The Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, MA 02108

MITT ROMNEY
Governor
KERRY HEALEY
Lieutenant Governor
TIMOTHY R. MURPHY
Secretary

Speaker Salvatore F. DiMasi, House of Representatives
President Robert E. Travaglini, Senate
Chairwoman Patricia A. Walrath, Joint Committee on Health Care Financing
Chairman Richard T. Moore, Joint Committee on Health Care Financing
Chairman Robert A. DeLeo, House Committee on Ways and Means
Chairwoman Therese Murray, Senate Committee on Ways and Means

Dear Senators and Representatives:

The healthcare reform signing ceremony at historic Faneuil Hall was truly a monumental occasion. On April 12, 2006, Governor Romney and the General Court agreed to blaze a new trail for one of the most pressing issues for confronting the residents of the Commonwealth. By working together, our state leaders fashioned an innovative blueprint that holds the promise of affordable health insurance coverage for every resident, quality improvements to our healthcare system, and a more rational and sustainable healthcare cost structure. So striking in its boldness, Chapter 58 of the Acts of 2006 (the "Act") has catalyzed the healthcare debate not only in the Commonwealth, but also across the nation.

Of course, the Act is just hopeful words. Only through effective implementation will these words bring about the positive changes envisioned by those that shaped its passage. The path to full implementation will be difficult and will challenge all stakeholders in the healthcare industry. I am confident that we will meet all challenges and indeed make things better for the residents of the Commonwealth.

Under the leadership of Governor Romney, the Administration has committed the necessary personnel and resources to execute the provisions of the Act. The Administration convened an inter-agency healthcare reform implementation management committee to guide and coordinate this effort. The management committee establishes project ownership, identifies multi-agency responsibilities, sets clear deadlines, and provides a forum for information sharing, progress updates and early problem identification.

The first sixty days of implementation have been productive with each state agency making significant progress against its responsibilities, including:

- Submission of the Section 1115 Waiver amendment to the Centers for Medicare and Medicaid ("CMS") within three weeks of the Act's passage;
- Meetings with federal officials to obtain CMS approval by July 1, 2006;
- Preparations by the Office of Medicaid to change eligibility criteria and benefits by July 1, 2006;
- Negotiations with Medicaid managed care organizations to increase actuarially sound rates pursuant to the Act;
- Medicaid rate increases for physicians beginning on July 1, 2006;
- Development of Medicaid rate methodologies for hospital rate increases on October 1, 2006;
- Beginning of the Medicaid provider re-credentialing project to improve MassHealth's program integrity;
- Appointment of the Commonwealth Health Insurance Connector Authority (the "Connector") board members by the Governor and the Attorney General;
- Selection of Jon Kingsdale as the Executive Director of the Connector Authority;
- Preliminary timetable for the development and implementation of the Commonwealth Care program and non-subsidized affordable health insurance products for individuals, small businesses and other eligible groups;
- Convening of the special commission to study the merger of the small group and non-group insurance markets;
- Discussions between state agencies to implement the various individual and employer provisions of the Act;
- Numerous meetings with providers, insurers, businesses and consumers; and
- Recommendations for technical corrections to the Act.

The months ahead will be challenging with numerous consequential decisions to be made. Issues such as product design, affordability, eligibility, and participation will be analyzed, considered, and decided. Undoubtedly we will confront issues that were not contemplated during the Act's passage. All stakeholders will need to work together to overcome these obstacles in order for the Act to become a successful reality.

Pursuant to section 132 of the Act; I am pleased to provide the General Court with this initial implementation plan.

Sincerely,

Timothy R. Murphy,
Secretary

Cc: Senator Brian P. Lees
Representative Bradley H. Jones
Representative Ronald Mariano
Representative Robert S. Hargraves

Chapter 58 Implementation Update

Governor Mitt Romney
Lieutenant Governor Kerry Healey
Secretary of Health and Human Services Timothy Murphy

June 12, 2006

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Section 1: Key Elements of Chapter 58 of the Acts of 2006

Individual Responsibility

As of July 1, 2007, residents of the Commonwealth age 18 and over are required to have creditable health insurance coverage with no lapse in coverage for more than 63 days. For the 2007 tax year, individuals will be required to indicate on their individual tax return whether they had creditable coverage as of December 31, 2007 either individually or as a named beneficiary, whether they are claiming an exemption from the requirement for religious reasons, or whether they have a certificate issued by the Commonwealth Health Insurance Connector (the "Connector") indicating that no health insurance offered through the Connector was deemed to be affordable for that individual. Individuals who fail to indicate whether they have creditable coverage or that they are exempt, or who indicate that they do not have creditable coverage will lose their personal tax exemption if they file individually or one-half of the personal tax exemption if they file jointly. Individuals will be able to dispute the application of the mandate or the affordability of coverage through an appeals process established by the Connector. Beginning January 1, 2008, individuals must indicate on their tax returns whether they had creditable coverage in force for each of the 12 months of the taxable year for which the return is filed. Penalties based on one-half of premium cost will be imposed on individuals who did not have creditable coverage or who fail to indicate that they have creditable coverage or are exempt. Such payments received will be deposited into the Commonwealth Care Trust Fund.

For more information on individual responsibility, see Section 9.

Insurance market reforms

The health insurance market in Massachusetts has several barriers that make it difficult for small employers and individuals, particularly part-time workers, contractors, workers with multiple jobs, and sole proprietors, to purchase affordable health insurance. Individuals face a choice of expensive products, while small employers face minimum participation and contribution requirements before insurers will do business with them. To level the playing field, the Act merges the non-group and small-group insurance markets, thereby pooling risk and creating more affordable choices for individuals seeking to buy health insurance. The Act also creates insurance products for young adults ages 19-26 with more flexible benefit packages, and extends dependent coverage through age 25 (or two years following the loss of dependent status under the Internal Revenue Code, whichever is earlier). The Act allows more flexibility in the market by permitting deductible levels consistent with federal Health Savings Accounts ("HSA") laws, permitting co-insurance, and updating preferred provider network and health maintenance organization laws to permit value-driven, tiered provider networks. The Act also imposes a moratorium on new mandated benefit legislation until at least January 1, 2008. Finally, the Act requires employers with more than 10 full-time employees to create "cafeteria

plans", as authorized by Section 125 of the Internal Revenue Code (26 U.S.C. §125), enabling employees to purchase health insurance on a pre-tax basis.

For more information on insurance market reforms, see Section 7 of this report.

Commonwealth Health Insurance Connector Authority (the "Connector")

The Act creates an independent public authority called the Connector to administer the Commonwealth Care Health Insurance Program and to facilitate the purchase of health insurance plans that meet quality and other standards set by the Connector's board. The Connector will have a board consisting of 11 members. Non-working individuals, employees of large employers who do not have access to employer-sponsored insurance, and employees of small employers (defined as those with 50 covered lives or less) can purchase plans through the Connector. Through the Connector, non-traditional workers, such as part-time and seasonal workers, contractors, sole-proprietors, and those with multiple jobs, will be able to purchase portable health insurance coverage that goes with them from job to job. Additionally, for workers with multiple jobs, the Connector can aggregate contributions from multiple employers. Through the Connector, small businesses will be able to offer a choice of affordable products to their employees, with the ability for employees to purchase health insurance on a pre-tax basis.

The Connector will determine the premium assistance subsidy levels for Commonwealth Care Health Insurance Program enrollees and will remit the premium assistance payments to the health plans offering the coverage beginning October 1, 2006. The legislative language creating the Connector reflects the expectation that there be significant involvement and agreement with MassHealth in developing and implementing the eligibility process for the Commonwealth Care Health Insurance Program.

