

Massachusetts Health Care Reform:
A Backgrounder on the Landmark Health Insurance Law

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Associated Industries of Massachusetts Foundation, Inc.
222 Berkeley Street/P.O. Box 763
Boston, MA 02117-0763
617-262-1180

Prepared by:
Polestar Communications & Strategic Analysis
77 Franklin Street, Suite 507
Boston, MA 02110
617-574-9282

Introduction

On April 12, 2006, Governor Romney signed into law landmark health care reform legislation that requires all residents to carry a minimum level of health insurance by July 1, 2007.¹

A confluence of influences made health care reform happen – the requirement imposed by the federal government to develop an innovative way of covering the uninsured or risk losing millions of dollars in Medicaid reimbursements; the threat of a ballot initiative that would make health care a constitutional right; introduction of an onerous new payroll tax through a ballot initiative; the willingness of all the vested interests in health care to work towards constructive change to the status quo; and the political will of the Governor, Senate President and House Speaker to implement meaningful reform.

Based on a compromise of reform measures contained in separate plans proposed by the Governor, the Massachusetts Senate and House, the law's underlying principle is that the government, employers, and individuals all share responsibility for expanded health care coverage.

While conceptually groundbreaking, the law requires a reorganization of the health care system and many of the implementation details have yet to be determined. Virtually all the key sections of the law will require the promulgation of regulations – involving at least nine different state offices. In addition, the administration and the legislature have both acknowledged that the law may need to be revised through the issuance of technical corrections.

It also remains possible that the statute could be challenged on the grounds that some of the provisions are pre-empted by ERISA – a federal law established in 1974 that sets minimum standards for pension and health plans in private industry.

Sponsored by the A.I.M. Foundation, this paper provides an overview of the health care reform law and A.I.M.'s understanding, as a primary negotiator in the process, of provisions where the statutory language is ambiguous or the details are still undetermined. Updates to this paper will be provided as progress is made in the rule-making process. In the interim, employers should review the new law and the many ways it could impact them.

The health care reform law is groundbreaking. But critical details were deferred. Many key sections of the law will require promulgation of regulations.

¹ Chapter 58 of the Acts of 2006 - An Act Providing Access to Affordable, Quality, and Accountable Health Care

Background on Massachusetts Health Care Reform

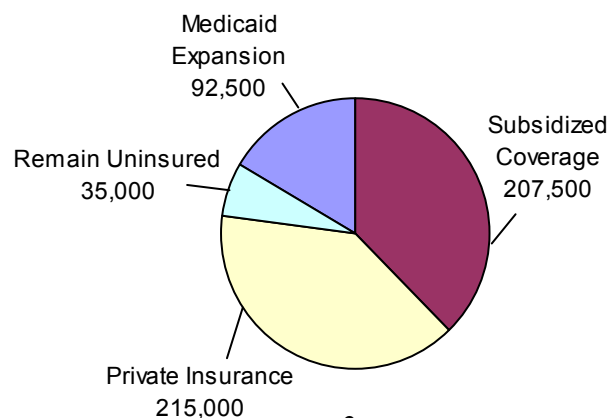
Three contributing factors led to the Massachusetts health care reform law. The most important was a federal requirement to make changes to the state's Medicaid ("MassHealth") Waiver by July 1, 2006 or jeopardize \$600 million in federal funds. This required that a new plan for covering the uninsured be developed. Second, rising health care costs were threatening the affordability and accessibility of care. Between 2000 and 2005, family plan premiums in the state increased by almost 50%. Lastly, strong grassroots efforts generated two potential health care reform ballot initiative questions.

The state was well positioned for reform. Compared to other states, the Commonwealth has a relatively low uninsurance rate, ranked 6th in providing coverage to residents. The state also has a strong base of employer coverage as 70% of the state's employers offer employee health insurance. In addition, Massachusetts has a generous Medicaid program and a strong network of safety net providers – community health centers and hospitals that provide care to the uninsured funded by the Commonwealth's Uncompensated Care Pool.

