Chapter 58 Implementation Report
Update No. 5

Governor Deval L. Patrick

Lieutenant Governor Timothy P. Murray

Secretary of Health and Human Services JudyAnn Bigby, M.D.

February 12, 2007

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Speaker Salvatore F. DiMasi, Massachusetts House of Representatives
President Robert E. Travaglini, Massachusetts 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:

Pursuant to section 132 of Chapter 58, I am pleased to provide the General Court with the fifth update on Chapter 58 implementation progress. As of December 31, 2006 the MassHealth program successfully implemented changes resulting in the enrollment of an additional 1,919 people in health plans through the Insurance Partnership program and 13,000 new and/or converted Children's Medical Security Plan members in MassHealth Family Assistance. As of February 1, 2007 the Massachusetts Health Insurance Connector Authority successfully enrolled nearly 45,000 people with incomes at or below 100% of the federal poverty level into the Commonwealth Care program. Further, as of January 1, 2007 the Connector successfully expanded Commonwealth Care eligibility to individuals earning between 100 and 300 percent of the federal poverty level. Approximately 80,000 of the potentially 140,000 people eligible for Commonwealth Care fall within this income range.

In upcoming months the Commonwealth faces a number of challenges and important decisions. A key design decision is balancing comprehensive coverage and affordability. The Connector Board is working to define minimum creditable coverage for compliance with the Commonwealth's health insurance individual mandate. The Connector is also awaiting information about premiums for plans offered through Commonwealth Choice, the Connector's commercial health insurance program scheduled for implementation on May 1, 2007. It is important that these plans are affordable so that residents of Massachusetts are able to comply with the individual mandate scheduled to go into effect July 1, 2007.

While work on program design continues to develop, the Commonwealth is working on a comprehensive communications strategy to inform residents of new health insurance options available to them and of the requirements under the state health insurance individual mandate. The Connector is establishing a web site with Frequently Asked Questions and has created a Public Information Unit devoted to handling Connector and health care reform related inquiries. The Connector executed a contract with Weber Shandwick for assistance in implementing a comprehensive integrated marketing, advertising, and outreach campaign for health care reform. We will keep the legislature updated as the communication strategy further develops.

It is crucial that constructive dialog between stakeholders including health plans, the Commonwealth, the legislature, consumers, and advocacy groups continues to ensure that health care reform is a success in Massachusetts. We all must work together to resolve issues as they arise and to ensure that Chapter 58 promotes universal health coverage for all residents of the Commonwealth.

If you would like any further information on the activities summarized in this report, do not hesitate to contact me or my staff.

Sincerely,

JudyAnn Bigby, M.D.
Secretary

Cc: Senator Richard R. Tisei
Representative Bradley H. Jones
Representative Ronald Mariano
Representative Robert S. Hargraves

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Section 1: MassHealth Update

The Office of Medicaid reports significant progress on Chapter 58 initiatives.

Insurance Partnership Expansion and Changes

On October 1, 2006, MassHealth successfully implemented an increase in the income limits for eligibility in the Insurance Partnership (IP) from 200% to 300% of the federal poverty level (FPL). As of December 31, 2006, 1,919 additional people have received health insurance coverage through the expanded Insurance Partnership program.

Enrollment Information for Children's Expansion up to 300% FPL

As of December 31, 2006, MassHealth has enrolled approximately 13,000 new members and/or converted Children's Medical Security Plan members as a result of the expansion of MassHealth Family Assistance coverage to children up to age 18 in households with incomes greater than 200% up to 300% of the FPL.

MassHealth Essential Update

As of December 31, 2006, 53, 784 individuals were enrolled in MassHealth Essential. With an enrollment cap of 60,000 MassHealth Essential still has room to enroll additional eligible people into the program. MassHealth does not anticipate having to reinstate a waiting list.

Wellness Program

Section 54 of Chapter 58 requires that MassHealth collaborate with the Massachusetts Department of Public Health (DPH) to implement a wellness program for MassHealth members. It specifies five specific clinical domains: diabetes and cancer screening for early detection, stroke education, smoking cessation, and teen pregnancy prevention. The law mandates co-payment and premium reduction for members who meet wellness goals.

A project structure has been established that includes a joint MassHealth/DPH Project Team, which reports to a Steering Committee chaired by the MassHealth Medical Director. The Steering Committee includes Office of Medicaid, DPH, Executive Office of Elder Affairs, and Department of Mental Health representatives. Both committees are advised by a member advisory group and an external stakeholder advisory group.

In January 2007 the Wellness Program work focused on research and data analysis to set a baseline for accurate tracking of MassHealth members' wellness behaviors. This work is essential for effective measurement and evaluation of the success of the Wellness project. Additionally, the project's external stakeholder advisory group held its first meeting January 17, 2007. The group is comprised of subject matter experts, provider groups, advocates and other MassHealth stakeholders.

Overall, considerable progress has been made in designing the wellness program and the method by which to evaluate and report on its effectiveness. The project is on the following implementation time track:

- Creation of overall program structure: May through August 2006 (complete)
- Research and program design: September 2006 through February 2007 (90% complete)
- Implementation planning: January through June 2007 (on schedule)
- Program Implementation and subsequent evaluation: July 2007 and ongoing (on schedule)

As reported in December, the co-payment/premium reduction requirement in the law has proven problematic. Most MassHealth members pay no premiums, and those who do generally pay negligible amounts. Consequently, MassHealth and DPH have concluded that such an incentive structure would have little impact on member compliance, and are currently exploring alternative member incentives. The Office of Medicaid and Wellness Project Leaders met with legislative staff in late December 2006 to discuss the change in the direction of the project from the original mandate and have received support to pursue alternative member incentives. The Office of Medicaid will recommend changes to the legislation to implement a different benefit for members that participate successfully in the Wellness Program.