For more information on the Connector Authority, see Section 5 of this report.

Commonwealth Care Health Insurance Program ("Commonwealth Care")

One of the most innovative features of the Act is a private insurance-based premium assistance program for currently uninsured individuals at or below 300% of the federal poverty level ("FPL") who are not eligible for MassHealth (Medicaid or Federal Title XXI ("SCHIP")) or Medicare. The Connector in consultation with the Office of Medicaid will administer Commonwealth Care. Commonwealth Care premium assistance payments will be expended from the Commonwealth Care Trust Fund and will be eligible for federal financial participation ("FFP") from the Safety Net Care Pool created in the MassHealth's 1115 Demonstration Project Waiver ("Section 1115 Waiver").

Any individual with household income at or below 300% FPL who is a resident of the Commonwealth for at least six months prior to application is eligible for the premium assistance program. In addition, the individual's employer must not have provided health insurance coverage for which the individual is eligible in the previous six months *and* for which the employer contributed at least 20% of the annual premium for family coverage or 33% of the annual premium for individual coverage. Finally, the individual must not have accepted any financial incentive from the employer to decline the employer's

subsidized coverage. Eligibility determinations for Commonwealth Care will be determined in coordination with and using MassHealth eligibility determination procedures, including use of the Commonwealth's on-line application system called the Virtual Gateway. Applicants for and enrollees in Commonwealth Care are entitled to various consumer protections, including notice and appeals rights. Initial enrollment in the program is expected to begin on October 1, 2006.

The Board of the Connector will develop annually an income-based premium schedule in consultation with the Office of Medicaid. Total premiums for Commonwealth Care products are yet to be determined, but are expected to be in the range of $300 per month with no deductibles. As noted earlier, funding for the premium assistance will come from the Commonwealth Care Trust Fund, and if funds are insufficient, enrollment in the program can be capped. There will be a comprehensive and extensive outreach and education plan developed and implemented by the Connector in conjunction with the Office of Medicaid, health plan representatives, safety net hospitals and consumer advocates.

The state legislation creates a special program under Commonwealth Care for individuals at or below 100% FPL. For these individuals, the Connector can procure basic benefit plans that must include inpatient services, outpatient and preventive services, prescription drugs, behavioral health services, and dental services. The only authorized cost-sharing is co-payments levels consistent with the MassHealth Standard program.

Certain private health insurance plans will offer health insurance products for Commonwealth Care. The Act establishes a three-year exclusivity period to health plans currently offering Medicaid managed care plans to the MassHealth program to serve as the health insurance providers to Commonwealth Care. These health plans include two commercial health insurance plans (Fallon Community Health Plan and Neighborhood Health Plan of Massachusetts) and two non-insurance licensed Medicaid-only health plans (Boston Medical Center HealthNet Plan and Network Health, an affiliate of Cambridge Health Alliance). The three-year market exclusivity, however, can be terminated if certain enrollment benchmarks are not met, including total enrollment of at least 40,000 by June 30, 2007 (or 12 months after the program is implemented, whichever is later) and 80,000 by June 30, 2008 (or 24 months after the program is implemented, whichever is later).

For more information on Commonwealth Care, see Section 6 of this report.

Health Safety Net Office and Health Safety Net Trust Fund

Beginning October 1, 2007, the Act establishes a new office within the MassHealth program called the Health Safety Net Office ("HSN Office"). The HSN Office will administer a Health Safety Net Trust Fund, which is the successor to the Uncompensated Care Pool ("UCP") starting in hospital fiscal year ("HFY") 2008. The HSN Office is tasked with establishing reimbursement rates for acute hospitals and community health centers for covered health services provided to uninsured and underinsured patients. Payment from the fund will be claims-based, fee-for-service, and calculated according to

Medicare reimbursement principles adjusted for a variety of factors stated in the Act, and as deemed necessary based on the circumstances of individual hospitals. Any shortfall must be allocated to reflect each hospital's proportional financial requirement for reimbursements from the fund. Eligibility criteria, payment methodologies, reimbursement rates, and shortfall allocation methods will need to be developed. The Executive Office of Health and Human Services ("EOHHS") is required by April 1, 2007 to submit to the legislature the new methodology for "equitably allocating free care reimbursements" in HFY 2008. The state also will submit the new methodology to CMS for approval. In addition to state general funds, existing provider and payer surcharges on hospital bills will fund the Health Safety Net Trust Fund. A major goal of the Act is that over time funding in Health Safety Net Fund will be transferred to the Commonwealth Care Trust Fund to help pay for premium assistance for low-income residents' health insurance costs.

Employer Enforcement

Internal Revenue Code ("IRC") Section 125 ("Section 125") provides tax savings by reducing employee medical premiums from their gross salary prior to calculation of federal income, social security and state income taxes. IRC Section 125 plans are sometimes referred to as "cafeteria" benefit plans. Under the Act, employers with more than 10 employees are required to offer IRC Section 125 plans to their employees, either under its own group health plan or through the Connector. The Act provides the employer in its sole discretion to determine the level, if any, of financial contributions toward an employees' health insurance cost.

Section 44 of the Act establishes a "free-rider" surcharge on companies with more than 10 employees, who do not offer to contribute toward, or arrange for the purchase of health insurance *and* whose employees use more than $50,000 in free care services in one year. A surcharged company may be liable for between 10 and 100% of state funded hospital costs of their employees' and dependents' use of free care services. The Act also requires companies with more than 10 employees who do not offer a group health plan and/or who offer a group plan but do not make a "fair and reasonable premium contribution" (see Section 47 of the Act) to pay an annual assessment of up to $295 per employee.

For more information on how employers are affected see Section 8 of this report.

Transparency in Quality and Cost

The Act creates a Health Care Quality and Cost Council to set quality improvement and cost containment goals for the Commonwealth. The Council has the authority to collect cost, price and quality data from health care providers, pharmacies, payers and insurers. The Council is responsible for developing and maintaining a web site for consumers and purchasers containing cost and quality information on providers. This feature will provide greater transparency and accountability on the part of providers and insurers and will better inform consumer and purchaser choices. Providers will also benefit by having comparative data available publicly in order to benchmark their quality and cost

performance versus their peer group. The Act requires disclosure of average charges and payments accepted for certain commonly performed services at hospitals, physician's offices and other providers, such as community health centers, and allows for additional data collection and input from other interested parties to develop quality measures for various procedures and disclose this information in a similar manner. The Council resides in EOHHS but is governed by an independent board consisting of public and private members.

For more information on the Healthcare Cost and Quality Council, see Section 10 of this report.

Medicaid Provider Pay-for-Performance

The Act commits the Commonwealth to a three-year process for increasing Medicaid reimbursement rates for acute hospital and physician services by a cumulative $270 million, or a 25 percent increase over projected state fiscal year ("SFY") 2006 spending. Beginning in year two of the Medicaid reimbursement rate increase (October 2007), such rate increases are dependent upon hospitals meeting quality improvement goals as determined by EOHHS, in conjunction with a newly created MassHealth Payment Policy Advisory Board. The EOHHS plans to confer with the Centers for Medicare and Medicaid Services ("CMS"), commercial payers and healthcare providers in order to develop meaningful and effective pay-for-performance measures.

For information on Medicaid pay-for-performance, see Section 4 of this report.