The health care reform law will apply different income-based approaches to assist the state's approximately 550,000 uninsured obtain health insurance:

- Medicaid eligible, but un-enrolled — enroll residents through targeted outreach efforts.
- Not Medicaid eligible, but cannot afford health insurance – provide government subsidy to purchase private insurance.
- Residents who can afford insurance, but choose not to – require the purchase of private insurance.

How Uninsured Will Be Covered Under the Health Care Reform Plan



The risk of losing federal funds, skyrocketing health insurance premiums, and the prospect of state ballot initiatives provided incentives for health care reform.

In summary, the law mandates market reforms to enable the development of affordable private insurance products and aims to eliminate cost shifting by holding individuals and employers responsible for contributing to health care. Federal and state government spending for free care will be redirected to help individuals pay for health insurance. The law will implement health care cost containment measures through the promotion of transparency of comparable provider cost and quality data.

For certain populations, the Medicaid program will be expanded by increasing income eligibility for children, increasing enrollment caps and restoring benefits previously cut. Reimbursements to Medicaid providers will also be increased based on performance goals.

These reforms – most of which will be implemented beginning in 2007 – will require regulatory changes and the formation of several new health care entities. Key components of the law are summarized below and in Table 1.

Reforms to Enable Affordable Insurance Product Development

The statute contains several industry market reforms that will allow private insurers to develop more affordable insurance products:

- merge the non- and small-group markets in July 2007 – a provision that is expected to decrease non-group premium costs by 24%. (The resulting bump-up in rates presumed for the small group market will not materialize as more people enter the insurance market as a result of the individual mandate and the risk pool grows);
- allow HMOs to offer high deductible plans that are linked to Health Savings Accounts, reducing costs for those who enroll in such plans;
- allow young adults to stay on their parents' insurance plans for two years past the loss of their dependent status or until they turn 25;
- develop lower-cost specially designed products for 19-26 year olds without access to employer-sponsored coverage that may exclude certain state mandated benefits; and
- allow insurers to rate individuals and small groups based on their smoking status and participation in wellness programs.

In addition, there will be a moratorium on the creation of new health insurance mandated benefits through 2008.

The health care reform law will require significant reorganization, cost shifting and containment. New health care regulations and entities will be developed.

Reforms will enable insurers to develop more affordable insurance products.

Preliminary estimates for “affordable plans” are \$200/month. Government subsidized plans would be \$30 to \$140/month – or free for qualified low-income residents.

Commonwealth Health Insurance Connector to Facilitate Insurance Purchase

The Commonwealth Health Insurance Connector, a quasi-public independent authority overseen by an appointed board of private and public representatives will serve two critical roles in this health care reform.

The first is to “connect” individuals and small businesses with affordable health insurance products developed by private insurers. The Connector will not design insurance products or regulate the insurers offering the plans – the Division of Insurance will continue to perform these functions. Rather, the Connector will facilitate the purchase of authorized health insurance plans by individuals and small businesses by “certifying” insurance plans that offer good value to consumers with a “Seal of Approval”. In order to receive this approval, insurance products must meet the requirements for health benefit plans under the small group insurance licensure regulations. The Connector will provide information on such products and arrange for the collection of premium payments beginning in April 2007.

Those eligible to purchase insurance through the Connector will include:

- non-working individuals;
- working individuals at companies that do not offer health insurance;
- working individuals not eligible for coverage at their place of business, such as part-timers, contractors and new employees;
- small businesses with 50 or fewer employees; and
- the self-employed.

Individuals who are employed will be able to purchase insurance through the Connector using pre-tax dollars (through Section 125 “cafeteria” plans set up by their employers), significantly reducing costs to individuals (between 10-40% depending on one’s federal tax bracket).

The Connector allows for portability of insurance as individuals move from job to job and permits more than one employer to contribute to an employee’s health insurance premium. This will allow companies to provide insurance to part-time workers and permits individuals who hold two or more jobs to combine premium contributions from multiple employers. Participating employers will have the ability to determine the eligibility criteria for their employees and the amount of their contribution, if any.

The second function of the Connector will be to administer the new Commonwealth Care Health Insurance product outlined below.

Businesses with 50 or fewer employees will be able to designate the Connector as its group health insurance plan.

Employees will be able to take their coverage from job to job. The Connector will ensure that premium payments will be on a pre-tax basis.

