes a Special Commission to determine and quantify the acceptable and unacceptable factors contributing to price variation among providers.
- Expands upon the existing consumer health information website to include more detailed comparative information on the cost and quality of health care services, including the individual prices of health care services. Adds new resources to the website such as the factors to consider when choosing an insurance product and shared decision-making tools.
- Increases the minimum premium savings for “tiered” or “selective” network health products from 12% to 14% and establishes a new “smart-tiering” option.
- Incentivizes the accelerated adoption of connected health technology, such as telemedicine.
- Requires the Commission to review methods and make recommendations relative to increasing the use of health savings accounts and similar tax-advantaged health plans.
- Allows nursing homes to move residents to a different room if the resident’s clinical needs have changed.
- Allows “limited services clinics” to provide the scope of services offered by a nurse practitioner.
- Allows nurse practitioners and physician assistants to be recognized as primary care providers.
- Allows primary care providers, behavioral health providers, and specialty care providers to be certified as patient-centered medical homes, providing patients with a single point of coordination.
- Establishes a new primary care residency program supported by DPH to increase the pipeline of primary care providers.

Transparency, Disclosure, and Administration Simplification

- Requires DOI to develop a summary of payments form to be used by all health care payers. The form would be provided to health care consumers and written in an easily readable and understandable format showing the consumer’s responsibility, if any, for payment of any portion of a health care provider claim.
- Requires the development of standard prior authorization forms, which would be available electronically, so that providers would use only one form for all payers.
- Authorizes penalties for non-compliance with standardized coding and billing requirements.
- Directs insurers to disclose in real-time the out-of-pocket costs for a proposed health care service and protects patients from paying more than the disclosed amount.
- Streamlines data reporting requirement by designating a single agency as the secure data repository for all health care information reported to and collected by the state.

HEALTH REFORM FACTS AND FIGURES

FALL 2012

Signed into law on April 12, 2006, the landmark Massachusetts healthcare reform represents a comprehensive effort to complement existing coverage programs. The goal is to provide near-universal coverage of the Massachusetts population.

KEY ELEMENTS

- Provides for legal residents who are not eligible for other public or employer-sponsored health insurance:
 - ✓ Completely subsidized, comprehensive health insurance to adults earning up to 150% of the federal poverty level (fpl).
 - ✓ Substantial premium subsidies to people earning above 150% and up to 300% of fpl.
 - ✓ Completely subsidized comprehensive coverage to children of parents earning up to 300% of fpl.
- Reforms the non-group and small-group health insurance markets to effectively lower the price and offer more choices for individuals purchasing unsubsidized products on their own.
- Requires adults in Massachusetts who can obtain affordable health insurance to do so.
- Requires employers of 11+ full-time equivalent employees in Massachusetts to make a fair and reasonable contribution toward coverage for full-time employees, or pay a Fair Share Assessment, and to offer both full-time and part-time employees a pre-tax, payroll deduction plan (a section 125 plan) for their own health insurance premium payments..

PROGRAMS

Commonwealth Care is a subsidized program for adults who are not offered employer-sponsored insurance, do not qualify for Medicare, Medicaid or certain other special insurance programs, and who earn up to 300% of fpl. In 2012, 300% of fpl is \$33,516 for an individual; \$69,156 for a family of four.

There are plans available with *no monthly premiums* for adults earning 100% or less of the federal poverty level and also up to 150 fpl if they choose the lowest-priced plan. That's \$11,172 for an individual and \$23,052 for a family of four up to 100 fpl; and \$16,764 for an individual and \$34,584 for a family of four up to 150 fpl. For premium payers, plans are currently available for \$39 a month for an individual earning between \$16,764 and \$22,344; \$77 for an individual earning between \$22,345 and \$27,936; and \$116 if earning between \$27,937 and \$33,516.

There are no monthly premiums for the children of adults covered by Commonwealth Care, as the children are covered by MassHealth (Medicaid).

Commonwealth Choice is an unsubsidized offering of private health plans, selected by competitive bidding, and available through the Health Connector to individuals, families and certain employers in the state. The private plans have received the Connector's "Seal of Approval" to offer a range of benefits options, grouped by level of benefits and cost-sharing at the Bronze, Silver and Gold levels. There is also a special, lower priced Young Adults Plan offering, exclusively for individuals between the ages of 18 and 26.

These plans are offered directly through the Health Connector by eight health insurance carriers, six of which are non-profit, Massachusetts based:

- ✓ Blue Cross Blue Shield of Massachusetts,
- ✓ BMC HealthNet Plan
- ✓ CeltiCare,
- ✓ Fallon Community Health Plan,
- ✓ Harvard Pilgrim Health Care,
- ✓ Health New England,
- ✓ Neighborhood Health Plan and
- ✓ Tufts Health Plan.

Together, these plans represent about 90% of the commercial, licensed health insurance market.

Each of the plans offered through the Health Connector by the six carriers may also be purchased directly from the individual carriers.

Small employers with 50 or fewer workers are also able to purchase directly through the Health Connector's Business Express program. Some small employers may also qualify for a rebate of 15 percent of the contribution they make to their employees' coverage by taking part in Wellness Track.

ENROLLMENT

There are now 439,000 newly insured in the Commonwealth of Massachusetts since the outset of healthcare reform. Between the fall of 2006 and 2008, as measured in a survey by the Urban Institute, uninsured working-age adults declined from 13% to 4%. Large declines were evident across income categories, for both those earning above and below 300% of fpl.

As of March 2011, about 71,000 are in private commercial insurance, purchasing either through the Commonwealth Choice offering or directly on their own from private insurance carriers. As of Sept. 1, 2012, CommChoice membership is approximately

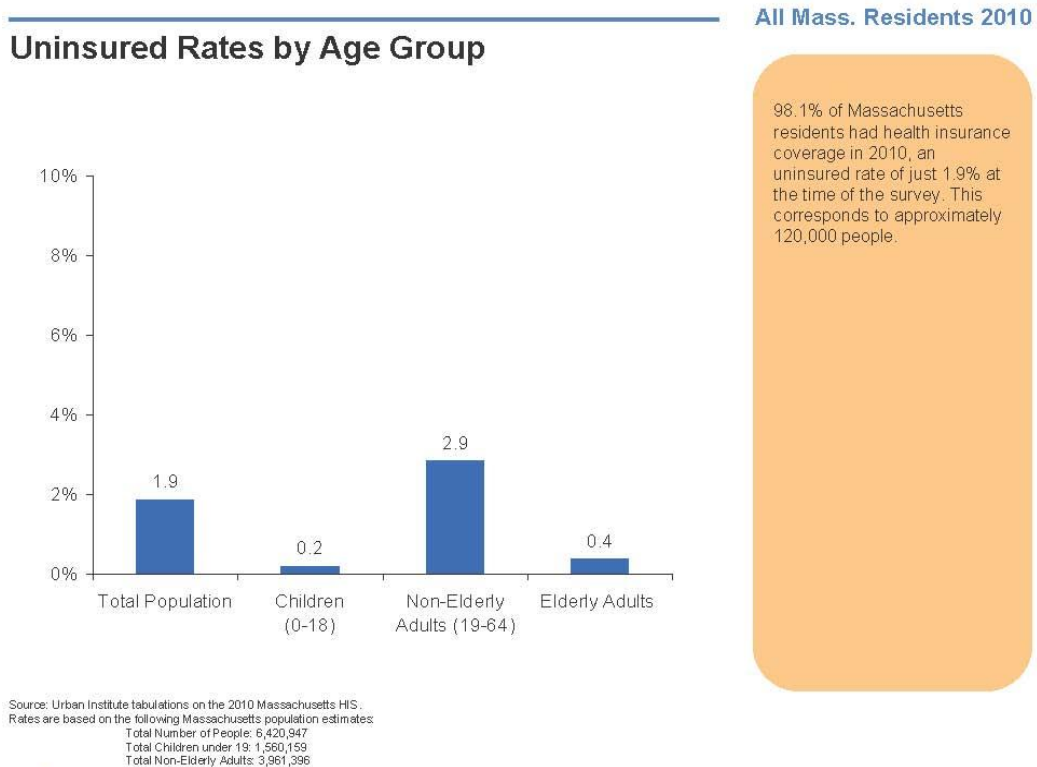
42,000. Approximately 4,500 of those members are small business workers and their dependents.

There are approximately 192,000 members in the Commonwealth Care program. About 72,000 pay a monthly premium. This includes members of the former Bridge program.

THE UNINSURED

Estimates of how many uninsured there were in Massachusetts when the landmark legislation was signed into law on April 12, 2006, range from 400,000 to 650,000. For tax year 2010, 92% of tax filers were insured for the full year while 96% were insured at some point during the year, according to the Massachusetts Department of Revenue. Only 44,000 were subject to the tax penalty. That figure has declined since the onset of reform when 67,000 were subject to a penalty in 2007, 53,000 in 2008 and 48,000 in 2009.

An estimate by the Division of Health Care Finance and Policy published in December 2010 showed that only 1.9% of Massachusetts residents remain uninsured as of summer of 2010.



ACCESS TO CARE

The Massachusetts Health Care Access Survey conducted by the University of New Hampshire Survey Center for the Blue Cross Blue Shield of Massachusetts Foundation and The Boston Globe in October 2008 reported that 92% of Massachusetts residents say they have a person they think of as their primary health care provider. Only 5% of Massachusetts residents said there was a time in the past year that they needed medical care, tests or treatments which they did not get. Only 1% of Massachusetts residents said they were unable to get needed counseling or mental health services.

COMMONWEALTH CARE PROGRAM COST

The Commonwealth Care program is funded by both the state and federal governments.

Spending was initially higher than projected because more members enrolled than had been anticipated. This suggests that the number of uninsured at the outset was closer to the federal estimate of more than 600,000 rather than the state's original estimate of 400,000.

Enrollment leveled off during FY 2009 as spending came in at \$805 million, which was \$69 million less than budgeted. When the legislative conferees who crafted the healthcare reform legislation in 2006 looked at future spending, they estimated it would cost \$725 million in FY09. Again, the difference is due to the number of eligible enrollees in Commonwealth Care.

Since the inception of the program in 2006, the average annual rate of increase in the capitation rate per covered person has been held to less than 2%. Governor Deval Patrick has proposed spending \$974 million for this program in FY 2013.

HEALTH SAFETY NET

Formerly known as the Uncompensated Care Pool, the Health Safety Net Fund provides medical services for residents whose income is below 400% of fpl and do not qualify for MassHealth and Commonwealth Care. Spending has declined significantly since the implementation of reform. It has gone from \$652 million in FY06 to \$414 million in FY09. These savings are being used to support several aspects of the Massachusetts healthcare reform effort, including Commonwealth Care.

Since health insurance provides a broader range of care, including visits to private doctors and specialists, than the episodic visits paid through the pool, reductions in free care spending will not cover the total cost of subsidies.

PUBLIC SUPPORT

Support for the initiative to insure nearly all Massachusetts adults has grown since implementation in 2006, according to surveys done by the Harvard School of Public Health and the Blue Cross Blue Shield Foundation of Massachusetts. In September 2006 support among likely voters was measured at 61%. Six years later, support remains strong at 63%. In another survey, support is estimated as high as 75%.

There is also broad support among the business community. A November 2007 survey commissioned by the Blue Cross Blue Shield of Massachusetts Foundation and the Robert Wood Johnson Foundation showed that 77% of employers in the state agreed that employers bear some responsibility for providing health benefits to their workers.

HEALTH REFORM IN MASSACHUSETTS

EXPANDING ACCESS TO HEALTH INSURANCE COVERAGE

ASSESSING THE RESULTS

MAY 2012



FOUNDATION
MASSACHUSETTS

May 2012

Health Reform in Massachusetts, Expanding Access to Health Insurance Coverage: Assessing the Results pulls together in one publication the findings of surveys and other efforts to monitor the impact of the 2006 Massachusetts health reform law.

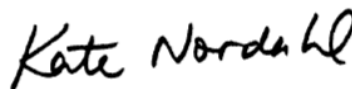
The charts in this report track the impact of Massachusetts health reform efforts on coverage and access to care, the response to the individual mandate, employer participation in providing coverage to employees, and public opinion. Data come from surveys and analyses by state government agencies including the Massachusetts Division of Health Care Finance and Policy, the Massachusetts Department of Revenue, and the Massachusetts Health Insurance Connector Authority. In addition, highlights from health reform tracking surveys conducted annually by the Urban Institute are included as well (the Massachusetts Health Insurance Survey and the Massachusetts Health Reform Survey).

This report has been designed to support use of the charts in slide presentations and we encourage readers to do so. We plan to update this publication regularly with the latest results from ongoing monitoring efforts as they become available.

Sincerely,



Sarah Iselin, President
Blue Cross Blue Shield of Massachusetts Foundation



Kate Nordahl, Director
Massachusetts Medicaid Policy Institute

TABLE OF CONTENTS

- SLIDE 3 Executive Summary
- SLIDES 4-5 Key Components of Massachusetts Health Reform
- SLIDES 6-12 Coverage
- SLIDES 13-15 Individual Responsibility
- SLIDES 16-22 Employer Responsibility
- SLIDES 23-30 Affordability, Access, and Use
- SLIDES 31-35 Public Support for Reform
- SLIDES 36-42 Remaining Opportunities and Challenges

EXECUTIVE SUMMARY

- 439,000 more Massachusetts residents have health insurance coverage than did before reform.
- Massachusetts has the highest rate of insurance in the country with 98.1 percent of residents insured.
- There has been no evidence of subsidized coverage “crowding out” employer-sponsored insurance, and employer offer rates have grown from 70 percent to 77 percent since implementation of reform.
- Public support for Massachusetts health reform has remained strong with two out of three adults supporting reform.
- Most employers believe health reform has been good for Massachusetts and 88 percent of Massachusetts physicians believe reform improved, or did not affect, care or quality of care.
- The cost of health care and the annual rate of increase in health care spending remains a challenge. With no intervention, per capita health care spending in Massachusetts is projected to nearly double by 2020.

KEY COMPONENTS OF MASSACHUSETTS HEALTH REFORM UNDER CHAPTER 58

INDIVIDUAL RESPONSIBILITY

- Applies to all adults (ages >17 years) if affordable coverage is available
- Coverage must meet “minimum creditable coverage” standards
- Mandate penalties may not exceed one-half of least expensive monthly premium available through the Health Connector and do not apply to individuals with incomes <150% FPL or those with a religious exemption

EMPLOYER RESPONSIBILITY

- Employers with ≥ 11 full-time equivalent (FTE) employees must demonstrate a “fair and reasonable” contribution towards employee coverage or pay a penalty of up to \$295 per FTE
- Employers with ≥ 11 FTE employees must offer a Section 125 plan or pay a “free rider” surcharge if employees use significant Health Safety Net resources

GOVERNMENT SUBSIDIES FOR LOW-INCOME RESIDENTS

- Expansion of Medicaid (MassHealth) for children up to 300% FPL
- Creation of subsidized insurance (Commonwealth Care) for adults up to 300% FPL offered through the Health Connector

EXPANDED INSURANCE OPTIONS FOR INDIVIDUAL DIRECT PURCHASE

- Merged small and non-group insurance markets to pool insurance risk and allow for broader array of products
 - Premiums based on broader risk pool of each insurer’s combined small group and individual purchase members
- Standardization of direct purchase products (Commonwealth Choice)
 - Premiums based on merged small and individual market within ratings bands (age, geography, industry)
 - Three standard benefit levels: Bronze, Silver, and Gold
 - Available for purchase via the Health Connector or directly from health plans
- Creation of new insurance products with limited benefits for young adults (ages 18 to 26)

NOTE: FPL is the Federal Poverty Level.

PRE-REFORM FACTORS FACILITATED MASSACHUSETTS HEALTH REFORM IMPLEMENTATION

- Low rate of uninsurance
 - Primarily due to high rates of employer offer of health insurance, prior Medicaid eligibility expansions, and deep Medicaid penetration among those eligible
- Strong existing financing infrastructure
 - Expansive Medicaid (“MassHealth”) 1115 waiver program upon which to implement eligibility determination and managed care plan contracting to support subsidized Commonwealth Care Plan
 - Existing 1115 waiver funding able to be shifted from institution-based support to subsidize coverage for previously uninsured
- Many key insurance market reforms already in place
 - Guaranteed issue in non-group market
 - Modified community rating in small group market
- Well-developed network of outreach programs and training
 - State and the Blue Cross Blue Shield of Massachusetts Foundation-funded mini-grants
- Ch. 58 intentionally focused on access to coverage; cost containment left for future reforms
 - Most significant cost containment element of Ch. 58 legislation was creation of a Health Care Quality and Cost Council to develop statewide goals for cost and quality and make cost and quality information transparent to consumers

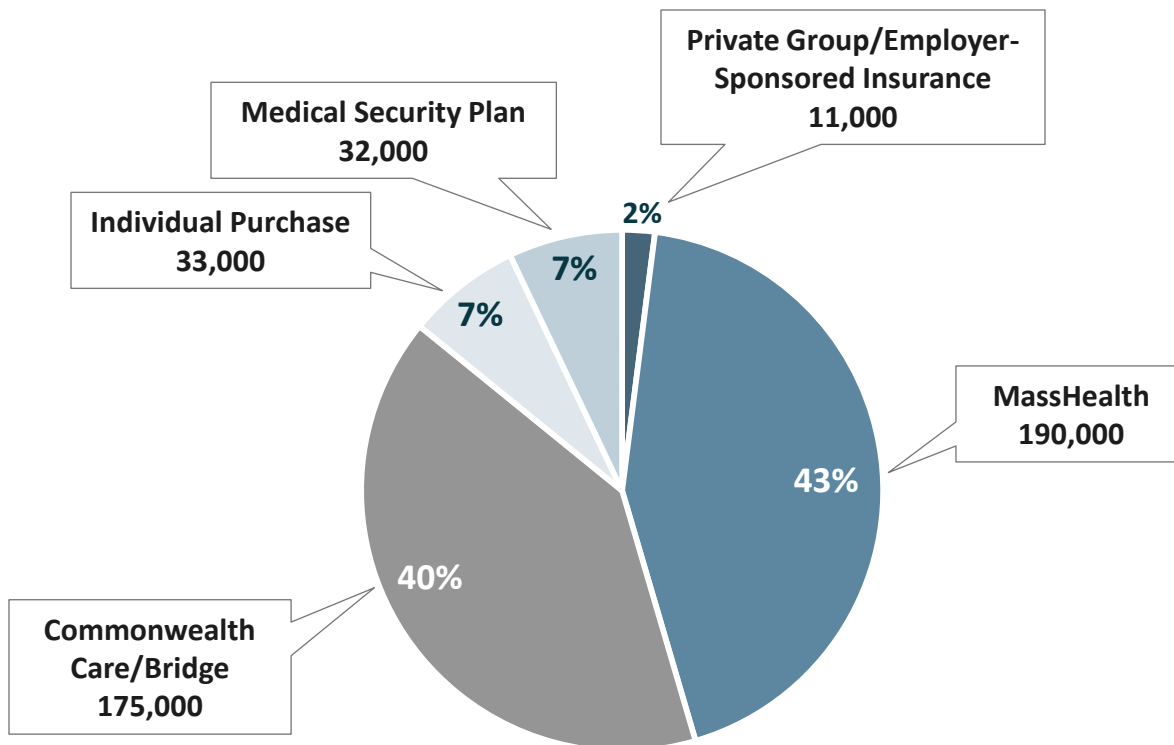
WHAT HAS MASSACHUSETTS ACHIEVED RELATIVE TO ITS HEALTH COVERAGE GOALS?

- 439,000 more Massachusetts residents have gained health insurance coverage than had it before reform.
- Massachusetts now has the highest rate of health insurance coverage in the nation.
 - 98.1 percent of Massachusetts residents are insured.
 - 99.8 percent of Massachusetts children are insured.
- Since reform, insurance coverage has increased most significantly for non-elderly adults, particularly for low-income adults.
- The remaining uninsured are more likely to be young, single, male, non-elderly low-income adults, and/or of Hispanic ethnicity.

SOURCE: Massachusetts Division of Health Care Finance and Policy, *Key Indicators*, June 2011 and *Massachusetts Health Insurance Survey*, 2010.

439,000 MORE RESIDENTS HAVE COVERAGE THAN HAD IT BEFORE HEALTH REFORM

INCREASE IN NUMBER OF INSURED MASSACHUSETTS RESIDENTS BETWEEN 2006 AND 2011, BY COVERAGE TYPE



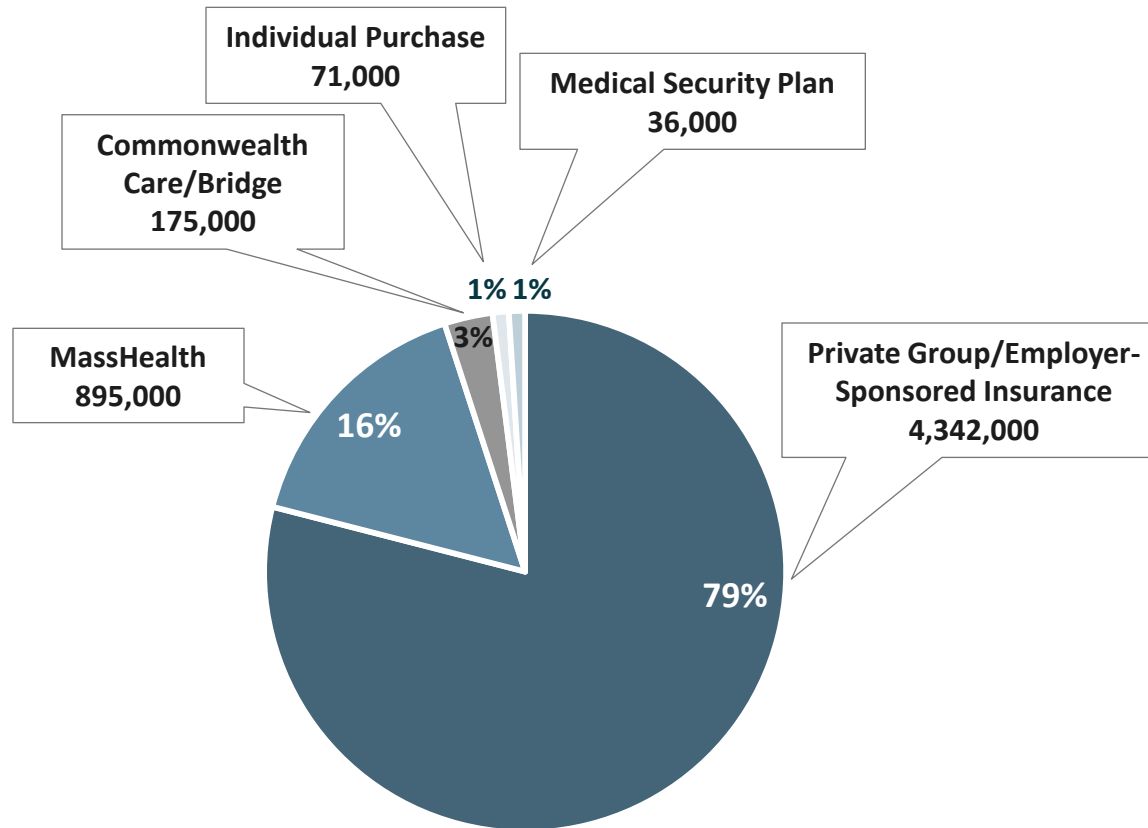
As of March 2011, most of the increased coverage since reform has been through public programs. Increases in employer-sponsored initially were much larger but have since declined as a result of the recession.

