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June 12, 2007

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Chairman Richard T. Moore, Joint Committee on Health Care Financing
Chairman Robert A. DeLeo, House Committee on Ways and Means
Chairman Steven C. Panagiotakos, 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 seventh update on Chapter 58 implementation progress. We continue to make significant progress towards full implementation as we complete various requirements of the law. The Connector now offers a choice of plans with affordable premiums through Commonwealth Choice. Outreach efforts to educate people about the new opportunities available to them under Chapter 58 are strong through websites, television and radio ads, and extensive grassroots support. MassHealth and the Connector have aligned premium requirements to allow families covered under Commonwealth Care to waive MassHealth premiums for their children and eliminated premiums for individuals up to 150% of the federal poverty level ($15,315 annual income for an individual). The Connector continues to make strides in extending opportunities to businesses in offering health insurance to their employees. We continue to meet the ambitious agenda laid out in Chapter 58 through strong collaboration across state agencies and with our many partners.

As of April 2007 the MassHealth program successfully implemented changes resulting in the enrollment of an additional 3,440 people in health plans through the Insurance Partnership program and 14,000 new and/or converted Children's Medical Security Plan members in MassHealth Family Assistance. Additionally, MassHealth has enrolled approx 8,000

individuals in the expanded Essential program for the long-term unemployed. Overall enrollment in MassHealth continues to grow due to eligibility expansions and ongoing outreach and enrollment efforts. As of June 1, 2007 the Massachusetts Health Insurance Connector Authority successfully enrolled nearly 80,000 people in subsidized health insurance programs who have incomes at or below 300% of the federal poverty level ($30,630 annual income for an individual).

The Commonwealth passed another milestone in implementation last month when the Connector began enrolling individuals in Commonwealth Choice, the Connector's commercial health insurance program. Coverage for individuals enrolling in these plans will become effective on July 1st and offers a variety of coverage levels depending on the enrollee's preference for coverage and monthly premium. Additional new coverage options for young adults between 19-26 years old are also available. Due to the high degree of collaboration between the many stakeholders involved, these plans are being offered at premiums that will enable many individuals to take up private insurance they could not previously afford. Bold efforts to publicize both the Commonwealth Care and Commonwealth Choice insurance plans will continue in advance of the July 1, 2007 implementation date of the requirement for residents to comply with the individual mandate.

This month, the Commonwealth launched a partnership with the Boston Red Sox and New England Sports News to educate the public about the benefits of insurance coverage and the availability of new products. The Connector in conjunction with the Department of Revenue is completing a direct mailing to 3 million taxpayers in the Commonwealth as well as to 193,000 businesses informing them of the upcoming changes in state requirements. There are two new websites, www.MAhealthconnector.org and www.gethealthcoverage.net, to provide individuals and outreach organizations with educational tools and information about new products. The Connector's Public Information Unit remains very active in responding to questions on all aspects of health reform and aiding individuals in understanding the new opportunities available to them under Chapter 58.

Following an extensive public hearing process, the Connector Board approved regulations regarding Minimum Creditable Coverage (MCC), affordability, and employer Section 125 plans on June 5, 2007. MCC benefits include preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services, mental health services, and prescription drug coverage. There are no annual or per sickness maximums, no indemnity fee schedule of benefits, and specific caps on deductibles and out-of-pocket spending. MCC requirements will be phased in starting July 1, 2007 with full MCC requirements becoming effective January 1, 2009. The affordability regulation approved by the Connector will encourage universal participation while ensuring that people have the opportunity to make a claim about whether they can afford the insurance given the availability of affordable insurance and individual or family financial circumstances. The Legislature has been instrumental in addressing technical changes to ensure its successful implementation. Several remaining issues are described on pages 8-11.

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

Sincerely,

JudyAnn Bigby, M.D.

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

Chapter 58 Implementation Report
Update No. 7

Governor Deval L. Patrick

Lieutenant Governor Timothy P. Murray

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

June 12, 2007

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Section 1: MassHealth Update

The Office of Medicaid reports the following progress on Chapter 58 initiatives:

Insurance Partnership
On October 1, 2006, MassHealth successfully implemented an increase in the income limit for eligibility in the Insurance Partnership from 200% to 300% of the federal poverty level (FPL). As of April 2007, the Insurance Partnership has added 3,440 covered lives through expansion of the program.

MassHealth is preparing for implementation of the Chapter 58 provision, effective July 1, 2007, that will discontinue employer subsidies for self-employed individuals who are enrolled in the Insurance Partnership. Advance notice of this change will be mailed to affected members in mid-June emphasizing that employee premium assistance subsidies will continue for the self-employed. It is important to note that both employer and employee subsidies will continue in the Insurance Partnership for arrangements other than self-employment.

