

overview: full speed ahead on reform

In Massachusetts, health care reform continued to be a key focus of regulatory activity during the second quarter of 2007.

With the individual-small group market merger approaching on July 1, the Health Connector board finalized related regulations covering minimum creditable coverage and affordability schedules. As marketing and operations intensified for the Commonwealth Choice (non-subsidized) products, the board turned its attention to finalizing requirements for Section 125 plans that will make these products more affordable. Employers with 11 or more full-time equivalent employees must file their plans by October 1. Meanwhile, membership in Commonwealth Care continues to grow. Under its final affordability regulations, the Health Connector board lowered the premium contributions for individuals in certain income brackets.

Several state agencies filled in the regulatory gaps. The Division of Insurance finalized its regulations overseeing rating requirements and procedural matters for the merged market, as well as its emergency regulations for young adult plans. The Division of Health Care Finance & Policy gave its final blessing to free rider surcharge and HIRD form regulations and drafted new rules for the operation of the pending Health Safety Net Trust Fund.

Aside from health care reform, state lawmakers passed bills that would allow municipalities to enroll members in GIC plans and that would add consumer protection to the release of personal information. Gov. Patrick recently signed both bills into law. The budget bill was passed and signed by the governor with little impact on health care issues.

In the U.S. Congress, a battle is waging over a proposal to reduce Medicare Advantage funding and shift the savings towards expansion of the State Children's Health Insurance Program, which would expire September 30. Meanwhile, CMS has set the timeline for 2008 Medicare Advantage marketing and enrollment.

in this issue ...

health care reform update—

■ [connector board adopts final regulations](#)

In June, the Health Connector board finalized regulations for minimum creditable coverage, affordability and Section 125 plans.

■ [connector offers section 125 guidance](#)

Administrative Bulletin provides guidance on employee exclusion and postpones filing until October 1.

■ [commonwealth choice hits market july 1](#)

Thousands sign up for individual coverage.

■ [commonwealth care contracts extended](#)

Existing carrier contracts expanded until June 30, 2008. Membership grows to 92,000.

■ [connector outreach to employers](#)

FAQ published to guide businesses through health care reform.

- [more change to come?](#)
Changes urged for employer contribution and employee participation requirements.
- [connector looks at prescription drug issue](#)
Proposals floated to mandate generic drugs and increase deductibles.
- [comings and goings on the board](#)
Bruce Butler steps down, other positions shift.

stateside—

- [state regulatory activity](#)
Division of Insurance regulations concerning July 1 market changes moved through the approval process during the second quarter. DOI also proposes a study of cost drivers. The **Division of Health Care Finance & Policy** finalized its regulations covering the free rider surcharge and HIRD forms. DHCFP also recently issued draft regulations to govern the operation of the Health Safety Net Trust Fund. ... and more.
- [state legislative activity](#)
Two new laws allow municipalities to enroll their members in the GIC health plans and create consumer-protection standards for the release of individuals' personal information.

the feds—

- [medicare](#)
CMS outlines rate and marketing timelines for 2008 Medicare Advantage plans.
- [federal legislative activity](#)
The U.S. Congress is debating future funding for both Medicare Advantage and the State Children's Health Insurance Program. Will Medicare Advantage cuts be used to fund SCHIP?

coming soon—

- [what's next?](#)

health care reform update—

■ health connector board adopts final regulations

The Commonwealth Health Insurance Connector Authority acted on draft regulations it had issued during the first quarter on three subjects: (1) requirements for **Section 125 plans**; (2) the definition of **minimum creditable coverage** for purposes of the individual mandate; and (3) **affordability and premium schedules** that will be used to evaluate requests for individual waivers from the requirement to buy health insurance.

Public hearings were held in May, and the Health Connector board finalized all three regulations in June.

In their final form, none of these regulations changed substantially from its earlier draft, although numerous minor edits were made as the result of testimony received at the public hearings. As originally drafted, more stringent requirements for minimum creditable coverage kick in on January 1, 2009. Under the affordability regulations, the Health Connector has estimated that approximately 60,000 residents will qualify for an automatic waiver, and others are likely to be granted waivers based on individual circumstances.

■ health connector offers section 125 guidance

To provide guidance on some of the administrative requirements and restrictions that apply to Section 125 plans, the Health Connector issued [Administrative Bulletin 02-07](#) on June 29, 2007. The bulletin particularly clarifies which employees can be excluded from Section 125 plan eligibility and also postpones the filing deadline until October 1, 2007.