Outreach Grants

As reported in the December Chapter 58 Implementation Report, MassHealth and the Commonwealth Health Insurance Connector Authority (Connector) released a Request for Response (RFR) on September 9 to solicit grant proposals from community and consumer-focused public and private non-profit organizations for activities directed at reaching and enrolling eligible Commonwealth residents in MassHealth programs or the Commonwealth Care program. MassHealth selected grantees in November. 24 Model A grants were awarded. Model A is for traditional community-based outreach, enrollment and re-determination services. Grantees must develop effective community-based strategies for reaching and enrolling eligible individuals into MassHealth programs or the Commonwealth Care program. Seven grantees have been selected for Model B grant awards for integrated outreach and marketing campaigns. These grantees must develop and conduct comprehensive broad-scale media or grassroots campaigns targeting individuals potentially eligible for either program.

Both Model A and Model B contracts have been executed. The first round of monthly reporting for both different models will be due mid-February 2007. Model A organizations are heavily underway with direct outreach and enrollment assistance activates. Model B organizations have submitted outreach materials to the state for accuracy review, which once approved, will be produced and distributed statewide to provider groups and community-based organizations.

Section 2: Connector Authority Update

Commonwealth Care

Commonwealth Care plans offer inpatient and outpatient services, prescription drugs, vision care, rehabilitation, mental health and substance abuse services. As of February 1st the Connector had enrolled nearly 45,000 people in Commonwealth Care's Plan Type 1 (which is available to people who earn up to 100% of the federal poverty level).

Beginning January 1, the Connector expanded Commonwealth Care eligibility to those earning between 100 and 300 percent of the federal poverty level. Depending on income these individuals may enroll in Plan Types II, III, or IV. Approximately 80,000 of the potentially 140,000 people eligible for Commonwealth Care fall within this income range.

The Commonwealth Care call center continues to be an effective resource for those needing program information and enrollment assistance. The Commonwealth Care website, www.macommonwealthcare.com, went live on January 2 and now serves as a tool for members to enroll, pay their premium, and search for providers.

MassHealth and Maximus Contracts

During its December meeting the Connector Board approved the Connector's contract (Interagency Service Agreement or "ISA") with MassHealth. This ISA will cover operational areas such as enrollment centers, the central processing unit, and eligibility determinations. The Connector Board also approved the contract with Maximus for its Commonwealth Care enrollment and customer service center. Although the Connector has a stand alone relationship with Maximus, the contract will be attached as an amendment to the existing Maximus contract with the Executive Office of Health and Human Services.

Commonwealth Choice

Commonwealth Choice is the Connector's commercial program. Individuals will be able to choose from a variety of private health insurance options and small employers will either contribute to and make available health insurance plans to their employees or allow for pre-tax premium deductions for health insurance through the Connector. The Connector is working hard on planning and initiating this program, with a go-live goal of May 1, 2007.

Key design decisions for Commonwealth Choice include: (1) how many health plans to offer; (2) how to structure plan choice for maximum value and market appeal, while minimizing confusion; (3) how to prevent adverse risk selection and consequent premium increases within the Connector; and (4) how to avoid unintended disruption of the small group market.

Part of the design of Commonwealth Choice entails identifying the kinds of benefits and levels of plan coverage that the Connector will offer. In addition, the Connector must

define Minimum Creditable Coverage (MCC), the lowest level of coverage that individuals must have in order to satisfy the new requirement that adults in Massachusetts have health insurance starting July 1, 2007,. The Board decided to postpone any final decision on MCC until after information was received from the health plans in response to the RFR that was issued in December.

Health Plan RFR

The Connector is working to offer a variety of comprehensive, affordable health plans through the Commonwealth Choice program. On December 6, 2006, the Connector issued a request for responses (RFR) to solicit fully insured health insurance product proposals from commercial health insurers licensed to do business in the Commonwealth.

The RFR requested carriers to submit four distinct types of health insurance products:

1. "Premier" plans with limited out-of-pocket cost sharing by enrollees - based on a comprehensive small group product offering, which includes inpatient, outpatient, physician services, diagnostic and ancillary procedures, and mental health coverage;
2. "Value" plans with higher out-of-pocket costs at the point of service – with a relative value of approximately 80 percent of the Premier plan;
3. "Minimum Creditable Coverage" plans representing the highest level of cost-sharing that will satisfy the individual mandate for health insurance coverage in Massachusetts – with a relative value of approximately 60 percent of the Premier plan; and
4. Young Adults Plans, to be offered solely through the Connector to individual, non-group purchasers ages 19 to 26.

The Connector will serve as the distribution channel for those products that best meet the criteria set forth in the RFR and that the Board of the Connector determines to be the most appropriate for inclusion in a package of health benefit plans to be offered for sale through the Connector. Plans selected by the Board will be designated with the Connector's Seal of Approval.

The Connector received responses to the RFR on January 16th. After further discussion, the Board decided to request rebids for the lowest tier products (60% of the Premier plan's value) and to defer until March a decision on what would constitute Minimum Creditable Coverage. These resubmissions will be due after the Connector Board's next meeting on Thursday, February 8th.