Children's Expansion up to 300% FPL
On July 1, 2006, MassHealth implemented expansion of MassHealth Family Assistance coverage to children in families with income greater than 200% up to 300% of the FPL. As of April 2007, there were 49,000 children enrolled in Family Assistance, up from 31,000 in June 2006. More than 14,000 of those children are new members and/or converted Children's Medical Security Plan members enrolled as a result of the income expansion.

MassHealth Essential
Effective July 1, 2006 the enrollment cap for MassHealth Essential was increased from 44,000 to 60,000. This allowed MassHealth to enroll more than 12,000 applicants who were on a waiting list at that time. As of April 2007, Essential enrollment was 51,800. Given the amount of additional enrollment capacity for the program, MassHealth does not anticipate having to reinstate the waiting list for Essential.

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 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. However, since members do not pay significant co-payments or premiums, alternative incentives have been recommended.

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 the Office of Medicaid, DPH, Executive Office of Elder Affairs, and Department of Mental Health representatives. Both committees receive guidance from the Wellness Program External Advisory Group.

The Wellness Program has completed 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.

In February the Wellness Program project management team proposed a two-phase implementation process to the Office of Medicaid leadership to permit the development of a flexible and sustainable incentive program and to ensure that MassHealth members and providers support and buy-in to the idea of wellness. The first phase will begin in June of 2007 and will focus on promoting and educating MassHealth members about the concept of wellness and healthy lifestyle activities. This education will be coordinated with the MassHealth providers. Phase one would not include incentives, nor would the possibility of incentives for participating in wellness activities be discussed with members. The Wellness Program incentive would be implemented in phase two, following research about the best way to track wellness activities and provide incentives to MassHealth members. Implementing the Wellness program incentive system requires surveying the marketplace which will be accomplished with a formal Request for Information (RFI) to vendors throughout the state.

MassHealth has made progress in planning the logistics of the RFI process with all necessary internal stakeholders. MassHealth has met as scheduled with the Wellness Program External Advisory Group to discuss incentive options for members. Additionally the Wellness Program management has met with MassHealth executives and CMS to discuss federal support for the member incentive system being investigated through the RFI. Currently RFI document is in development and an executive summary and timeline are being drafted to submit to the legislature as part of the Wellness Program Annual Report.

Since early April, the Wellness Program team has completed the design, review, and finalization of an English and Spanish wellness brochure, as well as an all-provider bulletin to educate providers about the program. The brochure was developed and reviewed by consumers, providers, and healthcare advocates with considerable support.

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 (complete)
- Phase 1 & 2 implementation planning: January through May 2007 (complete)
- Phase 1 outreach and education implementation: June 2007 (on schedule)
- Phase 1 and 2 program activities and development and subsequent evaluation: July 2007 and ongoing (on schedule)

As previously reported, 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 has recommended changes to the legislation to implement a different benefit for members that participate successfully in the Wellness Program. The proposed language in the House 1 budget amends the mandate as follows "This amendment allows EOHHS to reduce co-payments or premiums, or to provide other incentives for MassHealth members to meet wellness goals."

Outreach Grants

MassHealth and the Commonwealth Health Insurance Connector Authority (Connector) released a Request for Response (RFR) in September of 2006 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 and the Commonwealth Care program. Grantees were selected in November.

Twenty-four "Model A" grants, for traditional community-based outreach, enrollment and re-determination services, were awarded. Grantees were charged with developing effective community-based strategies for reaching and enrolling eligible individuals into MassHealth programs or the Commonwealth Care program. Seven grantees were selected to fulfill "Model B" requirements which focused on integrated outreach and marketing campaigns. Model B grantees developed and conducted comprehensive broad-scale media or grassroots campaigns targeting individuals potentially eligible for either program.

Both Model A and Model B organizations continue to submit outreach materials to the state for accuracy review by EOHHS and Connector staff. Model A organizations are heavily involved in day-to-day outreach and enrollment activities on the local level. Many creative outreach strategies are being pursued to reach difficult to reach populations.

Model B organizations are involved in collaborative efforts to produce widely-distributed materials for outreach. These include public service announcements for radio and television, video broadcasts for use in patient waiting rooms, and a website to make approved outreach materials, including materials developed by

Model A organizations, available to other outreach and community organizations state-wide.

In April all MassHealth Outreach and Enrollment Grantees convened at an Outreach Summit event. The all day event included presentations and working sessions with participation from the state agencies and grantees to establish best practices and share experiences.

Many grantees sponsored innovative outreach events during the Covering the Uninsured Week in April. A press event took place at the State House to unveil a joint effort among grantees' organizations in building a stand alone website: www.gethealthcoverage.net. This website is designed to assist consumers in learning more about health insurance options that are available. The website also provides community organizations with downloadable materials for consumers with questions about how to obtain health insurance.

