Massachusetts Health Reform of 2006

August 2007

Where Did the State's Coverage Expansion Efforts Start?

Massachusetts has a long history of health reform efforts, which culminated in legislation that was passed in 2006. Since 1988, state lawmakers have pushed for expanded coverage through public programs, greater employer participation, and safety net programs for the uninsured and underinsured.

Before embarking on this most recent sweeping reform, Massachusetts had taken incremental steps to create a robust safety net of public programs for low- and moderate-income residents. In 1985, Massachusetts established the **Uncompensated Care Pool** to reimburse hospitals and community health centers for care provided to uninsured and underinsured individuals with incomes below 200 percent of the federal poverty level ($20,420 for an individual in 2007). In 1995, the state obtained a Medicaid waiver that provided federal funding for the Uncompensated Care Pool and created **MassHealth**, an expanded Medicaid program that covers children, parents, and childless adults. Today, MassHealth is the state's combined Medicaid and SCHIP program.

Under the 1995 Medicaid waiver, Massachusetts created **MassHealth Essential**, which covers non-disabled, unemployed, childless adults with incomes below the poverty level ($10,210 for an individual in 2007). The MassHealth Essential benefit package is somewhat more limited than the benefits that are offered to other Medicaid enrollees (see "What Benefits Do People Receive?" on page 6). The state implemented MassHealth Essential in 1997, but in 2004, it halted enrollment due to an enrollment cap.

The 1995 waiver also allowed the state to implement **MassHealth Family Assistance**, which provides coverage for children with family incomes up to 200 percent of poverty ($34,340 a year for a family of three in 2007). The program also provides premium assistance for some low-income, working parents.

The 2006 reform built on Massachusetts' expanded public programs and its highly regulated insurance market. The state's small group and individual insurance markets were already subject to rate regulations that were designed to bring down premiums and provide greater access to health coverage.

Thanks in part to these earlier efforts, Massachusetts had fewer uninsured people than most other states: According to Health Care for All Massachusetts, the state had approximately 500,000 uninsured people in 2005. Massachusetts is among the 14 states with the lowest percentage of uninsured residents.[1]

The Massachusetts Health Reform of 2006 covered more people through MassHealth by expanding eligibility for MassHealth Essential and MassHealth Family Assistance. The reform also created two new programs to provide Bay Staters with affordable, comprehensive coverage: The **Commonwealth Care** Health Insurance Program provides subsidized private coverage for adults, and the **Commonwealth Choice** Insurance Program provides affordable private coverage for individuals, families, and small businesses.

One distinctive feature of the 2006 reform is the Commonwealth Health Insurance Connector Authority, also known as the Connector. The Connector is responsible for overseeing the implementation of the Health Reform law, making significant policy decisions, and helping people obtain coverage through the Commonwealth Care and Commonwealth Choice programs. The agency is directed by a board that includes representatives of business, labor, and consumers.

Who Is Eligible for the Coverage Expansions?

The Massachusetts Health Reform of 2006 aims for universal coverage. Everyone in the state is required to obtain health insurance if affordable coverage is available.

Expansion of Public Programs

The new law starts by expanding MassHealth.

The 2006 reform increased the enrollment cap on MassHealth Essential, allowing more eligible childless adults to enroll. To be eligible for MassHealth Essential, childless adults must meet the following criteria: (1) they must have been unemployed or underemployed for more than one year; (2) their income must be below the poverty level ($10,210 for an individual in 2007); (3) they cannot be eligible for unemployment compensation; (4) if they have a spouse, the spouse cannot work more than 100 hours per month; and (5) they must be citizens or qualified immigrants.[2]

The 2006 reform also increased the income eligibility limit for MassHealth Family Assistance. Children with family incomes up to 300 percent of poverty ($51,510 for a family of three in 2007) are now eligible for the program.

As of April 2007, MassHealth had 1,077,000 enrollees, an increase of 44,000 since April 2006.

Creating Affordable Private Coverage

The 2006 reform introduced two new programs, Commonwealth Care and Commonwealth Choice, for Massachusetts residents who do not qualify for MassHealth and who do not have employer-sponsored insurance. The Connector administers both programs by contracting with private plans to provide coverage.