NOTE: Numbers may not add due to rounding.

SOURCES: Massachusetts Division of Health Care Finance and Policy, *Key Indicators*, May 2011 and June 2011.

EMPLOYER-SPONSORED INSURANCE REMAINS THE DOMINANT SOURCE OF COVERAGE

INSURED POPULATION 2011, BY COVERAGE TYPE

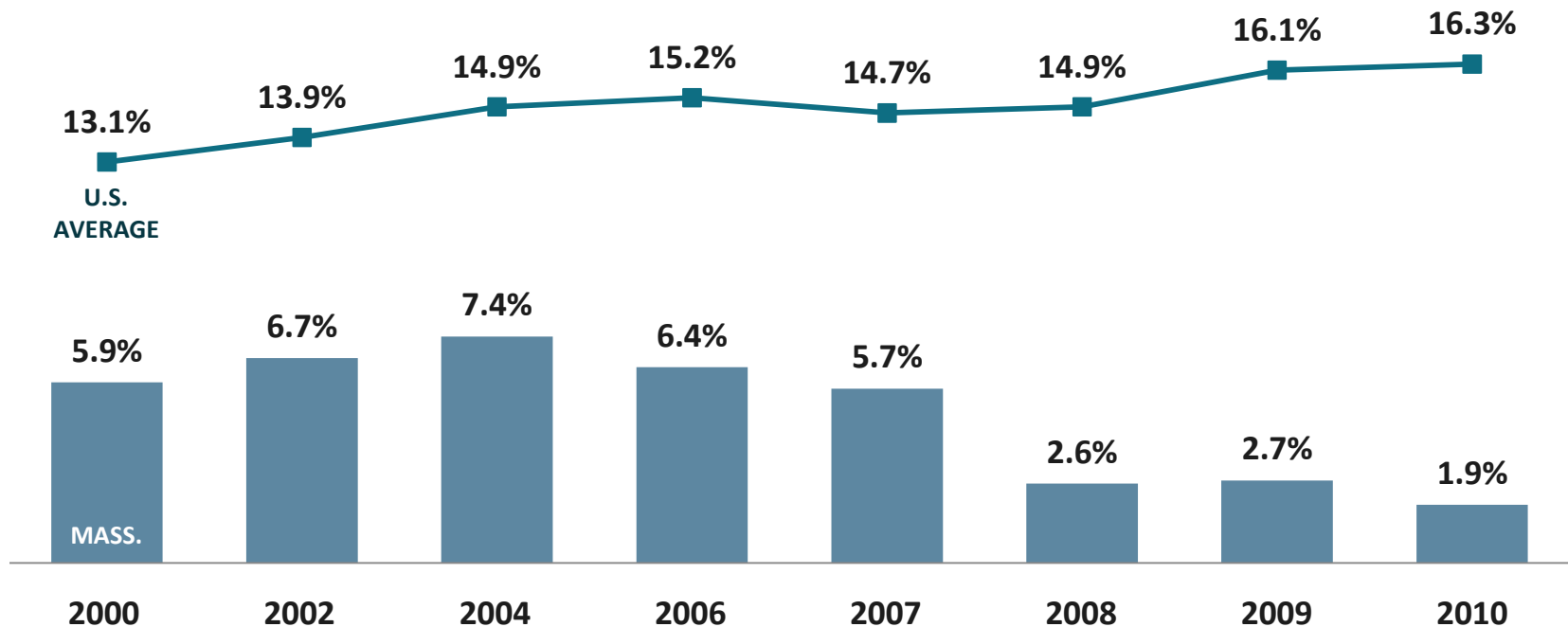


Private group and employer-sponsored coverage continues to be the most common type of coverage (79 percent) for Massachusetts residents under health reform.

source: Massachusetts Division of Health Care Finance and Policy, *Key Indicators*, June 2011.

MASSACHUSETTS NOW HAS THE LOWEST RATE OF UNINSURANCE IN THE COUNTRY

PERCENT UNINSURED, ALL AGES

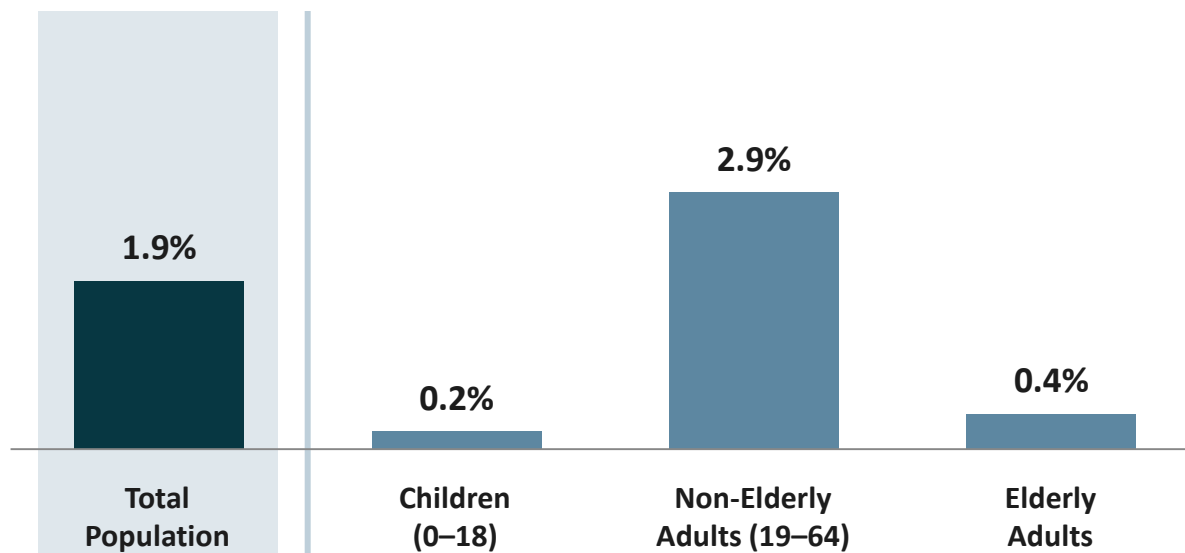


NOTE: The Massachusetts specific results are from a state-funded survey — the Massachusetts Health Insurance Survey (MHIS). Using a different methodology, researchers at the Urban Institute estimated that 507,000 Massachusetts residents were uninsured in 2005, or approximately 8.1 percent of the total population. Starting in 2008, the MHIS sampling methodology and survey questionnaire were enhanced. These changes may affect comparability of the 2008 and later results to prior years. The national comparison presented here utilizes a different survey methodology, the Current Population Survey, which is known to undercount Medicaid enrollment in some states.

SOURCES: Urban Institute, *Health Insurance Coverage and the Uninsured in Massachusetts: An Update Based on 2005 Current Population Survey Data In Massachusetts*, 2007; Massachusetts Division of Health Care Finance and Policy, *Massachusetts Health Insurance Survey 2000, 2002, 2004, 2006, 2007, 2008, 2009, 2010*; U.S. Census Bureau, Current Population Survey 2010.

NON-ELDERLY ADULTS ARE MORE LIKELY TO BE UNINSURED THAN CHILDREN OR ELDERLY ADULTS

PERCENT UNINSURED, 2010, BY AGE



Non-elderly adults represent 95 percent of the remaining uninsured in Massachusetts, but also experienced the greatest age-related gains in coverage under health reform.

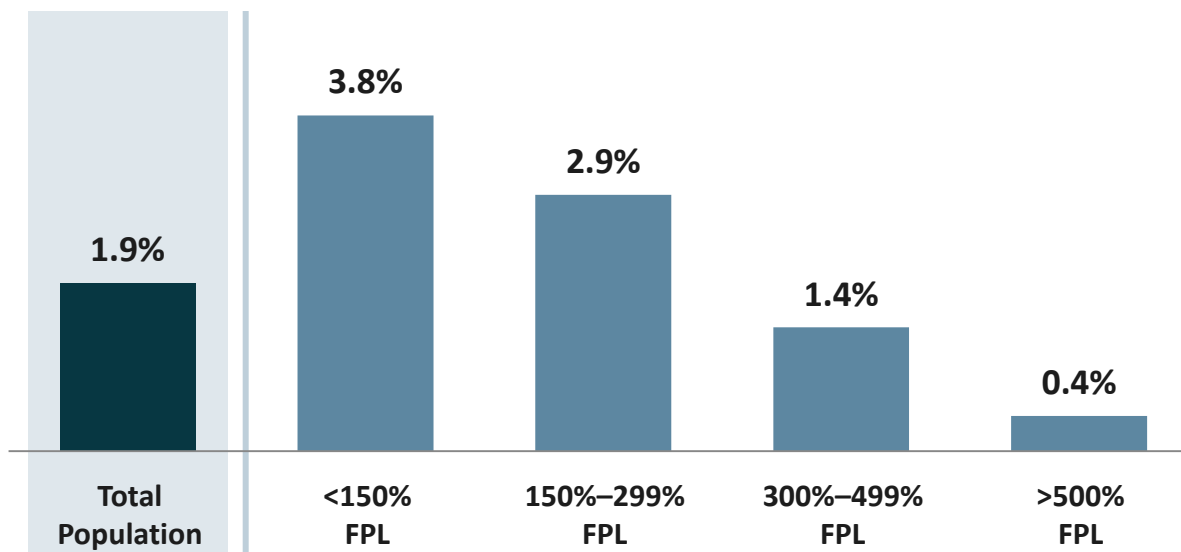
REMAINING UNINSURED, BY AGE

Total Uninsured	Children (0-18)	Non-Elderly Adults (19-64)	Elderly Adults
120,000	2.7%	94.5%	2.8%

SOURCE: Massachusetts Division of Health Care Finance and Policy, *Massachusetts Health Insurance Survey*, 2010.

LOW-INCOME RESIDENTS ARE MORE LIKELY TO BE UNINSURED THAN HIGHER-INCOME RESIDENTS

PERCENT UNINSURED, 2010, BY INCOME



REMAINING UNINSURED, BY INCOME

Total Uninsured	<150% FPL	150%–299% FPL	300%–499% FPL	>500% FPL
120,000	42.9%	29.2%	20.2%	7.7%

NOTE: FPL is the Federal Poverty Level.

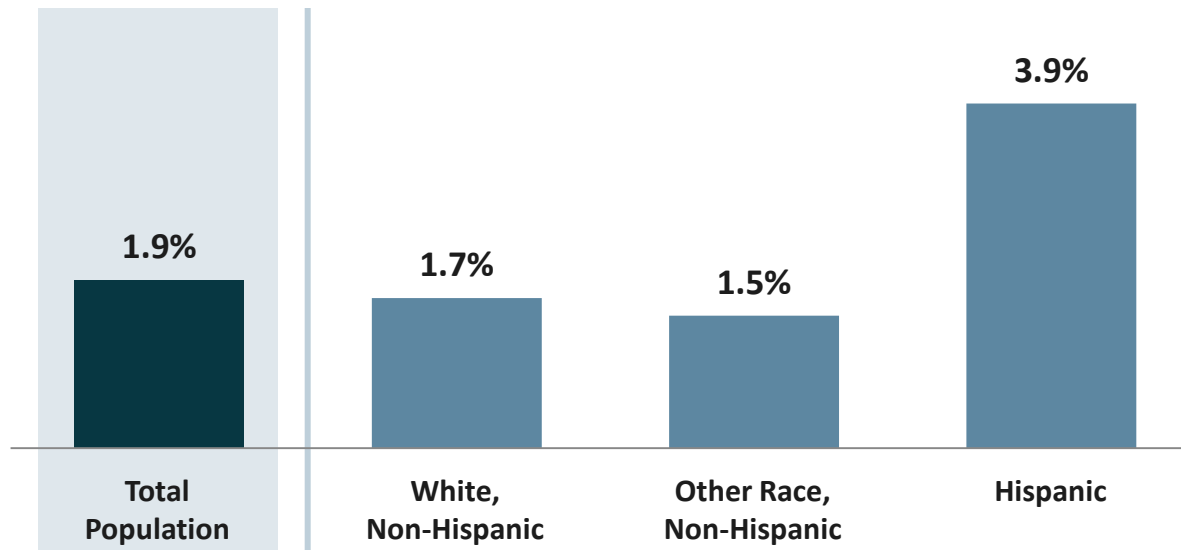
SOURCE: Massachusetts Division of Health Care Finance and Policy, *Massachusetts Health Insurance Survey*, 2010.

Low-income residents (family household income under 300 % of the FPL) comprise 72 percent of the remaining uninsured in Massachusetts, but only 40 percent of the insured population (data not shown).

While low-income residents are more likely to be uninsured, they have demonstrated the most dramatic income-related gains in coverage under health reform.

HISPANIC RESIDENTS ARE MORE LIKELY TO BE UNINSURED

PERCENT UNINSURED, 2010, BY RACE/ETHNICITY



REMAINING UNINSURED, BY RACE/ETHNICITY

Total Uninsured	White, Non-Hispanic	Other Race, Non-Hispanic	Hispanic
120,000	73.7%	10.8%	15.5%

While there are few disparities in coverage between white and other residents of non-Hispanic ethnicity, residents of Hispanic ethnicity are twice as likely to be uninsured and comprise nearly 16 percent of the remaining uninsured.

SOURCE: Massachusetts Division of Health Care Finance and Policy, *Massachusetts Health Insurance Survey*, 2010.

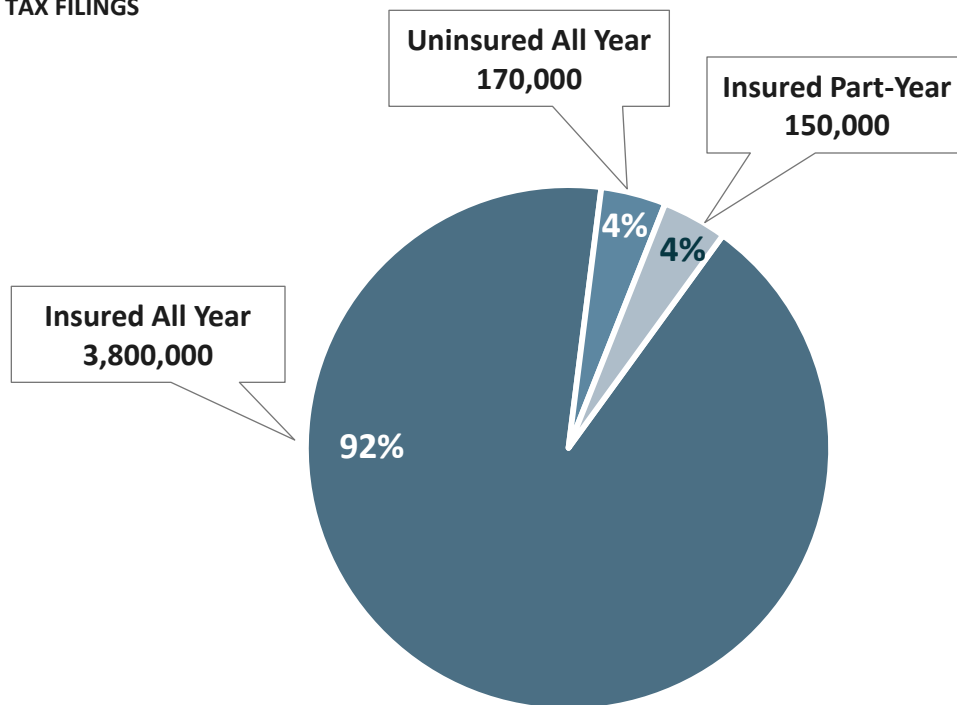
WHAT HAS BEEN THE EXPERIENCE WITH THE INDIVIDUAL MANDATE IN MASSACHUSETTS?

- 99 percent of the 4.2 million tax filers required to file information on their health insurance status complied with the filing requirement.
- Most (92 percent) tax filers comply with the individual mandate by having insurance year-round.
- Most uninsured tax filers were exempt from the individual mandate due to their low income (<150 percent of the FPL), inability to afford coverage, or religious exemption.
- Fewer than 1.2 percent of tax filers who were subject to the mandate were assessed a penalty on their 2009 return.

SOURCE: Massachusetts Health Connector and Department of Revenue; *Data on the Individual Mandate Tax Year 2009*, November 2011.

MOST MASSACHUSETTS TAX FILERS COMPLY WITH THE INDIVIDUAL MANDATE BY HAVING INSURANCE YEAR-ROUND

2009 TAX FILINGS

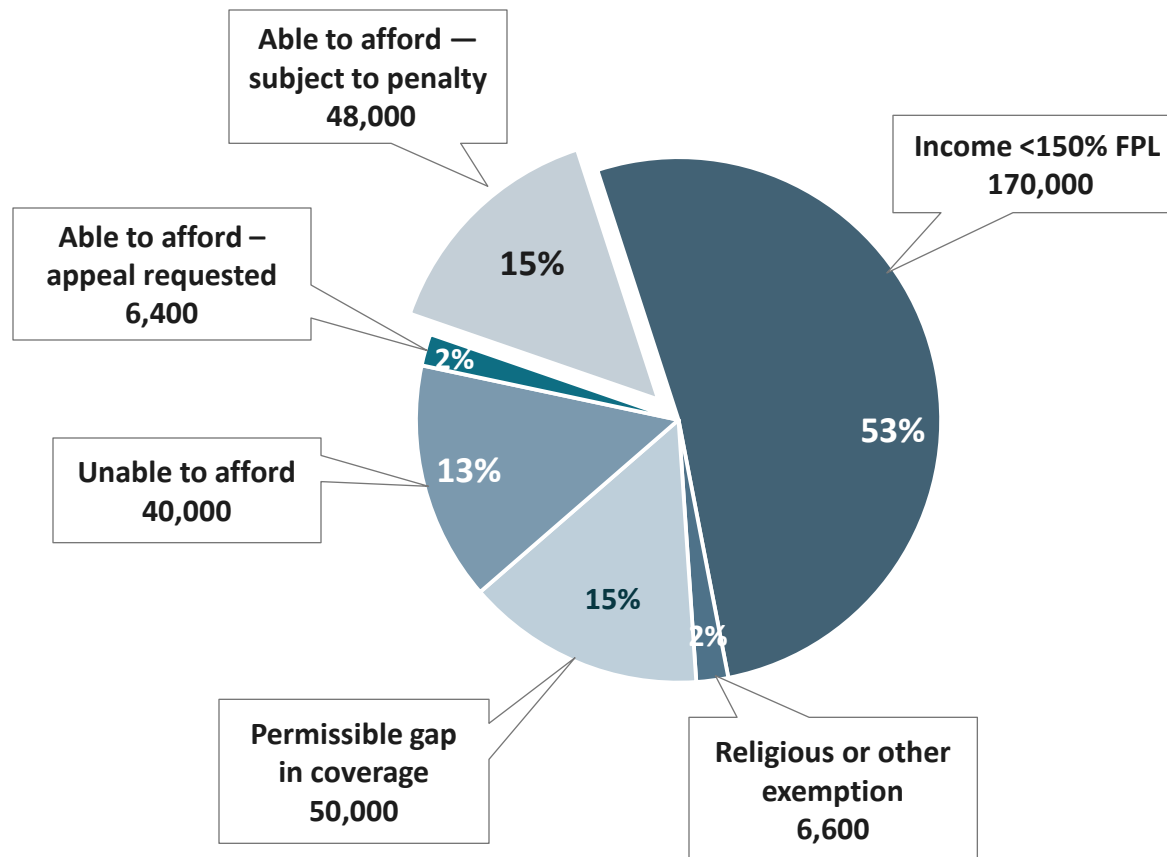


During calendar year 2009, 4 percent of tax filers were uninsured for part of the year and 4 percent were uninsured for the entire year.

SOURCE: Massachusetts Health Connector and Department of Revenue; *Data on the Individual Mandate Tax Year 2009*, November 2011.

VERY FEW MASSACHUSETTS TAX FILERS WERE SUBJECT TO A PENALTY

DISTRIBUTION OF FULL-YEAR AND PART-YEAR UNINSURED, 2009 TAX FILINGS



Most (81 percent) tax filers who were uninsured for some or all of the year were exempt due to low income, inability to afford coverage, or they experienced a permissible gap in coverage during the year.

SOURCE: Massachusetts Health Connector and Department of Revenue; *Data on the Individual Mandate Tax Year 2009*, November 2011.

WHAT HAS BEEN THE ROLE OF EMPLOYERS UNDER MASSACHUSETTS HEALTH REFORM?

- There has been no evidence of subsidized coverage “crowding out” employer-sponsored insurance (ESI).
 - Employer offers of coverage have increased.
 - Take-up of employer-offered coverage has remained high.
 - The number and percentage of people with ESI coverage has increased.
- Overall, employers have decreased their contributions towards the cost of employee health insurance as premiums have grown.
- Most employers have met the state’s “Fair Share” requirements.
- More employers are taking advantage of federal Section 125 tax provisions which allow employees to purchase health insurance on a pre-tax basis.

EMPLOYER OFFER RATES HAVE GROWN UNDER MASSACHUSETTS REFORM

PERCENT OFFERING INSURANCE COVERAGE AT TIME OF SURVEY

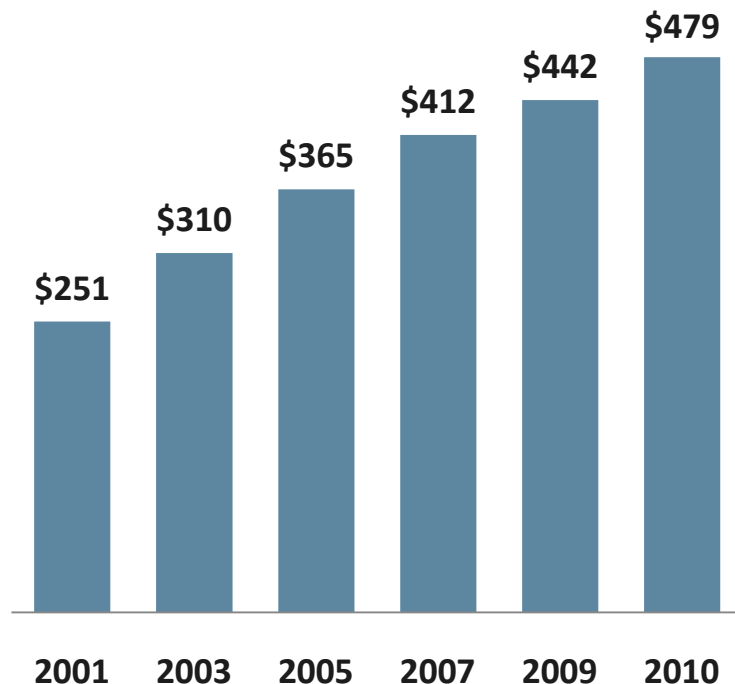


More Massachusetts employers are offering health insurance as compared to the national offer rate.