On June 27th, all grantees will reconvene to showcase their work via poster sessions and presentations. This meeting will also include a high-level review of the overall impact of the outreach grant project and look ahead toward next steps.

MassHealth Premium Changes

Effective July 1, 2007, MassHealth will make two important changes to premium requirements in the program. First, MassHealth will no longer charge premiums to enrollees in families with income less than 150% FPL. This change aligns MassHealth with the affordability standards established by the Connector.

Second, MassHealth premiums will be waived for children in MassHealth in families where there is a parent or caretaker who is enrolled in a Commonwealth Care health plan type that requires an enrollee contribution. MassHealth will check for Commonwealth Care enrollment status prior to monthly billing to determine if the premium should be waived. This change will protect families from "premium stacking" by MassHealth and Commonwealth Care, and is an important adjustment to the MassHealth program to help ensure that total health insurance costs are affordable to families participating in these programs.

MassHealth is in the process of making changes to its premium billing system and is preparing to send notification to affected families in mid-June.

Section 2 Connector Authority Update

The Connector Authority has made significant progress in implementing many of the important initiatives contained in the landmark health care reform legislation.

Commonwealth Care

Enrollment in Commonwealth Care, the subsidized insurance program for people with incomes under 300 percent of the federal poverty level is close to 80,000 enrollees as of June 1. This marks an increase of 10,000 enrollees, or 15 percent, over the previous month. The Commonwealth Care customer service center is receiving over 2,000 calls a day.

The Connector Board is moving to make Commonwealth Care more affordable for enrollees. They recommended that the income threshold for someone who does not have to pay monthly premiums increase from 100% of the federal poverty level to 150% of the federal poverty level. The monthly premium for those people earning between 151% and 200% of the federal poverty level would be reduced from $40 to $35. Moreover, the Administration decided to waive the premiums for children in MassHealth whose parents are paying premiums for Commonwealth Care. These changes will become effective July 1.

The Connector has also developed an appeals and waiver process for Commonwealth Care which is detailed in the recently issued Administrative Bulletin 01-07. This bulletin outlines the procedures for Commonwealth Care members to appeal their Commonwealth Care eligibility, request a change in health plan, request a waiver or reduction of premiums or co-payments because of financial hardship, and file an appeal.

Commonwealth Choice

On May 1st the Connector launched its commercial health insurance program, Commonwealth Choice, offering individuals unprecedented choice and affordability. The insurance carriers whose products are offered through the Connector are Blue Cross and Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan and Tufts Health Plan. Each of these carriers offers three levels of benefits: Gold, Silver and Bronze, as well as a Young Adults plan designed for individuals ages 19 to 26.

The Small Business Service Bureau (SBSB) is providing customer service for the Commonwealth Choice program at its call center. The Commonwealth Choice Customer Service Center is open from 8 a.m. to 6 p.m., Monday through Friday. In mid-May hours were extended to 8 p.m. Monday through Thursday. Individuals are also able to get information at SBSB's walk-in center in Worcester. Since the

Commonwealth Choice customer service center opened, it has received close to 600 calls per day.

The Connector's Public Information Unit continues to be available to answer questions on Commonwealth Choice, Commonwealth Care, and all matters of health care reform.

Employer Section 125 Plans

The Connector Board approved regulation 956 CMR 4.00 regarding Section 125 Cafeteria Plans. Employers with 11 or more employees are required to offer Section 125 plans by July 1. The Connector is offering Sec. 125 plans to employers, which will enable their part-time, temporary employees - and others not eligible for their employer sponsored plans - to purchase insurance on a pre-tax basis.

Website

The Connector launched its new website, www.MAhealthconnector.org in early May. This site provides information on Connector programs, health care reform, and also allows people to shop for health insurance through Commonwealth Choice. This shopping experience provides detailed information on all health plans, including covered benefits, premiums, co-pays, deductibles and out-of-pocket maximums. Visitors can examine plans individually as well as view side-by-side comparisons before making a selection. The website experiences an average of 17,000 page views a day.

Minimum Creditable Coverage and Affordability

Public Hearings were conducted across the state on the Minimum Creditable Coverage regulations, the affordability regulations, and the affordability schedule. The revised Minimum Creditable Coverage and affordability regulations were approved by the Connector Board on June 5. The Board will vote on the affordability schedule within the next month.

