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The Massachusetts Health Reform Plan: A Brief Overview

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Summary

In April 2006, Massachusetts passed legislation that aims to achieve near-universal health insurance coverage by expanding Medicaid and State Children's Health Insurance Program (SCHIP) eligibility, providing premium subsidies for certain individuals, and mandating the purchase of insurance for those who can afford it. To make private health insurance plans more affordable and accessible, it modifies state insurance laws (e.g., it merges the state's non-group and small group markets) and creates a public entity called the Connector to serve as a clearinghouse for the purchase of insurance by small employers and individuals who are not offered subsidized insurance by a large employer.

To pay for the legislation, the state will redirect some existing Medicaid funds that are used to reimburse health care providers (primarily hospitals) for treating uninsured and other patients who generate uncompensated care costs. It will also obtain additional federal Medicaid and SCHIP dollars using new state general fund appropriations and revenues from employers that do not offer health insurance. Another significant source of funding, while not necessarily flowing through state coffers, is the mandate that requires individuals to purchase insurance or face financial penalties. Over time, the state expects to redirect additional funds from uncompensated care reimbursement to other uses (e.g., premium subsidies) as its uninsured rate declines. However, the legislation continues to provide significant support for hospitals and other providers.

This report highlights major elements of the Massachusetts legislation and raises issues that Congress and other observers may consider as details of the state's health reform plan are worked out during implementation. It will not be updated.

Background

The state's low uninsured rate and its ability to redirect and augment existing financial resources were two key factors working in favor of the recently passed Massachusetts health reform legislation. Input and support from across the political spectrum also played an important role.

In terms of its uninsured population, Massachusetts has a lower percentage of uninsured residents than most states. According to data from the Census Bureau's Current Population Survey (CPS), 11.7% of Massachusetts residents were uninsured for all of 2004, compared to the national average of 15.7%.[1] Based on its own biennial survey, the state estimates an even lower uninsured figure.

Massachusetts spends about $2 billion annually in combined state and federal dollars to support health care providers (primarily hospitals) that treat uninsured and other patients who generate uncompensated care costs.[2] Much of this funding is provided through Medicaid, a joint federal-state program that finances health coverage for certain low-income individuals, as well as disproportionate share hospital (DSH) payments for hospitals that serve large numbers of low-income and Medicaid patients. Hoping to put existing funds to better use, the state obtained federal permission under its Medicaid waiver[3] to redirect approximately $1.3 billion in DSH and other Medicaid payments that largely benefit hospitals toward a plan to reduce its uninsured rate.[4]

The Massachusetts health reform legislation — whose details still must be approved by the federal government, as required under the state's Medicaid waiver — was more than a year in the making. With input from political leaders on both sides of the aisle, insurers, academics, businesses, hospitals, community organizations, and others, the legislation garnered widespread support. Whether or not this support will remain strong as details of the state's plan are worked out during implementation is an open question.

Highlights of the Legislation

Highlights of the Massachusetts legislation are presented below in terms of the impact on various stakeholders.[5] Although Governor Romney vetoed several of the provisions discussed here, they were preserved by the legislature through overrides. As mentioned earlier, there are varying estimates of the size of the uninsured population in Massachusetts. However, it has been widely reported that the state's health reform legislation assumes 550,000 uninsured residents, of whom 92,500 will obtain coverage

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[1] CRS Report 96-979, *Health Insurance: Uninsured by State, 2004*, by Chris L. Peterson.

[2] Providers may incur uncompensated costs when they provide free care to the uninsured, but also when they treat insured patients whose coverage excludes certain services or provides reimbursement below the actual cost of care (a frequent complaint about the Medicaid program). Because the state has a history of using complex financing mechanisms to obtain federal funds, not all of the $2 billion actually results in payments to providers. For more information, see Blue Cross Blue Shield of Massachusetts Foundation, *Roadmap to Coverage* (publications), available at [http://www.roadmaptocoverage.org/pubs/main.html].