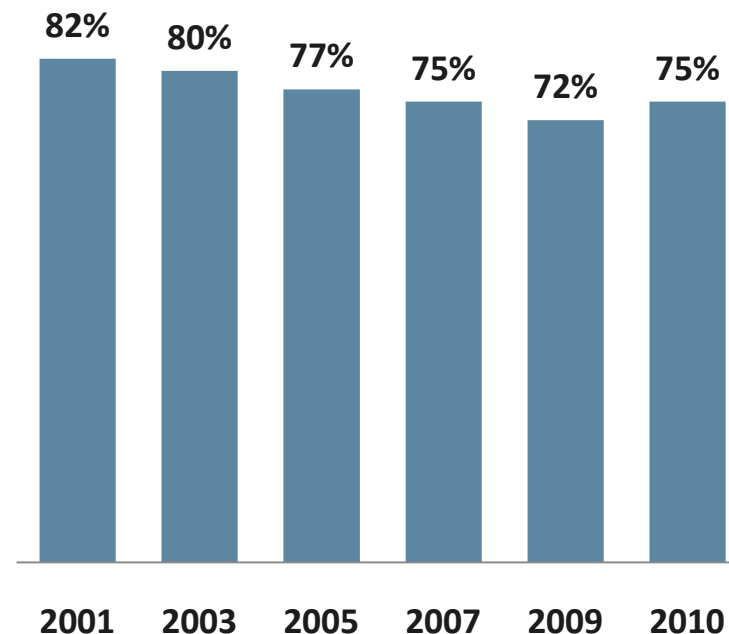
SOURCES: Massachusetts Division of Health Care Finance and Policy, *Massachusetts Employer Survey*, 2010; Kaiser/HRET, *Survey of Employer Sponsored Benefits*.

AS PREMIUMS HAVE INCREASED, EMPLOYERS' SHARE OF PREMIUMS HAS FALLEN OVERALL

MEDIAN PREMIUM FOR INDIVIDUAL COVERAGE IN MA



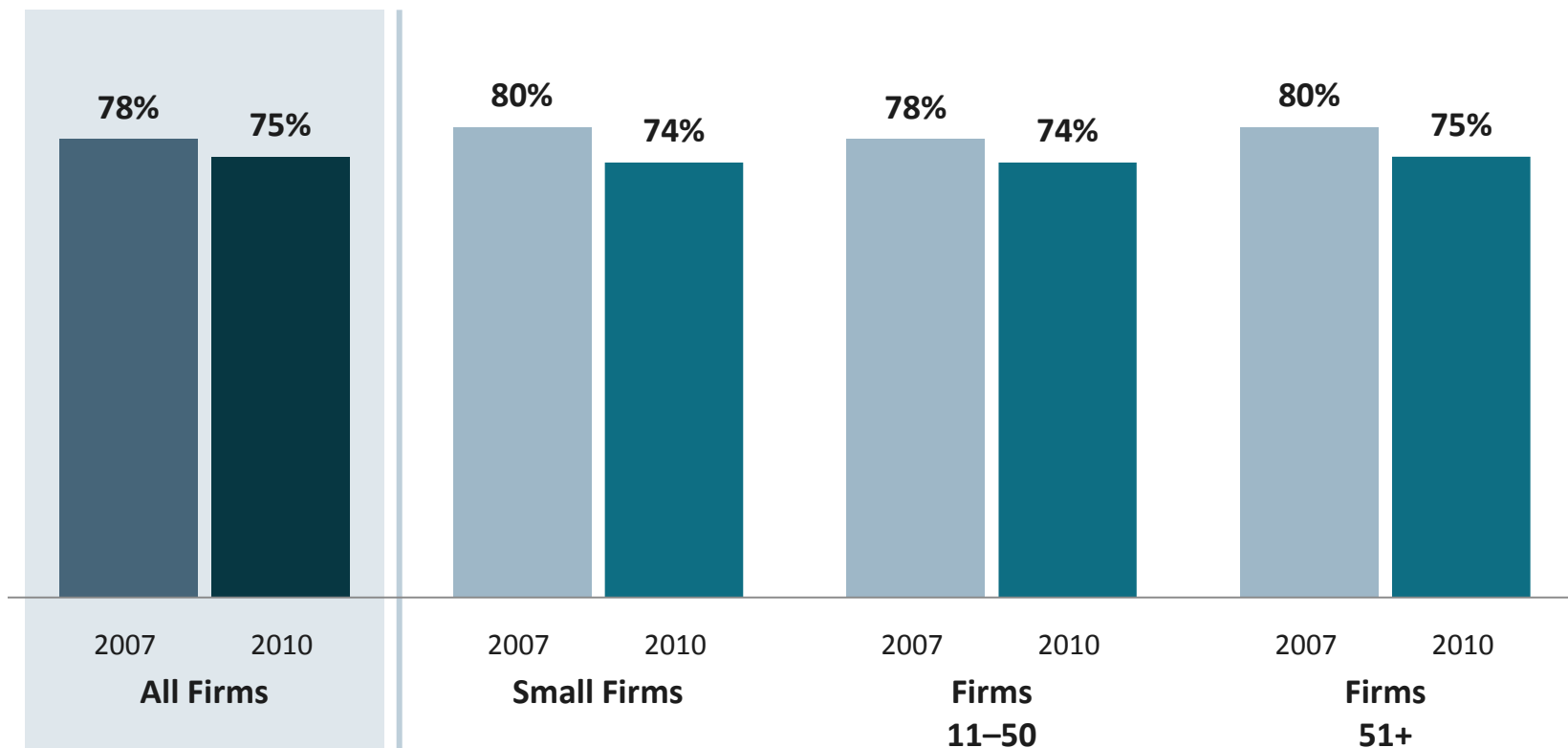
MA EMPLOYER CONTRIBUTION TOWARD INDIVIDUAL COVERAGE



source: Massachusetts Division of Health Care Finance and Policy, *Massachusetts Employer Survey*, 2010.

EMPLOYEE TAKE-UP OF EMPLOYER-SPONSORED INSURANCE HAS REMAINED STRONG OVERALL

PERCENT TAKE-UP OF EMPLOYER OFFER OF INSURANCE

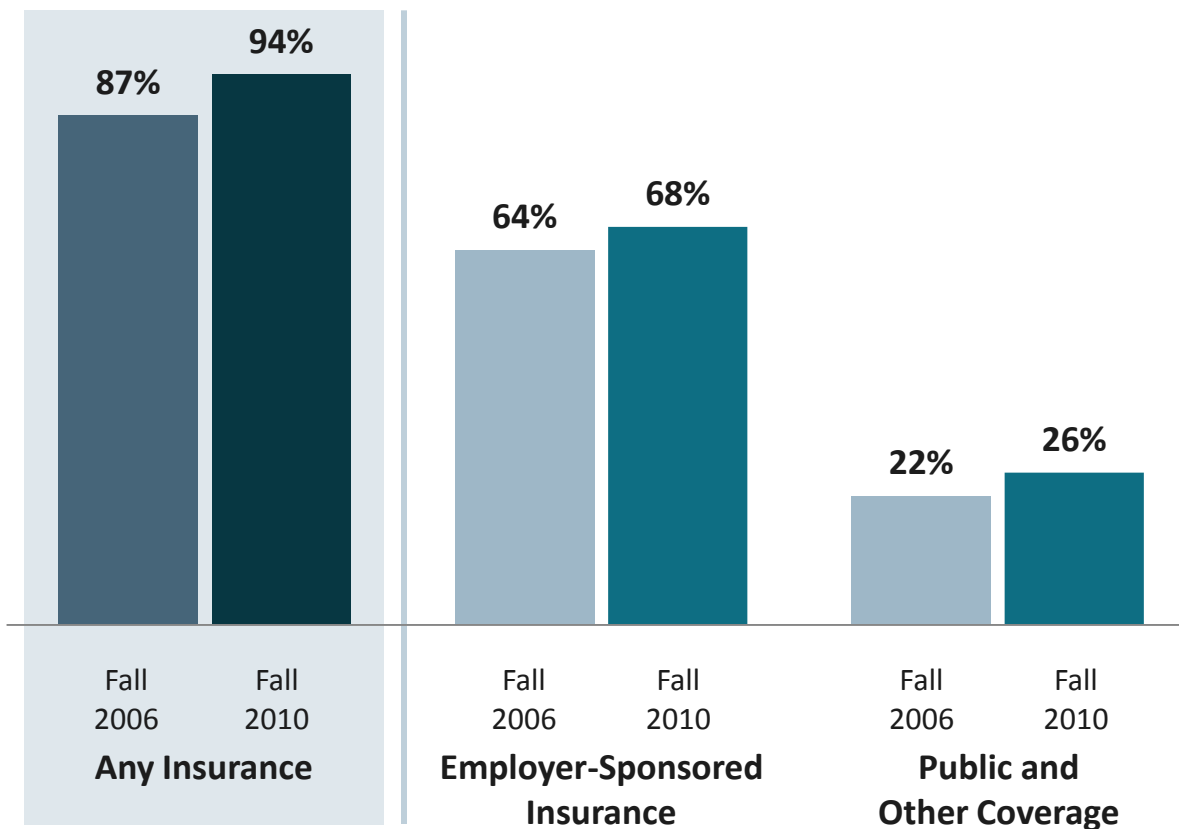


NOTE: In 2007, "small firms" referred to firm size of 2 to 9 employees whereas in 2009, this category referred to firm size of 3 to 10 employees.

SOURCE: Massachusetts Division of Health Care Finance and Policy, *Massachusetts Employer Survey*, 2010.

THERE IS NO EVIDENCE OF PUBLIC COVERAGE “CROWDING OUT” EMPLOYER-SPONSORED INSURANCE AMONG WORKING-AGE ADULTS

SOURCE OF INSURANCE COVERAGE FOR NON-ELDERLY ADULTS IN MASSACHUSETTS

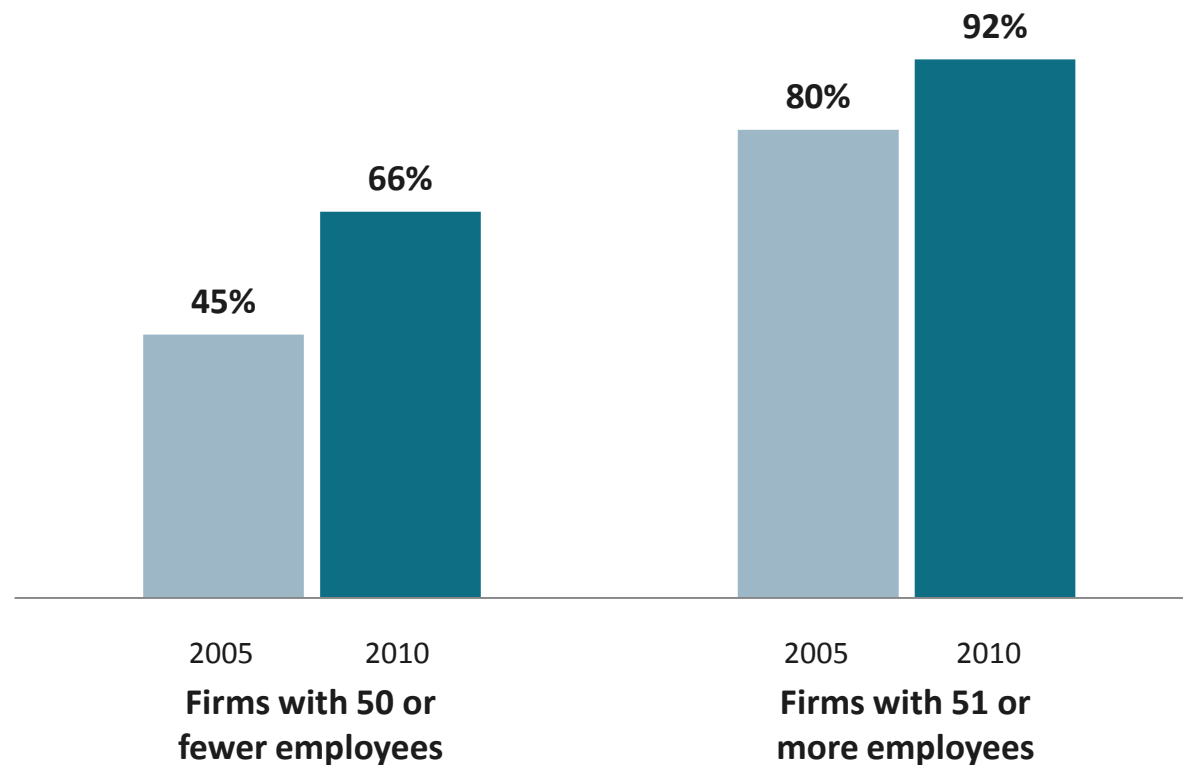


Most Massachusetts residents continue to be covered by employer-sponsored insurance. Since reform, the percent of Massachusetts working age adults with employer-sponsored coverage has grown.

source: Urban Institute, *Massachusetts Health Reform Survey*, 2012.

NEARLY ALL LARGE EMPLOYERS NOW OFFER SECTION 125 PLANS AND MANY MORE SMALL EMPLOYERS OFFER THEM THAN DID PRIOR TO HEALTH REFORM

PERCENT OF EMPLOYERS OFFERING SECTION 125 PLANS



Section 125 plans allow employees to purchase health insurance coverage using use pre-tax income.

Massachusetts health reform requires employers with 11 or more employees to offer a Section 125 plan. Many more small employers now offer them than did prior to health reform.

source: Massachusetts Division of Health Care Finance and Policy, *Massachusetts Employer Survey*, 2010.

MOST MASSACHUSETTS EMPLOYERS HAVE BEEN FOUND TO MEET THE STATE'S DEFINITION OF A "FAIR AND REASONABLE" CONTRIBUTION TOWARD HEALTH INSURANCE COVERAGE

- Approximately 12 percent of all employers in Massachusetts are subject to Fair Share requirements (i.e., have 11 or more FTEs).
- More than 95 percent of filing firms have passed the Fair Share test in each year of health reform implementation.
- In filing year 2010, 1,017 firms were found not to be making a "fair and reasonable" contribution and were liable for \$17.1 million in assessments.

NOTE: "Fair Share" was defined more leniently during FY07 and FY08. Firms with 50 or more full time equivalent employees (FTEs) were able to "pass" the Fair Share test if they either demonstrated 25% of employees take-up their employer's offer of insurance or they offered to pay 33% of insurance cost. In FY09, the test was changed such that an employer with more than 50 FTEs in Massachusetts needs to satisfy both conditions or, alternatively, have at least 75% of its FTEs enrolled in the employer's plan. Employers with 50 or fewer Massachusetts employees are still only required to satisfy either condition.

SOURCE: Percentage of firms subject to Fair Share based on data filed with Division of Unemployment Assistance. Data on Fair Share results from Massachusetts Division of Health Care Finance and Policy, *Fair Share Contribution: Filing Year 2010 Results and Analyses*.

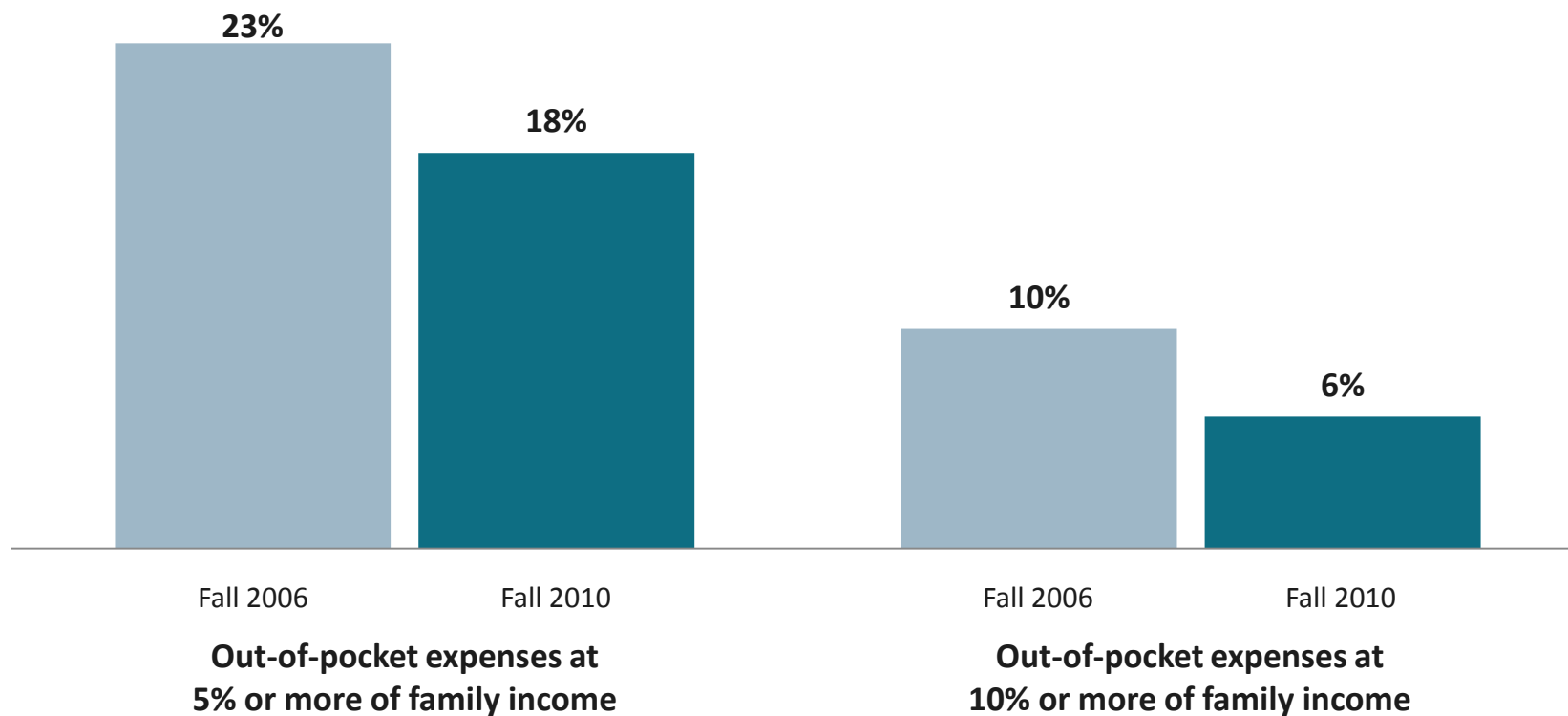
HOW HAS MASSACHUSETTS HEALTH REFORM AFFECTED AFFORDABILITY, ACCESS, AND USE OF HEALTH CARE?

- Low- and moderate-income adults are less likely to report high out-of-pocket health expenses.
- All adults, and lower-income adults in particular, experienced a significant decline in unmet health care needs due to cost.
- Access to care increased for all adults, with significant increases in the use of doctors, preventive care, and dental services, and in the percent of adults with a usual source of care.
- Unmet need for care decreased across middle and low-income, minority race/ethnicity, and chronically ill population groups.
- Racial and ethnic disparities in access to and use of care have decreased significantly.

source: Urban Institute, *Massachusetts Health Reform Survey*, 2010.

FEWER MASSACHUSETTS ADULTS HAVE SIGNIFICANT OUT-OF-POCKET HEALTH EXPENSES

PERCENT OF NON-ELDERLY ADULT POPULATION WITH FAMILY INCOME LESS THAN 500% FPL WHO SPENT 5 OR 10 PERCENT OF INCOME ON OUT-OF-POCKET HEALTH CARE COSTS

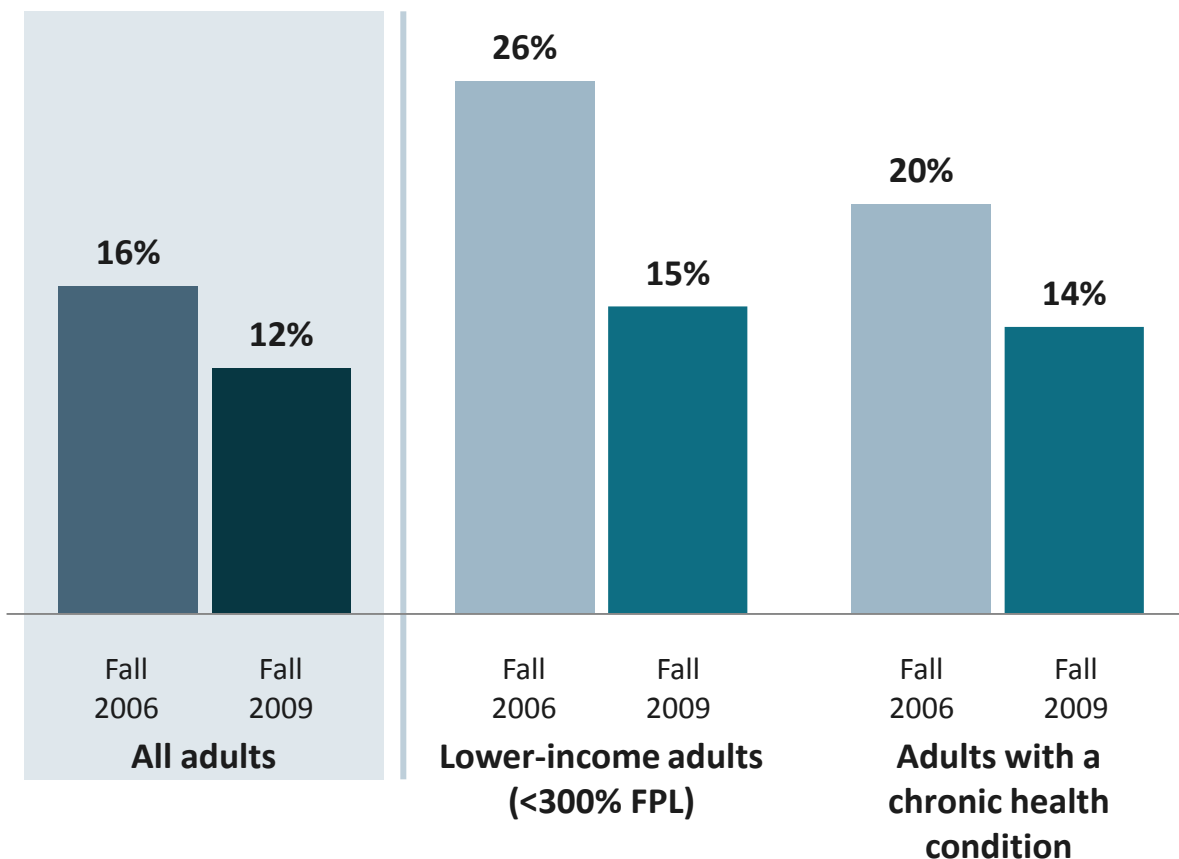


NOTE: "Out-of-pocket" health care costs includes deductibles, co-insurance, co-payments, but excludes the cost of premiums.

SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2012.