Marketing and Outreach

The Connector is partnering with the Commonwealth, the Boston Red Sox, and New England Sports Network (NESN) in a public education campaign to help reach and inform uninsured individuals about the individual mandate and the products available to them. This campaign also includes advertising, outreach partnerships with CVS, Comcast, Shaw's and Star Supermarket, the Greater Boston Interfaith Organization, International Brotherhood of Electrical Workers, Service Employees International Union 1199, Bank of America and the MBTA, along with a grassroots enrollment effort. Planned outreach efforts range from public service announcements, window signage, billboards, receipt messaging,

and in-store radio announcements to pro bono advertising and grassroots enrollment efforts.

Starting in May, postcards were sent out to close to 3 million Massachusetts taxpayers, informing them of the requirements of the new law and of new opportunities available through the Connector. In addition, a letter detailing requirements for employers was mailed to the Commonwealth's 193,000 businesses.

Section 3: Changes in the Legislation

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 decreasing the number of individuals who remain uninsured. We are working with the Legislature to develop the necessary changes.

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

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. Therefore it is necessary to place the Health Safety Net office to the Division of Health Care Finance and Policy rather than in the Office of Medicaid.

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. 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.

- Fourth, in order to maximize the utility of the HIRD form and in order to effectively implement the affordability clause of the individual mandate, it is necessary for DUA to share information with the Connector, the Division of Revenue, and the Division of Health Care Finance and Policy.

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 Uncompensated Care Pool (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 SSN's 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 regarding insurance coverage. This section also prohibits the use of SSN's. A similar amendment to the one described above would allow for the use of SSN's 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

Beginning July 1, 2007, most residents 18 and over must obtain and maintain health insurance, so long as affordable coverage is available to them, or face tax penalties. The Department of Revenue is responsible for enforcing the individual mandate through the state income tax returns. The most challenging issue to date is how to confirm that the health insurance information reported by the taxpayer is accurate.

The Department continues to make progress in this area. Beginning in 2008, insurance carriers and certain employers must send an annual written statement, called the MA 1099-HC (for health care), to every resident for whom coverage was provided in the previous calendar year. Taxpayers will use this statement, similar to other 1099-like statements, to transcribe the information from the MA 1099-HC onto the tax return. Every issuer of MA 1099-HC's will send DOR an electronic tape that contains all of the data on the MA 1099 HC's issued to their policyholders. The Department will match the data on the tax return to that data to verify the accuracy of the information provided by the taxpayer. In April, the Department initiated a Pilot Phase to develop the standards and procedures that all issuers of MA 1099-HC's will use to submit statements and reports. Six insurance carriers are participating in the Pilot and have begun to transmit test files to the Department. Over the next few months the Department will determine the final specifications and business rules.

The Department continues to work closely with the Connector to develop an appeal process for taxpayers to claim that a penalty should not be assessed because of a financial hardship that prevented them from purchasing coverage. The Department is also working with the Connector on the affordability tables, which will be used to determine whether the mandate and applicable penalties apply. Regulations defining the standards for the appeals and the affordability schedules are forthcoming.

In addition, the Department is developing a new Health Care Schedule for the 2007 tax return that taxpayers will use to report proof of insurance.

The Department is also preparing guidance for employers and employees to explain when imputed income results under federal law from employer-provided health coverage of grown children of employees.

Lastly, in an effort to promote public awareness about the new law, the Department is mailing information directly to taxpayers and employers informing them of their responsibilities. As of June 4, 2007, the Department mailed approximately 2.1 million postcards to taxpayers and roughly 65,000 letters to employers. The Department is on target to complete both mailings by the end of June.

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

Health Safety Net Trust Fund

Chapter 58 requires that, beginning on October 1, 2007, payments from the Health Safety Net Trust Fund are to be made on a claims basis using Medicare pricing principles, as modified to reflect the level of appropriation for the Health Safety Net. Chapter 58 also required that the Division of Health Care Finance and Policy, in consultation with the Secretary of Health and Human Services, file a report with the Committees on Ways and Means outlining a "new methodology for equitably allocating free care reimbursements from the Uncompensated Care Trust Fund to hospitals and community health centers beginning in hospital fiscal year 2008." The Division issued this report to the Committees on May 1, 2007. The report is available on the Division's website, http://www.mass.gov/dhcfp. Division staff is continuing to work with hospital representatives to develop the rates that will be used to pay hospitals for Health Safety Net claims beginning October 1, 2008 after an initial transition.

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

In addition, the Division is exploring the feasibility of using the MassHealth Pharmacy On-line Processing System (POPS) for prescription drug claims adjudication in community health center and hospital outpatient pharmacies. It is expected that this move will enable the Health Safety Net Office to achieve efficiencies through use of the pharmacy management tools available under the MassHealth pharmacy program.

