



Massachusetts Health Care Reform 2006

An Analysis of the Pros and Cons

Individual Mandate		
Key Components	What Supporters Say	What the Critics Say
<ul style="list-style-type: none"> • Beginning in July 2007, all residents must obtain health coverage if it is determined that people in their income bracket can afford insurance. Otherwise, they are granted a waiver. • Enforced through the state tax system: <ul style="list-style-type: none"> ➤ In 2007, the penalty for non-compliance will be loss of the personal exemption, worth almost \$3,600. ➤ In 2008 and beyond, the penalty will be half the cost of the lowest available yearly health insurance premium for an “acceptable plan.” (An acceptable plan cannot be a bare bones catastrophic plan or a minimal coverage plan). 	<ul style="list-style-type: none"> • Strengthens and stabilizes health insurance risk pools by making sure they include young and healthy individuals who otherwise might opt to risk being uninsured as well as those with the financial means to obtain coverage who instead rely on free care. This assures that the Uncompensated Care Pool funds will be available for insurance subsidies under Commonwealth Care. • Encourages personal responsibility. • Projections show that the vast majority of the uninsured will take coverage. • Penalty monies will be deposited in the Commonwealth Care Trust Fund for use by the Commonwealth Care Health Insurance program and other programs to expand insurance coverage. • People who do not have health insurance coverage still receive care if they are sick or injured. These costs are currently paid for by the free care pool and higher premiums for those that do have coverage. 	<ul style="list-style-type: none"> • Represents an unprecedented expansion of government power and intrusion in the American health care system • Success depends on the establishment of a reasonable standard for affordability; if the costs of plans offered through the Connector are too high to be affordable, the Connector may issue so many individual waivers that the reform will be ineffectual. • The state will have to offer incentives to generate enough interest among the insurance companies to develop these new, low-cost plans. Otherwise, carriers may refuse to play. • Invades individual privacy by (1) requiring employees and employers to sign, under oath, a “Health Insurance Responsibility Disclosure” form to certify they have purchased insurance, (2) monitoring an individual’s employment status to verify health insurance, and (3) allowing the Connector to gather income data. • The mandate went too far by legally restricting a person’s right to self-insure; the original bill would have allowed individuals to post a \$10,000 bond to demonstrate their willingness and ability to cover their own health care costs.

Employer Responsibility		
Key Components	What Supporters Say	What Critics Say
<ul style="list-style-type: none"> • Fair Share Contribution: Employers with 11+ full-time equivalent (FTE) employees who don't provide a "fair and reasonable premium contribution" to coverage pay up to a statutory maximum of \$295 per worker annually. • Regulations have defined "fair and reasonable" to be participation of at least 25% of employees with the employer paying a minimum of 33% to individual coverage. • Employers must facilitate employee pre-tax purchases through the Connector by adopting and maintaining IRS Section 125 "cafeteria plans" • Free Rider Surcharge: Non-offering employers (11+ FTE workers) with frequent free care pool users may be charged up to 100% of costs over \$50,000. Non-offering employers with Section 125 plans are exempt. 	<ul style="list-style-type: none"> • Since employers providing health insurance pay into the Uncompensated Care Pool through a premium tax, it is only fair to charge an assessment to employers not providing coverage. • The fair share assessment will be based on an annual calculation of the amount of uncompensated care used by workers employed in firms that don't offer health insurance. Since the legislation is designed to reduce uncompensated care, the employer fair share assessment will likely be less than the statutory maximum of \$295 per worker. Theoretically, if everyone obtains coverage as the new law requires, then an employer's fair share contribution will be zero. • Fair Share and Free Rider monies will be deposited in the Commonwealth Care Trust Fund for use by Commonwealth Care and other programs to expand insurance coverage. • The establishment of Section 125 plans offers part-time and contract workers the opportunity to pay premiums with pre-tax dollars. 	<ul style="list-style-type: none"> • The fair share contribution constitutes an additional business fee that can cause economic hardship and unfairly targets businesses of a certain size. • The fair share assessment represents a regressive tax on workers and their families, mainly in the form of reduced compensation or job loss. • The fair share contribution is still lower than the cost of providing health insurance, so it may not be a sufficient "stick" to convince businesses that currently offer health insurance to continue doing so, and is likely not sufficient to convince businesses that do not currently offer insurance to start doing so. • The law is flawed because it does not actually mandate employers to provide coverage or to pay a tax more in line with the actual cost of insurance. • Invades individual privacy by (1) requiring employers to sign, under oath, a "Health Insurance Responsibility Disclosure" form to certify they have purchased insurance, and (2) requiring the state to track the health records of non-offering employers and their employees/dependents to determine the amount of free care use.