FEWER MASSACHUSETTS ADULTS HAVE UNMET HEALTH CARE NEEDS DUE TO COST

PERCENT OF NON-ELDERLY ADULTS REPORTING UNMET NEED DUE TO COST, SELECTED POPULATIONS

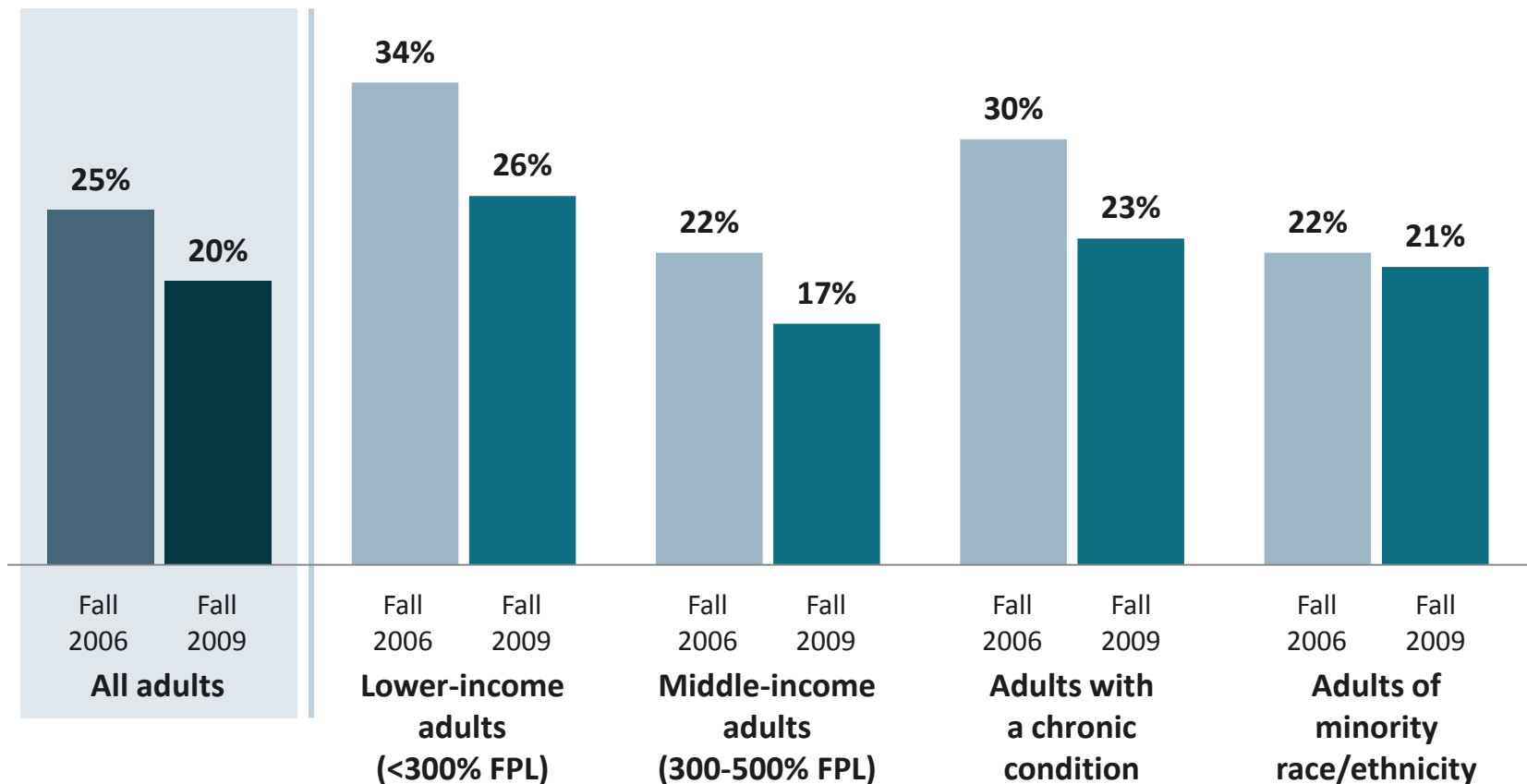


Under health reform, unmet needs due to cost fell between 30 and 40 percent among low-income residents and residents with chronic health conditions.

SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2010.

UNMET NEED FOR CARE FOR ANY REASON HAS DECREASED SINCE REFORM

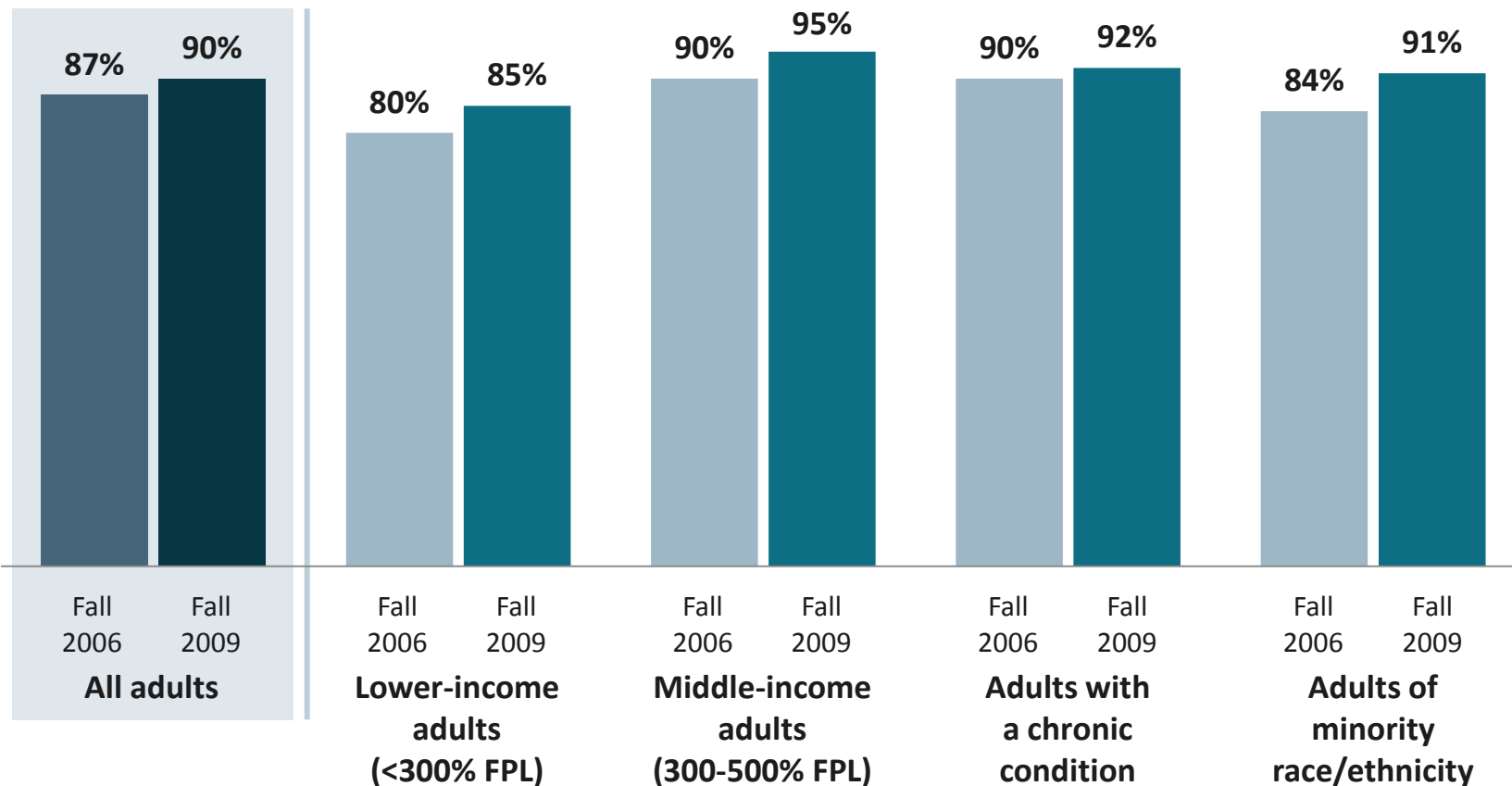
PERCENT OF NON-ELDERLY ADULTS REPORTING AN UNMET NEED FOR CARE FOR ANY REASON, BY SELECTED POPULATIONS



SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2010.

MORE MASSACHUSETTS ADULTS HAVE A USUAL SOURCE OF CARE

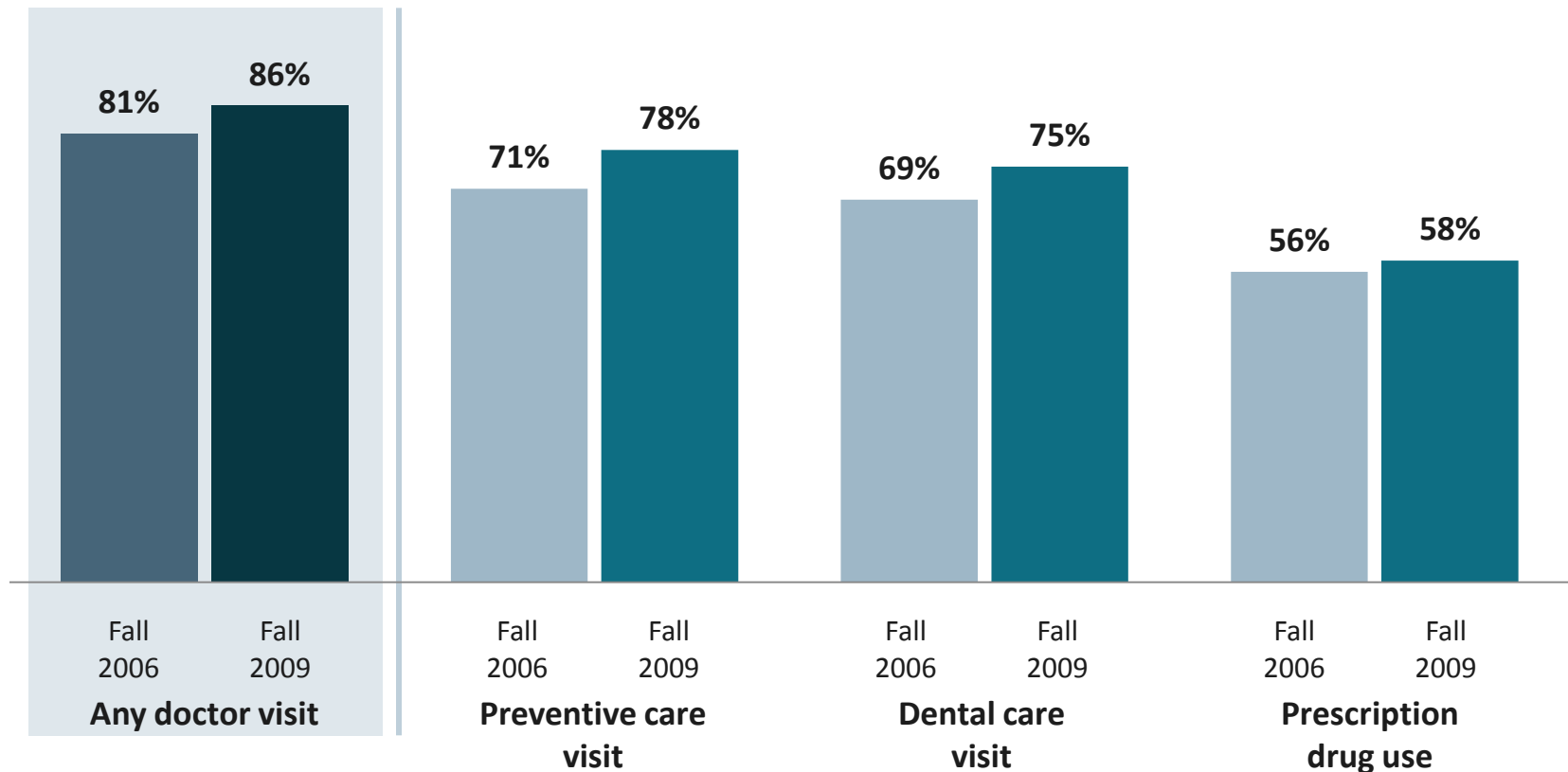
PERCENT OF NON-ELDERLY ADULTS REPORTING A USUAL SOURCE OF CARE, SELECTED POPULATIONS



source: Urban Institute, *Massachusetts Health Reform Survey*, 2010.

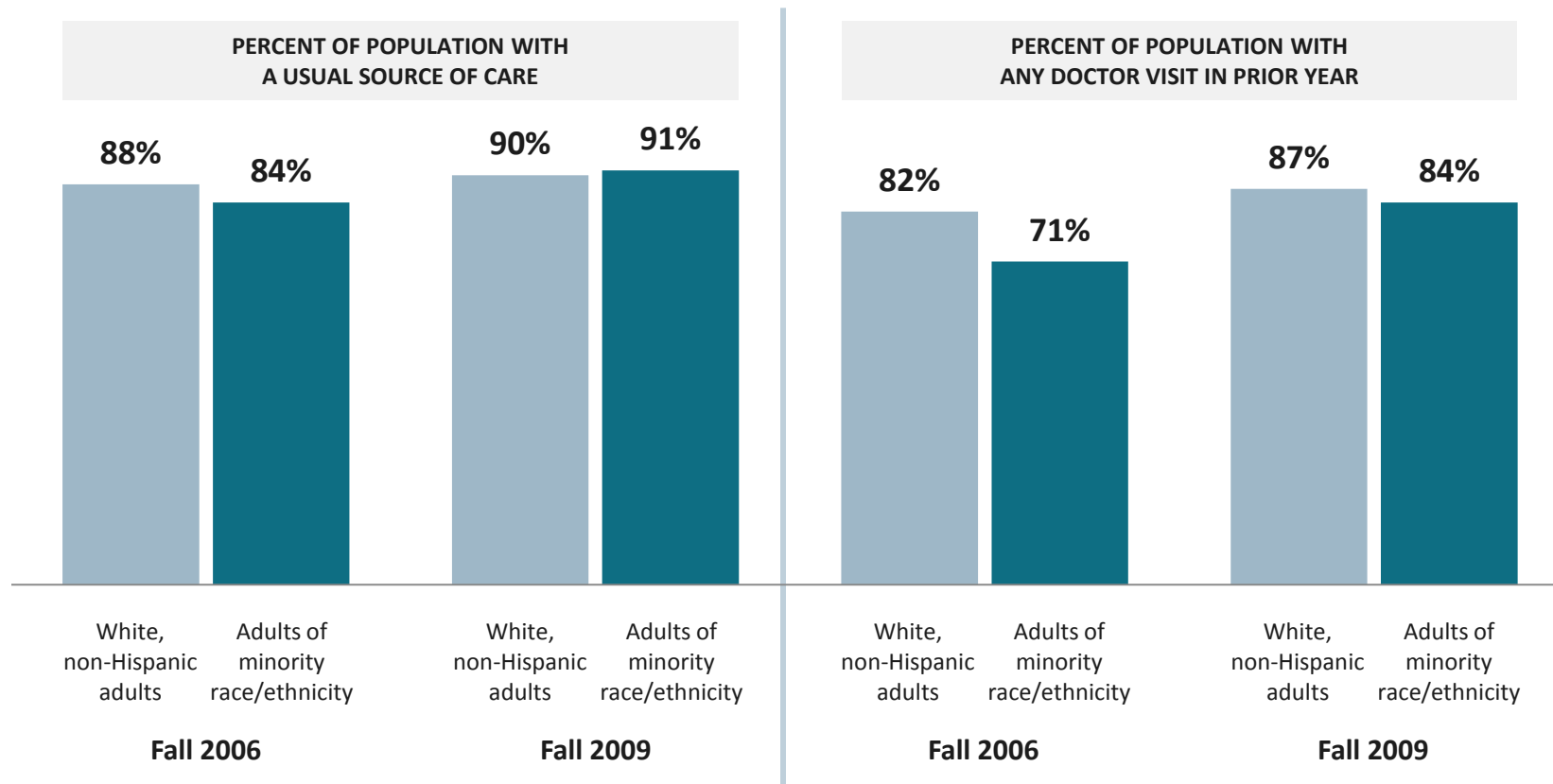
PREVENTIVE CARE AND USE OF OTHER MEDICAL SERVICES HAVE INCREASED AMONG MASSACHUSETTS ADULTS SINCE REFORM

PERCENT OF NON-ELDERLY ADULTS REPORTING USE IN PRIOR YEAR, BY TYPE OF SERVICE



SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2010.

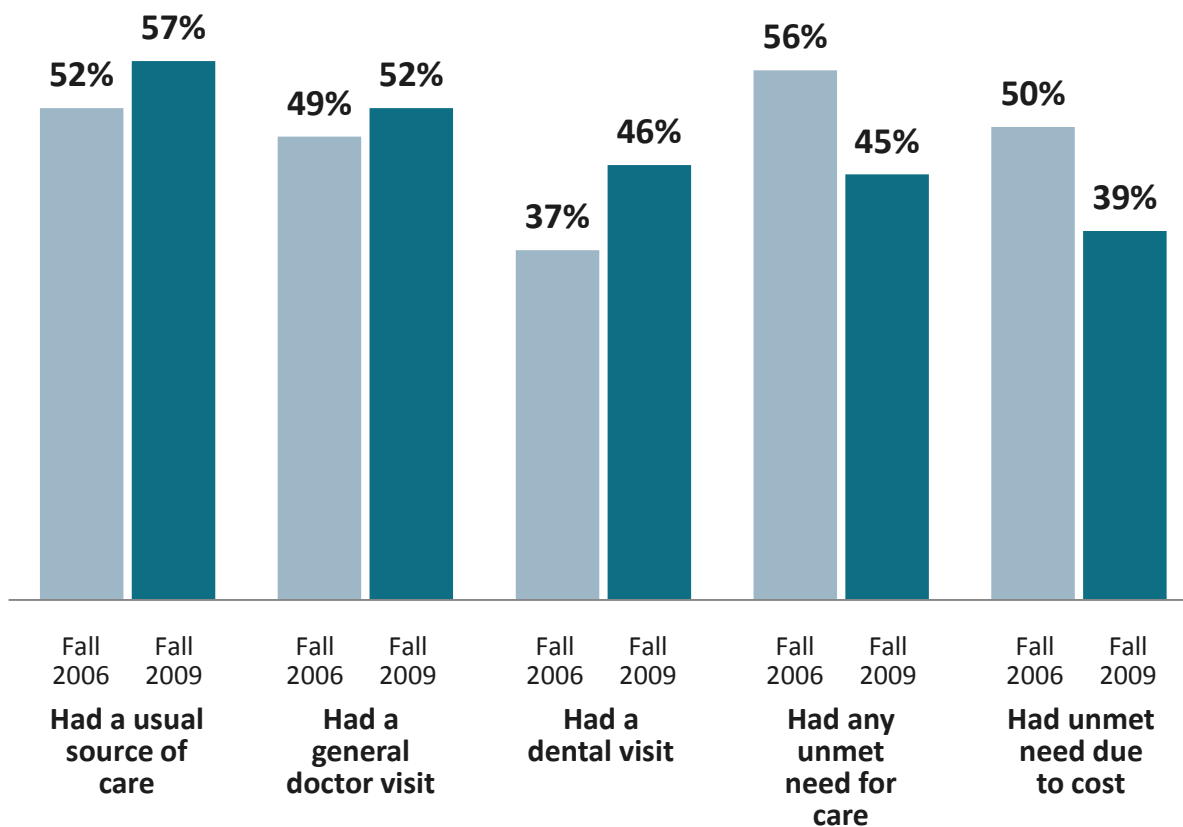
RACIAL/ETHNIC DISPARITIES IN ACCESS TO AND USE OF CARE HAVE LARGELY DISAPPEARED IN MASSACHUSETTS SINCE REFORM



source: Urban Institute, *Massachusetts Health Reform Survey*, 2010.

ACCESS AND USE IMPROVED AMONG REMAINING UNINSURED

PERCENT OF NON-ELDERLY ADULTS REPORTING USE IN PRIOR YEAR, BY TYPE OF SERVICE



Even for the remaining uninsured in Massachusetts, access to care has improved and barriers to care have decreased.

source: Urban Institute, *Massachusetts Health Reform Survey*, 2010.

HOW DOES THE PUBLIC FEEL ABOUT MASSACHUSETTS HEALTH REFORM?

- Two out of three adults support Massachusetts health reform.
- Physician support for reform remains high.
- Most employers agree that health reform has been good for Massachusetts.

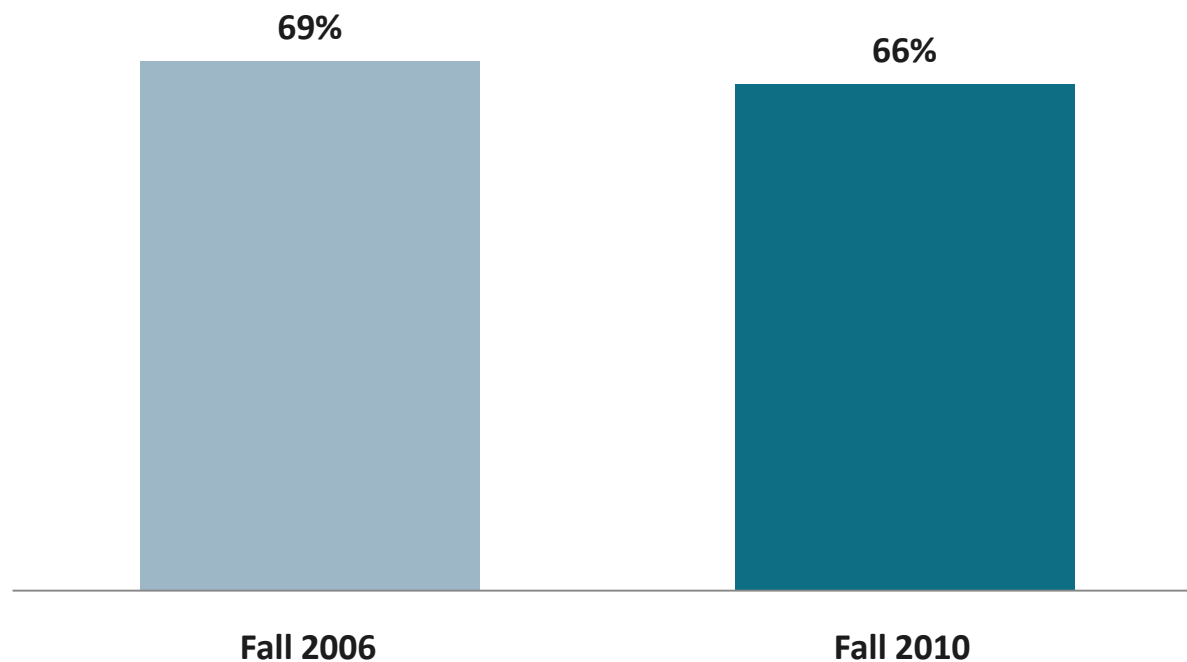
SOURCES: Urban Institute, *Massachusetts Health Reform Survey*, 2012.

