CENTER for STUDYING HEALTH SYSTEM CHANGE

Issue Brief

Findings from HSC

NO. 113 • JULY 2007

MASSACHUSETTS HEALTH REFORM: EMPLOYERS, LOWER-WAGE WORKERS AND UNIVERSAL COVERAGE

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As Massachusetts' landmark effort to reach nearly universal health coverage unfolds, the state is now focusing on employers to take steps to increase coverage. All employers—except firms with fewer than 11 workers—face new requirements under the 2006 law, including establishing Section 125, or cafeteria, plans to allow workers to purchase insurance with pre-tax dollars and paying a $295 annual fee if they do not make a "fair and reasonable" contribution to the cost of workers' coverage. Through interviews with Massachusetts health care leaders (see Data Source), the Center for Studying Health System Change (HSC) examined how the law is likely to affect employer decisions to offer health insurance to workers and employee decisions to purchase coverage. Market observers believe many small firms may be unaware of specific requirements and that some could prove onerous. Moreover, the largest impact on small employers may come from the individual mandate for all residents to have a minimum level of health insurance. This mandate may add costs for firms if more workers take up coverage offers, seek more generous coverage or pressure employers to offer coverage. Despite reform of the individual and small group markets, including development of new insurance products, concerns remain about the affordability of coverage and the ability to stem rising health care costs.

An Individual Mandate Coupled with New Employer Requirements

Massachusetts' universal coverage reform legislation, signed into law April 12, 2006, requires most uninsured adult residents—more than 300,000 people or about 9 percent of the adult population by state estimates—to have health insurance coverage by July 1, 2007. Nearly three-quarters of the uninsured are employed—approximately two-thirds work more than 35 hours a week and approximately two-thirds work for small firms.[1]

The law covers the lowest income and most vulnerable adults with free or subsidized coverage through Medicaid expansions or the new Commonwealth Care program. Most of the remaining uninsured—those with incomes above 300 percent of the federal poverty level—or $30,630 for an individual and $61,950 for a family of four in 2007—must purchase insurance on their own or through their employer. Forty-four percent of the uninsured earn more than 300 percent of poverty.[2]

To help people obtain insurance, the law requires employers to take steps to increase coverage (see Table 1). Employers are required to set up Section 125, or cafeteria, plans to allow employees to purchase health insurance with pre-tax dollars, which can reduce employee premiums by an average of 41 percent.[3] Employers with 11 or more full-time-equivalent employees that do not meet this requirement may be subject to a "free-rider" surcharge if their employees' or dependents' care is paid for by the state's uncompensated care pool.[4] Market observers do not expect the creation of Section 125 plans to be particularly burdensome for most employers, and they generally expect employers to be able to meet the requirement and avoid the free-rider surcharge.

In addition, employers that do not offer a "fair and reasonable" contribution for their employees' coverage will be assessed up to $295 per worker per year. While this component of the reform has received much attention, market observers do not expect this fee to have much impact overall. Observers view the fee as a way to offset the cost shifting that occurs when employers that provide health coverage to their workers also contribute to the uncompensated care pool; they do not expect the fee to induce employers that do not currently

offer coverage to workers to begin doing so since insurance costs significantly more than the fee. Likewise, many believe the fee is not large enough to impose a substantial financial burden on employers. Yet, for an employer with mostly minimum wage workers—$7.50 an hour in Massachusetts—the fee equals almost 2 percent of payroll. Observers also noted that employers who do offer insurance to their workers likely already meet the fair and reasonable threshold and, therefore, would not be subject to the fee. Overall, the fee is expected to generate relatively little revenue to offset the reform's cost, raising concerns that the fee will increase over time.

The greatest pressure on employers to offer health insurance to their employees is expected to come largely through the individual mandate. Because state residents will face tax penalties for going without health insurance, observers predict that employers that do not offer coverage may become less attractive to workers. Moreover, while the direct employer requirements are targeted at firms with 11 or more employees, the individual mandate applies to all residents, so it is likely to affect employers more broadly. For example, workers who now decline coverage offered by their employers may choose to participate because of the individual mandate, raising costs for employers.

The reform is also expected to affect some already insured people. Since individuals are required to have a minimum level of coverage ("minimum creditable coverage"), employers offering less than that might be pressured by workers to boost their coverage, which would likely increase costs unless offset by wage cuts.