Health Safety Net Regulations

The Division of Health Care Finance and Policy, in conjunction with the Office of Medicaid and the Executive Office of Health and Human Services, 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 Division 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 public consultative session has been scheduled for June 19, 2007. The Division will also consult with the Board of the Commonwealth Health Insurance Connector, the Director of the Office of

Medicaid, and representatives of the Massachusetts Hospital Association, the Massachusetts Council of Community Hospitals, the Alliance of Massachusetts Safety Net Hospitals, and the Massachusetts League of Community Health Centers, as required by Chapter 58. The Division, in conjunction with the Office of Medicaid and the Executive Office of Health and Human Services, expects to propose the Health Safety Net regulation in 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 has made significant progress on a number of fronts. The Council and its 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's new Executive Director started work on May 21.

Mission and Vision:
The Council approved Mission and Vision statements, as follows.

> Mission: To develop and coordinate the implementation of health care quality improvement goals that are 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.
>
> Vision: By June 30, 2012 Massachusetts will consistently rank in national measures as the state achieving the highest levels of performance in care that is safe, effective, patient centered, timely, efficient, equitable, integrated, and affordable.

Statewide Goals:
The Council developed a set of draft statewide goals that are 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. The Council also developed draft FY 2008 specific goals, measures for determining progress toward meeting the goals, and FY 2008 targets. The Council is reviewing feedback it received on the draft from its Advisory Committee, and plans to issue the goals publicly by July 1.

Data Collection:
The Council identified specifications for a health claims dataset similar to one already in use in Maine and New Hampshire. These states use this dataset to create health data websites for consumers, similar to the one the Council is mandated to produce. The Council and the Council's Advisory Committee reviewed these data specifications, and identified a number of issues. The Council established a Technical Advisory Group and charged it with resolving these issues.

Masshealth Payment Policy Advisory Board

The MassHealth Payment Policy Advisory Board held its second meeting on February 20, 2007. At the February meeting, Secretary Bigby addressed the

Board and expressed hope that its work will inform the agency and the public about Medicaid rate policy. Acting Medicaid Director Tom Dehner chaired the meeting, which included a presentation about the Open Meetings law from EOHHS General Counsel Kristin Apgar, and a more detailed discussion of the role and responsibility of the Board. The Board accepted a proposal of Division of Health Care Finance and Policy staff about a procedural matter involving how that agency will communicate with Board members about regulatory rate proposals.

The Board plans to reconvene in late June. Among the topics planned for discussions are principles of MassHealth reimbursement and an update on pay-for-performance planning pursuant to Chapter 58.

Members of the Board include Tristram Blake, Deborah Enos, An Hee Foley, Elizabeth Funk, Sarah Iselin, Patricia Kelleher, Joseph Kirkpatrick, Robert LeBow, David Matteodo, Robert Moran, Scott Plumb, Mark E. Reynolds, Robert Seifert, Elissa Sherman, David Torchiana and Tom Dehner.

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 completed translation of education materials into 5 languages and ran two rounds of program promotion in news and radio for four weeks each at 10 program sites statewide. The printing of education brochures in five languages is in process. A second round of news and radio promotions is scheduled to begin June 17.

Stroke Education (4513-1121) - $200,000

DPH has developed and disseminated culturally appropriate stroke education materials in English and Spanish. Materials have also been developed for Portuguese speakers. In addition to the materials being used throughout Massachusetts, 41 other states have ordered the materials in English. The Spanish version is the first time that a new product of this nature has been developed specifically for Spanish speakers. DPH is also working with community-based Spanish organizations to educate leaders on use of the materials so that it can be incorporated with other educational efforts with Spanish communities. To date two Spanish orientations have been scheduled in Boston and Lawrence.

Breast Cancer (Women's Health Network) (4570-1500) - 4,000,000

In 2006, the program expanded services to approximately 3000 women who would otherwise have been on a wait list for WHN services. In 2007, the program continues to rely on health care reform dollars to supplement federal funding in WHN provision of screening services and facilitate outreach and education services. Work continues on the Enterprise Invoice Management/Enterprise Service Management system to replace the current ACES information system. The implementation of the new model will occur in FY '08 and will be modified as needed to adjust for implementation of health reform.

Diabetes (4516-0264) – $350,000

The Diabetes Prevention and Control Program (DPCP) is initiating several activities to identify and increase the number of individuals with undiagnosed diabetes or prediabetes, or who are at risk for these conditions, to undergo a risk assessment and, if appropriate, undergo screening for these conditions. Initiatives are also geared to providing community support for healthful behaviors aimed at reducing the risk of developing diabetes, as well as educating providers about the importance of identifying and supporting prevention efforts in high-risk individuals. These activities include: 1) surveillance initiatives of a high-risk population, the Cape Verdean community in southeastern Massachusetts; 2)

conducting a Community Survey of all cities and towns in the Commonwealth regarding facilities and opportunities for people to improve their nutrition and increase their physical activity levels; and 3) issuing clinical guidelines for the identification and treatment of children and adults with Type II Diabetes and women with gestational diabetes, which puts them and their children at a higher risk of developing Type II Diabetes later in life.