1. The **Commonwealth Care** Health Insurance Program provides subsidized private coverage to adults who:
   - Do not qualify for any of the MassHealth programs;
   - Have an annual family income below 300 percent of poverty ($51,510 for a family of three in 2007);
   - Are citizens or documented immigrants (including those who are not eligible for Medicaid because they have not been U.S. residents for longer than five years—undocumented immigrants do not qualify);
   - Have not had employer-sponsored insurance within the past six months (through their own employment or a family member's) that covered at least 20 percent of the annual premium for individual coverage or at least 33 percent of the annual premium for family coverage; and
   - Are age 19 or older.

   Enrollment in Commonwealth Care was opened in two stages: In October 2006, enrollment was opened for people with incomes below 100 percent of poverty who did not qualify for MassHealth because they had not been unemployed for a year or more. In January 2007, enrollment was opened for people with incomes below 300 percent of poverty. As of July 2007, 93,000 people were enrolled.[3] The Commonwealth Care Health Insurance Program projects that it will enroll 150,000 to 200,000 uninsured people by 2009.

2. The **Commonwealth Choice** Insurance Program provides private coverage to individuals, families, and small businesses. The state does not subsidize premiums for Commonwealth Choice plans.

   Individuals who are not eligible for either MassHealth or Commonwealth Care can enroll themselves and their dependents in Commonwealth Choice. To enroll, individuals must be residents of Massachusetts or employees of a Massachusetts-based company.

   Small businesses can obtain private coverage for their employees through Commonwealth Choice if they have between one and 50 employees.

   Commonwealth Choice enrollment began on May 1, 2007 for coverage that started on July 1, 2007.

How Much Do People Pay for Coverage?

MassHealth Essential

Currently, people enrolled in MassHealth Essential are not charged premiums. Enrollees do pay copayments for prescription drugs: $1 for generic drugs and $3 for brand-name drugs.

Children in MassHealth Family Assistance

Families pay monthly premiums for children enrolled in MassHealth Family Assistance based on family income. Currently, the premiums are as follows:

- Caretakers of children with family incomes between 150 and 200 percent of poverty (between $25,755 and $34,340 for a family of three in 2007) pay a monthly premium of $12 for each child, with a family maximum of $84.
- Caretakers of children with family incomes between 200 and 300 percent of poverty (between $34,340 and $51,510 for a family of three in 2007) pay $20-$28 per child, with a family maximum of $84.
- Premiums are waived for children if the adults in the family are enrolled in Commonwealth Care.

There are no copayments for children enrolled in MassHealth Family Assistance.[4]

Commonwealth Care

In the fall of 2006, the Connector Board established premiums and cost-sharing for people with incomes below 300 percent of poverty who were enrolled in Commonwealth Care. In April 2007, as part of a larger discussion of affordability, the board revised its previous decision and further reduced premiums for low-income people.

Adults who qualify for subsidies through Commonwealth Care have the following out-of-pocket costs:

- Adults with annual incomes below 150 percent of poverty ($15,315 for an individual in 2007) pay no premiums and have no deductible. Adults with incomes below the poverty level ($10,210 for an individual in 2007) pay no copayments and adults with incomes between 100 and 150 percent of poverty ($10,210-$15,315 for an individual in 2007) pay copayments for some services. For example, these individuals pay $5 for doctor's office visits, $50 for inpatient hospital stays, $5 for generic drugs, and up to $30 for brand-name drugs.
- Adults with incomes between 150 and 300 percent of poverty ($15,315-$30,630 for an individual in 2007) pay premiums on a sliding scale, currently between $35 and $105 per month. They must also pay higher copayments for services. For example, these individuals pay $10 for doctor's office visits and $250 for inpatient hospital stays.
- People with incomes between 200 and 300 percent of poverty ($20,420-$30,630 for an individual in 2007) may choose between Commonwealth Care plans based on financial criteria: some plans charge lower monthly premiums and higher cost-sharing, and others charge higher monthly premiums and lower cost-sharing.

Commonwealth Choice

Beginning in December 2006, the Connector Board accepted and considered bids from private insurers that wanted to offer unsubsidized coverage in Commonwealth Choice. Insurers were required to submit plans with three different levels of cost-sharing, as well as a special low-cost plan to cover young adults. All plans had to have benefit packages that met state-established standards.[5] The governor and Connector Board pushed the insurers to come up with lower premiums than the premiums in their initial bids before they eventually selected six insurers to provide plans.

The Commonwealth Choice plans are administered by the Connector. Three packages are available: Bronze, Silver, and Gold. All three packages offer the same benefits, but they vary in terms of premiums and cost-sharing.