Yet the reach of the individual mandate is uncertain. Observers expect people to face little pressure to buy insurance the first year, when the tax penalty amounts to about $200. Some observers are even skeptical that the tax penalty in subsequent years is large enough to change behavior. A 37-year-old living in Boston, for instance, would be assessed about $1,000 in tax penalties—half of the annual premium of the lowest cost health plan available—if the person were uninsured for the entire year in 2008.

Table 1

Requirements of Employers with 11 or More Full-Time-Equivalent Employees

Fair Share Contribution: Employers must make a "fair and reasonable contribution" by either having at least 25 percent of full-time-equivalent employees, defined as working at least 35 hours a week, enrolled in the employer's group health plan or offering to pay at least 33 percent of the employer plan's premium cost for full-time workers employed at least 90 days during the period of Oct. 1, 2006, to Sept. 30, 2007. Employers that do not meet the fair and reasonable contribution standard must pay a fee of no more than $295 per employee per year. The assessment is pro-rated for part-time employees (effective Oct. 1, 2006; the state will start collecting the fee in the fall of 2007).
Section 125 plans/ Free-Rider Surcharge: Employers must make Section 125 plans available to allow employees to pay for health insurance on a pre-tax basis, even if the employer does not contribute to their coverage. Employers not offering a Section 125 plan whose employees or their dependents receive state-funded health services may be assessed a surcharge. The amount of the surcharge will be based on the number of employees and the utilization of the Uncompensated Care Pool, renamed the Health Safety Net Trust Fund (effective July 1, 2007).
Non-discrimination Requirement: Employers must offer the same health benefits contribution to all full-time employees and cannot make a higher premium contribution for the coverage of a higher-paid employee than a lower-paid employee. With certain limitations, employers can make larger premium contributions for the coverage of lower-paid workers[1] (effective July 1, 2007).
Employer Health Insurance Responsibility Disclosure (HIRD) Form: Employers must document how many full-time and part-time employees they have, whether they offer subsidized insurance to full- and/or part-time employees, and whether they offer a Section 125 plan (to be filed Nov. 15, 2007).

[1] Raymond, Alan G., "The 2006 Massachusetts Health Care Reform Law: Progress and Challenges after One Year of Implementation" (May 2007).

Source: The Commonwealth Health Insurance Connector Authority, http://www.MAhealthconnector.org, accessed June 27, 2007

Small Firms with Lower-Wage Workers on the Sidelines

Although the reform law involved a series of compromises with business groups, observers warned that the small employers most likely to be affected by the reform were largely left out of the discussion. Reportedly most of the employer members of the business groups involved in the discussions already offer insurance to their workers and tend to be supportive of a reform plan that puts pressure on other employers to do the same. Given the employer backlash to the employer coverage mandate that ultimately derailed the state's 1988 reform effort, this time policy makers and others solicited employer support by designing a plan with less onerous requirements. As one observer noted, "The business community clearly signed off on the reform." That support reportedly is not universal among smaller employers with lower-wage workers. In the words of an insurance broker, "Places like sandwich shops and auto repair companies are not embracing the reform."

Furthermore, there is concern that many smaller employers are unaware of what the reform will mean to them. As a market observer noted, "It's ironic. The big employers who will not be impacted probably know the most because they have the ability and staff to keep up with the changes. Small employers just don't have a lot of resources." In recent months, state agencies, business groups, health plans, brokers and others have launched educational efforts, including public forums, an employer handbook and a marketing campaign, to inform employers about key provisions. Yet observers warn that, as the individual mandate and specific employer requirements kick in, employers could start pushing back.

Insurance Market Reform

Another key component of the reform law is the merger of the small group and nongroup insurance markets to pool the health care risks of approximately 750,000 people in the small-group market (1-50 workers), and 50,000 people in the nongroup, or individual, market.

Premiums for both the small-group and nongroup markets are based on a modified community rating—meaning that premiums are based on the average cost of health services for people in the combined pool but vary by certain demographic characteristics. In Massachusetts, premiums can vary by age, geography and family size (single, couple or family), but not by health status and gender. While a modified community rating and a 2-to-1 rate band (meaning the highest premium cannot be more than double the lowest premium) remain under the reform, the underlying intention of merging the markets is to allow the lower-priced small-group market to subsidize the nongroup market, raising premiums slightly for small groups and lowering them for individuals. An actuarial study reports that, among the six largest insurance carriers in 2005, average nongroup premiums were $413 per month, while average small-group premiums were $304 per month—more than a 30 percent difference. The study projects small-group premiums to increase by 1 percent to 2 percent on average and nongroup premiums to decrease by 15 percent on average from merging the markets.[5]

Many market observers expect the individual mandate to bring younger, healthier people who currently do not purchase coverage to the combined pool and lower the overall risk, as well as increase the number of insurance product choices available. However, some observers are skeptical that the individual mandate is strong enough to encourage enough healthy people to purchase insurance to balance the costs of insuring sicker people.