The Connector will provide a “one-stop shop” framework for new insurance products meeting the needs of consumers rather than employers.

Subsidized Health Insurance for Low-Wage Individuals

A program within the Connector – called the Commonwealth Care Health Insurance Program – will provide government-funded subsidies to low-income individuals to assist with the purchase of health insurance, scheduled to begin October 1, 2006.

The Commonwealth Care Health Insurance Program will provide sliding-scale subsidies to individuals with incomes above Medicaid eligibility and less than or equal to 300 percent of the Federal Poverty Level (FPL) for the purchase of health insurance (\$29,400 for an individual and \$49,800 for a family of three). Individuals with incomes less than 100% of the FPL (\$9,800 for an individual) will not be required to pay premiums.

Plans offered through Commonwealth Care will have no deductibles. To transition from the current system, subsidized products will be offered exclusively by managed care organizations that participate in the Medicaid program through 2009 (Neighborhood Health Plan, Boston Medical Center Health Net, Cambridge Health Alliance Network and Fallon Community Health Plan).

After 2009, all insurers will be able to offer subsidized insurance products. Benefits in these subsidized plans will be comprehensive, and contain all mandated benefits. The funds currently spent on providing free care in hospitals will be redirected to pay for these subsidies.

An uninsured individual will be eligible to participate in the program if the individual:

- has household income that does not exceed 300% of the federal poverty level;
- has been a resident of the Commonwealth for the previous 6 months;
- is not eligible for any MassHealth, Medicare or child health program;
- or family member's employer has not provided health insurance coverage in the past 6 months for which the individual is eligible and for which the employer covers at least 20% of the annual premium cost of a family health insurance plan or at least 33% of an individual health insurance plan; and
- has not accepted a financial incentive from his employer to decline his employer's health insurance plan.

Sliding-scale subsidies for low-income residents will be developed by the Connector in consultation with the offices of Medicaid and Health Safety Net.

Individual Mandates

As of July 1, 2007, all residents of the Commonwealth ages 18 and older must have creditable health insurance coverage so long as it is deemed affordable under a schedule set annually by the Board of the Connector. Individuals will be able to challenge the affordability of products on the basis of their unique financial circumstances through a review process established by the Connector. The Connector will make that determination on a case-by-case basis. In cases where health insurance is deemed unaffordable, no penalty will be imposed for failing to obtain insurance coverage.

The state will enforce compliance by requiring residents to report on their state income tax forms whether they have maintained health insurance. Individuals who have not purchased affordable health insurance nor enrolled in an appropriate health insurance program such as MassHealth face the penalty of losing the personal exemption on their state income tax for 2007. For later years, failure to comply with the requirement will result in a penalty of up to 50% of the monthly “minimum insurance premium for creditable coverage” for each month without coverage.

Employer Requirements

Employers with 11 or more employees are required to:

- *Offer Section 125 “premium only” cafeteria plans.* To make insurance more affordable, employers must offer cafeteria plan coverage to their employees, either under their own group health plans or through the Connector – so that employees may purchase health insurance products on a pre-tax basis. (Employers should determine whether any changes to existing cafeteria plans are needed – as a separate plan may be required for employees to purchase insurance through the Connector.)
- *Potentially pay a free rider surcharge if Section 125 cafeteria plan not offered.* Employers who fail to establish a Section 125 cafeteria plan to enable their employees to purchase health insurance with pre-tax dollars through the Connector could potentially be subject to a new assessment, called the free rider surcharge, if an employee receives free care more than three times a year or a company has five or more instances of employees receiving free care in a year. The surcharge will range from 10% to 100% of the state’s cost of services provided to the employees and their dependents – with the first \$50,000 per employee exempted.
- *Potentially make a “Fair Share” contribution if insurance is not offered.* Certain non-providing employers will be required to make

Requiring individual responsibility allows federal and state monies to be reallocated to subsidize private insurance for low-income workers – subsidizing people not providers.