Section 2: Inter-agency Implementation Task Force

In order to manage and coordinate the complex implementation of the Act, the Administration convened an inter-agency healthcare reform implementation management committee ("Management Committee") chaired by the EOHHS Secretary Timothy Murphy. The following state agencies are represented on the Management Committee:

- Office of the Governor
- Office of the Lieutenant Governor
- Executive Office of Administration and Finance ("ANF"),
- Executive Office of Economic Development ("EED")
- Executive Office of Health and Human Services
- Commonwealth Health Insurance Connector Authority
- Division of Insurance ("DOI")
- Office of Medicaid (MassHealth)
- Department of Revenue ("DOR")
- Division of Healthcare Finance and Policy ("HCFP")
- Department of Public Health ("DPH")
- Department of Labor ("DOL")

The Management Committee first convened on April 26, 2006, ten business days after the enactment of the Act. At the first meeting each agency presented draft project work plans for implementation involving their respective agency. The Management Committee establishes discrete project ownership, identifies multi-agency responsibilities and sets clear deadlines. Meetings occur every two weeks and provide a forum for information sharing, progress updates and early problem identification. Management Committee members also provide periodic updates on the status of implementation to the legislature and outside stakeholders. A list of projects managed through the Management Committee is included in Appendix A of this report.

An early deliverable of the Management Committee was the development of a comprehensive list of technical corrections necessary for achieving legislative intent and effective implementation of the Act. The Administration is currently working with legislative leadership to develop and pass corrective legislation.

Section 3: Federal Approval Process Update

In January 2005, CMS approved the Commonwealth's Section 1115 Waiver extension for the period covering July 1, 2005 through June 30, 2008. Prior to signing the Section 1115 Waiver, negotiations between state officials and CMS focused on a few key areas of concern to CMS, including Medicaid managed care supplemental payments ("Supplemental Payments") and the use of inter-governmental transfer ("IGTs") funding mechanisms. By the end of SFY 2005, Supplemental Payments to the Boston Public Health Commission and the Cambridge Public Health Commission in support of Boston Medical Center HealthNet and Network Health, an affiliate of Cambridge Health Alliance reached a total of $770 million—$385 million in federal funds and $385 million in IGTs. CMS predicated the Section 1115 Waiver renewal on two key points: 1) payments to the Boston and Cambridge Public Health Commissions in support of the two Medicaid Managed Care Organizations ("MCOs") must conform to the Balanced Budget Act of 1997's Medicaid managed care regulations; and 2) the Commonwealth must terminate all then-existing IGT funding mechanisms.

Governor Romney, working with Senator Kennedy, proposed to address CMS' concerns by redirecting federal and state funds, including the $385 million at risk, from providers of uncompensated care to individuals for the purchase of private health insurance. Under the terms of the waiver, CMS agreed to this proposal and created a capped Safety Net Care Pool, included under the Section 1115 Waiver's total budget neutrality ceiling, dedicated to reducing the number of uninsured state residents. In addition, the Commonwealth agreed to end existing IGTs, which required the Commonwealth to identify new state funding sources to draw down federal financial participation (FFP). The Section 1115 Waiver extension allowed the Commonwealth to present to CMS other existing state-only healthcare spending that could be eligible for FFP. The Act provides detail as to the sources and uses of the $1.34 billion in the waiver's Safety Net Care Pool.

On May 1, 2006, EOHHS submitted to CMS a waiver amendment seeking approval for the incorporation of relevant sections of the Act into the Section 1115 Waiver. (The Section 1115 Waiver amendment is available on the EOHHS website at www.mass.gov/ehs.) Notwithstanding the Commonwealth's tardiness in providing CMS with a Section 1115 Waiver amendment and in recognizing that the state needs clarity on the status of federal funding for the new fiscal year beginning July 1, 2006, CMS committed to an expedited review of the Section 1115 Waiver amendment. Since submission on May 1, the EOHHS officials have been in daily contact with CMS officials in both the Boston and Baltimore offices.

During this review process, CMS has been focused on the budget neutrality calculation, the Commonwealth's justification for reimbursement levels to certain "safety net" hospitals, and the need for the Commonwealth to operate both the Commonwealth Care program and an expanded Insurance Partnership program.

In addition, CMS has expressed a concern that Section 125 of the Act could be in conflict with the goal of reducing the number of uninsured in the Commonwealth. Section 125 precludes HCFP, the current administrator of the Uncompensated Care Pool ("UCP")

mechanism, from making any changes to UCP regulations until October 2007, 12 months after the initiation of the Commonwealth Care program. Particularly concerning are the current regulations defining financial eligibility to receive free care from the UCP. If the eligibility regulations cannot be changed, then an individual who is determined eligible to receive premium assistance via Commonwealth Care might retain the ability to receive services at no cost via the UCP. In order to lower the rate of uninsured in the Commonwealth and to move care from expensive settings to lower-cost settings, it is critical that individuals currently receiving services from the UCP be converted to health insurance programs/products (e.g. Medicaid, Commonwealth Care or private insurance). Further, once someone is enrolled in a Commonwealth Care insurance plan, it is equally important that providers respect the covered services and drug formulary, as opposed to avoiding program rules by submitting claims to the UCP for payment. CMS and the Administration will address the issue of free care eligibility with the legislature via the technical corrections process under discussion.

As of June 12th, the date of this report, CMS has not approved or disapproved any portion of the Section 1115 Waiver amendment. However, based on feedback to date, EOHHS is cautiously optimistic that CMS will approve the Section 1115 Waiver amendment in a timely manner with only minor modifications required to implement healthcare reform as prescribed in the Act.

Section 4: Changes to the MassHealth Program

Assuming that the SFY 2007 General Appropriations Act includes adequate funding for the proposed changes to MassHealth as defined in the Act, the Office of Medicaid is on target to make available to eligible members the following benefits, consistent with normal protocols regarding medical necessity, beginning July 1, 2006:

- Dental services, including to MassHealth Essential members
- Eye glasses benefits
- Chiropractic benefits
- Prosthetic benefits
- Orthotic benefits
- Level 3B detoxification benefits
- Smoking cessation benefits (as part of a two year pilot program)

All MassHealth members who are newly qualified for the benefits listed above will receive a mailing from MassHealth offering information about the terms and scope of the restored and new benefits. Providers will also be notified of the change in covered benefits and MassHealth will be working with its network management organization to mitigate access issues resulting from members who have been in need of services but ineligible to receive them. In addition, MassHealth will coordinate its covered services with the HCFP to ensure that services that are now covered by MassHealth will not be offered as free care.

Section 29 of the Act also required the Office of Medicaid to create a wellness program for enrollees to encourage healthier behavior and activities that lead to better health outcomes. In exchange for participation in smoking cessation, diabetes screening, cancer screening and other preventive care programs, members could be eligible for reduced monthly premiums. As part of the technical corrections bill currently under discussion with legislative leadership, the Office of Medicaid is requesting a delayed implementation for the wellness program. In order to develop a robust clinical program with demonstrable health benefits for members and long-term financial benefit to MassHealth, the Office of Medicaid is requesting 12 months for design and implementation for the wellness program.

In addition to offering restored and new benefits on July 1, 2006 and contingent upon adequate funding levels and Federal approval, the Office of Medicaid will enroll approximately 12,000 individuals who have been determined eligible for the MassHealth Essential benefit but currently are on a waitlist due to enrollment caps beginning on July 1, 2006. In addition, MassHealth will maintain eligibility for approximately 3,000 aliens with special status in the Essential benefit at full state cost.