With regard to dental coverage:

Dental is not standard to most Commercial health insurance plans, so the RFR does not require that carriers include a dental benefit in their responses. Responses to the RFR may or may not include a dental benefit.

Sub-Connector RFR

The Connector will use a third party administrator (or "Sub-Connector") to provide customer service and enrollment transactions for Commonwealth Choice. The Connector has been reviewing responses to the Sub-Connector RFR that was issued on December 6 and will bring the staff's recommendation to the Connector Board for review and final approval on February 8.

Web Strategy
An RFQ for website strategy and development was issued on November 8. The Connector has selected and executed a contract with CSC Consulting Inc. to develop a state of the art website. This website will be a key tool that the Connector will use to attract and enroll additional customers, especially to the Commercial Plan.

Advertising and Marketing RFP
An RFP was issued on November 16 for Advertising and Marketing assistance. The Connector has selected and executed a contract with Weber Shandwick for their assistance in implementing a comprehensive and integrated marketing, advertising, and outreach campaign. The campaign's goal is to drive enrollment of uninsured individuals to qualifying health insurance plans while effectively establishing the Connector's brand.

Public Information Unit
The Connector recognizes the need for a public information unit to handle Connector and health care reform related inquiries. The public information unit went live on January 29 and can be reached by email at connector@state.ma.us or by phone at (617) 933-3140. Also, a comprehensive Frequently Asked Questions (FAQ) section has been added to the Connector website. These questions are divided into sections for individuals, for employers, for brokers, and for general health care reform information.

Section 3: Technical Corrections

The General Court has passed two separate bills making amendments to Chapter 58 to better align key provisions of the law and to ensure the successful implementation of all aspects of Health Care Reform.

There still remain, however, a number of outstanding issues that should be addressed to allow the Connector, the Division of Unemployment Assistance, the Department of Revenue, the Division of Health Care Finance and Policy and the Office of Medicaid to continue to make progress toward lowering the number of individuals who remain uninsured.

Transfer of the Health Safety Net Office to the Division of Healthcare Finance and Policy

Budget Neutrality

A critical element of the Centers for Medicare and Medicaid Services (CMS) approval of the MassHealth 1115 Waiver amendment that supported Health Care Reform, was the requirement that the Commonwealth demonstrate that the Waiver will be budget neutral through its current term. In July 2006 a federal budget neutrality calculation was submitted by the Commonwealth and accepted by CMS based on State Fiscal Year (SFY) 2005 actual expenditures and member months, trended for SFY 2006 through SFY 2008. This calculation resulted in an estimated budget neutrality "cushion" of $ 82 million over the 11 years of the Waiver (SFY 98- SFY 08). It is important to recognize that $82 million is a slim margin over 11 years and $46 billion worth of total expenditures, and is indicative of the serious challenge budget neutrality presents.

Budget neutrality calculations must be updated as actual expenditures become available. MassHealth is closely monitoring actual spending to gauge ongoing compliance with this fundamental waiver requirement.

The budget neutrality calculation approved by CMS in July 2006 did not include expenditures made from the Health Safety Net Trust Fund (HSNTF). The types of provider reimbursements to be made from the HSNTF have in previous years been made though the Division of Health Care Finance and Policy (DHCFP). As such, those expenditures were not included in the 1115 Waiver budget neutrality calculations. The terms and conditions of the 1115 Waiver specifically exclude expenditures made by other agencies (other than the Medicaid agency) from the budget neutrality test.

If the Health Safety Net Office, as manager of the HSNTF, is created in the Office of Medicaid, payments made to providers from the HSTNF must be included as Waiver expenditures. The Waiver will not be budget neutral if HSNTF payments are included. It is, therefore, critical that provider payments made from the HSNTF be made by the DHCFP, and continue to be excluded from the Waiver budget neutrality calculation.

Division of Unemployment Assistance

Chapter 324 of the Acts of 2006 (An Act Relative to Health Care Access) shifted responsibility for collection of the Fair Share Assessment to the Division of Unemployment Assistance. The following issues require legislative action:

- The Division of Unemployment Assistance is a federally funded agency, and therefore has no discretion under federal law to expend federally appropriated dollars specified for the collection of unemployment insurance on other activities. Without a separate appropriation to allow for the collection of the Fair Share Assessment, the Division is unable to begin the arduous task it faces in establishing new collection systems for this purpose. The need for appropriated dollars for the start up of this system is immediate. DUA estimated it needed funds by January 15, 2007 to ensure that the new collection system is operational by October 1, 2007. A budget proposal and detailed spending plan for the start up and first year operating expenses for this new requirement was forwarded to the Chairs of the House & Senate Ways & Means Committees and the Health Care Financing Committee on December 8, 2006. DUA recommends that, after the initial start-up year, the ongoing funding of the Division's responsibilities for the assessment be derived from a portion of the fair share assessment monies collected.

- Second, in order to encourage and maintain employer compliance with the filing and payment requirements of the collection of the Fair Share Assessment, the Division feels it is imperative that language be included allowing audit & enforcement authority consistent with the authority in the DUA statute relative to Unemployment Insurance, Chapter 151A. Specifically, the law requires DUA to implement penalties against employers who fail to pay the assessment. Since the requirement to pay the assessment falls within G.L.c.149 and not the Unemployment Insurance (UI) statute, DUA is not able to use the expedited and effective collection tools provided in G.L.c.151A for the collection of delinquent UI taxes. In many of these cases, a notice of intent to proceed with further legal action, citing the statutory authority to do so, was sufficient to obtain compliance with filing, payment and/or payment plan requirements. Without this technical amendment, the division's ability to enforce compliance by delinquent employers will be seriously hampered.