Ovarian Cancer (4513-1122) – $200,000
In 2006, the Ovarian Cancer Awareness Campaign included a coalition comprised of the National Ovarian Cancer Coalition, Inc. (NOCC), The Ovarian Cancer Education and Awareness Network at Massachusetts General Hospital (OCEAN), The Massachusetts General Hospital Cancer Center, and the M. Patricia Cronin Foundation to Fight Ovarian Cancer, Inc. (Cronin Foundation). The coalition made a concerted effort to raise awareness of ovarian cancer throughout Massachusetts. This campaign included media advertising (TV, radio, print, transit), a Web site, media event alignment, a cable television show, and government and legislative efforts and far exceeded the results of prior campaigns.

Osteoporosis Prevention (4513-1115) – $250,000
The updated osteoporosis directory is in final draft form and going through the internal review process. The ACCENT program, which is a nutrition and physical activity initiative for elders, will post a Request for Response in July. Contracts were initiated with a vendor to update the searchable physical activity inventory and include resources for seniors (including updated walking clubs) and persons with disabilities. This will allow for the identification of physical activity resources for seniors and persons with disabilities. The "Home Safety Checklist" which is an educational tool for seniors to use to "fall proof" their home is currently being reprinted and will be available for distribution by June 30.

Multiple Sclerosis (4513-1115) – $250,000
Chapter 58 earmarked funds for the Central New England Chapter of the Multiple Sclerosis Society. The contract was amended to undertake the enhanced data collection and outcome measurement, expansion of B.Fit, a wellness and rehabilitation program, increased outreach for people with MS, increased services for individuals with MS, and provision of short-term care management services during June and July 2005.

Renal Disease (4513-1116) – $100,000
These funds are earmarked for the National Kidney Foundation of MA, RI, NH, and VT. The funds will be used for the same types of services currently provided by the Foundation through an earmark on account 4510-0600. The program will provide nutritional supplements and early intervention services for people with kidney disease as well as those at risk for renal disease.

Tobacco Control (4590-0300) - $4,000,000

Promotion of tobacco cessation and systems changes in eight health care centers including Community Health Centers, hospitals, and in radio and transit advertisement is in place. Funding to secure additional compliance checks in unfunded areas of the state experiencing high rates of sales to minors has been completed.
Minigrants to youth groups for promotion of smoke-free schools and playgrounds have been distributed. As a result, creation of a youth website, promotion of video contest, and plans for a summit for youth participants are in process. Additional funding has also been targeted to reduce exposure to secondhand smoke by increasing inspections to enforce the statewide smoke-free workplace law.
Retailer education kits, school signs to promote no smoking policies, and materials for healthcare providers and consumers around cessation and the new MassHealth benefits are complete and ready for distribution.

Pediatric Palliative Care (4570-1503) - $800,000
Contracts are in place with 10 licensed hospices to provide pediatric palliative care services to residents of all cities and towns in Massachusetts and began in early 2007. Major start-up objectives include informing likely referral sources of the existence of the program, training staff to address gaps in knowledge and experience given limited pediatric hospice services in the past, setting up procedures for pediatric intakes and services, and providing services to children and families. All providers have had referrals of children for services and are working with families. Numbers served are small given the nature of the program and that providers are conducting start-up activities but growing as referral sources learn of the program. All providers are actively enrolling children with life-limiting illness and family members (parents and siblings primarily) receiving some kind of service (bereavement, counseling, etc.) As of May 25, there were 91 referrals to the Pediatric Palliative Care Program, 60 children enrolled/served, and 116 other family members who received services. Outreach materials for physicians and parents are being distributed.

Suicide Prevention (4513-1026) -$7 50,000
Health Care Reform funding has been used this fiscal year to augment activities of the overall program. Major areas of activity completed include funding of community-based suicide prevention services, education and training for a broad spectrum of community members, professionals and gatekeepers, and funding for surveillance. Funding is in place to support the ongoing activities of the Massachusetts Coalition for Suicide Prevention and the revisions of the Massachusetts State Plan for Suicide Prevention are in process.

Teen Pregnancy Prevention Services (4530-9000) - $1,000,000
Fifteen vendors currently receiving funds to implement science-based teen pregnancy prevention received additional funds to implement additional teen pregnancy prevention services to youth, parents/families and providers in communities with high teen birth rates. The increased funding has allowed

additional programs and activities to be implemented by current vendors including a provider conference, implementation of parent curricula, additional science-based curricula, HPV and teen pregnancy prevention awareness campaigns and collaboration with community agencies to open a teen center in one community. New programs in Attleboro, Taunton and Southbridge have begun serving youth.