Although the merger of these risk pools may be advantageous for individuals, the same benefits may not extend to small employers. As one market observer said, "Right now, small employers already have a lot of choices. What they don't have are affordable choices." With the projected premium increase for small groups, affordability is likely to remain a concern.

Connecting the Dots

As part of health reform, the state created the Commonwealth Health Insurance Connector Authority (the Connector), an independent public agency governed by a 10-member board of state officials and others appointed by the governor and attorney general. The Connector is charged with key decisions involving the reform. For example, the Connector is responsible for administering the Commonwealth Care program for low-income people eligible for subsidized coverage; determining the minimum level of coverage an individual must have to be in compliance with the mandate; approving Commonwealth Choice insurance products for individuals and small groups; and creating an affordability schedule for individuals to determine who will be subject to the mandate. Commonwealth Choice products became available for individuals in May 2007, with coverage beginning July 1, 2007. As of July 1, Commonwealth Choice products are also available as a voluntary benefit for part-time and contract employees (financed through pre-tax payroll deductions) through the Connector. Small employers will be able to start contributing to coverage for their full-time employees through the Connector later this year for coverage beginning Jan. 1, 2008.

Market observers expressed varied views about the role of the Connector—whether it is a market facilitator, purchaser or a competitor to health insurers and brokers. With the exception of the young adult products, which are only available through the Connector, all other insurance products offered by the Connector are available for purchase directly from health plans (or through brokers) for the same price. The question remains whether the Connector will attract only an isolated population or many small employers, employees and individuals. Market observers do not expect small employers that currently purchase health insurance to switch to the Connector, at least in the short term. One market observer stated, "The goal wasn't to disrupt the small-group market and have everybody

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go through the Connector." The Connector is, however, expected to provide a channel for those who do not currently have coverage. Small employers' main incentive to purchase through the Connector is to offer a choice of insurance carriers for their employees—smaller employers tend to offer products from a single carrier because of cost. Similarly, observers expect that offering this type of choice among carriers will allow more portability of insurance if a worker moves to a new job.

Observers generally agreed that a key role of the Connector is to approve insurance products that offer affordable and adequate coverage for small groups and individuals. But this has proved challenging in a state with mandates for specific benefits—in-vitro fertilization coverage, for example—beyond what many other states require.

While market observers do not expect a complete retreat from comprehensive products toward very limited benefit or health savings account-type products, to the extent that the individual mandate and employer requirements encourage more people to gain insurance, there could be a market for somewhat less comprehensive products with lower premiums. In fact, some already have such products. While the Connector board has defined minimum creditable coverage for individuals as a $2,000 maximum deductible, a $5,000 annual limit on out-of-pocket spending, first-dollar coverage for three preventive visits a year, and prescription drug coverage with a permitted additional deductible of up to $250, observers have expressed concern about currently insured people who do not meet the minimum requirements, particularly those without prescription drug coverage. While the state has delayed the deadline for meeting these standards until January 2009 to give employers and consumers time to adjust their level of coverage, the requirements could have a significant financial effect on employers that offer less comprehensive coverage.

The Connector board has struggled with the trade-offs between affordability and benefit adequacy. After considerable negotiations with health plans, the board approved and is offering products in four levels of coverage: bronze, silver, gold and young adult (see Table 2). To provide a sense of how the benefits compare, the actuarial value—the proportion of total medical services covered by insurance—of the bronze plan is approximately 60 percent of the gold plan. Premiums vary based on age, location and coverage level and are as low as $155 a month for a 19-year-old in eastern Massachusetts. However, the lowest available premium for an individual 56 years or older is $309 per month. Also, for the same benefit level there is as much as a $150 difference between carriers, which may limit the amount of real choice among carriers and compromise the attractiveness of purchasing coverage through the Connector.