Commonwealth Health Insurance Connector

Key Components	What Supporters Say	What the Critics Say
<ul style="list-style-type: none"> • Offers a menu of private health plan choices to small businesses (50 or fewer employees) and individuals. • Eligible workers and their families can buy coverage with pre-tax dollars. • The Connector will set subsidy levels for the Commonwealth Care Health Insurance program, set the affordability standards for the individual mandate, and decide what insurance plans can be offered through the Connector. • Allows multiple employers to contribute to a part-time worker's premium. • Coverage is portable among jobs as long as all employers use the Connector. 	<ul style="list-style-type: none"> • Independent quasi-public entity not subject to the supervision or control of any other executive office. • Like a stock exchange, provides a single place to match buyers and sellers efficiently and to facilitate the collection and transmission of premium payments, often from multiple sources. • The Connector provides easy access to coverage for individuals and families who do not have coverage through an employer and reduces an employee's out-of-pocket costs by allowing insurance coverage to be purchased with pre-tax dollars. Similarly, employees of employers designating the Connector as its employer-sponsored health insurance plan can receive tax-free premium contributions from their employer. • The Connector concept cuts down the administrative costs to insurers of marketing to small businesses. • Employees, not employers, become the customer for health insurance policies. • Promotes individual ownership and portability of health insurance coverage. • The Connector will create competition among health plans and greater choice for consumers. • Enables part-time, seasonal, and independent contract workers to afford coverage by possibly obtaining contributions from multiple employers 	<ul style="list-style-type: none"> • The Connector establishes a new, sophisticated bureaucracy with wide-ranging, complicated, and potentially costly responsibilities (e.g., collecting premiums from employers and individuals and remitting to insurers, determining eligibility for premium assistance, evaluating plans for affordability and quality, verifying employee eligibility, etc). • The Connector unfairly excludes medium and large size businesses that could benefit from participation in the new consumer-driven marketplace for health insurance.

Subsidized Health Insurance Coverage

Key Components	What Supporters Say	What Critics Say
<ul style="list-style-type: none"> Establishes the Commonwealth Care Health Insurance Program which provides sliding-scale, subsidized private health insurance coverage for low income uninsured individuals and families below 300% of the federal poverty line. No deductibles. No premiums if below 100% of poverty; sliding scale premiums if above 100% of poverty (\$20,000/family of 4). 	<ul style="list-style-type: none"> Subsidizes people, not providers: converts subsidies for uncompensated care (<i>a de facto</i> safety net for hospitals) into premium assistance for the low-income uninsured (<i>a de facto</i> consumer safety net.) Addresses current gaps in coverage for low-income adults without children and families with moderate incomes who do not qualify for Medicaid but cannot afford private health insurance. Discourages the use of the emergency room for non-emergency treatment by requiring enrollees with incomes below 100% FPL to make co-payments in such instances. 	<ul style="list-style-type: none"> If the Connector determines funds are insufficient to meet the projected enrollment costs, the director may impose a cap on enrollment. Success depends on the affordability of the individual plans offered. If plan costs are too high, the state will have to offer greater subsidies and funds may prove to be inadequate.¹ By excluding families earning more than 300% FPL from public subsidies, the legislation effectively places a tax penalty on middle-income families for whom health insurance will remain unaffordable. The Massachusetts reform plan will not be financially viable in the future as long as health care costs continue to outpace inflation. Also, the plan relies very heavily on federal Medicaid funds to finance the plan, including \$385 million in annual federal Medicaid payments.

MassHealth Coverage (Medicaid)

Key Components	What Supporters Say	What Critics Say
<ul style="list-style-type: none"> Expands coverage for children up to 300% of poverty (\$60,000/ family of 4). Increases enrollment cap on MassHealth Essential (unemployed), CommonHealth (people with disabilities), and HIV programs. Restores dental, dentures, eyeglasses, and other benefits cut in 2002 for adults on MassHealth. 	<ul style="list-style-type: none"> Because of MassHealth's reach, fewer families will need subsidized private coverage. With children covered to 300% FPL, many parents will only need private coverage for themselves—reducing out-of-pocket costs for them and reducing the cost of subsidies to the state. 	<ul style="list-style-type: none"> The expansion of MassHealth will crowd out other portions of the state budget, including education, transportation, and homeland security.