For children from a household with income between 200% and 300% FPL who do not currently have access to employer sponsored health insurance, the Act expands eligibility for MassHealth. The benefit package will be the same as that provided to current

children enrolled in the MassHealth Family Assistance program between 150% and 200% FPL. Premiums for the new enrollees in the program will be as follows:

Percent of FPL	Monthly Premium per Child	Family Maximum
150.1-200.0	$12	$36
200.1-250.0	$20	$60
250.1-300.0	$28	$84

The Office of Medicaid has reviewed current enrollees in the Children's Medical Security Plan ("CMSP"), a state-only funded public benefit plan that provides access to preventive care and prescription drugs but does not cover emergency services or provide hospitalization benefits to ascertain their eligibility for MassHealth Family Assistance. Approximately 9,000 children are estimated to be eligible for the MassHealth Family Assistance expansion created under the Act. Beginning in the week of May 23, the Office of Medicaid began notifying these CMSP enrollees via mail of their potential new benefit level and their options to join the state's Primary Care Clinician ("PCC") program or an MCO. Individuals will not be able to maintain CMSP in lieu of Family Assistance, as enrollees in CMSP rely on the UCP for hospitalization benefits. Individualized notices will be mailed to members in July.

In order to prevent currently insured individuals, excluding those converted from the CMSP program, from dropping private insurance coverage in order to avail themselves of public benefits (so-called private market crowd-out), a wait period of up to six months will be applied to children with family income between 200 and 300% FPL.

Given the significant changes to benefits and the large number of members affected, operations staff is preparing for an extended period of heightened customer service call volume at MassHealth call centers. MassHealth is working with its customer service vendor to maintain current customer service levels.

In addition to notifying existing MassHealth members and CMSP members of their benefit changes, the Office of Medicaid is developing a strategic outreach plan to engage individuals who may be currently eligible for MassHealth, but remain un-enrolled. The Act designated $3 million for an outreach and education effort. The Office of Medicaid will coordinate its marketing efforts with the Connector, which will be launching a statewide education campaign regarding the newly created Commonwealth Care program and the requirement that all individuals have health insurance by July 1, 2007. Research to date suggests that general public awareness of the changes to the MassHealth program and changes to Massachusetts' insurance laws remains very low.

Section 25 of the Act makes Medicaid rate increases to hospitals contingent upon adherence to quality standards and achievement of performance benchmarks, including the reduction of racial and ethnic disparities in the provision of health care (so-called pay-for-performance). In order to focus efforts on measurable outcomes and clinical factors of importance to the MassHealth population, the Office Medicaid will begin a comprehensive process, in coordination with providers, other payers and the Massachusetts Health Care Quality and Cost Council, to develop pay-for-performance

contracts for HFY 2008. By coordinating with other stakeholders' in the Massachusetts healthcare market, the Office of Medicaid hopes to avoid unworkable complexity for providers and drive better patient results through the application of consistent and robust performance standards.

In the interim year while hospital pay-for-performance standards are under development, the Office of Medicaid will apply the first round of rate increases mandated under Section 128 of the Act. Effective July 1, 2006, the Office of Medicaid plans to increase physician reimbursement rates an incremental $13.5 million. All physician categories will receive a 4.7% unit rate increase with certain exceptions. Obstetricians and gynecologists contracting with Medicaid for global maternity packages will receive an enhanced rate increase of 7.5%. In addition, practitioners will receive a 5% enhanced reimbursement for colonoscopy procedures. The Office of Medicaid's clinical and reimbursement staff have determined that access to OB/GYN and early prostate and colon cancer detection services are strategically important to the MassHealth population. Similar analysis has also determined that the MassHealth program is paying significantly higher than Medicare benchmarks for anesthesiology services. As such, anesthesia services will receive a lower rate of increase, 1.7% in SFY 2007. The changes described affect services delivered through the PCC Plan and the MassHealth fee-for-service ("FFS") program. Equivalent rate increases will be built into the capitation rates paid to Medicaid MCOs.

Beginning October 1, 2006, approximately $76.5 million annual rate increase will be applied to acute hospital rates in the PCC and FFS programs, representing a 9.6% annual increase over HFY 2006. The allocation between hospital inpatient and outpatient services is still under development. An equivalent base rate increase will be applied to the hospital portion of capitation rates paid to Medicaid MCOs.

Section 122 of the Act singled out two of the four managed care plans serving MassHealth for higher capitation payments. Specifically, Boston Medical Center HealthNet and Network Health, an affiliate of the Cambridge Health Alliance are mandated to receive capitation rates that are at least $87 million higher than the midpoint of Balanced Budget Act compliant actuarially sound rates paid in SFY 2006. Rate negotiations are currently under way between the Office of Medicaid and all four Medicaid MCOs. The rates offered to both Boston Medical Center HealthNet and Network Health are in compliance with section 122 of the Act. To avoid market distortion and an unfair competitive advantage, MassHealth will need increase capitation rates to the other two MCO vendors, Neighborhood Health Plan and Fallon Community Health Plan. As a result, the effective cost of the Section 122 of the Act will be approximately $111 million.

Section 16 of the Act prohibits MassHealth from implementing a proposed waiver amendment that would change the way the state determines the availability of work for members undergoing a disability evaluation. As such, the waiver amendment filed with CMS in August 2003 has been withdrawn and no further action will be taken.

The Act assigns an incremental $1.5 million to further enhance MassHealth program integrity efforts. Approximately $300,000 of the total is earmarked for the State Auditor and the Medicaid Fraud Control Unit in the office of the Attorney General. Given the expansion of benefits, the creation of new coverage types and programs and the investment in provider reimbursement contemplated in the Act, program integrity will be a critical component of ensuring MassHealth's program sustainability. The Office of Medicaid plans on using the bulk of the remaining dollars to embark on the first phase of a three-phase provider re-credentialing project. In the first phase, the Office of Medicaid will do a basic re-credentialing of all providers and do a more complete review and evaluation of approximately one-third of our providers. Although there has been no final determination as to which providers will be the focus of the more complete reviews, the targeted providers will include providers that are not otherwise licensed or overseen by the Commonwealth.

Section 5: Commonwealth Health Insurance Connector Authority

Governor Romney administered an oath of office to the Connector's Board of Directors ("Board") and its Executive Director on June 7, 2006. Immediately following their swearing in, the Board held its inaugural meeting. Although the Act created an 11-member governing board, only ten members were identified in the Act. In order to address the discrepancy, the Administration is recommending that the EOHHS Secretary be named as member to the Board, ex-officio, through the technical corrections process.

The Board is comprised of the following individuals:

- Thomas H. Trimarco, Chairman, Secretary, Executive Office for Administration and Finance, ex-officio
- Beth Waldman, Director, Office of Medicaid, ex-officio
- Julie Bowler, Commissioner, Division of Insurance, ex-officio
- Dolores Mitchell, Executive Director, Group Insurance Commission, ex-officio
- Jonathon Gruber, Professor of Economics, Massachusetts Institute of Technology, health economist appointed by Governor Romney
- Bruce Butler, Retired Blue Cross Blue Shield Chief Actuary, actuary appointed by Governor Romney
- Richard Lord, President and Chief Executive Officer, Associated Industries of Massachusetts, small business representative appointed by Governor Romney
- Celia Wcilso, SEIU 1199 Official, organized labor representative appointed by Attorney General Reilly
- Louis Malzone, Director, Massachusetts Coalition of Taft-Hartley Funds, employee health benefits plan specialist Labor representative appointed by Attorney General Reilly
- Charles Joffe-Halpern, President, Board of Directors for the patient advocacy group Health Care for All, consumer advocate appointed by Attorney General Reilly

The Board's Chairman is vested with the authority to select the Connector's Executive Director. On May 25, 2006 Chairman Trimarco announced the appointment of Jon M. Kingsdale, a career health insurance executive, as the Connector's first Executive Director. Mr. Kingsdale took office on June 5, 2006. Given that the Connector is a start-up operation, Director Kingsdale is in the process of hiring a senior management team, finding office space for operations and creating the basic financial, accounting and communications infrastructure necessary to operate the Connector.