- **Bronze** plans charge the lowest premiums but have the highest deductibles and copayments. **Silver** plans have moderate premiums, low (or no) deductible, and moderate copayments. **Gold** plans charge the highest premiums, have no deductible, and the lowest copayments.
- Enrollee premiums vary depending on the plan selected and the enrollee's age, location, and number of dependents.

    Example: In 2007, for a 37-year-old (the average age of the uninsured in Massachusetts) individual who purchases health coverage through the Connector, premiums will range from $175 to $288 per month.

- The Connector Board and participating insurers will negotiate "reasonable" premium schedules annually.
- Deductibles are capped at $2,000 for an individual and $4,000 for a family.

Young adults aged 19-26 without employer-sponsored insurance have special plan offerings through the Connector. These plans, known as Young Adult plans, are provided by the same six insurance companies as other Commonwealth Choice plans, but the benefit packages do not have to meet the same criteria. To attract young and healthy uninsured residents, the plans charge lower premiums than the Bronze, Silver, and Gold Commonwealth Choice plans. But most Young Adult plans have deductibles and charge somewhat higher cost-sharing, and some include annual benefit caps.

- Monthly premiums for Young Adult plans are between $105 and $205 depending on the insurance company and whether or not the plan includes drug coverage.
- Most of the plans have a $2,000 deductible.
- Some of the plans impose a cap on annual benefits (a maximum amount of money the insurer will pay for services, after which the enrollee must pay 100 percent of health care costs). Currently, no plan has an annual benefit maximum lower than $50,000. The Connector is expected to establish rules regarding the annual benefit maximum this year.

What Benefits Do People Receive?

MassHealth Benefits

As a result of the 2006 reform, children with family incomes up to 300 percent of poverty ($51,510 for a family of three in 2007) are now eligible for MassHealth Family Assistance. The benefit package for children in MassHealth Family Assistance includes:

- Emergency care;
- Inpatient hospital care;
- Outpatient physician services;
- Preventive care;
- Well-child visits and immunizations;
- Diagnostic services and laboratory work;
- Early intervention for developmental disabilities;
- Prescription drug coverage;
- Mental health services;
- Hearing and vision care;
- Dental services;
- Rehabilitative services;
- Home health care; and
- Medical equipment and supplies.

The 2006 reform also expanded coverage for childless adults in the MassHealth Essential program. Adults in this program receive a more limited benefit package than other MassHealth enrollees. MassHealth Essential benefits include:

- Inpatient hospital care;
- Outpatient physician services;
- Preventive care;
- Diagnostic services and laboratory work;
- Prescription drug coverage;
- Mental health and substance abuse treatment;
- Hearing and vision care;
- Dental services;
- Family planning;
- Rehabilitative services; and
- Medical equipment and supplies.

The reform also restored MassHealth's coverage of dental services, dentures, and eyeglasses for adults. These are all services that state Medicaid programs can cover under federal law, but they are not required to cover these services. Massachusetts had eliminated coverage of these services in previous years, but the state restored coverage in 2006.

Commonwealth Care Benefits

Parents and childless adults with incomes below 300 percent of poverty who do not qualify for MassHealth may enroll in subsidized private coverage through Commonwealth Care.

All Commonwealth Care plans must provide comprehensive benefits, including the following:

- Emergency care;
- Inpatient hospital care;
- Outpatient physician services;
- Preventive care;
- Diagnostic services and laboratory work;
- Prescription drug coverage;
- Mental health and substance abuse services;
- Vision care;
- Family planning;
- Rehabilitative services;
- Medical equipment and supplies; and
- Hospice care.

Dental benefits are included as part of Commonwealth Care coverage for adults with incomes below 100 percent of poverty ($10,210 for an individual).

Commonwealth Care plans also offer additional optional benefits, such as smoking cessation and weight loss programs, as well as management programs for asthma, diabetes, and other chronic conditions. For more information, see http://www.mass.gov/Qhic/docs/CCplanchart_030107.pdf.

For more information on benefits and cost-sharing in Commonwealth Care, see http://www.mass.gov/Qhic/docs/cc_benefits1220_pt234.pdf.

Commonwealth Choice Benefits

Individuals, families, and small businesses who purchase coverage through Commonwealth Choice receive comprehensive benefits. The Connector Board decided which benefits must be included in Commonwealth Choice coverage. Commonwealth Choice plans must provide all of the benefits mandated for licensed health insurers in Massachusetts, as well as the following:

- Emergency care;
- Hospitalization benefits;
- Outpatient services;
- Preventive and primary care;
- Rehabilitation services;
- Prescription drug coverage;
- Mental health and substance abuse services; and
- Vision care.