- Third, statutory language must be enacted to authorize DUA to promulgate regulations in order to establish definitions and requirements needed to administer the fair share assessment.

Executive Office of Health and Human Services/ MassHealth

- Section 23 of Chapter 62E of the General Laws, as amended by section 15 of Chapter 324 of the Acts of 2006, authorizes DOR to share wage reporting and

financial institution information with specified state entities. The amendment included in Chapter 324 adds language to permit DOR to share that information with the Division of Unemployment Assistance (DUA), the Department of Insurance, and the Division of Health Care Finance and Policy for purposes of administration and enforcement of the UCP, Health Insurance Responsibility Disclosure form, Free Rider surcharge, the fair share employer contribution requirements, and the responsibilities of EOHHS' Health Safety Net Office.

- Another technical change necessary to Chapter 324 concerns that of the definition of "creditable coverage". As written, the definition included in Chapter 324, and therefore Chapter 58 does not include coverage under Title XXI of the Social Security Act, the State Children's Health Insurance Program (SCHIP). SCHIP, as a comprehensive coverage plan, should be included as providing creditable coverage under Health Care Reform.

- Chapter 58 was enacted with the assumption that certain state Medicaid expenditures would be federally reimbursable. Specific language needs to be incorporated into the law to ensure that certain state Medicaid payment obligations are explicitly conditioned upon the availability of FFP and legislative appropriation. The language will need to identify those sections that calculated the availability of FFP as it relates to state funding of health care reform implementation. Such language would exclude FFP as a requirement for health care reform expenditures that calculated funding at 100% state cost.

Department of Revenue

- Section 6 of chapter 324 allows the Division of Insurance, upon request, to collect insurance information from insurance carriers and the Office of Medicaid. The statute prohibits the use of SSNs, which in many cases is a MassHealth recipient's identification number. Therefore, an amendment would permit the use of SSNs for MassHealth purposes only.

- A similar problem exists in section 11 of chapter 324, which requires insurers, self-insured employers and the Office of Medicaid to send an annual notice to each insured person regarding insurance coverage. This section also prohibits the use of SSNs. A similar amendment to the one described above would allow for the use of SSNs for MassHealth purposes only. Issuers of these notices would also be required to submit a report to DOR once a year. The reports must identify the carrier or employer, the covered individual and covered dependents, the insurance policy or similar numbers and the dates of coverage during the year, and other information as required by the commissioner of revenue for the purposes of verifying coverage for the named individuals. Section 11 allows DOR to share these reports with certain state agencies for health care related purposes. A further amendment to this section would allow DOR to also share these reports with the Executive Office of Health and Human Services to assist in the identification of other insurance coverage to ensure that the Commonwealth is the payor of last resort.

- Chapter 58 calls for DOR to share quarterly wage reports with the Connector to verify income eligibility for participants in the Commonwealth Care Health Insurance Program. A technical amendment would clarify the information to be contained in the data exchange agreements between DOR and the Connector. In addition, the statute currently authorizes DOR to release wage reporting data only. A further amendment would authorize DOR also to release tax return information for purposes of verifying eligibility.

- As described above, the statute allows DOR to share wage reporting information with the Connector for limited purposes – to verify income eligibility. The Connector may also need access to this information for other health care related purposes. An amendment would allow the Connector to access wage reporting and non-financial information contained on withholding returns for purposes of the administration and enforcement of health care reform.

- The individual mandate section currently applies to "every person who files an individual return." A technical amendment would expand the section to apply to every person who files or is "required to file" a tax return.

- Effective Tax Year 2007 only, every person who files a resident tax return must state whether, as of the last day of the taxable year, he or she met the individual mandate requirement. If the person answers "no" or leaves the question blank, the person loses his or her personal exemption (half the exemption is lost if one person answers "no" on a joint return). Technical amendments would clarify and define the penalty for year 1.

- Effective Tax Year 2008, every person who files a resident tax return must indicate on the return whether the individual mandate requirement was met for each of the 12 months of the taxable year. If the person says "no" or leaves the question blank, DOR must assess a penalty equal to half of the amount of premiums an individual would have paid toward an affordable premium. Technical amendments would clarify and define the penalty after year 1.

- Effective October 1, 2007, the Division of Health Care Finance and Policy must promulgate regulations requiring acute hospitals to submit data "that will enable the department of revenue to pursue recoveries from individuals who are ineligible for reimbursed health services and on whose behalf the Health Safety Net Trust Fund has made payments to acute hospitals for emergency bad debt." Technical amendments would establish procedures regarding the "recovery of payments," and clarify the information to be contained in data exchange agreements between DOR and DHCFP.

- The Department requires a change to references to nonprofit entities under the definition of employer to tax-exempt organizations consistent with Section 501 of the Internal Revenue Code.

- The Department also requires clarification that the same rules that apply to group health plans maintained by partnerships, and to their partners, also apply to limited liability companies.

- Another clarification to a reference to gross income is necessary to be consistent with Internal Revenue Code references.

- Finally, a clarification is necessary to allow that information exchanged with the Connector for purposes of verifying eligibility for participants in the Commonwealth Care Health Insurance Program must contain social security numbers.