Director Kingsdale is also working closely with the Office of Medicaid's operations team to prepare and adapt existing MassHealth infrastructure for Connector operations. For example, the Connector is exploring plans to leverage the EOHHS Virtual Gateway application for intake services for the Commonwealth Care program, which should facilitate operational simplicity for providers, insurers and other vendors. Similarly, the Connector is exploring the usage of MassHealth's member eligibility software called MA-21 to determine income eligibility for the Commonwealth Care program. MA-21

will allow the Connector to build upon existing data exchange arrangements with the DOR and its Child Support Enforcement Unit and the Federal government. By coordinating and leveraging existing Masshealth systems, the Connector should be able to provide more affordable and subsidized products to market in a more efficient and timely manner.

Pursuant to Section 133 of the Act, the Executive Director will submit a plan of operation and any recommendations for amendments to chapter 176Q of the General Laws or other general laws to assure the fair, reasonable and equitable administration and the effective operation of the connector that is consistent with said chapter 176Q and any other applicable laws and regulations on or before August 1, 2006. A copy of this report will be available to the legislature and the general public.

Section 6: Commonwealth Care Health Insurance Plans

The Connector Executive Director and EOHHS staff are in regular discussions with Medicaid MCOs and insurance carriers regarding the development of affordable and subsidized health benefit plans. The Connector is on schedule to publish guidelines for the development of Commonwealth Care products by July 1, 2006. In addition to product development guidelines, the Connector intends to facilitate actuarial analysis by publishing detailed diagnosis, utilization and demographic data from experience in the Commonwealth's free care pool and the state's household survey of insurance status.

As product development discussions and actuarial analysis progress, the Connector will use that information to inform the creation of an affordability scale and a corresponding income means-tested premium assistance structure. A final premium assistance schedule will be published in September after appropriate public input, the receipt of final benefit structures from the Medicaid MCO vendors, and Board approval.

The Executive Director presented a preliminary timetable for the development and implementation of the Commonwealth Care program and non-subsidized affordable health insurance products for individuals, small businesses and other eligible groups to the Board of Directors on June 7th (See Appendix E for the Executive Director Presentation.

Section 7: Insurance Market Reform

The Act contemplates significant changes to the Commonwealth's insurance laws and regulations. Given the complexity of the products involved, the complexity of existing law and the complexity of the proposed additions and changes, these sections of the Act have received a disproportionate focus from the technical corrections process under discussion with legislative leadership. In particular, feedback from insurers, employers, benefits administrators and the Division of Insurance has suggested a need to coordinate the effective dates of the many changes in a way such that they are logical and mutually reinforcing. The following table details some of the proposed changes to effective dates for insurance law changes:

	Description of Change to Insurance Law	Original Effective Date	Proposed Effective Date
1	Creation of a young adult product market and rating band	Immediate	July 1, 2007
2	Expanded definition of dependent up to age 25 (also recommended to expand to age 26 in technical corrections bill)	Immediate	July 1, 2007
3	Merger of the small group and non-group market	January 1, 2007	July 1, 2007
4	Reduction in permissible waiting periods and waiving of wait periods for the long-term uninsured	January 1, 2007	July 1, 2007
5	Changes to rating bands, modified community rating, and member definitions	April 1, 2007	July 1, 2007
6	Effective dates for affordable products sold through the Connector	April 1, 2007	July 1, 2007
7	Initiation of Connector open enrollment period	March 1, 2007	May 1, 2007

In addition to changes in effective dates, there are a large number of other technical corrections affecting the underlying insurance reform. Changes described above to underlying insurance law and to complementary regulations apply to the entire small group and non-group market and are not limited in scope to plans that are sold through the Connector.

The Executive Director of the Connector and EOHHS staff are now in regular discussions with executives and actuaries at each of the Commonwealth's major insurers. Discussions continue to be encouraging regarding the adoption of innovative features such as co-insurance, the approach for building narrow, high-performance network products, the development of chronic care management capability and the demographics of the target population. The Connector will publish specific guidelines for Connector-listed affordable products in October 2006.

Pursuant to Section 114 of the Act, the DOI has convened the special commission to study the effects of the merger of the small group and non-group markets. As of the publication of this report, one meeting has been held, a Request for Information ("RFI") has been issued in order to provide a vehicle for industry and other affected parties to comment and a Request for Proposal ("RFP") for consulting services will be issued including criteria that are derived from responses to the RFI. DOI believes that this analysis will be completed in December 2006.

Section 8: Healthcare Reform and Employers

Section 47 of Act pertains to an assessment of up to $295 per employee per year based on the free care utilization of employees of Massachusetts' employers with eleven or more full-time equivalents ("FTEs") that do not offer health insurance or do not make a "fair and reasonable" contribution to monthly health insurance premiums on behalf of the employee. The law does not define an "offering" employer nor does it provide a definition of a "fair and reasonable" contribution. The intent with regard to part-time workers and seasonal workers is also unclear. The Administration has been soliciting feedback and information from stakeholders.

HCFP is the state agency responsible for promulgating the regulations for Section 47 of the Act. To better inform its regulatory process, HCFP will hold three regional hearings in order to solicit feedback from employers. The hearings are planned for the third week in June in Springfield (June 20), Hyannis (June 21) and Boston (June 21). More information regarding the specific hearing locations and times is available on the HCFP website at www.mass.gov/dhcfp.

Based on input received at these hearings, HCFP will propose regulations that will define an offering employer and what constitutes a "fair and reasonable" contribution. These regulations will be subject to a public hearing in August. The regulations will also need to provide guidance to employers regarding permissible wait periods, definitions of a part-time employee and standards for seasonal workers. Regulations would take effect October 1, 2006 to align with the beginning of the HFY 2007. HCFP, the state agency that administers the state's UCP, will track free care utilization by employees of non-offering firms during HFY 2007.

The state does not currently collect information on an individual company level regarding the offer to and enrollment of employees in health insurance plans. This information is now required under Section 42 of the Act. In order to have this information available to calculate the assessment, HCFP is charged with developing a health insurance reporting and disclosure ("HIRD") process for businesses to report their health insurance statistics to the state. Establishment of the HIRD process will take place in the late summer/early fall of 2006 in order for companies to begin reporting their information to the state by the beginning of October 2006.

Because the assessment is based on actual free care utilization, the final amount of the assessment will not be known until the conclusion of HFY 2007, which ends September 30, 2007. In order to comply with the requirement that assessed employers may elect to pay either quarterly, semi-annually or annually, the state will determine an estimated fair share employer contribution. Final assessment amounts will be calculated and due from assessed employers after the close of the uncompensated care pool fiscal year.

In addition to the assessment described above, beginning January 1, 2007 employers with 11 or more FTEs will be required to have a Section 125 premium only plan in place to facilitate the purchase of health insurance on a pre-tax basis by their employees. In order to allow more time for education and for the Connector, which will play a critical role in

making model section 125 plans available to employers, to develop operational capability, the Administration is recommending that the requirement to adopt Section 125 plans be postponed until July 1, 2007.

Section 44 of the Act establishes a “free-rider” surcharge on companies with 11 or more employees, who do not offer to contribute toward, or arrange for the purchase of health insurance and whose employees use more than $50,000 in free care services in one year. A surcharged company may be liable for between 10 and 100% of state funded hospital costs of their employees and dependents use of free care services.