Fallon Community Health Plan has partnered with Benefit Strategies, LLC, to provide free services to help its eligible employer groups meet their Section 125 plan needs. For information, call 1-800-333-2535.

■ commonwealth choice hits market july 1

During the second quarter, the Health Connector worked with health plan staffs to roll out the new Commonwealth Choice merged-market plans, effective for July 1, 2007. These plans, which unlike Commonwealth Care are not subsidized, may be sold either to individuals or small groups.

Currently, group plans are available through the Health Connector only to employers making no contribution towards their employees' coverage; Commonwealth Choice plans are expected to become available to contributing employers in late 2007 or early 2008.

As of mid July, more than 2,500 individuals purchased plans directly through the Health Connector's Commonwealth Choice program. Another 12,500 people enrolled in insurance plans through their employers or directly with insurance carriers.

Fallon Community Health Plan is one of six health insurance carriers participating in Commonwealth Choice through the Health Connector. FCHP also is offering a wider variety of affordable health plans to this market directly and through its brokers and intermediaries. Interested individuals should call 1-888-PWR-FCHP (TDD/TTY: 1-877-608-7677).

■ commonwealth care contracts extended

Membership in the subsidized **Commonwealth Care** plans, first rolled out in late 2006, continues to grow. Approximately 92,000 individuals are now enrolled. FCHP continues to be one of four health insurance carriers participating in the program. For information about FCHP Commonwealth Care plans, interested individuals should call 1-888-PWR-FCHP (TDD/TTY: 1-877-608-7677).

When adopting affordability regulations, the Health Connector board eliminated premium contributions as of July 1, 2007, for Commonwealth Care enrollees with income levels between 100% and 150% of the poverty level, and made downward adjustments for some individuals above 150% of the FPL. (Individuals below 100% already had no premium contribution.)

On May 31, 2007, the Health Connector issued [Administrative Bulletin 01-07](#) to clarify procedures related to eligibility, enrollment, waivers and appeals for the Commonwealth Care program.

contracts extended and renewal date changed

The Health Connector announced plans to extend current carrier contracts for an additional six months, through June 30, 2008. A full re-contracting process (for the period commencing July 1, 2008) will be introduced this fall. The Health Connector originally planned to re-contract over the summer for a January 1, 2008, effective date. The shift to a July 1 renewal target synchronizes Commonwealth Care with the renewal cycle for Commonwealth Choice and with the state's fiscal year.

■ health connector outreach to employers

The Health Connector issued on June 22 its own FAQ piece, called [Health Care Reform Answers for Massachusetts Businesses](#). It noted, "Massachusetts businesses have a significant role to play in the implementation of the state's landmark health care reform law. Here are some frequently asked questions and answers to guide businesses through the process." The questions cover fair share contribution, Section 125 plans, HIRD forms and more.

■ more change to come?

Movement is currently afoot in the state legislature to modify the health care reform law. More than 75 senators and representatives are sponsoring a bill proposing changes ([S.661](#) and [H.1166](#)). At a hearing of the Joint Committee on Health Care Financing in mid July, dozens of advocates, providers, patients and self-employed individuals asked for alterations to what they see as controversial aspects of the law.

Two key areas of controversy are:

- How much employers should contribute to health insurance to avoid penalty under the "fair and reasonable" definition—many would like to see it increase from the 33% currently mandated to at least 50% of premium costs, and employee participation rise from 25% to 50%.
- How much individuals should have to pay for coverage—many propose it should be no more than 10% of income.

Committee co-chairman Sen. Richard T. Moore said that, before proceeding, he wants more information on the financial impact of proposed changes and to review a pending report from the state's inspector general on the law's implementation.

■ health connector looks at prescription drug issue

At its July 12 meeting, the Health Connector began to explore ways to make more affordable the prescription coverage it is requiring by January 1, 2009.

Staff members, with the help of pharmacy consultants, proposed a plan that would add a minimum amount to monthly premiums by mandating the use of generic drugs whenever possible. The plan also proposes deductibles in the range of \$500 to \$1,000 and sizeable copayments for most brand-name drugs. The current standards permit a maximum upfront deductible for prescription drugs of \$250 for individuals and \$500 for families.

To date, 33% of people who have enrolled in Commonwealth Choice plans have chosen plans with no drug coverage.

The Health Connector board postponed a vote in order to gather further information.