Commonwealth Choice also offers **Young Adult Plans**, which are available to individuals who are 19-26 years old. Young Adult Plans do not have to meet the same standards of coverage as other Commonwealth Choice plans. For example:

- Prescription drug coverage is optional.
- Insurers can impose annual benefit maximums as low as $50,000.

More information is available online at http://www.mass.gov/?pageID=hicutilities&L=1&sid=Qhic&U=may1.

Who Provides Coverage?

MassHealth

Children and adults enrolled in MassHealth receive care in a variety of ways. Depending on their eligibility category (that is, their income level, age, family status, etc.), they will either have their medical services paid for directly by the Office of Medicaid, receive care through a Medicaid managed care plan, or have their services managed by a primary care provider who may refer them to specialists who are directly paid by the Office of Medicaid. When it is cost-effective, MassHealth may provide premium assistance for eligible people enrolled in employer-sponsored plans rather than enrolling these individuals directly in MassHealth.

Commonwealth Care

For the first few years of the program, Commonwealth Care coverage will be provided exclusively through four managed care plans (the same four plans that contract with the state to cover some MassHealth enrollees).

Commonwealth Choice

In March 2007, the Connector Board used a competitive bidding process to select six private insurers to offer Commonwealth Choice coverage. As mentioned previously, the participating plans must cover all state-mandated benefits. Each insurer offers three levels of coverage—Bronze, Silver, and Gold—that vary in premiums, deductibles, and cost-sharing. They also offer special Young Adult plans.

What Incentives or Mandates Encourage Participation in This Program?

The Individual Mandate

The Massachusetts Health Reform of 2006 was the first state expansion to introduce an individual mandate, which required all residents over the age of 18 to obtain health insurance by July 1, 2007.

To encourage people to obtain coverage, the Massachusetts Department of Revenue will penalize people who do not comply. When residents file their state tax returns at the end of the year, those who have failed to obtain health insurance by the end of 2007 will lose their personal income tax exemption. The personal income tax exemption is about $217 for an individual or $437 for a family in 2007.

Starting in 2008, individuals who do not have health insurance will be required to pay a penalty for each month they are uninsured. The penalty will be equal to half of the premium for the lowest-priced health coverage available that meets the Connector Board's minimum standards.

Residents may be exempted from the individual mandate if they can demonstrate that, according to the Connector Board's affordability standards, they cannot afford insurance. If an individual cannot obtain coverage in his or her region for a price that is at or below the premium indicated by the affordability schedule, he or she will not be penalized for noncompliance with the individual mandate. Exemptions from the individual mandate will be granted to people in the following earning categories:

For individuals earning

- $30,631-$35,000 if the lowest available monthly premium exceeds $150;
- $35,001-$40,000 if the lowest premium exceeds $200; and
- $40,001-$50,000 if the lowest premium exceeds $300.

For couples earning

- $41,071-$50,000 if the lowest available monthly premium exceeds $270;
- $50,001-$60,000 if the lowest monthly premium exceeds $360; and
- $60,001-$80,000 if the lowest monthly premium exceeds $500.

For a family with one or more children

- $51,511-$70,000 if the lowest available monthly premium exceeds $320;
- $70,001-$90,000 if the lowest monthly premium exceeds $500; and
- $90,001-$110,000 if the lowest monthly premium exceeds $720.

Even if individuals should be able to find and buy insurance (according to the affordability standards), they are permitted to file a waiver for an exemption or appeal a penalty.

The Connector Board estimates that about one to two percent of the population—about 60,000 Massachusetts residents—could be exempted from the individual mandate because of the affordability standards. This means that 98-99 percent of people in the state will still have to comply with the mandate.[6] More information is available online at http://www.mahealthconnector.org/portal/site/connector/.

Defining What Counts as Adequate Coverage

The law requires people to obtain "minimum creditable coverage," or they will be penalized for noncompliance with the individual mandate. The Connector Board was charged with defining which services this coverage must include. The board defines such coverage as that provided by "comprehensive health plans that include preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services, mental health services and prescription drug coverage." The Connector Board also disallowed coverage that includes benefit caps, both caps on the amount of benefits covered in a year and caps on treatment for a specific condition. The board also set limits on deductibles and other out-of-pocket costs. However, representatives of businesses and health insurers protested, saying that many existing employer-sponsored and individually purchased plans did not meet the board's criteria, particularly with respect to drug coverage. As a result, the Connector Board decided to develop alternative minimum drug coverage requirements and put off enforcement of the minimum creditable coverage criteria until 2009.[7]

The Employer Assessment

The 2006 reform also requires employers to participate. Employers with more than 10 workers who do not contribute a "fair and reasonable" amount for employee health coverage will be required to pay the state a "Fair Share Contribution" of $295 per year for each full-time worker.