Section 9: Individual Requirement for Health Insurance

As of July 1, 2007, residents of the Commonwealth age 18 and over are required to have creditable health insurance coverage with no lapse in coverage for more than 63 days. For the 2007 tax year, individuals will be required to indicate on their individual tax return whether they had creditable coverage as of December 31, 2007 either individually or as a named beneficiary, whether they are claiming an exemption from the requirement for religious reasons, or whether they have a certificate issued by the Connector indicating that no health insurance offered through the Connector was deemed to be affordable for that individual.

While the individual requirement to have health insurance does not go into effect for 13 months, significant decisions must be made in the next two months to facilitate its implementation. For the insurance industry, they need immediate guidance on what information will be required by the state to verify that individuals were creditably covered at any time during the previous year. For example, many insurers have moved away from the use of social security numbers as a unique client identifier, yet the state DOR runs all of its systems based on social security numbers. Determining exactly what information will be required, how it will it be reported safely and with what frequency has been a key focus for the implementation Management Committee. To ensure appropriate input, the DOI has convened industry meetings together with EOHHS and DOR to identify issues and find solutions. A number of technical corrections under discussion with legislative leadership pertain to resolving issues identified grouping these meetings.

The urgency to resolve issues related to administering the individual requirement to buy health insurance is driven by several factors. The Act establishes the creation of a database of all insured individuals to be managed by the Health Access Bureau at the Division of Insurance by January 1, 2008. DOR, which will be responsible for assessing penalties beginning in 2008, wants to ensure that its systems are accurate and reliable. It is working with the DOI and the insurance industry so that the database will be ready for testing well in advance of the January 1, 2008 effective date.

It is also important that the elements of the database be identified early on, because DOR needs to communicate the format of 2007 returns to the software vendors whose software is used to prepare most returns no later than the fall of 2007.

The complex data systems and customer information systems used by the insurance industry will also require substantial programming and development in order to collect and update the information required to administer an individual mandate. If a decision can be reached regarding the collection and distribution of insurance data, the insurance industry will be able to move forward with the required capital investment. For most Massachusetts insurance carriers, the administration of the individual mandate will require meaningful operational changes that will require time to develop and implement.

In the brief time since the passage of the Act, it has also become clear that public awareness of healthcare reform is extremely low. The administration spoke with one Massachusetts insurance carrier who recently held a focus group to help them better understand how to develop products for lower income individuals. In the focus group of 60 adults, only one was aware that a law requiring the purchase of health insurance had passed in Massachusetts. Given the lack of awareness, the state and the Connector will need to coordinate a significant education and outreach campaign to ensure that residents are prepared to understand the options and decisions that will be presented to them in the Spring of 2007.

Section 10: Boards, Councils, Commissions and Reports

The Act creates three new boards, two new councils, one new commission and one advisory committee while also reconstituting and expanding one existing council and requiring 13 reports to the legislature. A total of 133 appointments are required to fill all of the positions created on the various bodies. The appointing entities include the Governor, legislative leadership and the Attorney General in addition to large numbers of ex-officio positions and designated representation by specific associations or advocacy groups.

At present, each board, council, commission and report are at different stages of development. The Administration expects that all of the boards, councils, and commissions will be operation during the summer.

Section 11: Public Health Programs

The Act makes significant investment in areas not directly related to health insurance or healthcare reform, namely, health screening, preventive care and health education. The appropriations call for establishing programs by July 1, 2006. Given that nearly all of the programs and investments made in the law pertain to existing programs or restore previous programs, DPH is prepared for its July 1 effective date.

Appendix A: List of Implementation Projects

	Planning and Coordination
1	CMS Submission for approval
2	Technical corrections bill
3	Implementation plan to legislature
4	Establish fund structure with Comptroller
5	Connector business plan and necessary legislation
6	Staffing plan and reserve allocation
	Boards and Commissions
7	Calendarize meetings for Secretary. Determine frequency
8	CHICA Board – 3 Gubernatorial appointments, 4 ex-officio notifications, 1 AG contact letter
9	Quality and Cost Council - 6 ex-officio contact letters, 7 Gubernatorial Appointments
10	Health Care Cost and Quality Advisory Committee - 28 Contact Letters
11	MassHealth Payment Policy Advisory Board - 12 Contact Letters
12	Insurer Assessment Elimination Board - 8 Contact Letters
13	Health Disparities Council - 34 Contact Letters
14	Commission to study small group and non-group merger - 9 contact letters
15	Public Health Council - 18 Contact Letters
	MassHealth Program
16	Development of FY07 actuarial rates for $87M to BMC and CHA
17	Expand Family Assistance benefit to 300% of FPL, including CMSP conversion
18	Federal SSI Standard - Withdraw Waiver Amendment
19	HIV to 200% and increase cap to 1,300
20	Increase CommonHealth Cap to 15,600
21	Increase MassHealth Essential Cap to 60,000
22	Insurance Partnership changes to self-employed members
23	Insurance Partnership to 300% pending CMS approval
24	AWSS>65 on MassHealth Essential
25	Benefit Restoration to 2002 - Dental, Level 3B, Chiro, Prosthetics
26	Creation of Dental Benefit for Essential
27	Wellness Program for MassHealth Members
28	Strategic plan and award outreach grants
29	Creation of a 2 year smoking cessation pilot program
30	Development of a payment methodology for block grants to BMC and CHA
31	Report on Medical Care Advisory Committee
32	Physician and Hospital Rate Increase Strategy and pay for performance development
33	Report on Viability of Selected Networks
34	Report to Committee on Mental Health and Substance Abuse regarding MCO/BH reprocurement
35	Medicaid disclosure of enrolled members to DOI
36	Study of providing MassHealth benefits to caregivers for elderly and disabled
37	Implementation of enhanced program audits
	Individual Requirement to Buy Health Insurance
38	Determination of Affordability; Development of Appeals process
39	Individual Mandate reporting and enforcement
40	Religious exemption to Individual Mandate
41	Penalties for non-compliance – administration
42	Creation and administration of Health Insurance Responsibility Disclosure

43	Determine Minimum Standards for Insurance
44	Develop Marketing Campaign for Insurance Awareness
45	Creation of a central insurance database
	Commonwealth Care Premium Assistance
46	Development of standards for affordable plans
47	Outreach plan for premium assistance program
48	Investigation of Federal Grants for High Risk Pool Reinsurance
49	Establish sliding scale premium schedule for 101%-300%
50	Conversion Strategy for current pool eligibles
51	Establish a "premium free" program for less than 100's
52	Harmonization of IP subsidies with Commonwealth Care
	General Insurance Changes
53	Determine phase-out of Reinsurance market
54	Plans for phase-out 176M and 176N
55	Create HealthCare Access Bureau
56	Clarification of MEWA and affiliated company purchasing
57	Work with insurers to develop affordable plans
58	Changing definition of Dependent for family coverage (up to 25)
59	Enforcement of Non-discrimination regarding employer contributions and income levels
60	Creation of separate, young adult regulatory structure (18-26)
61	Merger of Small Group and Non-group markets
62	Updating of network design regulations
63	Tobacco Usage rating regulations
64	Adjustment of waiting period regs
65	RFR for actuarial analysis for the small group and non group market merger commission
66	Regulatory foundation for statewide open enrollment in advance of individual mandate
	Fair Share Employer Contribution
67	Definitions of "offering", "fair and reasonable contribution", "part-time" and "seasonal"
68	Collection infrastructure for $295 fee for non-offerers
69	Mandatory Offer of Sec. 125 plans for companies with more than 10 FTEs
70	DOL report on impact of Fair Share Assessment
	Free Care Reform
71	Conduct statewide insurance survey and uninsured census on annual basis
72	Establish process for Essential Community Provider Fund grants
73	Coordination of Free Care eligibility to align with Commonwealth Care
74	Creation of Health Safety Net Office
75	Determination of new payment methodology
76	Definition of Covered Services
77	Determination of new hospital preference structure
78	Establishment of Pool Program Integrity Unit
79	Report to HWM/SWM regarding plans for reformed pool
80	Development of Free-Rider program
81	Development of $6M "care management" pilot to reduce the use of free care
	Public Health
82	Smoking Cessation Program Restoration
83	Statewide Infection and Protection Program
84	Pediatric Palliative Care Program
85	Study on efficacy of Community Health Workers