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

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

PUBLIC SUPPORT FOR MASSACHUSETTS HEALTH REFORM HAS REMAINED HIGH

PERCENT OF NON-ELDERLY ADULTS INDICATING SUPPORT FOR MASSACHUSETTS HEALTH REFORM LAW



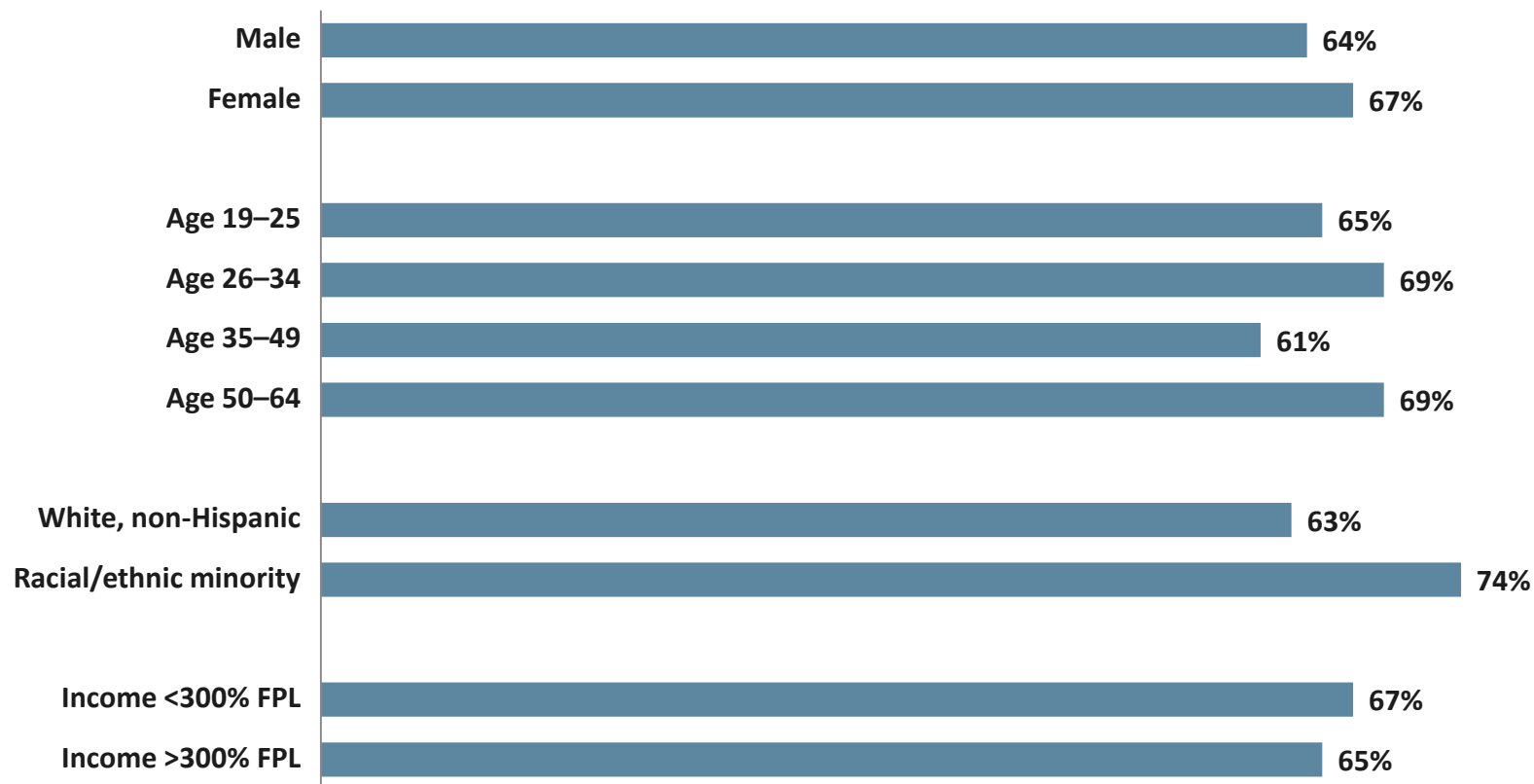
Two out of three adults support Massachusetts health reform.

Support for reform has been relatively stable throughout reform implementation.

SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2012.

PUBLIC SUPPORT FOR MASSACHUSETTS HEALTH REFORM IS CONSISTENT ACROSS VARIOUS POPULATION GROUPS

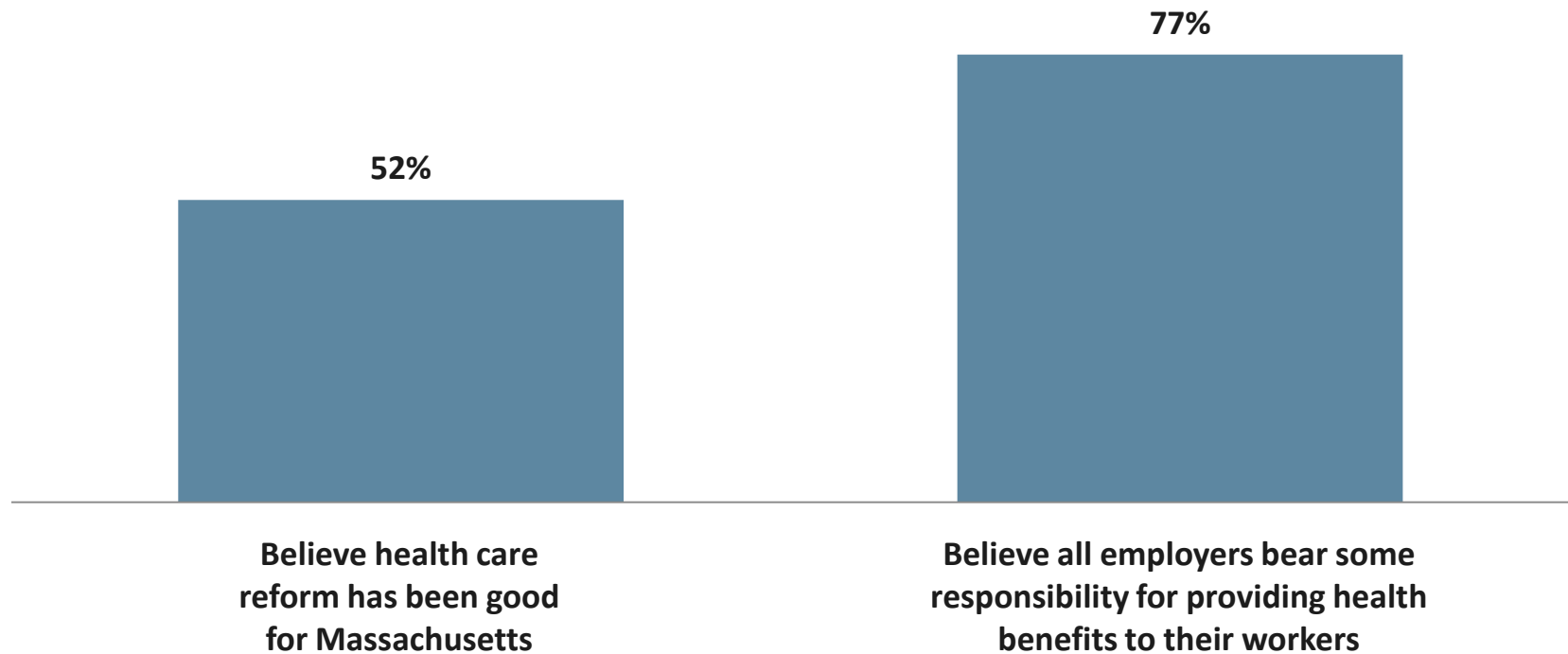
PERCENT OF NON-ELDERLY ADULTS INDICATING SUPPORT FOR MASSACHUSETTS HEALTH REFORM LAW, BY SELECTED POPULATIONS, 2010



SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2012.

MOST EMPLOYERS BELIEVE HEALTH REFORM HAS BEEN GOOD FOR MASSACHUSETTS

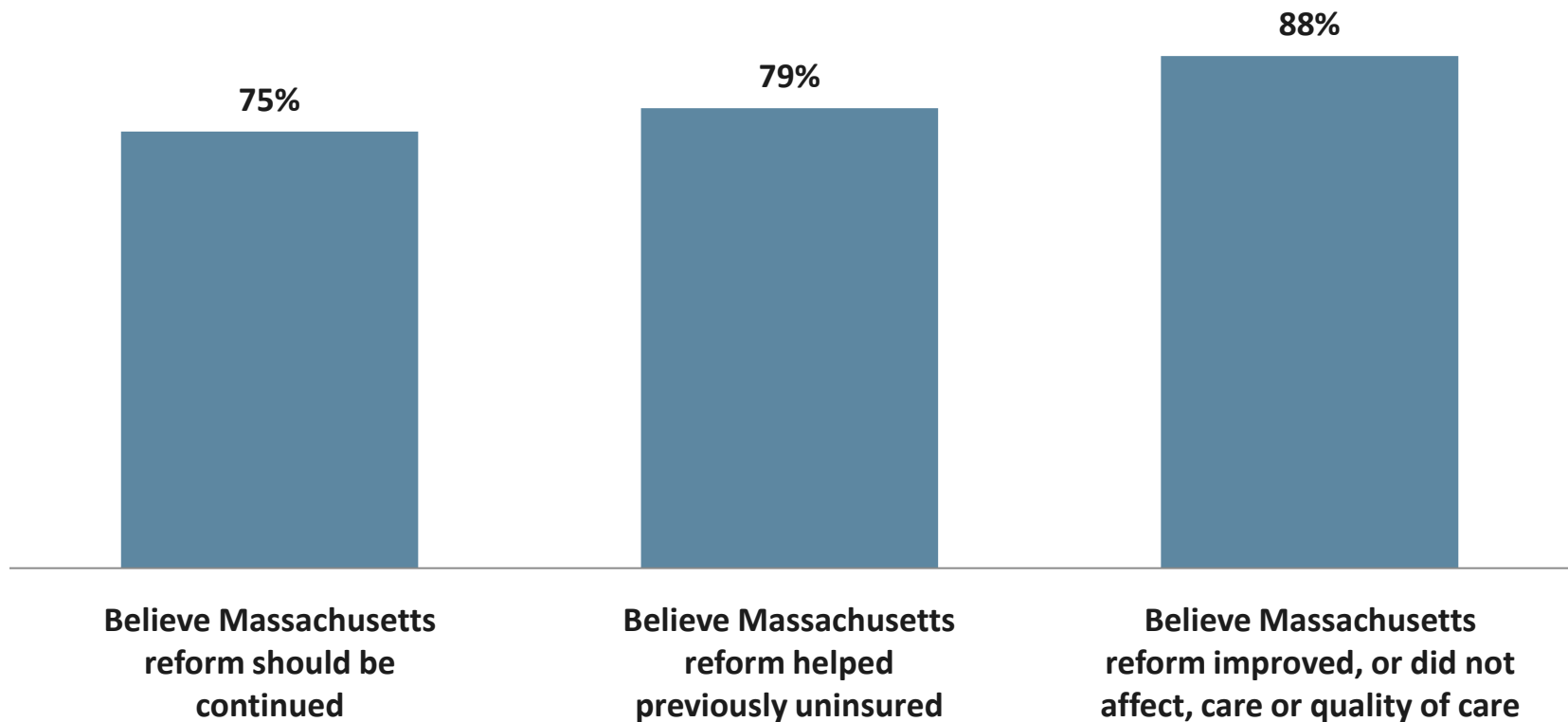
PERCENT OF MASSACHUSETTS EMPLOYERS REPORTING BELIEF, 2008



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

MASSACHUSETTS PHYSICIANS VIEW HEALTH REFORM AS A SUCCESS

PERCENT OF MASSACHUSETTS PHYSICIANS REPORTING BELIEF, 2009



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

WHAT CHALLENGES REMAIN FOR MASSACHUSETTS HEALTH REFORM?

- The remaining uninsured include some who may be more difficult to persuade to obtain coverage and many who do not qualify for government-subsidized or employer-sponsored coverage.
- Barriers to care persist for some populations.
- Rising health care costs, independent of reform, threaten the sustainability of the entire health care system.

ADULTS WHO HAD A PERIOD OF UNINSURANCE DURING THE PAST YEAR MAY BE DIFFICULT TO PERSUADE TO BUY COVERAGE OR MAY NOT QUALIFY FOR ESI OR SUBSIDIZED COVERAGE

- 31 percent are young adult (19–25 years of age).
- 60 percent are male.
- More than half (58 percent) work either full-time (37 percent) or part-time (21 percent).
- 87 percent report they were in good, very good, or excellent health.
- More than 73 percent have incomes less than 3 times the federal poverty level.

SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2012.

SOME BARRIERS TO PRIMARY AND PREVENTIVE CARE REMAIN IN MASSACHUSETTS

- 1 in 5 non-elderly adults report challenges finding a physician who would see them. ¹
- Only slightly more than half of adult diabetics receive recommended preventive care. ²
- Nearly half of emergency department visits are potentially preventable, and the number has decreased from 2008 to 2009. In FY2009, it is estimated that over \$570 million was spent on potentially preventable ED visits. ³
- In FY2009, 12 percent of adult hospitalizations could have been avoided with effective ambulatory care, representing an estimated \$719 million. ⁴

SOURCES:

¹ Urban Institute, *Massachusetts Health Reform Survey*, 2012.

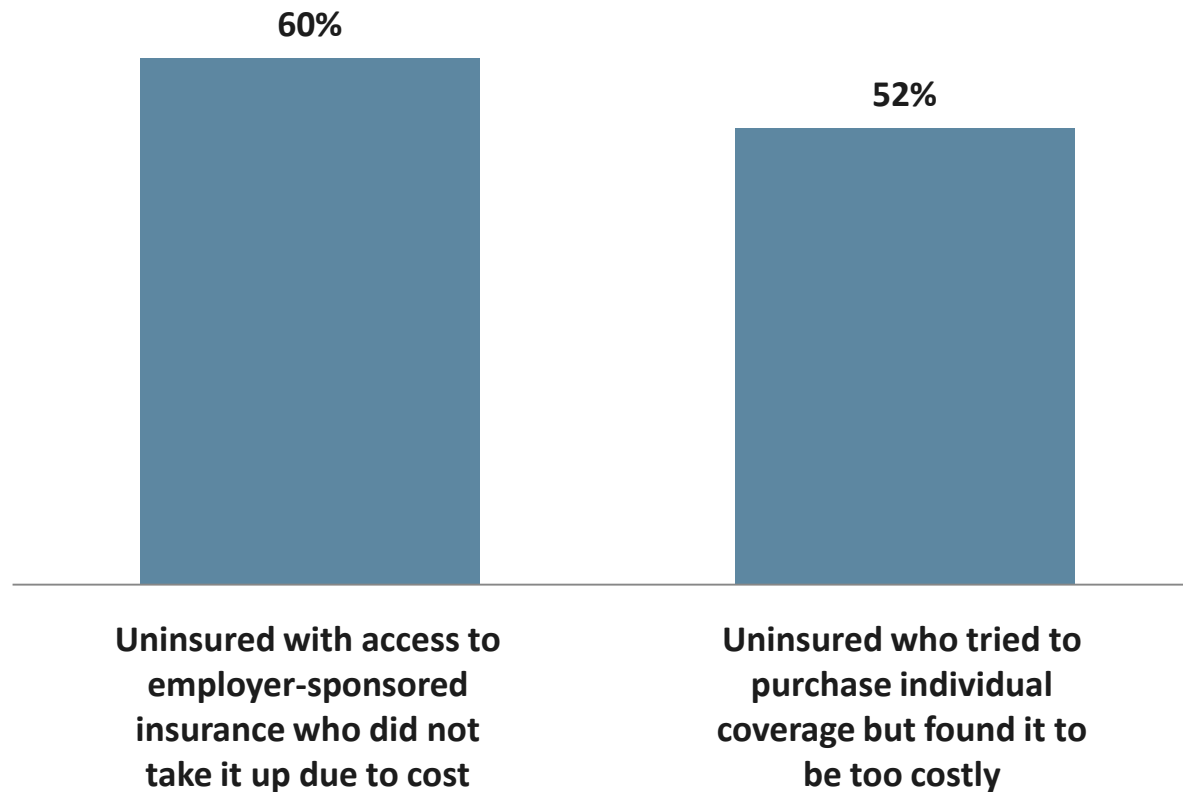
² Cantor JC, et. al. *Aiming Higher: Results from a State Scorecard on Health System Performance*.

New York: The Commonwealth Fund Commission on a High Performance Health System, The Commonwealth Fund, 2007.

^{3,4} Massachusetts Division of Health Care Finance and Policy, *Challenges in Coordination of Health Care Services*, June 2011.

AFFORDABILITY OF COVERAGE REMAINS A CHALLENGE IN MASSACHUSETTS

PERCENT OF NON-ELDERLY UNINSURED ADULTS REPORTING COST BARRIER TO OBTAINING COVERAGE, 2010

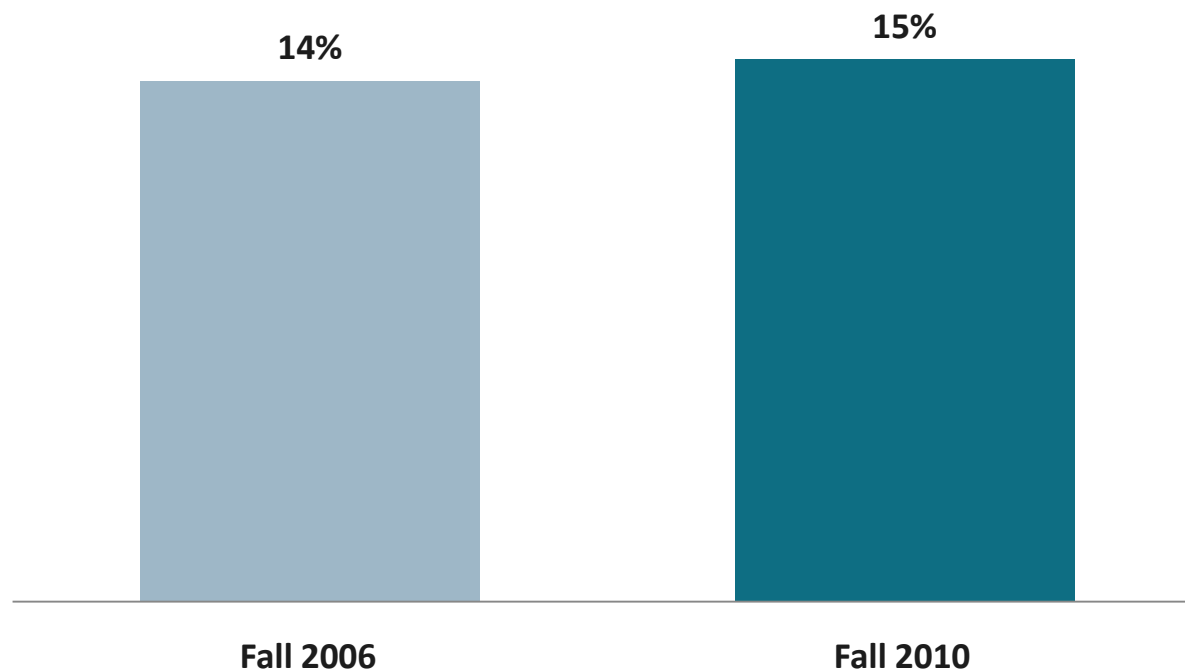


Many of the remaining uninsured report cost-related reasons for not obtaining coverage.

SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2012.

MORE INSURED ADULTS REPORT PROBLEMS PAYING MEDICAL BILLS

PERCENT OF INSURED NON-ELDERLY ADULTS REPORTING PROBLEMS PAYING MEDICAL BILLS



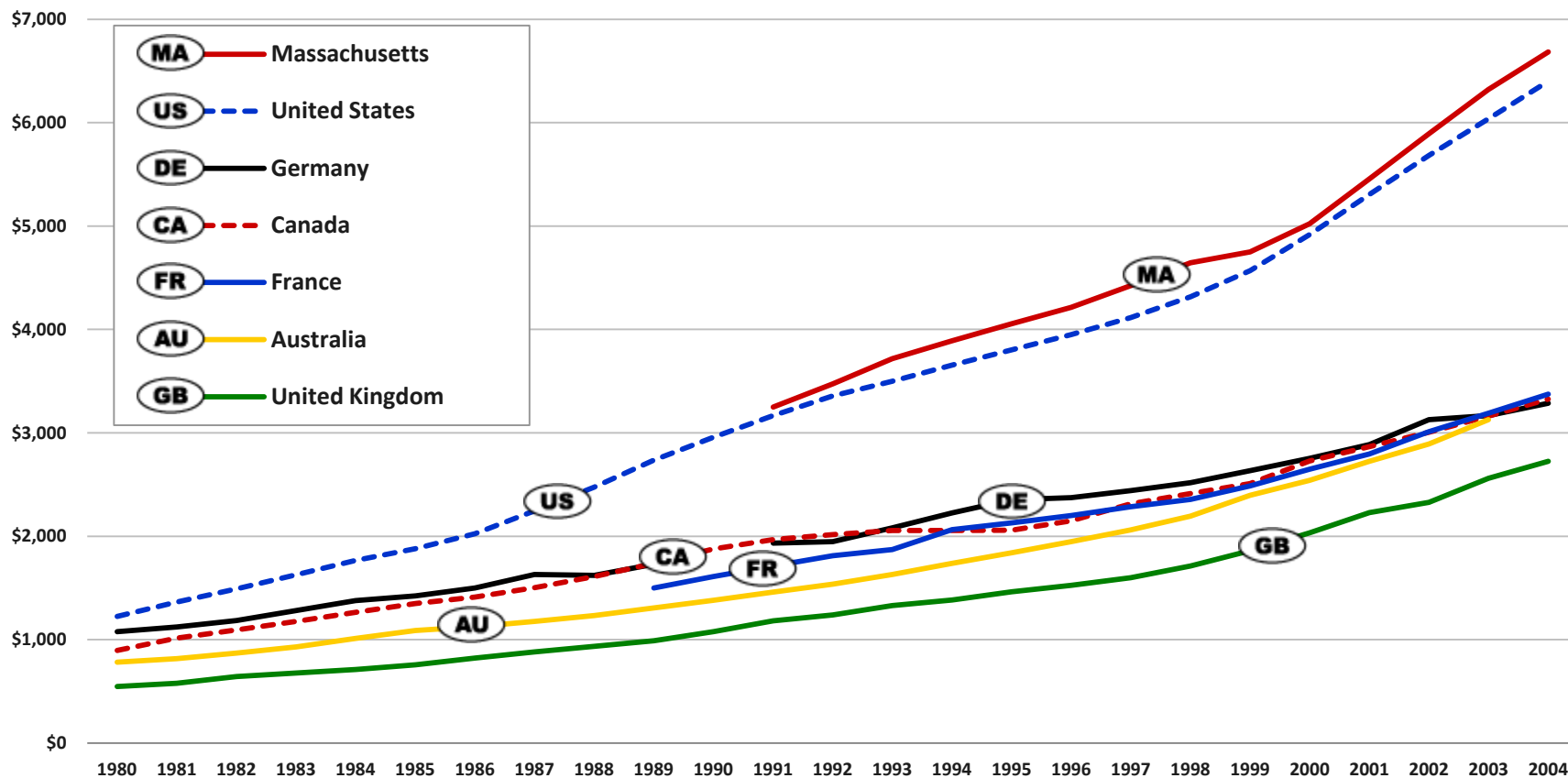
A greater percent of insured residents reported problems paying medical bills in 2010 than in 2006, most likely due to the economic recession.

Those with problems paying medical bills are more likely to be:

- Black, non-Hispanic
- Female
- Have a child under age 18
- Low-income
- In fair or poor health status

SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2012.