In recognition of Teen Pregnancy Prevention Month in May, Glynis Shea from Konopoka Institute, conducted a training for DPH and other state agency staff on how to frame adolescent health issues. The Connecting for Change! Youth Summit 2007 will be held in September.

Community Health Workers

The legislation calls for the department to "make an investigation and study relative to (a) using and funding of community health workers by public and private entities in the Commonwealth, (b) increasing access to heath care, particularly Medicaid-funded health and public health services, and (c) eliminating health disparities among vulnerable populations."

Due to an initial lack of funding, timely implementation was delayed. Subsequently, funding from other sources was identified, and staff has been hired to assist with implementation.

Three main activities are underway:

1) A survey of DPH community-based vendors who do outreach, to access the utilization and funding of CHWs, including an assessment of their effectiveness in increasing access to care. The survey has been pilot-tested and is being adapted to an electronic format. An electronic distribution list of vendors has compiled, with assistance from AIDS Bureau staff. The request to complete the survey will be sent out of vendors by the Commissioner.

2) The DPH CHW Advisory Council membership is currently being reviewed and is expected to be appointed shortly. This council will assist with the investigation of community health worker utilization and contribute to DPH recommendations to the Legislature in a final report.

3) A literature review on the role of CHWs in increasing access to health care and in reducing health disparities is being designed and will be implemented this summer.

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

The Betsy Lehman Center for Patient Safety and Medical Error Reduction (Lehman Center), established in Section 16E of Chapter 6A of the General Laws, was given a $500,000 appropriation for Fiscal Year 2007 in Chapter 58. The

mission of the Lehman Center 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 was launched in 2004. It released a landmark report on best practices in weight loss surgery from its Expert Panel in 2004, and also established a Patient Safety Ombudsman Office that same year. Each year the Center holds a conference convening experts to discuss a particular aspect of patient safety.

State Laboratory Account - (4516-1000)
The $2.418m in healthcare reform supplemental funding awarded to the State Lab account enabled DPH to finance a number of essential services at the State Lab that were in deficiency. These funds were intended to cover the State Lab's occupancy costs that had been severely underfunded for several years, as well as to restore funding to help overcome several years of underfunding of laboratory operations particularly for lab supplies, equipment and essential laboratory and disease control personnel.

The critical activities funded through these dollars require ongoing resource allocation. Costs for laboratory supplies continue to rise, due to increased volume of testing; increased cost of reagents and other supplies as test become more technologically sophisticated; and decreases in federal grant funding previously used to offset costs of laboratory supplies. These funds also enabled the State Laboratory, for the first time in several years, to replace broken and outdated equipment critical to laboratory operations.

Hepatitis C Program
The Hepatitis C Program has utilized the additional funds to expand available services to people at-risk for or infected with hepatitis C virus (HCV) and to increase the education for the general public and health care and social service providers. Additionally, funding has gone towards surveillance and evaluation efforts to ensure that data are collected on the extent of the problem and the impact of the initiatives to address it. All services have been integrated into HIV/AIDS or substance abuse services where possible. All projects are reviewed by the Statewide Hepatitis C Advisory Committee which meets on a quarterly basis.

Infection Control and Prevention Program
The goal of the Infection Prevention and Control Program is to develop statewide infection prevention and control program in licensed health care facilities. The initial project focuses on hospitals. An Expert Panel provides overall guidance to a series of Task Groups that develop recommendations on four of the most common infections - ventilator associated, blood stream, surgical site and MRSA - seen in facilities. Two other groups focus on data collection and reporting and designing the framework for recommendations. When all of the information is organized, DPH and the Betsy Lehman Center will provide evidence based

recommendations on the surveillance, prevention and reporting of specific health-care associated infections.

As the program is nearing the June 30, 2007 deadline, all Task Groups are continuing to meet regularly. The infection related groups (VAP, BSI/SSI and MRSA) have submitted their first set of recommendations for processes and outcomes to the full Expert Panel and will present their second set of recommendations on June 6, 2007. The literature review for ranking the evidence is completed except in cases where additional evidence is sought. The Public Reporting group is reviewing measurements that are based on good science, compatible with existing measurements and fall within hospital capability. Science and evidence are the priority criteria. The Program Design group is examining the issues related to the impact of public reporting on infection control programs and vaccinations for healthcare workers. The Leadership Group met with the information technology vendor, Strategic Solutions Group (SSG), to establish the parameters of the electronic data portion of the project and will update the Expert Panel in June on their progress. Relevant data from the Hospital Survey is being used by each of the task groups.