	Cost and Quality
86	Health Care Cost and Quality Council Work Plan
87	Re-brand and re-launch website
	Other
88	Business plan for CPOE investment
89	Essential Community Provider Grant Program Criteria
90	GIC to develop insurance via Connector for Commonwealth employees

Appendix B: Timing of Key Regulations

Description of Proposal	Estimated Date
MassHealth eligibility and program modifications	June, 2006 (emergency)
Guidelines for Commonwealth Care insurance products • Less than 100% FPL • 100% to 300% FPL	July, 2006
"Fair Share" assessment • Offering employer • Fair and reasonable • Definition and treatment of part-time employment • Permissible wait periods	August, 2006
Quality and Cost Council data collection and use protocols	September, 2006
Uncompensated care eligibility	September, 2006
Guidelines for Connector-approved affordable insurance products	October, 2006
Definition of affordability	October, 2006
Free-Rider Assessment	November, 2006
Terms of Individual Mandate	November, 2006
Insurance Market • 176J (small group), 176M (residual non-group), HMO and PPO • Extended definition of dependent • Young adult (19-26) insurance products • Definition of Qualified Medical Insurance • Minimum standards and guidelines	December, 2006
Health Safety Net parameters	December, 2006
MassHealth Pay-for-Performance	August, 2007

Appendix C: Calendar of Implementation Reports

Description of Report	Release Date
Connector business and operations plan (4 months)	August 1, 2006
Implementation update #2 (6 months)	October 10, 2006
Implementation update #3 (8 months)	December 11, 2006

Appendix D: Connector Board Meeting Presentation

Appendix E: Sample MassHealth Notification

Appendix F: List of Acronyms

Acronym	Definition
ACT	Chapter 58 of the Acts of 2006
ANF	Executive Office for Administration and Finance
BMC	Boston Medical Center
CHA	Cambridge Health Alliance
CMS	Centers for Medicare and Medicaid Services
CMSP	Children's Medical Security Plan
CONNECTOR	Commonwealth Health Insurance Connector Authority
DOI	Division of Insurance
DOL	Department of Labor
DOR	Department of Revenue
DPH	Department of Public Health
ED	Executive Director, Connector Authority
EED	Executive Office of Economic Development
EOHHS	Executive Office of Health and Human Services
FFP	Federal Financial Participation
FFS	Medicaid Fee For Service
FFY	Federal Fiscal Year
FPL	Federal Poverty Level
FTE	Full Time Equivalent
GAA	General Appropriations Act
GIC	Group Insurance Commission
HCFP	Division of Health Care Finance and Policy
HFY	Hospital Fiscal Year
HIRD	Health Insurance Reporting and Disclosure Form
HSA	Health Savings Account
HSN	Health Safety Net Office
IGT	Inter-Governmental Transfer
IRC	Internal Revenue Service Code
MassHealth	Commonwealth of Massachusetts Medicaid Program
MCO	Medicaid Managed Care Organization
PCC	Medicaid Primary Care Clinician Plan
RFI	Request For Information
RFP	Request For Proposal
SCHIP	State Children's Health Insurance Program
SEIU	Service Employees International Union
SFY	State Fiscal Year
Tital XIX	Title XIX of the Federal Social Secuirty Act
Title XXI	Title XXI of the Federal Social Security Act
UCP	Uncompensated Care Pool

Commonwealth Health Insurance Connector Authority

"The goal of the board is to facilitate the purchase of health care insurance products through the connector at an affordable price by eligible individuals, groups & commonwealth care health insurance plan enrollees."

[176Q, Section 3]

Primary Role of the Connector

- Contract for “Commonwealth Care” private health coverage, and subsidize its purchase by eligible residents:
  - >18
  - ≤ 300% FPL
  - Otherwise ineligible for public or group coverage

- Select affordable, high quality licensed health insurance plans, and organize this purchase by:
  - Employers of 1-50 employees
  - Individuals not eligible for group coverage

- Facilitate the choice and adoption of private health insurance coverage

- Work with DoI, DoR, MassHealth, etc. to implement c.58

Primary Role: Commonwealth Care

	Connector Activity	Date	Board's Role
1)	Publish criteria for selection of CCHIP's	7/01/06*	Approve
2)	Develop eligibility criteria & contract for eligibility determination	8/06	Review
3)	Develop preliminary schedule of premium assistance payments	8/06	Review
4)	Approve CCHIPs, rates, marketing & sales, & other related processes	9/06	Oversight
5)	Develop sliding-scale contribution and premium assistance payments	9/06	Approve
6)	Develop eligibility determination, enrollment & payment remission processes	9/06	Oversight
7)	Develop eligibility appeals criteria and process	9/06	Review

Primary Role: Non-Group/Small Group Market

	Connector Activity	Date	Board Role
1)	Conceptualize\structure the Connector's role, functions, processes	9/06	Review
2)	Contract w/ sub-connectors	10/06	Oversight
3)	Develop criteria for selection of licensed health plans	10/06	Approve
4)	Publish RFP	11/06	Oversight
5)	Develop criteria for determination of affordability & credible coverage	12/1/06*	Approve
6)	Develop certification & appeals process for affordability	1/07	Oversight
7)	Select licensed health plans	3/07	Oversight
8)	Publish schedule of affordability	4/07	Approve

Primary Role: Outreach & Adoption

	Connector Activity	Date	Board's Role
1)	Develop preliminary plan & budget for promotion & outreach	8/1/06	Review
2)	Promote availability of CCHIPs to eligibility populations	9/06	Oversight
3)	Start to educate employers, public, others about C.58, Connector, mandates, etc.	9/06	Oversight

Organizational & Additional Board Responsibilities

Connector Activity		Date	Board's Role
1)	Adopt by-laws, elect officers confirm committees, etc.	7/06	Approve
3)	Plan of operations, including amendments to c. 58	8/1/06*	Review
3)	Business plan & budget	9/06	Approve
4)	Facilities plan	9/06	Approve
5)	Monthly reports/updates, starting	10/06	Review

MassHealth

Commonwealth of Massachusetts
EOHHS
Office of Medicaid

May 2006

Dear CMSP Member, Parent, or Caretaker:

We are pleased to tell you that because of a new state law, your child may get better health-insurance coverage than he or she is now getting from the Children's Medical Security Plan (CMSP) or the Uncompensated Care Pool (UCP). (UCP is also called Partial Free Care.) Based on your family income, your child may soon get more complete benefits under MassHealth Family Assistance.

During July and August, we will send letters to the homes of all children who move from CMSP to MassHealth with the date MassHealth coverage will start. On the date that MassHealth coverage starts, your child will no longer be eligible for CMSP. Instead, your child will get more benefits through MassHealth. Below is some basic information about this new MassHealth coverage and important information about what you will need to do to make sure your child gets this new coverage.

Help with health-insurance premiums

If your employer offers family health-insurance coverage that you have not been able to afford, MassHealth may be able to help you pay the premiums for this coverage instead of providing benefits to your child directly. You will be required to enroll in qualifying employer-sponsored insurance that is offered to you at your job. **Signing up for family health-insurance coverage at your job is a great way to get health insurance for parents and children.** We will send you more information about this in the future if we receive information that your child can get qualified health insurance through your employer. MassHealth will cover your child directly for a period of time while you make arrangements at your job to enroll in family health-insurance coverage.