■ comings and goings on the board

The Health Connector board has undergone a transition in membership during the past few months:

- The board is currently one member short of full membership, as actuary **Bruce Butler recently stepped down**, citing conflicts of interest with his private consulting business. Gov. Patrick has yet to appoint his replacement. The board term of Rick Lord, also a gubernatorial appointment, expired on July 1, 2007, but **the governor re-appointed Lord** to a new three-year term.
- The term of **Charles “Chip” Joffe-Halpern** (whose slot is an Attorney General’s appointment) also expired on July 1, 2007. Joffe-Halpern stayed on for the July board meeting, but in early August Attorney General Martha Coakley announced that **he will be replaced by Nancy Turnbull**. A lecturer and dean at the Harvard School of Public Health, Turnbull has extensive experience working in health care and health insurance, including stints serving as president of the Blue Cross Blue Shield Foundation and as deputy commissioner at the DOI.
- JudyAnn Bigby, Secretary of the Executive Office of Health & Human Services, recently announced that **Tom Dehner has been named to the post of Medicaid Director**—one of four state government positions whose occupants hold a **permanent seat on the Health Connector board**. Dehner had been serving as acting Medicaid Director (and thus serving on the board) since the resignation of Romney-administration appointee Beth Waldman in January.

stateside—

■ dehner given nod as medicaid director

As noted above, Tom Dehner, who has been serving as interim director since January, has been named Medicaid Director. Previously, Dehner served as Deputy Medicaid Director and was responsible for managing MassHealth’s operational and clinical work, including the MassHealth Operations Unit. In 2003-2004, Dehner was Chief of Staff for the Commonwealth’s Division of Medical Assistance.

In announcing his appointment, Secretary Bigby said, “Tom Dehner’s extensive knowledge about and experience with Medicaid will ensure that MassHealth delivers quality services to a diverse range of people in Massachusetts. As Medicaid Director, he will play a critical role in the implementation of health care reform.”

■ state regulatory activity

- Division of Insurance regulations concerning July 1 market changes moved through the approval process during the second quarter.

In April, the DOI finalized regulations governing plans sold in the merged individual/small group market. The regulations govern the form and content of rate and policy form filings, review and hearing procedures for closed individual health plans and closed guaranteed-issue health plans ([211 CMR 41.00](#)) and establish new rating requirements for products to be offered to eligible individuals and eligible small groups in the new merged market ([211 CMR 66.00](#)).

In July, the DOI finalized without fanfare its [regulations](#) governing **young adult plans**, which it had issued on April 17 as emergency regulations (211 CMR 63.00)—as such, they were effective immediately, but subject to change pending a public hearing.

- The Division of Insurance recently announced plans to conduct a **major study of the trends that drove health insurance rate increases from 2002 to 2006**. The DOI has hired a consultant to perform the study, for which all licensed HMOs will be required to submit information. This project is being conducted under the authority of a section of the health care reform law that created a “Health Care Access Bureau” within the DOI. The Bureau is charged with

disseminating information to consumers relative to health insurance coverage and, specifically, access to affordable insurance products.

- In June, the **Division of Health Care Finance & Policy** reissued its regulations covering the [free rider surcharge](#) and the [HIRD forms](#) that it had released and then withdrawn early in the year. The HIRD forms will be used for data reporting to enforce both the fair share assessment and free rider surcharge. The DHCFP issued both regulations on an emergency basis, which makes them effective immediately but subject to change pending a public hearing. The hearings are scheduled for September 5 (HIRD) and September 6 (employer surcharge), both at 10 a.m. at 2 Boylston St., Boston.

Most of the revisions made to the original regulations standardize them with related regulations issued by the Health Connector and other agencies. Further guidance issued by DHCFP indicates that **the employer HIRD filing is planned as an electronic filing**, which will go to the Division of Unemployment Assistance as part of the employer's fair share contribution worksheet, and won't be due until November 15.

- **DHCFP** also recently issued [draft regulations](#) (114.6 CMR [13.00](#) and [14.00](#)) to govern the operation of the **Health Safety Net Trust Fund**, which will replace the current Uncompensated Care Pool on October 1, 2007, as the funding source for free care in Massachusetts. The proposed regulations aim to find a balance between encouraging people to get insurance and providing a safety net for those who may have no, or inadequate, coverage. According to the division, the proposed regulations define eligibility criteria for reimbursable services; the scope of health services eligible for reimbursement; standards for medical hardship; and standards for reasonable efforts to collect payments for the costs of emergency care. The proposed regulations are scheduled for a public hearing on August 22.
- **The Health Care Quality & Cost Council** recently issued **draft regulations concerning the annual collection of data from health insurers**. The Council will use this data to establish a consumer health information Web site and undertake other projects to improve the availability of information related to cost and quality in health care.