THE U.S. HAS THE HIGHEST HEALTH CARE EXPENDITURES PER CAPITA AMONG INDUSTRIALIZED NATIONS, AND MASSACHUSETTS HAS THE HIGHEST HEALTH CARE COSTS IN THE U.S. (1980-2004)

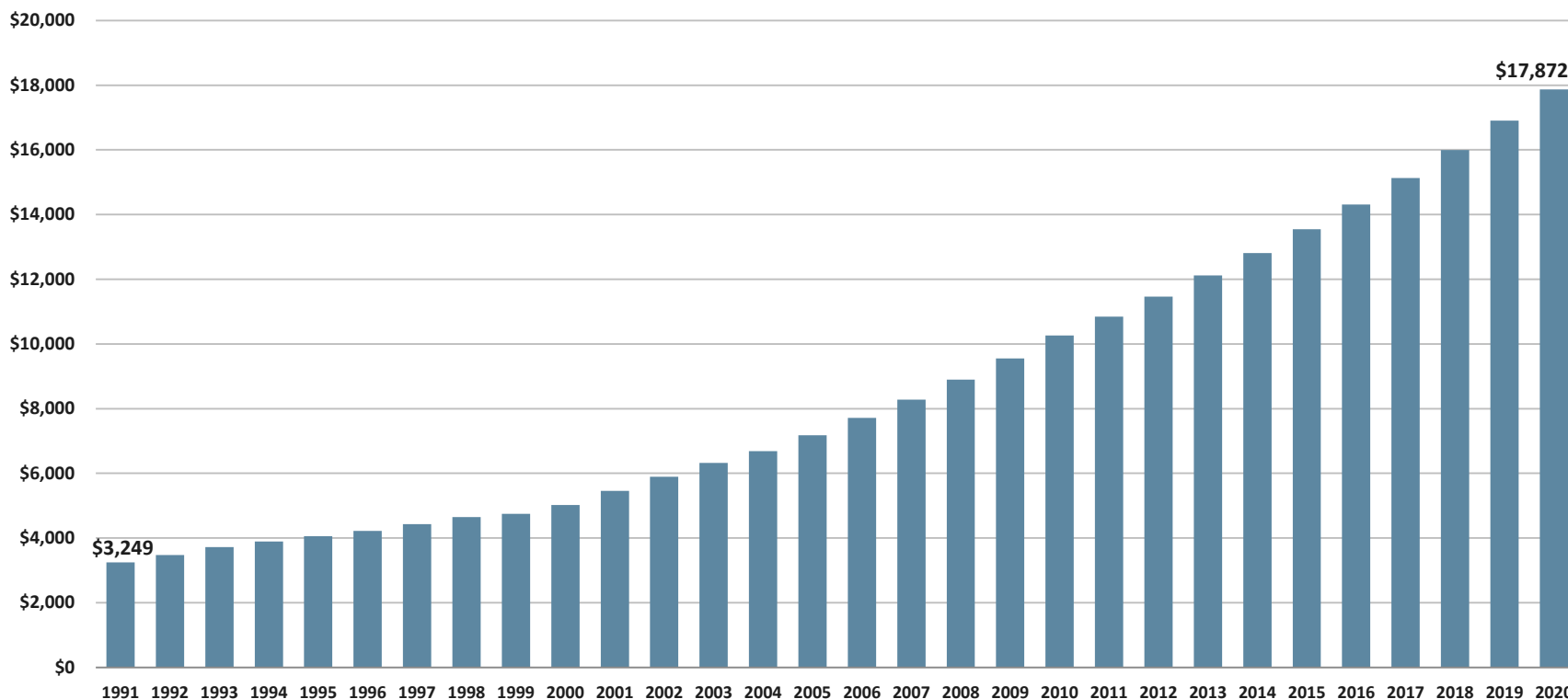


NOTE: U.S. dollars are current-year values. Other currencies are converted based on purchasing power parity.

SOURCE: Commonwealth Fund (2008), CMS (2007), U.S. Census (2009).

WITH NO INTERVENTION, PER CAPITA HEALTH CARE SPENDING IN MASSACHUSETTS IS PROJECTED TO NEARLY DOUBLE BETWEEN NOW AND 2020

MASSACHUSETTS PER CAPITA HEALTH CARE EXPENDITURES



NOTE: Health expenditures are defined by patient residence and include personal health expenditures, which exclude expenditures on administration, public health, and construction. Data for 2005–2020 are projected assuming 7.4% growth 2005–2010 and 5.7% growth 2010–2020.

SOURCE: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, 2007. Projections for 2005–2020 by MA Division of Health Care Finance and Policy.



*Massachusetts Health Reform
Spending, 2006-2011:
An Update on the
“Budget Buster” Myth*

APRIL 2012

MTF

The Massachusetts Taxpayers Foundation is a nationally recognized, nonprofit research organization whose purpose is to promote the most effective use of tax dollars, improve the operations of state and local governments, and foster positive economic policies. Our credibility is based upon independent, objective, and accurate analysis of state and local spending, taxes, and the economy. Over the past decade the Foundation has won fourteen national awards for our work on transportation reform, business costs, capital spending, state finances, MBTA restructuring, state government reform, and health care.

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*Massachusetts Health Reform
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We would like to recognize Alan G. Raymond as
the principal author of this report.

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Cross Blue Shield of Massachusetts Foundation.

MASSACHUSETTS HEALTH REFORM SPENDING, 2006-2011:
AN UPDATE ON THE “BUDGET BUSTER” MYTH

Table of Contents

OVERVIEW 1

KEY PROVISIONS OF THE LAW 2

INCREASES IN STATE SPENDING 3

DECREASES IN STATE SPENDING 5

CONCLUSION 6

APPENDICES 7

- Appendix A: Methodology
- Appendix B: Federal Poverty Level Guidelines
- Appendix C: Health Safety Net Use Since Health Reform

MASSACHUSETTS HEALTH REFORM SPENDING, 2006-2011: AN UPDATE ON THE “BUDGET BUSTER” MYTH

Overview

Six years after Massachusetts enacted its groundbreaking health reform law, Chapter 58 of the Acts of 2006, more than 98 percent of the state's residents have health insurance, access to needed care has improved, and the percentage of employers offering coverage to their workers has climbed despite the national recession.

The gains of health reform have been achieved without placing an unexpected or unmanageable burden on the state's budget. Annual spending for programs affected by Chapter 58 grew from \$1.041 billion in fiscal 2006 to \$1.947 billion in fiscal 2011, an increase of approximately \$906 million (Table 1). The state's share of this spending increase is \$453 million, or 50 percent of the total. While critics periodically claim that health reform has been a “budget buster,” additional state spending attributable to the health reform law accounted for only 1.4 percent of the Commonwealth's \$32 billion budget in fiscal 2011.

Over the five full fiscal years since the law was implemented, the incremental additional state cost per year has averaged \$91 million, an amount that is well within projections made prior to the law's enactment.¹ These figures are consistent with the findings in the Taxpayers Foundation's 2009 report, *Massachusetts Health Reform: The Myth of Uncontrolled Costs*.

Table 1: Spending on Health Care Reform (Fiscal 2006-2011, in millions)

Program	2006	2007	2008	2009	2010	2011	Total Change 2006-2011	State Share of Change
Commonwealth Care and Commonwealth Care Bridge	\$0	\$133	\$628	\$805	\$749	\$835	\$835	\$442
MassHealth Coverage Expansions, Benefit Restorations, and Rate Increases	\$0	\$224	\$355	\$569	\$399	\$391	\$391	\$196
Health Safety Net Trust Fund	\$656	\$665	\$416	\$417	\$420	\$420	\$(236)	\$(118)
Supplemental Payments to Medicaid MCOs	\$385	\$0	\$0	\$0	\$0	\$0	\$(385)	\$(193)
Supplemental Payments to Safety Net Hospitals	\$0	\$287	\$287	\$287	\$307	\$301	\$301	\$125
Total	\$1,041	\$1,309	\$1,686	\$2,078	\$1,875	\$1,947	\$906	\$453

¹ Four months before enactment of the law, the Massachusetts Taxpayers Foundation recommended that the state earmark an additional \$100 million per year for implementation of health reform (*Health Care Reform: Expanding Access Without Sacrificing Jobs*, December 2005).

Key Provisions of the Law

Based on the concept of “shared responsibility” among government payers, employers, and individuals, the programs and incentives in the 2006 Massachusetts health reform law have worked in concert to expand access to affordable coverage while encouraging enrollment in employer-sponsored and individual health insurance plans.²

As Table 1 indicates, the calculation of spending for health reform does not start at zero in 2006 because the state's investment in expanded coverage for low-income adults and children had, in fact, begun almost a decade earlier. In 1997, Massachusetts was granted a federal Section 1115 “research and demonstration” waiver that gave the state greater flexibility to develop health insurance programs for low-income adults and children, with roughly half of the dollars for subsidized coverage coming from federal matching funds.³ This led to the creation of MassHealth, a public insurance program that includes both Medicaid and the Children’s Health Insurance Program (CHIP). Even earlier, the state had set up an Uncompensated Care Pool to pay hospitals and community health centers for certain types of medical services provided to low-income residents who were uninsured or underinsured.

In 2005, federal and state officials agreed on the terms of a renewed Section 1115 MassHealth waiver that provided the financial underpinnings for health reform, based on the premise that state and federal money that was funding uncompensated care should be redirected to provide subsidized health insurance coverage for low-income uninsured residents. To accomplish this, the health reform law created a new public health insurance program called Commonwealth Care for low-income adults who do not have access to employer-sponsored health insurance or Medicaid. The law also expanded and restored certain categories of MassHealth coverage for adults and children and transformed the Uncompensated Care Pool into the Health Safety Net Trust Fund, with new eligibility and payment rules.

The health reform law also created a quasi-public agency – the Commonwealth Health Insurance Connector Authority – to oversee the Commonwealth Care program and act as an “insurance exchange” through which individuals and small businesses may purchase unsubsidized, private health insurance plans that meet state standards for adequacy of coverage and overall value.

The most debated provision of the law, nationally if not in Massachusetts, is the individual mandate – a requirement that all Massachusetts residents 18 and older obtain health insurance if affordable coverage is available to them, or be subject to a state income tax penalty. And while lawmakers rejected creating an equivalent employer mandate, employers with 11 or more full-time equivalent employees are required to pay a “fair share assessment” to the state if they do not make a “fair and reasonable contribution” to their employees' coverage. The amount of the assessment, \$295 per employee, is based on the estimated cost of uncompensated care for employees who work for employers that do not meet the fair and reasonable contribution standard.

² An annotated text of Chapter 58 of the Acts of 2006 is available at bluecrossfoundation.org.

³ Section 1115(a) of the Social Security Law allows states to obtain “research and demonstration” waivers from the federal government to experiment with new ways of structuring and running their Medicaid programs. These waivers are time limited, usually for 3 to 5 years, and renewable if the U.S. Department of Health and Human Services and the state can reach agreement on terms and conditions.

What Has Massachusetts Health Reform Accomplished?

The positive impact of health reform on access to coverage and needed care has been documented through numerous studies and reports.* The most recent data show that:

- Health insurance coverage is nearly universal in Massachusetts. Fewer than two percent of residents lack health insurance, compared with a nationwide average of more than 16 percent uninsured.
- Expanded coverage has been accompanied by improved access to needed care, especially among middle and low-income residents, racial and ethnic minorities, and people with chronic diseases.
- Seventy-seven percent of Massachusetts employers with three or more employees offered health insurance coverage to their employees in 2010, up seven percentage points since 2005. This compares with 69 percent of employers offering health coverage to their workers nationwide.
- Surveys consistently find that about two-thirds of residents support Massachusetts health reform, the same as when the law passed in 2006.
- The affordability of health care, which was not directly addressed by the health reform law, remains a concern for many residents. More than a quarter of adults reported that their health care spending in 2010 had caused financial problems, including the need to cut back on health care services and other spending or to reduce savings.

** The Blue Cross Blue Shield of Massachusetts Foundation is a sponsor of the Massachusetts Health Reform Survey, which has been conducted annually by the Urban Institute since fall 2006. Results of this research and a five-year progress report on health reform are among the comprehensive resources available at bluecrossfoundation.org.*

Increases in State Spending

Commonwealth Care

As an entirely new program, Commonwealth Care accounts for the largest increase in state spending for health reform—approximately \$442 million of the increase between fiscal 2006 and fiscal 2011 (Table 1). The program uses a combination of state funds and the federal matching dollars available through the state's MassHealth waiver to provide income-based premium subsidies for adult residents earning up to 300 percent of the federal poverty level (Appendix B). As a condition of eligibility, the applicant cannot have access to employer-sponsored health insurance or Medicaid coverage. The state enrolls Commonwealth Care members in private health plans that are selected through an annual procurement process conducted by the Health Connector. Approximately half of all Commonwealth Care members pay a partial premium and half pay no premium.

Most of the enrollment and spending growth in Commonwealth Care occurred during the first two years after the program's launch in mid-2006 thanks to a comprehensive outreach, education, and enrollment effort by state agencies, community organizations, and providers that serve low-income residents.

Enrollment in the program has leveled off, although the numbers for the next fiscal year will increase because of a court-ordered change in eligibility rules for documented immigrants. At the outset of health reform, policymakers decided to include low-income, documented immigrants in Commonwealth Care even though the federal government does not provide matching funds for this population. However, when the state was faced with a severe revenue shortfall in mid-2009 as a result

of the national recession, the governor and Legislature agreed to stop new enrollment of documented immigrants in Commonwealth Care and developed a scaled-back coverage plan called Commonwealth Care Bridge for those already enrolled. Advocates mounted a court challenge, and in January 2012 the Massachusetts Supreme Judicial Court ruled that the cutbacks were an unconstitutional denial of equal protection. As a result, the state is restoring full Commonwealth Care coverage to an estimated 40,000 eligible immigrants – approximately 13,000 will be transferred from Commonwealth Care Bridge, with the remainder coming from a waiting list. In fiscal 2014, federal matching funds for coverage of documented immigrants are due to become available under the provisions of the Patient Protection and Affordable Care Act.

MassHealth Coverage Expansions, Benefit Restorations, and Rate Increases

Although MassHealth (Medicaid and CHIP) spending has grown significantly since 2006, an estimated three quarters of the increase in enrollment has been in categories that predated the 2006 law and would have occurred in the absence of reform.⁴ Table 1 shows that the five-year increase in the state's share of MassHealth spending that can be attributed directly to provisions in the health reform law was \$196 million.

When health reform was enacted, about one million residents were receiving MassHealth coverage, but cutbacks during a prior state budget crisis had resulted in a loss of coverage for certain categories of low-income residents that had once been eligible for membership. The reform law restored eligibility and reopened enrollment for several of these categories, which include people living with HIV/AIDS, adults and children with disabilities, and the long-term unemployed. In addition, the law raised the family income ceiling for CHIP eligibility from 200 percent of the federal poverty level (FPL) to 300 percent. This allowed the state to take full advantage of federal matching dollars and close the remaining gaps in coverage for low-income uninsured residents.

In addition to these eligibility changes, the health reform law included a three-year increase in MassHealth provider reimbursement rates. Without some relief from historically low MassHealth payments, physicians and hospitals would have faced a growing financial burden as MassHealth membership rose. Business groups, concerned that continued government underpayment would result in greater cost shifting to the private sector in the form of higher premiums, supported the increases as well. The health reform law increased MassHealth provider payment rates by approximately \$90 million per year for fiscal years 2007, 2008, and 2009, but the recession led to state budget cuts that have effectively eliminated the increases. As a result, the shortfall in MassHealth payments to providers has returned to pre-reform levels.

Supplemental Payments to Safety Net Hospitals

The health reform law included special provisions to assist the two Massachusetts hospitals that had traditionally provided the highest level of free care to uninsured patients, Boston Medical Center and Cambridge Health Alliance. As Table 1 indicates, the hospitals received \$287 million in annual supplemental payments for three years, starting in fiscal year 2007, to help them through the transition to providing more insured care to their low-income patients and to support their continued role as safety net providers for a disproportionate share of people who remain uninsured or under-insured. The two hospitals faced the prospect of significant financial losses after the health reform law's three-year authorization of supplemental payments expired, but the state was able to secure an amendment to the MassHealth waiver that allowed supplemental payments to continue in fiscal 2010 and 2011.

⁴ Massachusetts Medicaid Policy Institute. *Growth in MassHealth Enrollment Since Reform*. May 2011.

Decreases in State Spending

Uncompensated Care Pool/Health Safety Net Trust Fund

A major premise behind the Section 1115 MassHealth waiver renewal that preceded enactment of health reform was that the added costs of expanding public health insurance coverage would be largely offset by reductions in spending for uncompensated care that would occur as previously uninsured residents enrolled in Commonwealth Care or other coverage. As Table 1 illustrates, annual state spending for uncompensated care dropped by \$118 million over the first five years of reform.

Annual Health Safety Net (HSN) spending fell by one-third from fiscal 2006 to fiscal 2008, reflecting a more than 50 percent decline in the number of inpatient discharges and outpatient visits for which HSN payments were made during that period. Since fiscal 2008, the use of the HSN has trended back up as a result of the economic downturn, but it is still well below pre-reform levels (Appendix C). Another factor contributing to the increased use of the HSN was the 2009 change in Commonwealth Care coverage for documented immigrants described earlier. The combined effects of a freeze on new enrollment and the scaled-back benefits in the Commonwealth Care Bridge program meant that an increasing number of low-income documented immigrants were uninsured or underinsured, and therefore eligible for the HSN.

The Health Safety Net is funded through a combination of assessments on acute care hospitals and surcharges on payments made by insurers and self-insured employers for hospital and ambulatory surgery services, and state and federal funds available through the MassHealth waiver. The private sector contributions are fixed at \$320 million annually. The state's contribution is subject to appropriation, and, as Table 1 indicates, combined state and federal spending did not increase from fiscal 2010 to fiscal 2011 despite an increase in HSN use during that period. When the amount owed to providers for safety net care exceeds the amount of HSN funds available, the shortfall is distributed among hospitals using a formula that is intended to cushion the impact for the hospitals that care for most of the state's uninsured and underinsured residents. The shortfall is estimated at \$134 million in fiscal 2012 and at least that amount in fiscal 2013.

Supplemental Payments to Medicaid Managed Care Organizations

The 1997 MassHealth waiver that triggered the first round of expanded public coverage for low-income adults and children led to the creation of Medicaid managed care organizations (MCOs) operated by the state's two largest safety net hospitals, Boston Medical Center (at the time called Boston City Hospital) and Cambridge Health Alliance (formerly Cambridge City Hospital). The waiver authorized additional financial support in the form of supplemental payments to the MCOs because they were expected to enroll a disproportionate number of people with complex medical and social needs, while at the same time accepting payments for members that would be less than the hospitals had received for providing uncompensated care. The MCO supplemental payments, which totaled \$385 million in fiscal 2006, were eliminated as part of the waiver renewal that preceded the health reform law, but Massachusetts was allowed to retain the federal dollars to help fund expanded insurance coverage for low-income, previously uninsured individuals.⁵ Table 1 shows that the net effect on state spending for health reform was a reduction of approximately \$193 million.

⁵ Stephanie Anthony, J.D., M.P.H., Robert W. Seifert, M.P.A., Jean C. Sullivan, J.D. Center for Health Law and Economics, University of Massachusetts Medical School. *The MassHealth Waiver: 2009-2011 ...and Beyond*. February 2009.

Conclusion

Summarizing the net effect of the increases and reductions in state spending that can be attributed to the 2006 health reform law, this analysis shows that incremental state spending attributable to the law was approximately \$453 million, or 1.4 percent of the state's \$32 billion budget in fiscal 2011. The average annual increase in state spending for health reform between fiscal 2006, prior to implementation of the law, and fiscal 2011, which ended on June 30, 2011, was just under \$91 million.

The 2006 health reform law was designed to expand access to affordable coverage, not to address the cost of care. It did, however, help trigger a series of legislative, regulatory, and private sector initiatives directed at controlling the state's historically high costs, and there is early evidence that a transformation is underway, centered around provider payment reform. A majority of the state's primary care physicians are now participating in health plan contracts based on some form of "global payment," which rewards the quality and efficiency of care rather than quantity, and several long-term contracts between health plans and hospital systems have been renegotiated at lower rates of payment. Payment reform has, in turn, been an added catalyst for hospital systems and physician groups to invest in better coordination of care and in improving outcomes for their sickest patients. In addition, Massachusetts has seen the rapid proliferation of health insurance products that allow employers and consumers to save money by using lower-cost providers or by choosing limited provider networks.

It would be premature to claim that the state's historically high health care costs have been tamed, but there are encouraging signs of progress. For example, in the latest round of proposed premiums for the merged health insurance market for small businesses and non-group individuals, health plans sought average increases of just two to three percent, compared with increases of 15 to 20 percent two years ago. Although the trend of slower premium growth is currently a nationwide phenomenon and may be, in part, a function of the economic recession, Massachusetts is experiencing a notably slower rate of growth than the national average. In fact, recent data show that family premiums for private, employer-sponsored coverage in Massachusetts fell by an average of nearly one percent from 2009 to 2010, while the country as a whole saw a six percent increase. As a result, the state's ranking for family premiums fell from the highest in the country in 2009 to ninth place in 2010. Similarly, individual premiums for Massachusetts workers rose by just 2.8 percent in 2010 versus 5.8 percent for the nation as a whole.⁶

Governor Deval Patrick and the leaders of the Massachusetts House and Senate have said they expect to approve some form of cost containment legislation in 2012 that would accelerate reform of provider payment and health care delivery and set the stage for sustainable reductions in the underlying trend. If passed, it would build on a 2008 law that created a process to examine the causes of the state's high health care costs, and a 2010 law aimed primarily at giving small businesses more options for managing their health insurance bills. While the state's private sector stakeholders hold divergent views on some of the issues under consideration, the broad coalition of providers, health plans, business groups, and consumer advocates that formed during the first round of health reform has remained engaged and united around the shared goals of expanding access to coverage, improving quality and outcomes of care, and reducing the growth of health care spending.

⁶ C. Schoen, A. Fryer, S. Collins, and D. Radley, *Realizing Health Reform's Potential*, The Commonwealth Fund, November 2011, and MTF analysis of data from the Agency for Healthcare Research and Quality.

Appendix A

Methodology

Estimates of government spending attributable to the 2006 Massachusetts health reform law are based on a Massachusetts Taxpayers Foundation analysis of data provided by the Commonwealth's Executive Office for Administration and Finance.

The state share of health reform spending was calculated using a conservative assumption that federal support was 50 percent, even though the actual federal match was temporarily increased during FY2009, 2010, and 2011 by the American Recovery and Reinvestment Act, thereby reducing the state share during those years. MTF's estimates account for the fact that the state has paid the full cost of Commonwealth Care, and subsequently Commonwealth Care Bridge coverage, for eligible documented immigrants (see page 4). The Supplemental Payments to Safety Net Hospitals category includes special federal payments that did not require a state share because they were funded through Intergovernmental Transfers (see page 4).

The Foundation's analysis does not include adjustments for the rate of health care inflation from 2006 to 2011, which was significantly higher than the overall rate of inflation. As a result, the effect of health reform on state spending is most likely less than the data indicate. It should also be noted that, starting in fiscal 2009, the economic recession became a factor in driving health reform spending as more residents became eligible for MassHealth and Commonwealth Care.

Appendix B

Federal Poverty Level Guidelines

Gross Annual Income Limit: Effective March 1, 2012 – February 28, 2013

Family Size	100% of FPL	300% of FPL
1	\$11,170	\$33,510
2	\$15,130	\$45,390
3	\$19,090	\$57,270

Source: U.S. Department of Health and Human Services

Appendix C

Health Safety Net Use Since Health Reform (in thousands)

	2006*	2007	2008	2009	2010
Hospitals	1,613	1,184	715	703	800
Community Health Centers	446	342	262	287	312
Total HSN Use**	2,059	1,526	977	990	1,112

** Prior to health reform, the HSN was called the Uncompensated Care Pool (UCP).*

*** Health Safety Net use includes hospital inpatient discharges, hospital outpatient visits, and community health center outpatient visits. Health Safety Net use fell dramatically during the first two years of reform, then started an upward trend that continued into HSN fiscal 2011.*

Source: Division of Health Care Finance and Policy: Health Safety Net/Uncompensated Care Pool annual reports

COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY

Commonwealth of Massachusetts



STRATEGIC PLAN-IN-BRIEF
2013-2015

Jean Yang | Executive Director

MESSAGE FROM THE EXECUTIVE DIRECTOR

Massachusetts's landmark health care reform law continues to serve as a model at the national level for how to expand health care access and reach near-universal levels of coverage. Thoughtfully crafted regulatory and program initiatives, as well as collaboration with stakeholders and interested consumers, have paved the way for dramatic improvements in access to care without significantly increasing costs or disrupting the existing market.