More complete benefits

MassHealth provides Family Assistance direct coverage for children when employer-sponsored health insurance is not available. This coverage includes all the benefits now covered by CMSP and UCP, and many more benefits if they are medically necessary services, including:

- **Inpatient and outpatient hospital coverage:** MassHealth **includes** inpatient hospital coverage that CMSP does not. And, unlike UCP, MassHealth has no deductibles. You will not have to worry about hospital bills for your child!
- **Dental coverage:** MassHealth **does not limit** dental benefits to $750 the way CMSP does.
- **Full pharmacy coverage:** MassHealth **does not limit** pharmacy benefits to $200 the way CMSP does.
- **Mental health and substance abuse treatment services:** MassHealth **does not** limit these services the way CMSP does.
- **MassHealth provides eyeglasses, medical supplies and equipment, and more.**
- **No copayments**: Unlike CMSP, MassHealth **does not charge** copayments for any benefits for children and, unlike UCP, MassHealth **has no** deductibles or coinsurance for children.

Choice of health plans

MassHealth offers a choice of health plans if you cannot get health insurance from your employer. Under these health plans, children have access to thousands of health-care providers across the state, including primary-care physicians, specialists, hospitals, community health centers, and more.

MassHealth premiums

You will not have to pay any copayments or deductibles for MassHealth direct coverage, but you will be charged a monthly premium. Depending on your family income, you will be charged either $20 per child per month (up to a maximum of $60 per month for three or more children) or $28 per child per month (up to a maximum of $84 per month for three or more children).

The letter you will get from MassHealth will tell you what your monthly premium amount will be. If at times you cannot pay your monthly premiums, MassHealth has payment plans. There are also waivers of premium payments if you have a hardship. You will receive more information about MassHealth premiums in future letters from MassHealth.

What you need to do now

- Continue to pay CMSP premiums until your child's new MassHealth coverage begins.
- Respond to any requests for information or redeterminations from CMSP.
- Tell MassHealth if you move.

Important: If your child loses CMSP coverage because premiums are not paid or because you did not respond to information requests, MassHealth **will not** be able to automatically enroll your child in Family Assistance and your child will not be able to reenroll in CMSP.

Questions

If you have any questions, please call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss), Monday through Friday, 8 AM to 5 PM.

MassHealth–a better plan for your child.

Commonwealth of Massachusetts
EOHHS
Oficina de Medicaid

Mayo, 2006

Estimado afiliado de CMSP, padre o guardián:

Tenemos el placer de informarle que debido una nueva ley del estado, su hijo puede tener una mejor cobertura de seguro médico que la que hoy tiene a través del Plan de seguridad médica para niños [Children's Medical Security Plan (CMSP)] o del Fondo no común no compensado para servicios médicos de Cuidado [Uncompensated Care Pool (UCP)]. (UCP también se conoce como Cuidado parcial gratuito o Partial Free Care). Basado en sus ingresos familiares, su hijo podrá pronto obtener beneficios más completos a través de MassHealth Family Assistance.

Durante julio y agosto, enviaremos cartas a las casas de todos los niños que se transfieren de CMSP a MassHealth con la fecha en que comenzará la cobertura de MassHealth. En la fecha en que comience la cobertura de MassHealth su hijo ya no será elegible para CMSP. En su lugar, su hijo recibirá más beneficios a través de MassHealth. A continuación hay alguna información básica sobre esta nueva cobertura de MassHealth e información importante sobre lo que usted debe hacer para asegurar que su hijo tenga esta nueva cobertura.

Ayuda con las primas del seguro médico

Si su empleador ofrece un seguro médico de cobertura familiar que usted no ha podido pagar, es posible que MassHealth pueda ayudarle a pagar sus primas para esta cobertura en lugar de proveer directamente beneficios a sus hijos. Usted tendrá que afiliarse a un seguro calificado que sea patrocinado por su empleador y ofrecido en su lugar de trabajo. **El afiliarse a una cobertura de seguro médico familiar en su trabajo es una gran manera de tener seguro médico para padres e hijos.** Le enviaremos más información sobre esto en el futuro si recibimos información de que su hijo puede recibir un seguro médico calificado a través de su empleador. MassHealth cubrirá a su hijo directamente por un período mientras que usted hace las gestiones necesarias en su trabajo para enrolar su familia en un seguro médico familiar.

Beneficios más completos

MassHealth provee cobertura directa a través de Family Assistance para niños cuando no existe por parte del empleador un seguro médico. Esta cobertura incluye todos los beneficios que hoy día cubren CMSP y UCP, y muchos otros beneficios si fueren médicamente necesarios, tales como:

- **Cobertura hospitalaria para pacientes hospitalizados y ambulatorios:** MassHealth **incluye** cobertura hospitalaria para pacientes hospitalizados que CMSP no provee. Al contrario que UCP, MassHealth no tiene deducción de gastos. ¡Usted no tendrá que preocuparse sobre las facturas del hospital para sus hijos!
- **Cobertura dental**: MassHealth **no limita** los beneficios dentales a $750 como hace CMSP.
- **Cobertura total para la farmacia**: MassHealth **no limita** los beneficios de farmacia a $200 como hace CMSP.
- **Servicios para la salud mental y tratamiento del abuso de substancias**: MassHealth **no limita** estos servicios como hace CMSP.
- **MassHealth provee gafas, suministros y equipos médicos y mucho más.**
- **No hay copagos**: Al contrario que CMSP, MassHealth **no impone** copagos en los beneficios para niños y, al contrario que UCP **no tiene** deducciones de gastos o coseguro para los niños.

Elección de planes médicos

MassHealth ofrece una selección de planes médicos si usted no puede recibir un seguro médico a través de su empleador. A través de estos planes médicos, los niños tienen acceso a miles de proveedores de cuidados para la salud en todo el estado, incluyendo médicos de cabecera, especialistas, hospitales, centros de salud comunitarios y muchos más.

Primas de MassHealth

Usted no tendrá que efectuar copagos o tendrá deducciones en la cobertura directa por MassHealth, pero se le cobrará una prima mensual. Dependiendo de sus ingresos familiares, se le cobrarán $20 al mes por niño (hasta un máximo de $60 al mes por tres o más niños) o $28 al mes por niño (hasta un máximo de $84 al mes por tres o más niños).

La carta que recibirá de MassHealth le dirá cual será su prima mensual. Si hay momentos en que usted no pueda pagar sus primas mensuales, MassHealth tiene planes de pago a plazos. Existen también exenciones del pago de la prima mensual si usted pasa por un momento difícil. Usted recibirá más información en cartas futuras sobre las primas de MassHealth.

¿Qué tiene usted que hacer ahora?

- Continúe pagando las primas de CMSP hasta que comience la nueva cobertura de MassHealth para su hijo.
- Conteste a cualquier petición de información o determinación de CMSP.
- Notifique a MassHealth si se muda.

¡Importante! Si su hijo pierde la cobertura de CMSP debido a que las primas no se pagaron o porque usted no respondió a peticiones de información, MassHealth **no podrá** enrolar a su hijo automáticamente en Family Assistance y su hijo no podrá reinscribirse en CMSP.

Preguntas

Si usted tiene alguna pregunta, llame al Centro de servicios al cliente de MassHealth: 1-800-841-2900 (TTY: 1-800-497-4648 para personas con sordera total o parcial) de lunes a viernes, de 8 de la mañana a 5 de la tarde.

MassHealth–el mejor plan para su hijo.