Division of Insurance

- Chapter 58 added section 4R to the M.G.L.c.176G, the requirement for dependent age up to age 26. However, DOI has become aware that Chapter 172 of the Acts of 2006, An Act Relative to HIV and Hepatitis C Prevention, also inserted a new section 4R of M.G.L.c.176G. DOI recommends that the section number be amended in order to avoid confusion.

- Changes made in section 4 of Chapter 450, which amended the Chapter 175 section 110(O), nondiscrimination of premium contribution provision by excluding stand-alone dental services from the requirement inadvertently dropped the provision to allow separate contribution levels under collective bargaining agreements.

  Chapter 58 also added this nondiscrimination provisions to the BCBS and HMO statutes (See C.58 sections 52, 55 & 59) and the collective bargaining language remains in place under these statutes.

Section 4: Individual Mandate Preparations

Since June, the Division of Insurance (DOI) and the Department of Revenue (DOR) have worked closely with the insurance industry and business groups to identify a method for documenting compliance with the individual mandate. Chapter 58 originally contemplated that DOI would create an insurance database from insurer-provided monthly reports. Based on feedback from the insurance community, DOI and DOR developed an alternative to the insurance database, which was included in chapter 324 of the Acts of 2006. Beginning in 2008, insurers and employers will be required to provide an annual written statement, called the MA 1099-HC (for health care), to each person residing in the Commonwealth to whom creditable coverage was provided in the previous calendar year. Taxpayers will transcribe the information from the statement onto the tax return. Issuers of this statement are also required to provide a separate report electronically to DOR verifying the statement. The statements and reports must identify the employer or the insurance carrier, the covered individual and covered dependents, the insurance policy number and the dates of coverage. DOR is working with the insurance community to develop procedures and standards to implement this new process.

DOR is also working with the Connector to mail a notice in the spring to taxpayers explaining the requirements to establish and maintain health care coverage.

Section 5: Health Safety Net Trust Fund and Essential Community Provider Grants

Health Safety Net Trust Fund

Chapter 58 requires that, effective October 1, 2007, payments from the Health Safety Net Trust Fund be made on a claims basis using Medicare pricing principles, as modified to reflect the appropriation. The Executive Office of Health and Human Services (EOHHS) released a Request for Responses (RFR) seeking a vendor to process and adjudicate the claims for the Health Safety Net Trust Fund in December 2006. Responses to the RFR were due to DHCFP on January 29, 2007. DHCFP extended the deadline for responses to January 30, 2007, however no responses were received. This procurement has since been closed. The feedback the division received indicated that the timelines set forth in the RFR were too aggressive, and the proposed contract duration too short. The division is evaluating the appropriate course of action. To facilitate the implementation of the claims based system, staff from the Division of Health Care Finance and Policy have formed a technical advisory working group consisting of representatives of several hospitals and the Massachusetts Hospital Association. The advisory group has begun discussions to ensure a smooth transition to the claims adjudication model.

Chapter 58 also requires that Community Health Centers, effective October 1, 2007, be paid no less than the Medicare Federally Qualified Health Center visit rate plus additional payments for services not included in that rate. The Division has begun analysis to determine the effect of these changes. The division will shortly form a Community Health Center technical advisory committee to facilitate the transition to a modified payment system.

Health Safety Net Regulations

The Division of Health Care Finance and Policy has begun the process of formulating policy options regarding services and eligibility under the new Health Safety Net regulations. The Division is researching the types of services providers have billed to the Uncompensated Care Pool to inform the decision making process. The executive office expects to seek input from interested parties and stakeholders via consultative sessions about the services to be covered by the Safety Net Care Pool. The executive office expects to propose the Health Safety Net regulation in June or July 2007 for an October 1, 2007 effective date.

Section 6: Boards, Councils, Commissions and Reports

Health Care Quality and Cost Council

The Health Care Quality and Cost Council and the Advisory Committee each meet monthly to consider the work of the subcommittees and measure progress on the requirements set forth in Chapter 58.

Executive Director:

The Council is in the process of selecting an Executive Director to support the achievement of its stated and mandated goals. The position description was posted through the Commonwealth's employment opportunities website, as well as other internet employment websites. The Governance Subcommittee of the Council will propose 3 candidates to the full Council at its next full meeting in February.

Communications:

The Communications Subcommittee has drafted and will soon release a Request for Proposals from communications consultants to begin formalizing a plan to make price and quality information about health care available and useful to the general public. The audience will be consumers, providers, payers, employers, agents and policymakers. The Council is seeking communications assistance from experienced individuals or firms for the purpose of developing a comprehensive communications plan aimed at reaching a multitude of constituencies including consumers, media outlets, providers, policy makers and agent/brokers of the Commonwealth, all of whom will stand to benefit by the information the Council produces.

The plan will include steps to inform people about the availability of information on cost and quality; guidelines for presenting information in the most understandable and useful way, based on input from consumers; strategies for disseminating the information via multiple media, including a website; and a means to solicit ongoing feedback from consumers to inform adjustments to the approach.

Cost Subcommittee:

One of the Cost Subcommittee's goals is to establish statewide cost containment goals and work with the quality subcommittee to develop quality improvement goals that are intended to lower or contain the growth in health care costs. The Cost Subcommittee therefore plans to release a Request for Information on proposals from individuals or groups that can identify reasonable goals that are within the control of that individual or group's health care sector. The goal should be "intended to lower or contain the growth in health care costs while improving the quality of care, including reductions in racial and ethnic health disparities" [MGL c.6A, S.16L(a)]. The respondents may also include suggestions for additional goals that could be addressed by that respondent's sector in coordination with other sectors of the health care system. Responders who do not represent a particular health care sector may also suggest goals, as outlined below.