[3] Section 1115 of the Social Security Act gives the Secretary of Health and Human Services the authority to waive certain statutory requirements of the Medicaid program (and others), thereby allowing states to operate their programs in ways not otherwise allowed under federal rules.

[4] See Massachusetts Medicaid Policy Institute, *The MassHealth Waiver* (Apr. 2005), available at [http://www.massmedicaid.org/pdfs/MassHealth_Waiver.pdf].

[5] Unless otherwise noted, sources include *Health Care Reform Conference Committee Bill* (presentation, Apr. 3, 2006), *Health Care Access and Affordability Conference Report* (summary and fact sheet), and Chapter 58 of the Acts of 2006, available at [http://www.mass.gov/legis].

through the state's MassHealth program, 207,500 will obtain subsidized private insurance through a new Commonwealth Care program, 215,000 will obtain private insurance as a result of the individual mandate, and 35,000 will remain uninsured.

Insurance Market. To make private health insurance plans more affordable and accessible, the legislation modifies state insurance laws and creates an independent public entity called the Commonwealth Health Insurance Connector to serve as a clearinghouse for the purchase of insurance. As of July 2007, the state will merge its non-group and small group (50 or fewer employees) health insurance markets. Prior to the merger, a special commission will examine the impact on premiums.[6] (In 2005, the median total monthly small group premium was $365 for an individual and $950 for a family in Massachusetts.[7]) There is a moratorium on the creation of new state-mandated health benefits until at least January 2008. To increase the range of high-deductible plans linked to health savings accounts (HSAs) with lower premiums that are available in the state, health maintenance organizations (HMOs) will be allowed to offer such plans. Insurers offering family policies will be required to cover children for two years after they lose dependent status or through age 25, whichever occurs first.

The Connector will facilitate access to private insurance plans for small employers and individuals who are not offered insurance by a large employer (one with more than 50 employees) that pays part of the premium. Plans will be offered through the Connector beginning in April 2007. These plans will have to meet the same requirements as other plans in the state, except that they may contract with selected providers (allowing plans to negotiate lower payment rates or steer individuals to quality providers) instead of "any willing provider" (allowing individuals with insurance to have more choices). The Connector will be the only source for specially designed, lower-cost plans for young adults (ages 19 through 26). The board of the Connector will establish and manage a system for collecting all premium payments made by or on behalf of individuals obtaining insurance through the Connector. Small employers that obtain insurance through the Connector must accept a binding agreement that specifies conditions of participation (e.g., the employer may only change its health plan eligibility criteria or contribution amounts during a time period designated by the Connector).

Individuals. The legislation aims to insure nearly all state residents through a combination of expanded Medicaid and State Children's Health Insurance Program (SCHIP) eligibility, premium subsidies, and an individual mandate. As of July 2006, children's eligibility for MassHealth, the state's public coverage program funded with Medicaid and SCHIP dollars, will increase from 200% of the federal poverty line (FPL) to 300%. (In 2006, 300% FPL is $49,800 for a family of three and $60,000 for a family of four.) Enrollment caps for certain disabled, HIV-positive, and unemployed adults will be raised. Benefits that were cut in 2002 (e.g., dental, vision) will be restored. Eligibility

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[6] The state estimates that non-group premiums will drop by 24%. Although a recent study found that merging the markets could increase small group premiums, it did not take all components of the final bill into account (e.g., an expanded risk pool as a result of the individual mandate). See Karen Bender and Beth Fritchen, *Impact of Several Proposed Changes in the Individual and Small Group Insurance Market* (Mercer Oliver Wyman, Dec. 15, 2005).

[7] Massachusetts Division of Health Care Finance and Policy, *Massachusetts HRSA State Planning Grant* (Oct. 2005), available at [http://www.statecoverage.net/statereports/ma50.pdf].

for the Insurance Partnership Program, a part of MassHealth that helps pay the employee share of premiums for individuals who work for a small employer that pays at least half of its employees' premium costs, will increase from 200% to 300% FPL.