Massachusetts **Health Care Reform** has **expanded health insurance coverage to more than 400,000 residents, making care more accessible and affordable** for this population of newly insured. Innovative procurement strategies for government-sponsored insurance programs, expanded rate reviews in the non and small-group market and the implementation of cost-containment legislation have resulted in savings both to the system and consumers.

These achievements, while significant, are only the beginning of the Commonwealth's work to improve access, quality and costs. The Affordable Care Act (ACA), signed into law by President Barack Obama in March 2010, will bring many of Massachusetts's successes to other states, while at the same time providing the Commonwealth with opportunities to enhance and improve reforms already in place.

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

With the strong leadership of the Health Connector Board and enduring support of the Patrick Administration and the Legislature, we remain confident that the Health Connector will continue to make a positive difference for the people of Massachusetts.



Jean Yang
Executive Director



MISSION, VISION AND POLICY CONTEXT

OVERVIEW

In 2006, Massachusetts enacted landmark health reform legislation, chapter 58 of the Acts of 2006, and created the Commonwealth Health Insurance Connector Authority (Health Connector), an independent state agency tasked with promoting access to affordable health insurance for the Commonwealth's residents and small businesses.

The Health Connector has been a major contributor to the success of Massachusetts health reform. The organization now morphs into "Connector 2.0" – a health insurance exchange that not only complies with the federal Affordable Care Act when the main provisions in the law take effect in 2014, but also makes it easier than ever for individuals and small employers to access comprehensive, affordable health insurance.

ACHIEVEMENTS

In the years following the passage of chapter 58, the Commonwealth expanded its focus in order to better address the impact of increasing health care costs on Massachusetts residents and businesses. The Health Connector has been privileged to serve as the organization at the forefront of newly available health insurance programs for the previously uninsured and to have played key roles in the implementation of this pioneering effort.

With nearly 440,000 newly insured since the passage of Massachusetts Health Care Reform in 2006, the Commonwealth continues to boast the highest rate of coverage in the nation. Health care reform has provided Massachusetts residents better access to health care services, as well as protection against the financial risks of serious illness and injury by enabling them to obtain and maintain sufficient health insurance coverage.

MISSION

Improve **access to high-quality health care** and transform the health care system by serving as the **leading-edge marketplace** for Massachusetts residents and small businesses to come together and easily find and enroll in **affordable health insurance**.

VALUES

- Structure a health insurance shopping experience that makes it **easier than ever before for individuals and small businesses** to understand their health insurance options and choose, enroll in and maintain affordable coverage that best meets their needs
- Transform the health insurance market and health care system through the **power of competition**
- Expertly execute health care reform **policymaking and other regulatory responsibilities** to promote health insurance coverage and shared responsibility for sustaining health care reform
- Fully **embody the high standards** inherent to serving as the Commonwealth's official public Health Insurance Exchange
- Promote **robust public engagement** in and understanding of health care reform

- **Coverage Success**

In Massachusetts, 98.1 percent of all residents and 99.8 percent of all children are covered by health insurance. Since 2006, approximately 440,000 individuals are newly insured. Additionally, the percentage of businesses offering coverage has grown since reform from 69 percent in 2001 to 77 percent in 2010.

People are healthier and getting better treatment, more people are receiving cancer screenings like colonoscopies, more women are getting pre-natal care and emergency room visits have decreased.

There is no argument that health reform in Massachusetts has achieved its goal of near universal coverage. Health care reform is not only providing peace of mind for the 440,000 previously uninsured, it is also saving lives.

- **Fair, Effective Steward of Individual Mandate**

Most Massachusetts adult residents are required to maintain affordable

health insurance for each month of the year. Since 2009, adults have been required to obtain a health insurance policy that meets the state's Minimum Creditable Coverage (MCC) standards if an affordable plan is available to them.

Recent tax data continues to demonstrate near universal compliance with the requirement that Massachusetts residents report their health insurance information on tax filings.

- **Commonwealth Care Costs**

Commonwealth Care provides subsidized health insurance to adult residents earning up to 300 percent of the Federal Poverty Level (FPL) that generally do not have access to other health insurance. At the end of 2012, nearly 200,000 Massachusetts residents were receiving assistance with their health care costs through Commonwealth Care.

In the six years since Massachusetts health care reform became law, the Health Connector has demonstrated

that, through the power of competition, high-quality and dependable coverage can be provided at an affordable cost. In that time period, the per member per month rate the commonwealth pays to insurance carriers for Commonwealth Care coverage has increased by an average of less than two percent. This is in contrast to trends in the Massachusetts private market where, between 2008 and 2010, commercial insurance premiums grew by 7.5 percent.

Statewide fiscal challenges continue in FY13. The slow economic recovery coupled with increases in Commonwealth Care enrollment demanded another aggressive procurement. The results of the procurement were, once again, tremendously successful, yielding a five percent decrease in aggregate capitation rates for the second year in a row, for a total aggregate decrease of 12 percent over FY11. Every plan now has rates lower than those from two years ago without cutting benefits or significantly increasing member co-pays.

Conditional Approval as ACA-Compliant Exchange

In December 2012, the U.S. Department of Health and Human Services conditionally approved the Health Connector's application to be a federally-compliant health insurance exchange under the Affordable Care Act. Massachusetts was one of six early applicant states to receive conditional approval to operate a state-based Exchange; all states electing to operate a state-based Exchange are required to demonstrate their ability to perform all required Exchange functions in compliance with the Affordable Care Act by 2014.

Conditional approval reflects the substantial progress the Health Connector has made to demonstrate our ability to perform all required Exchange functions in compliance with the Affordable Care Act by 2014. This is a significant milestone in the overall Exchange certification process that indicates to our State and Federal partners that we are on track to provide affordable, quality coverage for individuals and small businesses through an ACA-compliant state based Exchange in 2014.

- **Student Health Insurance Plans**

For the past three years, the Health Connector has played an integral role as a member of the Student Health Program Steering Committee. Overall, the Steering Committee's efforts have significantly improved health insurance coverage for public college and university students.

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

Thousands of college students now have improved access to providers and wellness programs and nearly 200,000 students now have out-of-pocket maximums to protect them

from excessive out-of-pocket spending. In addition, 7,500 students newly have access to prescription drug coverage while another 20,000 have coverage without benefit caps.

- **Medical Security Plan Direct Coverage**

Because of the Health Connector's track record as an entity with procurement expertise that has benefitted the public interest and delivered increased value for Massachusetts taxpayers, in FY11, the Patrick Administration requested that the Health Connector work with the Department of Unemployment Assistance (DUA) to launch a competitive re-procurement for the Medical Security Plan (MSP) Direct Coverage Program. The MSP Direct Coverage Program offers subsidized health insurance for low-income Massachusetts residents receiving unemployment benefits. The Medical Security Trust Fund, which finances MSP and is funded by employer contributions, had been under major financial stress due to increases in the number of residents eligible for

unemployment benefits and federal legislation extending the duration of unemployment benefits.

The MSP procurement was conducted in 2011 by DUA, with operational and analytical support, including actuarial assistance, supplied by the Health Connector. A Request for Responses (RFR) was released in July 2011. After careful review of the responses, staff from the Health Connector, DUA and the Executive office of Administration and Finance (A&F), selected Network Health to provide MSP Direct Coverage, saving the program \$19.8 million in CY12, even without factoring in enrollee premium collection. In addition to program cost savings, MSP members saw significant improvements in coverage, such as the reduction of co-payments, the elimination of deductibles and improved continuity of care coverage as they transition to other subsidized health insurance programs.

- **Commonwealth Choice**

Commonwealth Choice, the Health Connector's unsubsidized health

insurance program, offers individuals and small businesses high-quality, private health insurance. As of the end of 2012, eight of Massachusetts's leading health insurance carriers provided health coverage to more than 40,000 members.

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

In the fall of 2012, the Health Connector introduced a Plan Helper Tool that provides decision support to help consumers narrow and filter available plans to identify those that best fit their needs. The Plan Helper tool also features [video tutorials](#) that walk people through out-of-pocket expenses, annual deductibles, provider networks, and co-insurance. Each tutorial is accompanied by a web

page with easy-to-understand, detailed explanations.

Health Connector staff are working with Massachusetts health plans participating in the Commonwealth Choice program to design and operationalize the programmatic changes necessary for compliance with federal requirements under the ACA.

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

The re-launch of the Health Connector's Business Express program (BE) in February 2012 was a major milestone for the Health Connector as it marked the first time in the history of the program that all of the major health insurance carriers in the state were participating.

BE makes it easier than ever for small employers to compare their health insurance options on an apples-to-apples basis and find the coverage that best suits the needs of their workplace. In January 2013, the Health Connector added 22 new plans, introducing several innovative products geared to small businesses. In addition, a new carrier joined the Health Connector product shelf in 2014. Small employers can now choose from among 99 health insurance plans from nine leading insurance carriers.

- **Wellness Track**

In 2011, the Health Connector launched Wellness Track, a program that provides small businesses with the opportunity to implement evidence-based employee health and wellness programs. Wellness Track provides participating small employers and their employees with a suite of tools, such as health and nutrition trackers, and exercise videos, aimed at jump-starting wellness activities in the workplace. While all small businesses enrolled in a group health plan

through the Health Connector may participate in Wellness Track, certain employers may also be eligible to receive a rebate of up to 15 percent of the employer's share of eligible employee health care costs.

The Health Connector recently overhauled eligibility criteria to make it possible for even more small businesses to take advantage of the Wellness Track rebate program. As of February 1, 2013, any employer can register for Wellness Track if they enroll in a small business group health plan through the Health Connector and purchase health insurance coverage for up to 25 employees, excluding sole proprietorships. The new eligibility criteria eliminate previous employee salary caps and now include owners and family member employees in the rebate calculation.

- **Health Insurance Exchange/
Integrated Eligibility System**

As an existing Exchange, the Health Connector provides access to affordable health insurance for nearly 230,000 members. Informed by that

Public Support for Health Care Reform

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

Physicians in Massachusetts have also expressed a positive view of reform. Nearly 80 percent of physicians believe reform has helped the previously uninsured and three out of four physicians believe reform should continue in Massachusetts.

experience, the Health Connector will be re-platforming its entire online experience and supporting infrastructure through the Health Insurance Exchange/Integrated Eligibility System (HIX/IES) project and, by 2014, will have a common suite of systems tailored to support all customer segments. The Health Connector, in conjunction with the Executive Office of Health and Human Services (EOHHS) and the University of Massachusetts Medical School (UMMS), is working to develop a fully integrated, real-time eligibility determination system for enrollment in health insurance coverage.

The HIX/IES project is a critical piece of the puzzle in transitioning from Connector 1.0 to Connector 2.0 in compliance with the ACA. In order to meet the new ACA requirements (*e.g.*, real time eligibility, integration with the Federal Data Services Hub), new IT systems that currently do not exist need to be developed. This transition also allows the Health Connector to develop a more attractive shopping experience for all customers (*e.g.*, individuals, brokers, small businesses)

seeking subsidized, non-subsidized, and small group health insurance, now with additional opportunities for premium assistance. In addition, the Health Connector can utilize HIX/IES to enhance back-end operations (*e.g.*, premium billing, premium rating engine) to be more efficient, flexible and better support the needs of our customers. This is all made possible through a once-in-a-generation opportunity to build new, state of the art systems.

This inter-agency HIX/IES Project will enhance the state’s existing eligibility determination system and will leverage the Federal Data Services Hub to ensure a seamless path to coverage for Massachusetts residents. The HIX/IES Project is supported, in part, by the \$45 million Early Innovators grant, which was awarded to UMMS in February 2011.

Massachusetts officials, specifically staff from UMMS, the Health Connector and EOHHS, are using these funds to support work with other New England states to design and implement an information technology

infrastructure that will improve how individual consumers and small businesses shop for health insurance. The primary focus of the Massachusetts Early Innovators grant is to build the HIX/IES for Massachusetts and create, “reusable technology components” (*i.e.*, business rules engine, interfaces with the Federal Data Services Hub) that can be used by other participating New England states.

CHALLENGES

The Health Connector has made substantial progress on the path to Connector 2.0, but there is important work remaining to be done. The Affordable Care Act, though modeled after the success of Massachusetts, brings significant legal, policy and programmatic changes to agencies and residents. Differences between the two laws require some changes to the Massachusetts model. Implementation, therefore, requires a very informed and engaged stakeholder community to ensure individuals and small businesses are aware of the benefits the Affordable Care Act offers and that their perspectives are

incorporated into the policy and programmatic decision-making processes.

The Commonwealth's Inter-Agency Task Force on Implementation of Health Care Reform, chaired by the Secretary of EOHHS, convenes quarterly open stakeholder meetings, where any interested stakeholder or member of the general public can hear updates on implementation activities. The Task Force's subsidiary inter-agency workgroups are also able to utilize stakeholder feedback to identify and make recommendations for the resolution of issues that arise as a result of the intersection of state and federal law. The Commonwealth has a strong foundation of consumer and stakeholder engagement in health care and has designed its approach to this transition to Affordable Care Act compliance to prioritize transparency, collaboration and inclusion.

The Health Connector is working with MassHealth and other state partners to plan for smooth coverage transitions among the nearly 240,000 Health Connector members – and some individuals in other state programs – who will be eligible for new programs in 2014.

Under those new programs, some current Health Connector members may move to MassHealth, while others may move to new programs within the Health Connector. Many who are currently receiving subsidies as well as some who currently receive no government assistance will get advanced premium tax credits instead. A robust public outreach and education campaign, rivaling those undertaken quickly after the enactment of Massachusetts health reform, will help ensure public awareness of new coverage options and resources.

SUPPORTING THE ADMINISTRATION

In fulfilling the Health Connector's mission to improve access to high-quality health care and transform the health care system, the Health Connector supports A&F's strategic goal of Better Health Care.

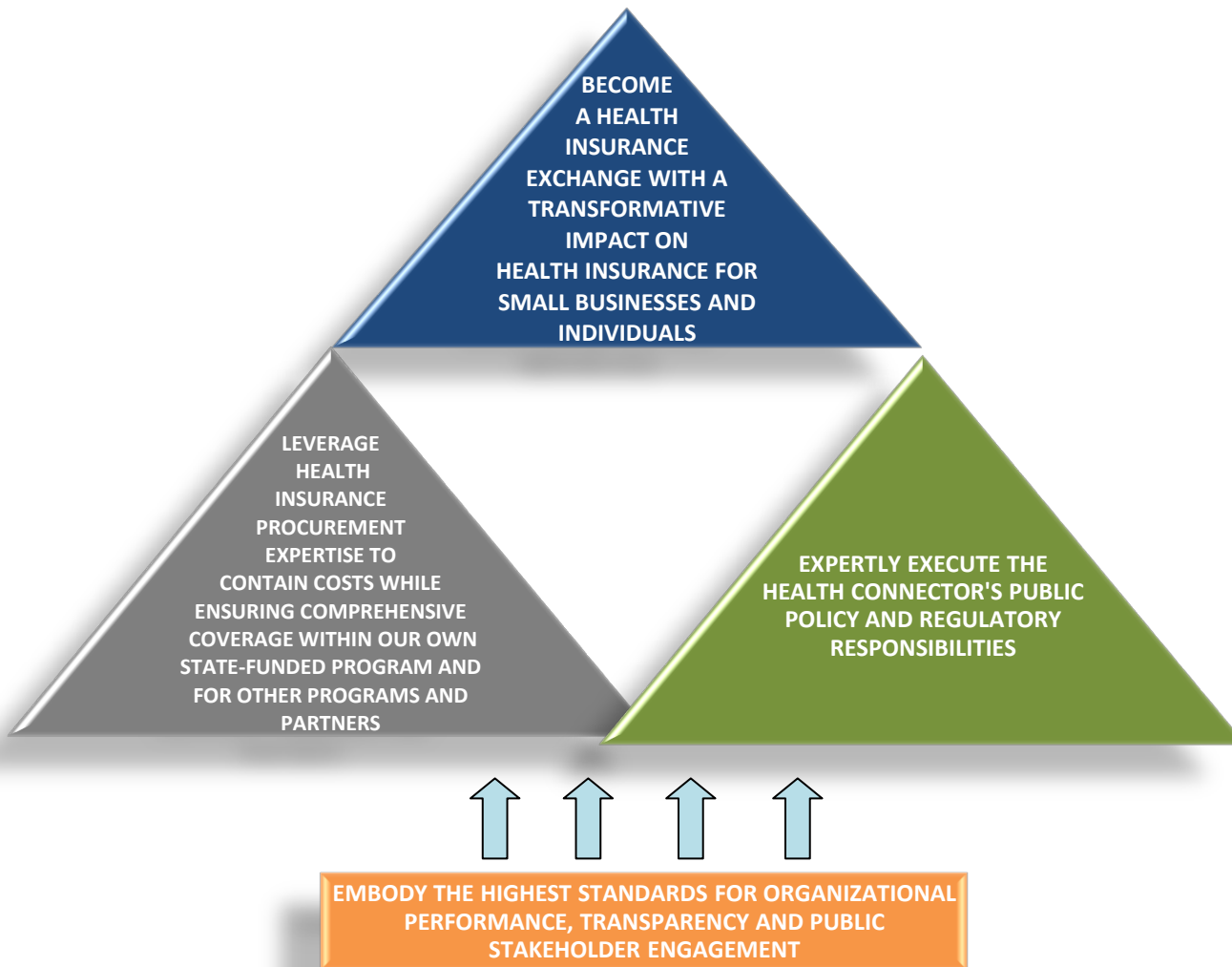
Within the greater strategic goal of Better Health Care, the Health Connector directly supports A&F on the following actions:

- Work to execute the cost containment initiatives instituted in the budget for all public programs

- Expand the Health Connector's role in assisting government funded programs with health insurance procurements
- Transition the Health Connector to a federally compliant state health insurance exchange by 2014
- Increase enrollment in the Health Connector's Commonwealth Choice program
- Increase participation in wellness programs
- Promote innovation in benefit design and expand the choice of affordable products

Through the implementation of wellness programs, continued efforts to become a fully certified ACA-compliant exchange and leveraging procurement expertise to contain costs while providing affordable and quality products, the Health Connector exhibits a commitment to the shared goal of Better Health Care. The Health Connector looks forward to working closely with the Patrick Administration and A&F to promote their goal of Better Health Care and thoughtful health care cost containment.

STRATEGIC GOALS & ACTIONS



VISION

By refining our goal setting process for FY13 and beyond to more clearly articulate our core vision, we **emphasize the most important priorities** for effectuating it and identifying key metrics to measure our progress.

While the Health Connector still needs to **maintain “Connector 1.0” Operations**, much of our organizational efforts are now focused on “Connector 2.0”.

To succeed as “Connector 2.0”, the Health Connector must **build upon its efforts since the enactment of Massachusetts Health Reform**, using not only the tools provided by the Affordable Care Act, but also **lessons learned during its experience as one of the only health insurance Exchanges in the country.**

BECOME A HEALTH INSURANCE EXCHANGE WITH A TRANSFORMATIVE IMPACT ON HEALTH INSURANCE FOR SMALL BUSINESSES AND INDIVIDUALS

Supporting Goals

Provide users with “choice made easy” when it comes to health insurance and evidence-based tools to improve wellness

Promote competition on price and value and positive innovation among health insurance carriers

Ensure full compliance with the Affordable Care Act

To deliver these results, the Health Connector will take the following actions:

- **Offer a range of products and carriers** that can meet the needs of a diverse set of consumers
- **Enhance consumer or user experience** from eligibility determination to shopping to enrollment to payment
- **Ensure consumers know about opportunities to access coverage through the Health Connector**
- Connect customers to evidence-based tools to **improve wellness**
- **Understand the customer, market and partner needs** through engagement of key market participants
- Fashion **easy-to-understand, user-friendly Health Connector shopping experience** so that high-value health insurance options have the potential to differentiate and grow
- **Make it as easy as possible for carriers to offer high-value health insurance options** through the Health Connector
- **Develop a customized approach to promoting payment reform** as part of the QHP certification process (Seal of Approval) for coverage effective January 2014
- **Use federal grant revenue to ensure a successful transition to an ACA-compliant Exchange**, with proper audit and compliance procedures
- **Meet requirements for federal approval** of the Health Connector as an ACA-compliant Exchange
- **Maintain a comprehensive Transition Roadmap** detailing all major ACA deliverables with specific timelines for development, testing and implementation
- **Maintain an internal Project Management Office and governance structure** to ensure full execution of the Roadmap
- **Educate the public, partners and other stakeholders** about the Affordable Care Act
- **Manage member transitions** from current Health Connector programs to those they are eligible for in 2014

STRATEGIC GOALS & ACTIONS

LEVERAGE HEALTH INSURANCE PROCUREMENT EXPERTISE TO CONTAIN COSTS WHILE ENSURING COMPREHENSIVE COVERAGE WITHIN OUR OWN STATE-FUNDED PROGRAM AND FOR OTHER PROGRAMS AND PARTNERS

Supporting Goals

Partner with other public entities to assist with procurements for health insurance

Expertly manage Commonwealth Care as the program winds down its life cycle

Provide substantive and strategic advice and technical assistance with efforts to transition state-funded health insurance programs towards alternative payment methodologies promoting efficient, evidence-driven and coordinated care

Continue to assist colleges and universities in procuring health insurance for their students

To deliver these results, the Health Connector will take the following actions:

- Participate formally on **Group Insurance Commission's procurement** team for 2014 coverage for state and municipal employees
- Participate formally on the **Department of Corrections' procurement** planning team
- **Advise Division of Unemployment Assistance** on renewal of MSP Direct Coverage in light of program experience and subsidized coverage transitions under the ACA
- **Engage other state agencies** on opportunities to assist with pending or future procurements for state-funded coverage
- Manage program costs and promote positive member experience during FY13
- Engage MCOs and customer service vendor on **coverage and customer service mechanics** for first half of FY14, coordinated with the strategy for managing member transitions within the Health Connector and to MassHealth based on the ACA]
- **Enhance tobacco cessation coverage in Commonwealth Care** and modify coverage for dental and other benefits as required by the FY13 budget
- Participate in workgroup designed to **develop strategy for MassHealth's engagement of ACOs**
- Support the ongoing PCMH Initiative in the Commonwealth Care program
- Implement provisions of chapter 224 of the Acts of 2012 (relating to payment and delivery system reform) that are applicable to the Health Connector
- **Promote awareness** and help colleges engaged with the Health Connector to develop strategies to come into compliance with new ACA rules
- Under chapter 224 of the Acts of 2012, assume responsibility for establishing **minimum benefit standards** for student health insurance coverage
- Develop **educational resources for students** with interactive solutions to explaining health insurance coverage and student health plans
- Partner with DHCFP to **report publicly on student health insurance** coverage and cost trends in Massachusetts
- Continue to **assist public colleges and universities** with health insurance procurements/renewals and determine best approach to engaging additional institutions of higher education

EXPERTLY EXECUTE THE HEALTH CONNECTOR'S PUBLIC POLICY AND REGULATORY RESPONSIBILITIES

Supporting Goals

Implement Affordable Care Act policy and regulatory changes for which the Health Connector is responsible and assist other agencies as needed with their ACA-related policy projects

Augment Health Connector research and publication agenda to proactively report on key findings, trends and lessons learned from our programmatic and policymaking experiences to date

To deliver these results, the Health Connector will take the following actions:

- **Mesh state individual mandate** (including affordability schedule and MCC and enforcement/appeals) **with relevant ACA rules** (federal individual mandate affordability/penalty/appeals framework, benefit standards through MCC and EHB rules, required enrollee contributions to subsidized coverage in MassHealth and the Health Connector)
- **Lead development of state-based methodology** for instituting cross-small/non-group market risk adjustment, including efforts to secure federal authorization for the Commonwealth to implement this approach
- Pursuant to chapter 224 of the Acts of 2012, assume responsibility for **policymaking with respect to employer responsibility policies**, and accordingly play a leading role in efforts to mesh existing state rules with new ACA standards
- **Assist/coordinate with other state agencies** with respect to ACA-related policy and regulatory responsibilities under their principal jurisdiction
- Report on number and percent of Health Connector **enrollees participating in wellness initiatives** (Wellness Track and My Wellness Track)
- Report on **percent increase in Health Connector small groups participating in Wellness Track** before and after changes to eligibility criteria are implemented
- Annual **reporting on Student Health Insurance Programs (SHIP) in the Commonwealth** including financial and performance metric analysis, as well as enrollment and carrier information
- Produce **programmatic reports** throughout the year (*i.e.*, annual high-level progress report, data-rich annual report to the Massachusetts Legislature)
- **Collaborate with other state agencies** to make data related to Massachusetts health care reform available (*i.e.*, annual report on the individual mandate with DOR, quarterly Key Indicator reports with the Center for Health Information and Analysis (CHIA))
- Be **fully transparent** about the process, substance and rationale for organizational decisions related to **ACA implementation** and report publicly and objectively on outcomes via the Health Connector website and at public stakeholder meetings

STRATEGIC GOALS & ACTIONS

EMBODY THE HIGHEST STANDARDS FOR ORGANIZATIONAL PERFORMANCE, TRANSPARENCY AND PUBLIC STAKEHOLDER ENGAGEMENT

Supporting Goals

Proactively and consistently engage our Board of Directors on our priorities and activities

Attract and retain high-quality staff

Fully engage the public and stakeholders on the activities of the Health Connector

To deliver these results, the Health Connector will take the following actions:

- Conduct Board meetings with **ample preparation and regular follow-up** on Board meeting topics of discussion and outstanding questions
- Conduct **enhanced engagement on ACA transition activities** (provide regular updates on ACA transition activities at Board meetings, have Board members formally participate on ACA planning committees, etc.)
- Empower Board to **conduct rigorous oversight of programs and finances**
- Conduct **updated personnel resource assessment** in light of evolving responsibilities
- Conduct **thoughtful performance reviews/performance-based adjustments to compensation** where feasible
- Create **positive work environment**, underscoring our public mission and fostering teamwork and professional development
- Participate in **multi-agency stakeholder engagement** activities (e.g., EHS-led public forums)
- **Solicit public feedback** from open Board of Directors meetings, social media, sister agencies, advocacy organizations and members to provide input related to Health Connector policymaking, operational decision-making and strategic vision
- Lead **consumer and small business road shows** throughout the Commonwealth to educate the public about opportunities and responsibilities under the ACA in Massachusetts
- Engage with **business representatives and employer associations** to communicate the Health Connector's value proposition for employers
- Hold quarterly meetings with the Health Connector's **Broker Advisory Council**, comprising a diverse group of brokers serving different sized employer groups throughout Massachusetts
- Hold **bi-monthly consumer advocates meetings** to proactively engage them in Health Connector issues, obtain their feedback and insight on Connector 2.0 planning and help them in their efforts to educate the community in Massachusetts

OUTCOME MEASURES

The Health Connector will use the high-level performance measures below to assess success in achieving its strategic goals.