According to the [draft regulations](#) (129 CMR 1.00), the first submission would be due in December. Along with the DOI study noted above, this represents a second new major data request for health plans over the second half of 2007. A public hearing on the regulations was held August 7.

This marks the first significant undertaking of the Council, a new agency created by the health care reform law.

■ **state legislative activity**

- In early July, the legislature submitted to Gov. Patrick its **budget bill** for the fiscal year beginning July 1. The governor signed the bill on July 12, after exercising his line-item veto authority to cut specific funding and to reject a few sections outright. Analysis of the final budget is ongoing, but there were relatively few contentious issues during the budget process involving health care or health insurance.
- Gov. Patrick recently signed into law two bills that will affect health insurers. [The Act to Reduce the Reliance on Property Taxes Through Municipal Health Care](#) allows municipalities to enroll their members in the Group Insurance Commission's (state employees) health plans rather than procure their own health insurance. The [Act Relative to Security Freezes and Notification of Data Breaches](#) would create consumer-protection standards around the release of individuals' personal information. While drafted in reaction to the TJX data breach incident and directed primarily at the financial services industry, this law also affects health insurers.

the feds—

■ **medicare**

- The 2008 Call Letter from the Centers for Medicare & Medicaid Services indicates that CMS will finalize premium rates and contracts for **Medicare Advantage plans** in late August. Medicare Advantage plans may begin 2008 marketing on October 1, 2007, and may begin accepting enrollments on November 15, 2007, for a January 1, 2008 effective date. Fallon Community Health Plan submitted its annual bids to CMS in June for 2008 Fallon Senior Plan™ HMO, Fallon Senior Plan PPO and Summit ElderCareSM plan offerings.

■ **federal legislative activity**

- The U.S. Congress is currently debating future **funding for both Medicare Advantage and the State Children's Health Insurance Program** (a subsidized program for children that is administered as part of the MassHealth program in Massachusetts).

There is significant support in Congress for expanding the SCHIP program. Some lawmakers feel that the Medicare Advantage program is over-funded in some respects, and they see savings from Medicare Advantage cuts as a source of increased funding for SCHIP. Others argue that the two programs should not be pitted against each other, a viewpoint advocated by the America's Health Insurance Plans.

On August 1 and 2, the U.S. House and Senate respectively approved SCHIP-related legislation, called **Kids Come First Act of 2007** (H.R.1111 and S.95). Representatives approved a \$50 billion increase financed by higher tobacco taxes and cuts in payments to private insurers in the Medicare Advantage program. The Senate version provides an extra \$35 billion to the SCHIP program by raising taxes on tobacco products (e.g., 61 cents more on a pack of cigarettes).

The Bush administration opposes both cutting Medicare Advantage and expanding SCHIP. President Bush instead has proposed adding \$5 billion over five years to the current \$25 billion funding level for SCHIP. He has threatened to veto the proposed legislation, which he sees as a step toward nationalized health care. (He advocates using tax breaks to make health care more affordable.)

The next step is for Congress to hammer out a compromise bill both chambers can agree on. Congress currently is on its summer break until September 4. The SCHIP program will expire September 30, 2007, if Congress and the White House can't agree on terms for continuing it.

coming soon—

- **Fall:**
 - Re-contracting process introduced for Commonwealth Care carriers for July 1, 2008.
 - Inspector General releases report on implementation of health care reform law.
- **October 1:**
 - Health Safety Net Trust Fund replaces Uncompensated Care Pool.
 - Deadline for employers to file Section 125 plans.
 - Marketing may begin for Medicare Advantage plans.
- **To be determined:**
 - Final regulations from DUA covering fair share assessment.

for more information

For details on health care reform and FCHP products, turn to our Web site, www.fchp.org, and click on our home page link. And be sure to ask your sales executive or account manager for a copy of FCHP's brochure, *Get in the Know: Health Care Reform and Your Business*.

Eye on Government is published quarterly to help FCHP brokers and employers keep up with the latest developments related to the state and federal governments' oversight of health care. Please e-mail your questions or comments to either broker.services@fchp.org or Employer.Edge@fchp.org, or call your sales executive or account manager at 1-800-333-2535.