An employer is judged to be making a "fair and reasonable" contribution, and will be exempt from paying the assessment, if either

- 25 percent of the company's full-time employees are enrolled in the company's insurance plan, OR
- the employer contributes at least 33 percent toward employee premiums.

Employers with more than 10 full-time employees must also allow their employees to purchase health coverage on a pre-tax basis. Section 125 of the tax code allows employees to pay for health insurance this way, which results in tax savings of up to 48 percent off the cost of the premiums for employees.[8] As of July 1, 2007, employers that do not comply with this requirement and whose employees are found to be using the Uncompensated Care Pool must pay a "Free Rider Surcharge." The Division of Health Care Finance and Policy is responsible for determining the amount of the surcharge and for enforcing payment collections.

Employers with 10 or fewer full-time employees are exempt from these requirements.

How Is the Reform Financed?

In fiscal year 2007, a variety of sources provides funding for the Massachusetts reform:

- A 2005 Medicaid waiver allows the state to redirect funds from its Uncompensated Care Pool toward expanded coverage, bringing in $605 million.
- The state will receive about $154 million in federal matching funds for expanding its Medicaid and SCHIP programs.
- The existing assessment on hospitals and third-party payers[9] will generate a total of $320 million.
- The 2006 legislation provided the Connector with $25 million in funding to start, with the goal that it be financially self-sustaining by 2009. The Connector will generate revenue by charging the insurers in Commonwealth Care and Commonwealth Choice an administrative fee for each person the agency enrolls in the insurers' plans.
- Fair Share Contributions by employers that do not make a "fair and reasonable" contribution to employee health coverage are estimated to generate an additional $24 million.
- In addition to these sources, the state will use $300 million in general funds.

How Did the Reform Affect Insurance Regulations?

Massachusetts already had a highly regulated insurance market: The state's small group and individual insurance markets were subject to regulations that were designed to make coverage more accessible and affordable. These regulations include the following:

- Guaranteed issue of insurance, which means that insurers cannot deny coverage to people based on their health status; and
- Adjusted community rating, which prohibits insurers from raising premiums based on an individual's health or medical claims history.

The 2006 reform made a few advances on the state's existing regulations.

- On July 1, 2007, the state merged the small group and individual insurance markets in order to make coverage for individuals more affordable. Individuals who obtain insurance only for themselves often have above-average medical costs, whereas small groups share risk and attract people who have a full range of medical costs. Merging these markets pools risk and lowers premiums for those with individual coverage.
- Young adults aged 19-25 are now permitted to remain on their families' health plans for two years after they lose their dependent status.

What Other Major Provisions Did the Reform Include?

Other major provisions:

- The reform allocated $20 million for public health initiatives aimed at reducing diabetes, cancer, infections, smoking, and other health problems.
- It established a **Quality and Cost Council**. The council must set benchmarks for quality improvement and cost containment, collect data on health outcomes and health system spending from providers throughout the state's health care system, and publish its findings on its Web site.
- The reform also established a statewide **Racial and Ethnic Health Disparities Council** to track disparities data and create Pay for Performance benchmarks.

The achievement of universal coverage will depend heavily on successful outreach, enrollment, and marketing strategies. The Connector and other stakeholder groups are working together on an aggressive outreach campaign to enroll low- and moderate-income people in the state's subsidized programs (MassHealth and Commonwealth Care), educate employers and individuals about the requirements regarding their participation, and market affordable Commonwealth Choice products to people who are not eligible for subsidies.

- The legislation appropriated $3 million for grants to community-based organizations (CBOs) to identify people who are eligible for subsidized coverage and enroll them in MassHealth or Commonwealth Care.
- The Connector launched a Web site to provide consumer-friendly information about eligibility and benefits for Commonwealth Care (www.macommonwealthcare.com), as well as a Web site to help consumers shop for insurance that is available through Commonwealth Choice (www.mahealthconnector.org).
- In May 2007, the Connector began an advertising campaign to widely publicize the Commonwealth Care and Commonwealth Choice programs.