At a minimum, companies will be required to establish a Section 125 cafeteria plan so employees can purchase insurance with pre-tax dollars. Employers with 10 or fewer employees are exempt from all provisions.

payments to the free care pool to cover the cost of providing care to the uninsured. The determination as to “non-providing” is made by a two-part test. Does the employer: (1) offer a qualified plan (2) to which a “fair and reasonable” premium contribution is made? Perhaps the most contentious provision in the new law, A.I.M. worked to make sure it was not onerous for employers. Therefore, there is no requirement that the qualified plan be offered to all employees, or even to all full-time employees.

If an employer offers health insurance to a portion of its workers, the employer is not subject to the fair share assessment. For an employer that is subject to the assessment, the amount will be determined by a formula, not exceeding \$295, multiplied by the total number of full-time employee equivalents (defined as 2000 hours worked). The amount of the assessment is tied to the usage of the free care pool, and is expected to diminish considerably over time.

- *Administer Health insurance Responsibility Disclosure Forms.* Compliance will require the generation and administration of more record-keeping as employers and employees will have to complete annual disclosure forms indicating whether the employer has offered to pay for or arrange for the purchase of health care insurance for its employees and whether the employee has accepted or declined such coverage.

In addition, employers will be prohibited from discriminating against an employee if free care is received (i.e., free rider surcharge) – this may require revision of employer anti-discrimination policies, etc.

Medicaid Eligibility and Program Expansion

MassHealth eligibility will be extended to children in families earning up to 300 percent of the FPL (\$49,800 for a family of 3). Enrollment caps on existing MassHealth programs for adults will also be raised, including MassHealth Essential (additional 16,000 people), HIV program (additional 250 people), and CommonHealth (additional 1,600 people). In addition, MassHealth benefits that were cut in 2002 will be restored (dental, vision, chiropractic, prosthetic services).

In response to concern that Medicaid has underpaid many of its providers in the past, the bill sets aside \$90 million in increased provider payments for FY2007, \$180 million for FY 2008 and \$270 million in FY 2009. Such increases are tied to performance goals and will be dependent upon hospitals meeting quality improvement goals as determined by the Executive Office of Health and Human Services. The law also requires

Part of the uncompensated care pool is paid by businesses via a surcharge on private insurance ~ \$62/worker/year. The \$295 assessment fee requires companies that do not offer insurance to contribute.

Companies will administer disclosure forms – as well as potential revisions to anti-discrimination policies.

Increasing Medicaid reimbursement rates is beneficial. When reimbursements fall short, the difference is reflected in higher insurance premiums paid by employers.

Medicaid to develop pilot programs for smoking cessation and a wellness program that encourages enrollees to participate.

Elimination of Uncompensated Care Pool

On October 1, 2007, the Uncompensated Care Pool will be eliminated and replaced with the Health Safety Net Fund – which will be administered by a newly created Health Net Safety Office (HSN) located within the Office of Medicaid. The purpose of the Fund will remain the same – to maintain a health care safety net by reimbursing hospitals and community health centers for a portion of the cost of services provided to low-income, uninsured or underinsured residents. The HSN Office will develop a new standard fee schedule for hospital reimbursements, replacing the current payment system. It is anticipated that as free care use declines due to higher insurance coverage required by the law, funds from the Health Safety Net Fund will be transferred to the Commonwealth Care Health Insurance Program.

New Cost and Quality Measures

A Health Care Quality and Cost Council will be created to set quality improvement and cost containment goals. The Council will reside in the Executive Office of Health and Human Services, but will be governed by a board consisting of public and private members. It will be responsible for collecting cost and quality data from health care providers and for developing and maintaining a consumer website. These efforts will provide greater transparency and accountability on the part of providers and will better inform consumer choices. Insurers will have to submit data to the Council as required by regulations to be promulgated. Financial penalties will be assessed, up to \$50,000, for failure to report data in a timely manner.

Availability of cost data by provider will increase competition and lower costs. Consumers will have information to choose high quality, lower cost health care.

Reform Funding – Leading to Cost Containment and Reduction

Funding for health care reform will come from a variety of sources – most of which will result from redirecting funds currently spent on free care through the Uncompensated Care Pool (about \$1 billion), which is funded from a combination of hospital, insurer, and state and federal funds. No new taxpayer funds have been determined to be needed – however \$200 million from the general revenues will be used for the initiative. Moreover, significant new revenue is expected from the premium dollars spent by those entering the insurance market for the first time as a result of the individual mandate.