Expenditures:
A Budget Request for Fiscal Years 2007 and 2008 has been submitted to the Executive Office for Administration and Finance. The request includes funding for staff salaries, general office expenses, website development and maintenance, consultant costs and funds to support a communications strategy. No funding has been allocated or appropriated to date.

MassHealth Payment Policy Advisory Board
The MassHealth Payment Policy Advisory Board is set to meet for the second time on February 22, 2007.

Section 7: Public Health Implementation

The Department of Public Health (DPH), Center for Community Health reports the following progress on implementation of components of Chapter 58:

Prostate Cancer (Men's Health Partnership) (4513-1112) - $1,000,000
The Men's Health Partnership has finalized plans for targeted outreach efforts and expanded outreach and care coordination is in place at each vendor site to enhance follow-through for screening and treatment.

Stroke Education (4513-1121) - $200,000
The following activities are in process: stroke education materials have been translated into Spanish and will be available to the public in March. Follow-up work with hospitals is in process to determine additional needs in hospitals for stroke education and outreach. Ten Public Service Answering Points (PSAPs) have been funded to purchase software and equipment to ensure that response to stroke and other emergencies are appropriate and consistent. Funded PSAPs are meeting quarterly.

Breast Cancer (Women's Health Network) (4570-1500) - $4,000,000
Women's Health Network eliminated the wait list in FY06 and is continuing to serve all eligible women in FY07. Screening services have been targeted to minority and underserved areas of the state. The Enterprise Invoice Management/Enterprise Service Management system, which will replace the existing ACES data system, is continuing to be developed and is in the process of being linked to Common Intake so as to facilitate the enrollment of women into MassHealth and Connector programs if eligible and into Women's Health Network if they do not have other insurance. This data system will provide in addition to the better integration across systems additional data regarding the women using services and their outcomes.

Diabetes (4516-0264) - $350,000
Health education/communication and community health interventions have been expanded to identify and increase the number of individuals with undiagnosed diabetes or pre-diabetes, or who are at risk for these conditions, to undergo a risk assessment and if appropriate, receive blood testing to screen for diabetes and determine the need for follow-up. Appropriate information about risk reduction is being distributed to individuals who are identified with pre-diabetes or considered to be high-risk, but do not yet have diabetes or pre-diabetes. In accordance with recommendations from the American Diabetes Association, screening would only be undertaken in settings where a health care infrastructure is in place to ensure adequate access to health care and follow-up.

In addition, plans for two surveys are currently underway: 1) A survey of the Cape Verdean community will be conducted in New Bedford, Fall River, and Brockton to gather information on the residents' diabetes status, preventive care practices, and related

health behaviors; participants will also be offered an opportunity to have a free screening test for blood glucose levels; and 2) A Community Survey of the Commonwealth's 351 cities and towns will be conducted to assess what is being done to promote diabetes screenings, physical activity, good nutrition, and other policies and practices that either facilitate or pose barriers to the identification and treatment of individuals with undiagnosed diabetes, diabetes, and prediabetes.

Ovarian Cancer (4513-1122) - $200,000
The Ovarian Cancer Education Initiative will consist of two components for each area: screening and treatment. An external vendor contract is in place which will adapt the Ovarian Cancer National Alliance media campaign, "Until there is a Test, Awareness is Best," for Massachusetts women. This campaign acknowledges that there is currently no accepted screening test for ovarian cancer. Women 50 years and older are at the highest risk and will, therefore, be the targeted population. The second component marketing the Speakers' Bureau developed by National Ovarian Cancer Coalition (NOCC) through a Gillette Foundation grant has been finalized. The NOCC has trained 14 ovarian cancer survivors representing all the high-risk groups including women 50 years and older, women with a history of breast and colorectal cancer, Ashkenazi Jewish and other minority women to use the Gillette sponsored educational CD presentation on ovarian cancer education. Both components will emphasize the importance of women discussing their personal risk of getting ovarian cancer with their physician.

The plan to provide all women diagnosed with ovarian cancer with access to a cancer information specialist so that they can share in the decision making about their treatment options is in process. Also in process is the development of the materials to educate newly diagnosed ovarian cancer survivors about the importance of clinical trials as a vital option in expanding the quality and longevity of their lives. Both of these components will be implemented at the forty-eight Commission on Cancer approved facilities in Massachusetts.

Osteoporosis Prevention (4513-1111) - $100,000
The development of an educational curriculum for seniors called ACCENT is moving forward. The strength training component has been completed and the osteoporosis section is being developed. Mini grants will be going out in the spring to Councils on Aging to implement the revised curriculum. The Osteoporosis Directory is in being updated with surveys mailed out to health care and fitness providers. Responses are being input into a database which will be used to update the directory.

Multiple Sclerosis (4513-1115) - $250,000
These funds are earmarked for the Central New England Chapter of the National Multiple Sclerosis Society to support its Multiple Sclerosis Home Living Independently Navigating Key Services (HomeLINKS) program. A contract is in place and services have been expanded.

Renal Disease (4513-1116) - $100,000
These funds are earmarked for the National Kidney Foundation of MA, RI, NH and VT (Foundation). This contract has been amended and funds have been awarded.