As discussions continue and decisions are made, the groups may conduct additional literature reviews to ensure that the most current practices are captured. The Public Reporting and Program Design groups continue to develop frameworks for measuring and reporting HAIs. The Public Reporting and Communication Task Group have drafted "plain language" explanations for HAI terms appropriate for readers with various levels of literacy. The hospital survey has provided guidance on current reporting of outcome and process measures and infrastructure for data collection, prevention, surveillance, screening and staffing. The VAP group is working to standardize definitions. MRSA is focusing on surveillance. BSI/SSI is looking at the complexity of relevant infections. As the groups formulate more of their recommendations, they will consider hospital capacity for data collection and reporting and measures recommended by national groups studying the same issues. Meetings with hospital CEOs are being conducted and discussions are beginning on the best way to disseminate findings and educate hospital professionals on best processes.

Section 8 Insurance Market Update

Merger of Nongroup and Small Group Insurance Markets

Small Group and Nongroup Regulations
Revisions to the nongroup health insurance regulations, 211 CMR 41.00, and the small group health insurance regulations, 211 CMR 66.00 were published in the Massachusetts Register on April 20, 2007.

Communications
The Division of Insurance posted open enrollment information and revised product information related to the merger of the two markets on the Division website for the start of the open enrollment period which runs from May 1, 2007 through July 31, 2007. The Division is developing communications related to the open enrollment and product information to be distributed to certain targeted audiences by the end of June.

Young Adult Health Benefit Plan

Young Adult Health Benefit Plan Regulations
The Division of Insurance published the Young Adult Health Benefit Plan Regulations, 211 CMR 63.00, as emergency regulations on April 7, 2007. A hearing was held on May 30, 2007. The DOI is currently working with the Connector to determine the best way to respond to the issues raised in the testimony from the hearing.

Health Carrier Requirements

Nondiscrimination
The Division of Insurance issued a Bulletin on April 6, 2007 that provides clarification of the statutory provisions requiring that carriers contract to sell health insurance plans only if employers 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. In addition to other clarifications, the Bulletin provided definitions for full-time, temporary and seasonal employees that were intended to be consistent with the definitions used by the Division of Health Care Finance and Policy and by the Connector in their respective regulations related to Health Care Reform.

Health Access Bureau

The Division of Insurance developed job descriptions and posted positions for an actuary and a research analyst within the newly formed Health Access Bureau. The Division is also developing a job description for a financial analyst for the Health Access Bureau. To complete some of the duties required by the Health

Access Bureau prior to filling the internal positions, the Division has contracted with outside actuaries to develop targeted reports.

Section 9: Updates on Employer Provisions

Several aspects of Chapter 58 related to employers have also seen progress during the past few months.

Division of Health Care Finance and Policy

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 2006, 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 has held a public hearing on its proposed regulations governing the administration and collection of the Employer 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 implemented 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 has begun the regulatory approval process and will shortly issue a new regulation in order to adopt the regulation to be effective July 1, 2007. The revised regulation will reflect the amended 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 of the regulation will be 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 implemented 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 has begun the regulatory approval process and will shortly issue a new regulation in order that the regulation be effective July 1, 2007. The 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.

Division of Unemployment Assistance in the Department of Workforce Development (DUA)

The first annual reporting period for determining employer liability for the Fair Share Contribution (FSC) will begin on October 1 for the first 12-month base year ending on September 30, 2007. DUA received funding to proceed with FSC program and system development in a supplemental budget in February 2007. Collaborative Consulting, the vendor working with DUA to build the Automated Collection System for Fair Share Contribution reporting and payment, has completed the documentation of the Business Requirements. System development and programming has begun.

DUA has agreed to accommodate the request of EOHHS' Division of Health Care Finance and Policy to incorporate the employer-mandated Health Insurance

Responsibility Disclosure (HIRD) report into DUA's FSC on-line filing application, offering "one-stop" reporting for both employer mandates.

DUA is planning to conduct a "pilot test run" of the Employer Self-Service web portion of the new system in mid-July, to serve as a vehicle to try out the new application with actual employer filings prior to the October 1, 2007 start of the annual filing period (which runs through November 15). This will also give employers an opportunity to provide feedback about the filing requirements and the filing process prior to production cutover. Toward this end, DUA is working with Associated Industries of Massachusetts and Smaller Business Association of New England to recruit employers willing to participate in this pilot test run.

DUA's draft regulations were advertised in major newspapers in April and published in the MA Register. A public hearing was conducted on May 24, and the comment period ended on that date. DUA is reviewing comments will finalize the regulations before the end of July 2007.