What Have Massachusetts Advocates Learned from the 2006 Reform Experience?

Massachusetts advocates who worked to pass the 2006 reform legislation, and who continue to work on its implementation, have the following lessons to share based on their experiences:

- **Massachusetts is not a blueprint for other state expansions.** The state started with a great deal of funding, uncommonly strong public programs for low-income people, and a highly regulated insurance market. Most states that are in the process of crafting a plan to expand coverage will have to include a significant expansion of public programs, as well as private market reforms.

- **However, Massachusetts can serve as a model for the kinds of political negotiations that may need to take place to move reform efforts forward.** For example:
  - The Democratic-controlled state legislature worked with Republican Governor Mitt Romney to reach many compromises that were necessary for the plan to become law.
  - The Connector Board, which is responsible for much of the implementation, is composed of members who represent diverse interests, including the business community, labor, insurance companies, and consumers.

  All stakeholders made compromises in order to reach a consensus and move the reforms forward.

- **Creating a strong coalition** of stakeholders to promote important goals and principles is key. Health Care for All Massachusetts spearheaded the Affordable Care Today (ACT!!) coalition–a group of advocates, health care providers, consumers, religious groups, labor unions, businesses, and community-based organizations. ACT!! worked during the legislative process, and continues to campaign, for its goals of creating a stronger MassHealth program; affordable coverage for moderate-income working families; improved provider reimbursement; a meaningful level for employer contribution; and sustainable funding for the health reform package.
- **Insurance reform** is a critical first step. It is not realistic to expect to subsidize coverage or require people to purchase insurance in a dysfunctional market.
- **It is important to begin with advocating for coverage** for low-income people to "fill the glass from the bottom," taking incremental steps from there.

For more information:

- Health Care for All (www.hcfama.org) has been involved in the reform effort since the beginning, and the group remains engaged in the debate around affordability, enforcement of the individual mandate, and outreach and enrollment issues. Their blog (http://blog.hcfama.org/) contains a great deal of information about the law and the process of implementation. More information about ACT!! is also available on the group's Web site (http://www.hcfama.org/act/about.asp).
- The Commonwealth Health Insurance Connector Authority (http://www.mass.gov/connector) has a central role in implementation.

Endnotes

[1] Kaiser State Health Facts Online estimates the number of uninsured in Massachusetts in 2005 to be approximately 647,000, or 12 percent. Nationally, 17 percent of residents are uninsured. Kaiser State Health Facts Online, "Massachusetts: Health Insurance Coverage of Non-elderly 0-64, states (2004-2005), U.S. (2005)," available online at http://www.statehealthfacts.org/cgi-bin/health-facts.cgi?action=profile&area=Massachusetts&category=Health+Coverage+%26+Uninsured&subcategory=Health+Insurance+Status&topic=Nonelderly+%280%2d64%29, accessed on June 8, 2007.

[2] The rules for qualified immigrants are the same as those that apply to federal Medicaid programs.

[3] Approximately 60,000 of the enrollees in Commonwealth Care were automatically enrolled because they were previously in the Uncompensated Care Pool. Alan Raymond, *The 2006 Massachusetts Health Reform Law: Progress and Challenges after One Year of Implementation* (Boston: Blue Cross Blue Shield of Massachusetts Foundation, May 2007).

[4] Children who receive premium assistance to enroll in an employer-sponsored plan are subject to the copayments required by the plan. However, the Department of Medical Assistance (DMA) will reimburse families for copayments spent on well-child care. Once a family has incurred out-of-pocket spending of more than 5 percent of family income, the DMA will pay all other out-of-pocket costs.

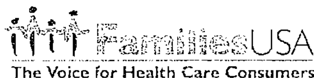
[5] Commonwealth Connector Final Regulations 5.00, "Commonwealth Health Insurance Connector Authority: Minimum Creditable Coverage," effective July 1, 2007, available online at http://www.mass.gov/Qhic/docs/956%20CMR%205.00%20Final%20060507.pdf.

[6] Alan Raymond, op cit.

[7] Ibid.

[8] Ibid.

[9] John McDonough, Brian Rosman, Fawn Phelps, and Melissa Shannon, "The Third Wave of Massachusetts Health Care Access Reform," *Health Affairs* 25, no. 6 (September 14, 2006): w420-w431.



1201 New York Avenue NW, Suite 1100 ■ Washington, DC 20005

Phone: 202-628-3030 ■ E-mail: info@familiesusa.org

www.familiesusa.org