As of October 2006, certain uninsured individuals with family incomes at or below 300% FPL ($29,400 for a single person) will be eligible to have premium assistance payments made on their behalf through a Commonwealth Care Health Insurance Program operated by the Connector. To qualify, individuals must neither be eligible for public coverage nor eligible (either directly or through a family member) in the past six months for insurance offered by an employer that pays at least 20% of the premium for family coverage or 33% for individual coverage. Program enrollees will face no deductibles. Those at or below 100% FPL ($9,800 for a single person) will receive full premium subsidies, and those between 100% and 300% FPL will receive subsidies on a sliding scale determined by the board of the Connector. Until June 2009, the state's four Medicaid managed care organizations are the only plans that may receive premium assistance payments from the program unless specific enrollment targets are not met.

As of July 2007, all adult residents of the state are required to have health insurance if it is deemed "affordable" at their income level under a schedule to be set by the board of the Connector. Individuals will report their insurance status on state income tax forms. Beginning with tax year 2007, those who do not have insurance and are not exempt from the mandate will lose their state income tax personal exemption. (The current state income tax rate is a flat 5.3%, with a personal exemption of $3,575 for singles and double that amount for married couples. If the personal exemption did not apply, the maximum increase in tax liability would be $189 for a single person and $379 for a couple. Some state or federal tax provisions could reduce this liability.) Beginning with tax year 2008, an additional penalty will be levied for each month an individual is without insurance, equal to 50% of the lowest premium for which he or she would have qualified. It will be collected through withholding of state income tax refunds. If no refund is due or the penalty exceeds the refund amount, the state will notify the taxpayer and may use existing state income tax enforcement and collection procedures to obtain the balance owed.

Employers. To help finance the legislation, some employers that do not offer insurance will pay fees to the state. If an employer with more than 10 employees does not offer a group health insurance plan to which it makes a fair and reasonable premium contribution (to be defined in regulation), it will pay a "fair share employer contribution" of no more than $295 per employee per year. If employees or their dependents incur $50,000 or more in free care costs paid by the state in any given year, a separate "free rider surcharge" of between 10% and 100% of the state's cost may be levied. The free rider surcharge will not apply to employers that offer to contribute toward or arrange for the purchase of health insurance (including through the Connector or the state's Insurance Partnership Program), are subject to a collective bargaining agreement that governs the employment conditions of an individual receiving free care, or have 10 or fewer employees. Employers with more than 10 employees also must adopt and maintain a "cafeteria plan" that allows health insurance premiums to be paid on a pre-tax basis.

Health Care Providers. Although the state expects to redirect additional funds from uncompensated care reimbursement to other uses (e.g., premium subsidies) as its uninsured rate declines, the legislation continues to provide significant support for hospitals and other providers. In each of FY2007-FY2009, $90 million will be used to

increase Medicaid payment rates for hospitals and physicians. Hospital rate increases after FY2007 will be contingent on adherence to quality standards and achievement of performance benchmarks. A new state health care quality and cost council will establish goals, develop performance benchmarks, and maintain a consumer health information website with cost and quality data (organized to the extent possible by facility, clinician, or physician group practice). Payment rates for two Medicaid managed care organizations affiliated with hospitals in Boston and Cambridge that treat large numbers of uninsured and other patients who generate uncompensated care costs will be maintained with $87 million in each of FY2007-FY2009. These hospitals and others in the state will continue to receive significant Medicaid payments (more than $1 billion in FY2007[8]) to cover uncompensated care costs.

State and Federal Budgets. To pay for the legislation, the state will redirect some existing Medicaid funds that are used to reimburse health care providers (primarily hospitals) for uncompensated care costs (e.g., the state will redirect $160 million to Commonwealth Care premium subsidies in FY2007). Massachusetts will also obtain additional federal Medicaid and SCHIP dollars (at least $144 million in FY2007) using new state general fund appropriations ($125 million) and revenues from employers that do not offer health insurance (at least $45 million).[9] Another significant source of funding, while not necessarily flowing through state coffers, will be insurance premiums paid by those who comply with the individual mandate and financial penalties paid by those who do not.