Table 2
Commonwealth Choice Insurance Products

Level of Coverage[1]	Gold	Silver	Bronze
Description	Low copayments, no deductible, prescription drugs required	Moderate copayments, some with no deductible, prescription drug coverage	Low premium, most have deductibles and copayments. Available with and without prescription drug coverage[3]
Price Range[2]			
19 Year Old	$301-$433	$238-$335	$155-$252
35-39 Year Old	$304-$583	$240-$431	$156-$288
56+ Year Old	$601-$865	$475-$670	$309-$505

[1] The Connector also offers young adult plans for individuals aged 19-26. These plans have monthly premiums ranging from approximately $100-$200, are available with and without prescription drug coverage and some have an annual limit on benefits.

[2] These numbers, which are rounded to the nearest dollar, reflect the range of prices across insurance carriers for the eastern region of Massachusetts, which includes Boston. Prices differ in the central and western regions.

[3] The lowest premium in each range does not include prescription drug coverage; the highest premium includes prescription drug coverage.

Source: The Commonwealth Health Insurance Connector Authority

Market observers reported that the reform's rapid pace of implementation has stifled innovation. As one state official noted, "I think there are other things you can do [to bring down costs], like only using efficient providers or focusing on disease management, but I don't know that insurers have had the time to really be creative."

For these reasons, the more important role of the Connector for employers and individuals may be as a regulator that influences the attractiveness, affordability and availability of insurance products, rather than its role as a marketplace to directly purchase insurance. Despite the Connector's ability to approve insurance products, many observers argued that the reform lacks a true mechanism to encourage the development of products that will prove to be both affordable and of value to employers and consumers. As one employer noted, "There is nothing in this reform that makes health care affordable and that's the reason we have uninsured. The reason it's not affordable is that the cost of care is high and there is nothing in the reform that will bring that cost down." While the reform law created the Massachusetts Health Care Quality and Cost Council to develop quality improvement and cost containment goals and strategies, market observers do not underestimate the significant challenges of controlling health care costs.

Universal Coverage, but at What Cost?

In rapid fashion, Massachusetts has made efforts to both ignite demand for health insurance and establish a marketplace for individuals and small employers to purchase coverage. Market observers applauded the reform's coverage of more than 135,000 of the lowest-income uninsured residents through the Medicaid expansion and the subsidized Commonwealth Care pro-

gram. Yet, there are many challenges and unknowns ahead that HSC will continue to track, including many that pose substantial threats to the goal of near universal coverage.

Perhaps the most fundamental challenge is the issue of affordability. While most market observers agree that the primary goal of the reform is to improve access to health insurance, they contend that its ultimate success depends on affordability—both in the short term, as well as the long term. If affordable coverage is not available, it is unlikely that small employers on the cusp of offering insurance to their workers will be motivated to do so. Instead, they are more likely to pay the $295 annual fee rather than incur the greater costs of offering insurance.

Affordability is also a concern of individuals and, despite the individual mandate to have health insurance, there are likely to be some people who will forgo coverage and pay the tax penalty. They may decide this based on individual assessments that they cannot afford coverage, which for lower-income individuals, in particular, may mean that basic needs such as housing and food take precedence over obtaining health insurance. Efforts in other states to reduce the number of uninsured by creating purchasing pools, offering insurance subsidies to employers and employees, tax credits or limited benefits often have struggled for precisely this reason—individuals' perceptions that they cannot afford coverage or that what they are buying is not worth the cost. In April, the Connector board reported plans to exempt nearly 20 percent of uninsured adults (approximately 60,000 people) ineligible for state subsidies from the individual mandate after determining that even the lowest cost insurance is unaffordable for them.[6] The Connector board currently is revisiting the premium levels that will be considered affordable for people at all income levels, after learning that its proposed schedule would exempt significantly more people from the individual mandate than originally intended.[7]

The challenge of affordability extends to a policy debate about what should be the balance between the financial obligations of individuals and the state. The less affordable coverage is for consumers, the more likely the state will have to commit additional monies to subsidize people to achieve near universal coverage. In fact, the state recently expanded subsidies for people who qualify for Commonwealth Care so that now individuals earning up to approximately $15,000 a year pay no premium (the program originally provided free coverage to people earning up to approximately $10,000 a year). This expansion is expected to include approximately 52,000 people at an estimated additional cost to the state of approximately $13 million.[8] There is also the issue of whether the Connector adds additional administrative costs to the system. Evidence from other states' purchasing pool initiatives suggest that the administrative costs of marketing, enrollment processing and premium collection, for example, can be significant. While it is unclear how this will eventually play out in Massachusetts, it could place additional financial pressures on the reform.