Tobacco Control (4590-0300) - $4,000,000
The Tobacco Control program has awarded contracts to expand culturally sensitive smoking cessation programs in community health centers and to develop pregnancy smoking cessation pilot projects in hospitals. The mini-grants to youth groups have been expanded from 40 to 80. In addition, local programs with boards of health and other community agencies to partner with schools, health care providers and community agencies have been expanded. These programs will enforce smoke-free schools, educate local retailers about not selling tobacco to minors, and educate children and youth about the dangers of tobacco. All programs will be targeted to communities with smoking prevalence higher than the state average and must utilize strategies with proven effectiveness.

Pediatric Palliative Care (4570-1503) - $800,000
The Pediatric Palliative Care Program has established draft standards of care, program standards, and funding criteria. Contracts
Contracts have been awarded to10 hospice agencies who are in the process of beginning to provide services. Children under 19 years old will be eligible for the program if they are:

- Diagnosed with life-limiting illness, such as cancer, AIDS, and other advanced illnesses; however, no life expectancy requirement may be imposed; and,
- Not covered by a third party payer for the services provided.

The services provided by the program will include pain and symptom management, case management and assessment, social services, counseling, bereavement services, volunteer support services and respite services.

Suicide Prevention (4513-1026) - $750,000
Suicide prevention services through existing community-based programs have been expanded to gatekeeper training for elders and elder caregivers, screening for depression for men of middle age, survivor support services and post-prevention services after the occurrence of a suicide. Existing initiatives are in the process of being expanded for professional education, gatekeeper training, environmental strategies to reduce lethal means, the development of regional coalitions, reducing stigma, increasing awareness, improving linkages between mental health and substance abuse services and coalition development activities. Current surveillance of suicide and self-inflicted injuries have been enhanced to better understand the risk factors and circumstances associated with these injuries in Massachusetts' residents and to develop and disseminate data reports. An evaluation component is in the process of being finalized.

Teen Pregnancy Prevention (4530-9000) - $1,000,000
Two new programs have been established in Taunton and Attleboro. Citizens for Citizens, Inc. will be funded to replicate the "Focus on Kids" program in Taunton and

Community Care Services, Inc. will be funded to replicate the "Making Proud Choices" program in Attleboro. In addition, Health Awareness Services of Central MA was awarded the contract to replicate the California Siblings Project (case management) for the community of Southbridge, as required by legislative earmarking.

Work continues on the expansion of programs to enhance healthy decision making, develop parent activities/workshops, trainings for youth service providers and provide technical assistance.

Community Health Workers

The final survey draft for DPH vendors who employ community health workers has been developed and is being pilot tested to prepare for broad distribution. A system for data analysis and report generation is being designed.

The CHW Advisory Council members are in the process of being identified, and will be convened in March.

Betsy Lehman Center for Patient Safety and Medical Error Reduction (4000-0140) - $500,000

The Lehman Center's statutory mission (MGL Ch. 6E, Sec. 16E) is to serve as a "clearinghouse for the development, evaluation and dissemination, including, but not limited to, the sponsorship of training and education programs, of best practices for patient safety and medical error reduction." The Lehman Center has continued implementation of projects in the following areas: patient safety in weight loss surgery; developing an accountability model for adverse events; developing medication safety models for long-term care facilities; developing an ambulatory medication card for patients; and holding an annual conference on patient safety. The Lehman Center has convened an Expert Panel for Healthcare Associated Infections to develop practices necessary to implement a statewide infection prevention and control program under line item 4570-1502. The Lehman Center is also developing an expert panel to recommend best practices for patient safety in obstetrics. Although the Lehman Center is within, but not under the control, of the Executive Office of Health and Human Services (line item 4000-0140 in the EOHHS section 1 of Chapter 58), it is included within the public health implementation section of this report because the Center is physically housed pursuant to an ISA within the Department of Public Health, and has a close connection with staff and work performed by the MDPH Office of Patient Protection.

Section 8: Merger of Non-group and Small Group Health Insurance Markets

Study on the Merger of the Nongroup and Small Group Markets

The Special Commission to study the impact of merging the nongroup and small group insurance markets submitted a final report to the Legislature on December 29, 2006.

The report estimates that the merger of the small group and nongroup markets on July 1, 2007, along with the change in the rating rules, will result in an increase at that time to current small group premiums of about 1% to 1.5% and a decrease to current nongroup premiums of about 15%. This represents an approximate $25-38 million subsidization of the nongroup plans by small groups in the current market, or approximately $2.96-$4.50 per member per month. The report also notes that the impact to rates will vary substantially by carrier, ranging from a decrease estimated to be as much as 50% for some nongroup subscribers to an increase estimated to be as much as 4% for some small group subscribers. It is also estimated in the report that, in subsequent years, in addition to the annual trend increase in health care spending and health insurance premiums, the premiums of the merged market may vary by as much as a 6.2% increase or 3.2% decrease depending on the way that various factors emerge as the uninsured population begins to enter the market.

The report also includes an estimate that the number of uninsured will decrease from the current estimates of between 372,000 to 570,000 persons to between 75,000 and 110,000 by the year 2012, based on a medium uptake assumption. (The estimate of uninsured is expressed in ranges due to the use of two different surveys – the Massachusetts Household Survey and the adjusted U.S. Census Current Population Survey – for estimating the current number of uninsured in Massachusetts.)

The Special Commission emphasized that in developing the above-noted projections, the contractor made assumptions in certain areas for which decisions were not yet final, for which the impact was yet to be determined or for which accurate data was not readily available. The use of these assumptions was necessary due to the time constraints for developing the report in order to meet the requirements of Chapter 58 and, thus, the projections may differ from actual outcomes.