Issues to Consider

In any health insurance system, including the one that Massachusetts has planned for itself, there are two overarching tradeoffs. The first is between benefits and costs: more generous coverage entails higher costs, which must be borne by someone. The second is among participants who share the costs: insurers, providers, employers, families and individuals, government, and taxpayers. The Massachusetts legislation provides a framework for achieving near-universal health insurance coverage that attempts to balance these tradeoffs. It also leaves many important details to be worked out during implementation. The remainder of this report discusses some of the issues Massachusetts will face as it continues to address tradeoffs in its health reform plan.

Individual Affordability. Since many people will be required to purchase health insurance, a key question is how much premiums will cost. In 2005, the median total annual small group premium was $4,380 for an individual and $11,400 for a family in Massachusetts. For a single person making $29,400 per year (300% FPL), the median premium represents almost 15% of gross income. For a family of four making $60,000 (300% FPL), it represents 19%. (Premiums may represent a smaller percentage of income if they are paid on a pre-tax basis since the tax savings in effect reduce the cost.) If lower-cost health insurance plans are not available, some people could be exempted from the individual mandate under the Connector's affordability schedule. Others who purchase

[8] Massachusetts Executive Office of Health and Human Services, *CMS Waiver Submission Information*, available at [http://www.mass.gov/eohhs].

[9] Premium subsidy spending and Medicaid and employer revenues, ibid.

plans that offer lower premiums in exchange for high deductibles or other significant cost-sharing requirements may find it difficult to pay for care.

State Cost. Premium costs are also a concern for the state because it will be providing subsidies for individuals at or below 300% FPL via the Commonwealth Care program. Since it has an ongoing relationship with the Medicaid managed care organizations that have been given exclusive rights to the program's subsidies until June 2009, initial premium costs may not be a major issue. However, if more people qualify for subsidies than anticipated, or plan premiums are higher than expected, state costs could increase. As a safety valve, the legislation allows for a cap on Commonwealth Care enrollment. However, this could leave some individuals unable to afford insurance.

Another issue for the state is that its federal Medicaid funding is capped under its Medicaid waiver. If program costs surpass a fixed budget ceiling, the state must fund the excess with state-only dollars or cap enrollment. In recent waiver documents, the state estimates that its health reform legislation leaves approximately $12 million in "room" below its Medicaid budget ceiling over the next two years.

Subsidy Design. The design of sliding scale premium subsidies for the Commonwealth Care program will affect both individual affordability and state cost. Presumably, consideration will be given to how the subsidies interact with the affordability scale set by the board of the Connector. For example, if the board determines that an affordable policy for a single person at 200% FPL ($19,600) should cost no more than 10% of income, a subsidy might be set to equal the difference between 10% ($1,960) and the lowest premium available to the individual. If the gap between affordable and actual premiums is large, subsidy costs for the state could be high.

Employer Coverage. There are a number of provisions in the Massachusetts legislation that are designed to prevent employers from dropping coverage or offering different health plans to different workers, and to prevent individuals from dropping private coverage in favor of public. However, state officials have noted that "creative" behavior down the road may require additional policy changes to discourage erosion of the employer market.

Federal Perspective. As discussed earlier, although Massachusetts expects to obtain additional Medicaid dollars to help finance the legislation, federal funding will not exceed a cap agreed to under the state's Medicaid waiver. The state will also rely on SCHIP, another capped funding source. To date, the federal government has assisted Massachusetts and other states that have exhausted their federal SCHIP funds by redistributing unspent funds from other states and, more recently, providing an additional appropriation. A less straightforward federal (and state) "cost" of the Massachusetts legislation may come in the form of forgone tax revenue. Because employers will be required to set up cafeteria plans that allow health insurance premiums to be paid on a pre-tax basis, income and payroll tax receipts may be reduced.

Aside from the issue of financing, there are other ways in which federal legislation could have an impact on the state's health reform efforts. For example, bills such as S. 2510 and S. 1955, which contain reforms intended to improve access to health insurance for small businesses (e.g., new purchasing arrangements, federal standards for benefit coverage), might require the state to rethink major elements of its legislation.