Aside from the affordability issue, there are a number of other reasons why individuals may opt not to comply with the mandate. For example, they may not understand the individual mandate and their specific responsibilities surrounding it. Others may dislike what they perceive as government interference in requiring that they have health insurance coverage. In some ways, this is akin to automobile insurance—while it is required, not all car owners buy it. A recent public opinion poll found that Massachusetts residents' support of the individual mandate was 52 percent of residents in September 2006 and increased to 57 percent by June 2007.[9]

What happens, however, if people forgo health insurance coverage, but still receive care? While some employers will be assessed a surcharge for costs their uninsured employees incur for care paid for by the state's uncompensated care pool, this has significant financial implications for the reform since much of the reform is expected to be financed by reallocating funds from the uncompensated care pool. The state is working to update the uncompensated care pool rules in an effort to align incentives so that individuals with access to affordable insurance take up coverage instead of relying on the pool.

The reform is being implemented during a time when the state's economy is strong

In rapid fashion, Massachusetts has made efforts to both ignite demand for health insurance and establish a marketplace for individuals and small employers to purchase coverage.

Data Source

HSC researchers visited Massachusetts in January 2007 to explore the potential impact of the Massachusetts universal coverage initiative on employers and their insurance offerings for their employees. With funding from the Robert Wood Johnson Foundation, researchers interviewed approximately 25 market observers, including representatives of employer groups, state agencies, health plans, providers, advocates and other health care leaders knowledgeable about the reform. Researchers did not interview individual employers as a separate employer survey is being fielded. HSC's Community Tracking Study site visit to Boston in June 2007 provided additional perspectives on the reform. HSC will continue to track the reform's impact with a follow-up site visit in 2008.

ISSUE BRIEFS are published by the Center for Studying Health System Change.

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and unemployment is low. What happens if there is an economic downturn? Typically, during economic slowdowns, unemployment rises and in turn people lose their employer-sponsored health insurance. Then, costs for public programs, such as Medicaid, increase as more people become eligible. Finally, state revenues decline, reducing the ability to support these programs.

While the individual mandate took effect July 1, the penalties for people who remain uninsured are relatively small this year. In 2008, the financial penalties for individuals opting out of coverage are more substantial. Consequently, it is unlikely that the first year of the reform will provide answers to key questions about the individual mandate. Additionally, most small employers have already renewed coverage for 2008, so it will be some time before more is known about the effects of the reform on their behavior with regard to health insurance coverage.

The issue for Massachusetts may come down to how close to the goal of universal coverage is realistically attainable. The state has a lower percentage of uninsured people compared to most other states, which increases the feasibility of achieving near universal coverage. But at what point do the costs to the state getting one additional individual insured outweigh the benefits? At some point, and probably not too far in the future, this is a question that Massachusetts will likely be required to answer. ■

Notes

1. Massachusetts Division of Health Care Finance and Policy, "Health Insurance Status of Massachusetts Residents, Fifth Edition" (December 2006).
2. The Commonwealth Health Insurance Connector Authority, *http://www.mahealthconnector.org*, accessed July 12, 2007.
3. The Commonwealth Health Insurance Connector Authority, "Health Care Reform Answers for Massachusetts Businesses," News Release (June 22, 2007).
4. The Uncompensated Care Pool is a state fund comprised of general revenues and assessments on hospitals, health plans and other third-party payers that reimburses hospitals and health centers for providing care to uninsured and underinsured patients. Under the reform, the Uncompensated Care Pool is renamed the Health Safety Net Trust Fund.
5. Gorman Actuarial, LLC, et al., "Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets" (Dec. 26, 2006).
6. "Health Plan May Exempt 20% of the Uninsured," *The Boston Globe* (April 12, 2007).
7. "Waiver Rules Eyed on Health Insurance," *The Boston Globe* (June 6, 2007).
8. "Health Plan May Exempt 20% of the Uninsured," *The Boston Globe* (April 12, 2007).
9. The Kaiser Family Foundation/ Harvard School of Public Health/Blue Cross Blue Shield of Massachusetts Foundation, Massachusetts Health Reform Tracking Survey (June 2007).