Small Group and Nongroup Regulations

The Division of Insurance has completed its weekly sessions with insurance carriers, representatives of the Connector and other interested parties, and is preparing a package of final revisions to the regulations for the small group and the nongroup plans for review by the Administration prior to beginning the normal public hearing process.

Young Adult Health Benefit Plan

Young Adult Health Benefit Plan Regulations

The Division of Insurance has been working with the Connector to draft regulations for the young adult health benefit plans relying upon the Connector's recommendations for benefit parameters. After the Connector completes its review of these draft regulations,

the Division intends to distribute to the insurance industry for comment. Meetings are scheduled with the insurance carriers to review the revisions preparatory to proceeding with the promulgation process.

Health Carrier Requirements

Dependent Age

The Division of Insurance has completed sessions with insurance carriers and other interested parties, and on January 18, 2007 issued a Bulletin related to eligibility for dependents in insured health plan. The Bulletin notifies of and clarifies the requirement that carriers include coverage for dependents up to age 26 or two years past the dependent's status as a dependent as defined by the federal Internal Revenue Code.

Nondiscrimination

The Division of Insurance has been working with health carriers in reviewing a draft Bulletin regarding the requirement that carriers may only contract to sell health insurance plans to employers that offer the health plan to all full-time employees who live in Massachusetts and only if the employer does not require a greater premium contribution from lower wage employees than they do from higher wage employees. As the original implementation date of January 1, 2007 for this requirement was not synchronized with the availability of Connector products, effective July 1, 2007, and this requirement had the potential of resulting in the unintended consequence of an increase of the number of uninsured persons in the Commonwealth. As a result, it was recommended that the effective date be changed to coincide with the July 1, 2007 availability of commercial products through the Connector. The effective date was changed in the technical corrections bill, Chapter 450 of the Acts of 2007. The Division is continuing to work on the bulletin expects to distribute it in the near future.

Section 9: Employer Regulatory Provisions

The Division of Health Care Finance and Policy has made several regulatory changes in response to Chapter 450 of the Acts of 2006, which made technical corrections to some of the employer requirements under Chapter 58 of the Acts of 2006:

In July, the Division proposed three new regulations to implement three statutory requirements of Chapter 58:

114.5 CMR 16.00: Employer Fair Share Contribution
114.5 CMR 17.00: Employer Surcharge for State Funded Health Costs
114.5 CMR 18.00: Health Insurance Responsibility Disclosure (HIRD)

The Division held public hearings in August, 2006 on all three regulations. The Division adopted 114.5 CMR 16.00 in September, but delayed adoption of 114.5 CMR 17.00 and 114.5 CMR 18.00 pending enactment of technical corrections to Chapter 58. Since that time, Chapter 450 of the Acts of 2006 has delayed the effective date of the Employer Surcharge and HIRD requirements.

114.5 CMR 16.00: Employer Fair Share Contribution

The Division adopted 114.5 CMR 16.00: Employer Fair Share Contribution on September 8, 2006. This regulation governs the determination of whether an employer makes a fair and reasonable premium contribution to the health costs of its employees. The Division has determined that Section 16.03 (2) (a) Employee Leasing Companies requires clarification. Under that section, Employee Leasing Companies will be required to perform the fair share contribution tests separately for each Client Company. Although the Employee Leasing Company is responsible for collecting and remitting the Fair Share Contribution on behalf of its Client Companies, the Client Company is responsible for any Fair Share Contribution liability.

The Division of Unemployment Assistance will issue rules, regulations and forms for the collection of the fair share contribution.

114.5 CMR 17.00: Employer Surcharge for State-Funded Health Costs

The Division initially adopted Regulation 114.5 CMR 17.00: Employer Surcharge for State Funded Health Costs on December 22, 2006, with an effective date of January 1, 2007. This regulation implements the provisions of M.G.L. c. 118G, § 18B. Following enactment of Chapter 450 of the Acts of 2006 on January 3, 2007, the Division repealed this regulation. Chapter 450 changed the effective date of M.G.L. c. 118G, § 18B from January 1, 2007 to July 1, 2007. The Division will issue a new proposed regulation and schedule a public hearing for a regulation to be effective July 1, 2007. The revised regulation will reflect the recent legislation clarifying that a "non-providing employer" subject to surcharge is an employer that does not comply with the requirement in M.G.L.

c. 151F to offer a Section 125 cafeteria plan in accordance with the rules of the Connector. The new effective date is consistent with the July 1, 2007 effective date of the Section 125 cafeteria plan requirement to be implemented by the Connector.

114.5 CMR 18.00: Health Insurance Responsibility Disclosure

The Division initially adopted 114.5 CMR 18.00: Health Insurance Responsibility Disclosure as an emergency regulation effective January 1, 2007, but the Division has now repealed the regulation. The regulation implements M.G.L. c. 118G, § 6C, which was previously effective on January 1, 2007. Chapter 450 of the Acts of 2007, which became effective on January 3, 2007, changed the effective date of M.G.L. c. 118G, § 6C from January 1, 2007 to July 1, 2007.

The Division will issue a new proposed regulation and schedule a public hearing for a regulation to be effective July 1, 2007. The revised regulation will reflect the provisions of Chapter 324 which significantly reduced the amount of information the Division is required to collect from employers. In addition, only employees that have declined to enroll in employer sponsored insurance or to participate in a Section 125 cafeteria plan will be required to sign an Employee HIRD form