The Commonwealth must obtain approval from the federal government for any payments and payment methodologies using federal funds. The federal

government is expected to approve the state's health care reform plan before July 1, 2006.

Once the reform measures are implemented, employers should expect to see some health care cost stabilization — and eventual reduction as the changes to the marketplace evolve.

Looking Ahead

The enactment of the bipartisan health care reform bill was a significant accomplishment. Properly implemented, it will expand coverage, provide greater consumer choice, contain rising health care costs and promote competition among insurers and providers. Despite the national headlines the legislation has attracted, its success will largely depend on the details yet to be worked out.

Over the next few months, A.I.M. will continue to advocate on behalf of its members to ensure regulations are promulgated and details fleshed out in the best interest of the business community.

Employers should become familiar with the proposed changes to the Commonwealth's health care system and pay close attention to rules and details as they emerge, particularly concerning:

- *Commonwealth Health Insurance Connector:* how it is structured, the process for purchasing insurance for employees, and how to establish a Section 125 cafeteria plan that permits employees to purchase health care through the Connector with pre-tax dollars.
- *Employer Requirements:* how the "fair share contribution" will be determined – what the employer payment to the free care pool will be if a "qualified plan" is not offered to which a "fair and reasonable" premium contribution is not made.
- *Employer Compliance Procedures:* the disclosure rules to demonstrate whether employers have offered to pay for or arrange for the purchase of health care insurance for employees and whether employees have accepted or declined such coverage.

On behalf of its members, A.I.M. will continue to work with lawmakers to clarify details as they emerge and participate in the rule making process. Updates and their implications will be provided as progress is made.

Table 1 -- Key Provisions of Massachusetts Health Care Reform

Health Care Reform Provision	General Description	Key Known Uncertainties
Market Reforms <ul style="list-style-type: none"> ➤ Merger of non- and small-group markets ➤ Extended coverage for young adults (family policies for up to age 25) ➤ Special products for ages 19 thru 25 ➤ High deductible health plans (HDHP) offered in conjunction with a Health Savings Account 	Will enable private insurers to develop affordable health insurance benefits to small businesses and individuals	Actuarial study of market merger to be performed Raises questions about existing approved HDHPs by the Mass Division of Insurance that are not offered in conjunction with HSAs Young adult plan regulations needed
Commonwealth Health Insurance Connector* <ul style="list-style-type: none"> ➤ Permits private insurers to offer new affordable policies to small businesses and individuals ➤ Reduces cost through pre-tax treatment of premium contributions 	Will connect individuals and eligible small groups with health insurance products that have been certified with a “seal of approval”, allows portability of insurance, facilitates employer contributions for individuals working part-time or for more than one employer	Rules to be established for new low-cost health insurance products including required basic coverage and premiums. Definition of “affordable” to be established Connector board/staff to be established
Commonwealth Care Health Insurance* <ul style="list-style-type: none"> ➤ Redirect funds currently spent on providing free care in hospitals toward subsidizing health insurance 	A subsidized program operated through the Connector for low-income individuals. Premiums will be on sliding scale based on household income	Eligibility standards for health insurance subsidies to be established
Individual Mandates <ul style="list-style-type: none"> ➤ Promotes personal responsibility 	Requires residents ages 18 and older to carry health insurance, as long as affordable coverage is available	A sliding “affordability” scale to be set annually by the Board of the Connector to be established
Employer Responsibility <ul style="list-style-type: none"> ➤ Encourage contribution toward coverage 	Offer Section 125 cafeteria plan, Make “fair and reasonable” contribution, Free Rider Surcharges	Definition of “fair and reasonable” to be established
Medicaid Expansion*	Increase eligibility, and reimbursement to hospitals	Hospital quality improvement goals to be determined
Uncompensated Care Pool Elimination*	Replaced with Health Safety Net Fund	Health Net Safety Office to be created and payment rules to be developed
Cost and Quality Programs*	Collect cost and quality data from health care providers and disseminate to consumers for greater accountability and to influence consumer behavior	Health Care Quality and Cost Council to be created. Types of data/ methods of collection to be defined

*Requires establishment of new health care entity