¹ In early September 2006, the Connector approved the following health insurance rates for low-income residents: individuals with incomes between 100% and 300% of the federal poverty level will pay premiums equal to 1.8% to 4.7% of their incomes, or a range of \$18 a month to \$106 a month; premiums for couples would be twice this dollar amount. Copayments will vary from \$20 for a visit with a specialist to \$250 for a hospital stay. Some residents will be able to choose plans with lower copays for some services in exchange for slightly higher premium contributions. Residents who cannot afford the rates can appeal to the Connector to avoid tax penalties for not having insurance.

Insurance Market Reforms

Key Components	What Supporters Say	What Critics Say
<ul style="list-style-type: none"> • Insurers are encouraged to create plans with lower premiums that still provide comprehensive benefits. Current mandated health benefits, including mental health care, are protected. • Non-group (individual) health insurance market merges into the small group market • New, reduced-benefit, lower-premium plans will be created for 19 to 26 year olds who do not have access to employer group coverage. • Requires health plans to offer family coverage to young adults for two years after they lose their dependent status or up to age 25, whichever comes first. • Moratorium on new mandated health benefit legislation pending a comprehensive review of current mandated benefits 	<ul style="list-style-type: none"> • Could cut individual premiums by 25%. • Increases product choice. • Since 19 to 26 year olds are the most likely to go without coverage, the new, less expensive, reduced-benefit plans will go a long way toward covering that cohort. 	<ul style="list-style-type: none"> • The law did not go far enough to address affordability. Since all current Massachusetts mandates are protected, insurance costs are still higher than they would be if the mandates were removed.

Uncompensated Care Pool (“Free Care Pool”)

Key Components	What Supporters Say	What Critics Say
<ul style="list-style-type: none"> • Uncompensated Care Pool continues with no changes in funding or regulations until October 1, 2007. • On October 1, 2007, the Uncompensated Care Pool becomes Health Safety Net Trust Fund administered by Office of Medicaid. • Remaining year-end balances in the Health Safety Net Trust Fund are transferred to the Commonwealth Care Trust Fund. 	<ul style="list-style-type: none"> • Funds needed for the Health Safety Net Trust Fund are likely to decline as more people acquire health insurance through the Connector and Commonwealth Care. 	

Provider Rate Increases		
Key Components	What Supporters Say	What Critics Say
<ul style="list-style-type: none"> • State pays hospitals and physicians \$90 million additional per year for 3 years. Increases rates from ~80% of costs to ~95% of costs in 3 years. • Hospitals and providers must meet quality benchmarks to get increased rates. 	<ul style="list-style-type: none"> • The provision to increase Medicaid payments was important for garnering the support of providers and insurers. • MassHealth payments will be more in line with the private sector, and may help reduce cost shifting to the private sector. • Increases are tied to meeting quality standards, which could increase care quality and reduce racial and ethnic disparities. 	<ul style="list-style-type: none"> • Provider rate increases raise the cost of the Medicaid program without increasing services or coverage. • Medicaid reimbursement increases tied to quality and performance harm the patient-physician relationship because the physician’s incentives are aligned with reimbursement and established guidelines rather than with high-quality personalized patient care.
Other Components		
Key Components	What Supporters Say	What Critics Say
<ul style="list-style-type: none"> • Establishes a Disparities Council to reduce racial and ethnic disparities. • Creates the Quality and Cost Council to establish health care quality improvement and cost containment goals while improving access to care • Restores \$20 million for public health prevention programs. • Allocates \$3 million in outreach grants to community groups. • Convenes an Advisory Council to study Community Health Worker Outreach to reduce barriers to health care, particularly in ethnic and racial minority communities. • Establishes a consumer health information website comparing the cost and quality of health care services by facility and, as applicable, by clinician or physician group practice. 	<ul style="list-style-type: none"> • While the primary focus of the law is on access, these councils and initiatives could help develop future solutions in the cost and quality areas. 	<ul style="list-style-type: none"> • The reform plan creates a host of new government bureaucracies to manage the health care system.

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Acknowledgements

The Health Policy Institute of Ohio (HPIO) would like to thank the Sisters of Charity of St. Augustine Health System for helping to sponsor this paper and its related forum.

HPIO would also like to thank Michael Doonan, Executive Director of the Massachusetts Health Policy Forum, for his contributions to this paper.

About the Author

Janet Goldberg, MPA

Janet Goldberg is a Policy Analyst with the Health Policy Institute of Ohio and holds a Master of Public Administration degree from the Ohio State University School of Public Policy and Management. Before joining HPIO, she worked as an analyst/senior consultant for M.S. Gerber & Associates, Inc.

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37 West Broad Street, Suite 350
Columbus, OH 43215-4198
Phone: 614.224.4950; Fax: 614.224.2205
www.healthpolicyohio.org