GOAL	MEASURE	DEFINITION / NOTE	DATA SOURCE
BECOME A HEALTH INSURANCE EXCHANGE WITH A TRANSFORMATIVE IMPACT ON HEALTH INSURANCE FOR SMALL BUSINESSES AND INDIVIDUALS	# of individuals enrolled in Commonwealth Choice	Total enrollment in the Health Connector's Commonwealth Choice Program	Health Connector
	% of Commonwealth Choice members expressing satisfaction with customer service	Evaluated based on annual focus groups and member surveys	Health Connector
	Call center performance metrics, including Abandonment Rate, Average Hold Time, and Average Talk Time	Call center performance is tracked regularly against performance benchmarks and customer surveys	Health Connector
	# of federal dollars received through grant application process	The Connector will lead federal support received for Affordable Care Act compliance efforts	Health Connector
	# of market research activities with consumers and small businesses that are completed by the Health Connector	Quantitative and qualitative research of two primary markets: consumers and small businesses with up to 50 employees (including members and non-members) to determine attitudes toward health insurance eligibility, costs of health plans, purchasing health insurance online, related customer preferences, and awareness of the Affordable Care Act	Health Connector
	# of participants in Wellness Track	# of small businesses that enroll through Business Express that sign up for Health Connector sponsored wellness program	Health Connector
	# of enrollees in Commonwealth Choice by plan-design	Through Seal of Approval process use research, focus group data and member surveys to develop a competitive product portfolio	Health Connector
	% of Roadmap deliverables that are executed by due dates	# of milestones completed	Health Connector
	Average premium trend for Commonwealth Choice products	Internal premium trend reports reflect average premium trends	Health Connector

GOAL	MEASURE	DEFINITION / NOTE	DATA SOURCE
LEVERAGE HEALTH INSURANCE PROCUREMENT EXPERTISE TO CONTAIN COSTS WHILE ENSURING COMPREHENSIVE COVERAGE WITHIN OUR OWN STATE-FUNDED PROGRAM AND FOR OTHER PROGRAMS AND PARTNERS	# of Group Insurance Commission premium changes	Participate in procurement process as part of Group Insurance Commission team	Health Connector/GIC
	# of Department of Corrections premium changes	Assist Department of Corrections in health insurance procurement	Health Connector/DOC
	# of Commonwealth Care members expressing satisfaction care access, health plans and customer service	Conduct survey of Commonwealth Care population to evaluate all aspects of program (access to care/barriers to care/affordability/satisfaction with plan/satisfaction with customer service)	Health Connector
	# of higher education institution premium changes	Compare premium cost trend and plan design on yearly basis	Health Connector/Department of Higher Education
	% change in tobacco cessation benefit utilization before and after the launch of the tobacco cessation awareness program	Take up of the tobacco cessation benefit is a key measure of how well the awareness program has performed	Health Connector
	% of Commonwealth Care, Commonwealth Choice and GIC members enrolled in narrow network products	Narrow networks are products where there is a materially smaller provider network than the broadest networks available in the applicable market	Health Connector, GIC
	% of Commonwealth Care, Commonwealth Choice and GIC members enrolled in tiered network products	Tiered networks are products where member point-of-service cost sharing is tiered into different amounts based on the actual doctors and hospitals visited	Health Connector, GIC
EXPERTLY EXECUTE THE HEALTH CONNECTOR'S PUBLIC POLICY AND REGULATORY RESPONSIBILITIES	Publish yearly progress report on time	Published report of year's accomplishments of Health Connector	Health Connector
	Publish yearly legislative report on time	Report for legislature on achievements and future projects of Health Connector	Health Connector
	Submit Massachusetts state-based approach to risk adjustment to federal government on time	Propose state-based approach to risk adjustment to federal government, work with federal government to create final approach. The state-based approach would more accurately	Health Connector

GOAL	MEASURE	DEFINITION / NOTE	DATA SOURCE
		and equitably distribute risk among Massachusetts insurance carriers by considering state-specific considerations and market dynamics	
	Amount of legislation introduced and enacted to ensure state compliance with federal law	The Health Connector is leading efforts to support develop and pass legislation to comply with the Affordable Care Act	Health Connector
	% of Notice of Proposed Rule Making (NPRMs) responses completed on time by the due date	NPRMs are formal notices to the public by a government agency that they intend to create new regulations or modify already existing ones. The Connector will work with other relevant state agencies and other states to provide comments to federal health rules.	Health Connector/ other state agencies/other states
EMBODY THE HIGHEST STANDARDS FOR ORGANIZATIONAL PERFORMANCE, TRANSPARENCY AND PUBLIC STAKEHOLDER ENGAGEMENT	# of Board of Directors meetings	Ensure that there is a Board of Directors meeting held on a monthly basis to receive input from Board and obtain necessary votes	Health Connector
	# of phone calls and e-mails sent to Board members to update them on Health Connector advancements	Regular interaction with Board members will help the Connector obtain their feedback	Health Connector
	# of committees and advisory councils on which Board members sit	Track the involvement of Board members in Health Connector committees and advisory councils	Health Connector
	# A&F Subcommittee Meetings	Hold public meetings to engage Health Connector board on budget issues	Health Connector/ A&F
	# of participants in ACA Learning Series	Hold quarterly meetings to educate staff who currently assist Commonwealth Care, Commonwealth Choice, MassHealth and Health Safety Net (HSN) members at Massachusetts hospitals, health centers and community-based organizations by disseminating Affordable Care Act information and distributing post-meeting surveys to evaluate effectiveness	Health Connector/ EOHHS
	% of participants who felt that the ACA Learning Series was beneficial		
	# of quarterly Stakeholder Meetings	Hold open meetings to discuss implementation activities with stakeholders and the general public	Health Connector/ other state agencies

GOAL	MEASURE	DEFINITION / NOTE	DATA SOURCE
	# key hires yielding high-quality staff	The Health Connector seeks to hire high quality staff, as evaluated by the Health Connector's performance evaluation cycle	Health Connector
	% of performance reviews for staff that are completed on time	Completion of performance evaluation cycle for each staff member	Health Connector



THE NEXT PHASE OF MASSACHUSETTS HEALTH CARE REFORM

Massachusetts is poised to address one of the greatest challenges of our generation: Reducing the growth in health care costs while improving health care quality and patient care. From 2009 to 2020, health spending is projected to double, outpacing both inflation and growth in the overall economy. The rapid rate of growth squeezes out other spending, for individual households, for businesses, for communities and in the state budget. That is why this effort is essential for our long-term economic competitiveness and for the health of our residents. This comprehensive bill will build on past reforms through innovative, market-based solutions, by:

Setting Health Care Cost Growth on a Sustainable Long-Term Path

- Establishes a statewide health care cost growth goal for the health care industry pegged at an amount no greater than the growth in the state's overall economy.
 - *For 2013- 2017: Set at the potential growth rate of the state's gross state product (GSP)*
 - *For 2018-2022: Set at, or slightly below, the potential growth rate of the state's gross state product (Between GSP - 0.5% and GSP)*
- This will result in savings of up to **\$200 billion** over the next 15 years.

Leading by Example

- Requires the state's Medicaid program, the state's employee health care program, and all other state-funded health care programs to transition to new health care payment methodologies. These payment models incentivize the delivery of high-quality, coordinated, efficient and effective health care while reducing waste, fraud and abuse.
- Authorizes targeted Medicaid rate increases of up to \$20 million for providers that demonstrate a significant transition to new payment methodologies.
- Establishes a certification process for accountable care organizations or "ACOs" – health care provider systems dedicated to cost growth reduction, quality improvement and patient protection. These ACOs would receive a contracting preference in state health programs.
- Establishes a certification process for patient-centered medical homes – a care delivery model that provides patients with a single point of coordination for all their health needs.

Enhancing Transparency and Accountability of the Health Care Marketplace

- Requires all health care provider systems to register with the state and report regularly on financial performance, market share, cost trends, and quality measures.
- Charges the Attorney General to monitor trends in the health care market including consolidation in the provider market in order to protect patient access and quality.
- Establishes a new "Cost and Market Impact Review" to examine changes in the health care industry and the impact of these changes on cost, quality, and market competitiveness. The findings of this review may be referred to the Attorney General for further investigation.
- Develops a process to track price variation among different health care providers over time and establishes a Special Commission to determine and quantify the acceptable and unacceptable factors contributing to price variation among providers.



THE NEXT PHASE OF MASSACHUSETTS HEALTH CARE REFORM

Investing in a Healthy Future for the Commonwealth

- This bill dedicates \$60 million over the next 4 years in a historic investment in community-based prevention, public health, and wellness efforts to reduce the rates of costly preventable chronic diseases, such as obesity, diabetes, and asthma.
- Establishes a new wellness tax credit for businesses that implement recognized workplace wellness programs, up to \$10,000 per employer. These programs will improve employee health, reduce recidivism, and help control the growth in employer health care premiums.
- Requires the Department of Public Health to develop a “model guide” for wellness programs for businesses and to provide stipends to help businesses establish programs.
- Requires health insurance companies to provide a premium adjustment for small businesses that adopt approved workplace wellness programs.

Building the Health Care System and Workforce for the 21st Century

- Dedicates \$135 million over the next 4 years to support investments in our community hospitals to support the infrastructure necessary to build the health care system of the 21st century. This funding, targeted for financially distressed hospitals, will assist in the transition to new payment methodologies and care delivery models.
- Commits an additional \$30 million in investments for other eligible health care providers to accelerate the on-going statewide adoption of interoperable electronic health records.
- Establishes a Health Care Workforce Transformation Trust Fund to invest in the training, education, and skill development programs necessary to help workers succeed in the health care system of the future. This Fund received \$20 million in the fiscal 2013 budget.
- Incentivizes the accelerated adoption of connected health technology, such as telemedicine.

Increasing Access to Essential Care Services

- Expands the role of physician assistants and nurse practitioners to act as primary care providers in order to expand access to cost-effective care.
- Expands the role of “limited-service-clinics” to act as a cost-effective and convenient point of access for health care services provided by nurse practitioners.
- Expands an existing workforce loan forgiveness program to include providers of behavioral, substance use disorder, and mental health services.
- Establishes a new primary care residency program supported by the Department of Public Health in order to increase the pipeline of primary care providers.

Promoting Administrative Simplification for Health Care Providers

- Requires the development of standard prior authorization forms, which would be available electronically, so that providers would use only one form for all health insurance carriers.
- Authorizes penalties for non-compliance with standardized coding and billing requirements.
- Streamlines data reporting requirement by designating a single agency as the secure data repository for all health care information reported to and collected by the state.



THE NEXT PHASE OF MASSACHUSETTS HEALTH CARE REFORM

Reforming Medical Malpractice Laws

- Reduces unnecessary litigation and malpractice claims costs by creating a 182-day cooling off period while both side try to negotiate a settlement. Requires the exchange of information between the plaintiff and defense to promote early settlement.
- Allows a health care provider or facility to admit to a mistake or error. The admission cannot be used in a court as an admission of liability. However, if a provider lies under oath about the error or mistake, then the statement can be used as an admission of liability.
- Creates a task force to study defensive medicine and medical overutilization.

Improving Consumer Transparency of Health Care Costs

- Establishes new transparency tools to help consumers make health care purchasing decisions based on comparative cost and quality, including the establishment of a consumer health information website with transparent prices and shared-decision making online tools.
- Directs health insurance carriers to disclose the out-of-pocket costs for a proposed health care service and protects patients from paying more than the disclosed amount.
- Requires health insurance carriers to provide a summary to health care consumers in an easily readable and understandable format showing the consumer's responsibility, if any, for payment of any portion of a health care provider claim.

Enhancing the Affordability and Efficiency of Health Insurance Products

- Extends key provisions of small business health insurance legislation passed in 2010, including a requirement that the Division of Insurance rigorously review premium filings to ensure that small businesses and individuals receive the most efficient products possible.
- Extends the current authority of the Division of Insurance to help mitigate and stabilize large “spikes” in premium increases from year to year.
- Increases the minimum premium savings for “tiered” or “selective” network health products from 12% to 14% and establishes a new “smart-tiering” option.

Protecting Consumer Access to Necessary Care

- Requires certified ACOs, patient-centered medical homes, and provider organizations that receive a risk-based payment to set up a system of internal appeals. The appeals process may last no longer than 14 days.
- Requires certified ACOs to guarantee access to all medically necessary services for patients, either internally or through providers outside of the ACO.

Integrating Behavioral, Substance Use Disorder, and Mental Health Services

- Requires health insurance companies to comply with federal mental health parity law and submit documentation to the Attorney General certifying compliance.
- Establishes a special task force to make recommendations on how to integrate behavioral health services in the payment and delivery systems developed under this bill.



THE NEXT PHASE OF MASSACHUSETTS HEALTH CARE REFORM

Other Important Provisions:

Governance – Health Policy Commission (HPC)

- Reforms and reorganizes an existing state entity, the Health Care Quality and Cost Council, into the **Health Policy Commission**.
- The Commission will be governed by an 11 member board within, but not subject to the control of, the Administration and Finance (similar to the Group Insurance Commission).
- This Commission, under the authority of the board, will oversee policy development necessary for the implementation of the overall legislation, including setting and enforcing the health care cost growth benchmark, certifying new payment methods and care delivery models, and conducting the new “Cost and Market Impact” reviews of market changes.

Governance- Center for Health Information and Analysis (CHIA)

- Reforms and reorganizes an existing state entity, the Division of Health Care Finance and Policy, into the **Center for Health Information and Analysis**.
- The Center will be an independent state agency, governed by an executive director appointed by majority vote of the Governor, Attorney General, and State Auditor (similar to the Inspector General).
- The Center will act as the designated health care data collection, dissemination, and analysis agency of the Commonwealth and will provide critical, independent analysis of the how the state’s policies are affecting cost trends.

Mandatory Overtime - Bans the use of mandatory overtime for nurses in a hospital setting unless patient safety requires it in an emergency situation or there is no reasonable alternative.

Fair Share Assessment- Raises the full-time equivalent (FTE) threshold for fair share contributions from 10 to 20 employees and adds a provision that employees who have health insurance from other sources will not be included in the calculation of whether an employer is a contributing employer.. (Changes effective July 1, 2013).

State Health Plan - Establishes a health planning council to develop, every 5 years, a state health plan determining the future medical capital needs of the Commonwealth.

Health Savings Accounts- Requires a review and recommendations relative to increasing the use of health savings accounts, flexible savings accounts, and other “consumer-driven plans.”

Pharmaceutical Cost Containment- Directs state agencies responsible for the purchase of prescription drugs to form a uniform procurement unit to negotiate for bulk purchases and creates a commission to review methods to reduce the cost of prescription drugs for public and private payers.

The Top Ten Facts about Massachusetts Health Care Reform

1 Massachusetts now has a 98% coverage rate, the best in the nation, by far. About 439,000 Massachusetts residents are newly insured. Nearly all children (99.8%) and seniors (99.6%) have health insurance. Furthermore, racial and ethnic disparities in health coverage have been significantly reduced.

Massachusetts reform and improved coverage has led to better health among Commonwealth residents. More people are receiving cancer screenings like colonoscopies, more women are getting pre-natal care, and more than 150,000 have stopped smoking after getting coverage for smoking cessation in MassHealth, the state's Medicaid program.

2 Popular support for the law remains high, ranging from 59% to 75% in independent polls. Even in the midst of a polarizing debate over national health care reform, strong public and bipartisan support has been sustained.

3 Access to care has improved in Massachusetts. A fall 2008 survey by the Blue Cross Blue Shield of Massachusetts Foundation and *the Boston Globe* found that more than 90% of individuals reported having a primary care provider, and only 5% said there was a time in the past year that they needed medical care, tests or treatment that they did not get. Access to care is far better in Massachusetts than nationally. For instance, in 2007, about 20% of the U.S. population reported not getting or delaying needed medical care at some point in the previous 12 months.

The supply of primary care physicians is a national problem, and Massachusetts reform has stimulated creative approaches to further improve access. In 2008, the private sector, with some state contribution, developed a loan repayment program for physicians and nurses who make a two- to three-year commitment to practice primary care in a Massachusetts community health center. Some 118 primary care clinicians, able to care for more than 209,000 patients, have been recruited or retained because of this incentive program. Additionally, the state's decision in 2007 to allow carefully regulated development of primary care nursing services in commercial pharmacies and other settings is also expanding access for minor ailments.

4 Health care reform in Massachusetts has not been a budget buster. Independent analysis by the Massachusetts Taxpayers Foundation concurs with state data showing the cost of the law has been relatively modest, with increased net spending in FY 2010 accounting for just over 1 percent of the state budget. The state has held the line on rates in both MassHealth and Commonwealth Care, with trends far below the experience in the commercial market. Moreover, nearly half of Commonwealth Care members pay premiums for their coverage.

5 Since health reform, more employers are offering coverage to their employees, bucking the national trend. In 2010, 77% of Massachusetts employers offered health insurance, up from 69% in 2001. In contrast the national trend which has seen employer offerings remain flat from 68% in 2001 to 69% in 2010. The dominant form of coverage in the state remains private insurance. In the midst of the worst recession since the Great Depression, public

sector coverage has predictably increased. But these individuals have not lost coverage - a strength of the Massachusetts model. As more people return to the workforce, reliance on public sector insurance will decrease.

6 Massachusetts health reform provided the model for national reform. Like Massachusetts, the new national law calls for the formation of Exchanges. The Health Connector's tiering system, which offers consumers a choice of gold,

silver or bronze coverage, was also adopted in a slightly expanded way. Like Massachusetts, the national law sets minimum coverage standards and will include benefits like elimination of pre-existing condition exclusions. A number of the benefits in the Massachusetts law are enhanced under national reform, most notably extension of subsidy assistance for individuals from 300% to 400% of the federal poverty level, extension of federally-subsidized coverage to legal immigrants and extension of insurance protections to self-funded private coverage.

7 The individual mandate has worked fairly and effectively to expand coverage in Massachusetts. Some 97% of the taxpayers are complying with new health reform filing requirements. Furthermore, the Health Connector's appeals process, which rules on hardship exceptions, has been fair to taxpayers, with a 65 percent approval rate for those who follow through with an appeal.

8 As a result of the merger of the small- and non-group markets, individuals who had a hard time finding affordable coverage now can. Their premiums for comparable coverage dropped on average about 20% in 2007 right after passage of the law. This is significant progress in a market that had typically experienced double-digit annual premium increases. A Massachusetts Division of Health Care Finance and Policy report found that, as of June 2011, individual, non-group coverage grew by 33,000 individuals since reform, with most purchasing through the Health Connector's Commonwealth Choice program.

9 Massachusetts has been proactive in helping small businesses. Governor Patrick implemented a series of initiatives that led to lower premiums for small businesses, including denying rate increases proposed by health insurers. This led to negotiated rates and lower costs for employers. Other Administration and legislative initiatives were included in a comprehensive small business health care cost containment law. While not the ultimate solution to rising premiums, these actions were significant steps forward.

In February of 2010, the Health Connector launched the Business Express program which gives small employers the ability to make apples-to-apples comparisons of plans and benefits and pick the one that is right for them and their employees, potentially saving money. The Legislature also created the Small Business Wellness Incentive Program that will provide some small employers with a rebate of up to 15% if their employees participate in a wellness program offered through the Health Connector. This incentive program, which became effective July 1, 2011, enhances the small business tax credit program available through national reform.

10 Massachusetts is taking on the challenge of cost containment. Progress has already been made through the enactment of two comprehensive cost containment bills since health care reform. Moreover, a commission made up of leaders from state government, providers, insurers and other experts unanimously endorsed a groundbreaking blueprint to reward value instead of volume when it comes to paying for health care. As noted by Nobel Prize-winning economist and New York Times columnist Paul Krugman: "So, where in America is there serious consideration of moving away from fee-for-service to a more comprehensive, integrated approach to health care? The answer is: Massachusetts." (NYT 7/23/09) As a first step toward comprehensive payment reform, Governor Patrick filed legislation on February 17, 2011.



*Abbie von Schlegell,
Commonwealth Choice Member*



*Matt McGinity, small business owner
Business Express member*

