

State Notes

TOPICS OF LEGISLATIVE INTEREST

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Massachusetts' Approach to Health Insurance Reform

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This past April, after a lengthy negotiation between Governor Mitt Romney and the Massachusetts General Court, legislation that will significantly modify the structure of health care in the Commonwealth of Massachusetts was enacted. The expressed goal of this health care reform effort is to ensure insurance coverage for every citizen in the Commonwealth. This article will provide a summary of the reform plan, describe some of the advantages and disadvantages of the Massachusetts approach, and make some observations on the applicability of this plan to the State of Michigan.

General Description

The most significant element of the Massachusetts reform effort is the creation of an individual insurance mandate. Massachusetts will require that all Commonwealth residents have health insurance by July 1, 2007; proof of coverage will be a required element of state income tax filings. Uninsured residents with access to affordable health insurance will be forced to pay financial penalties, beginning with the loss of the personal tax exemption for a first violation with increasing fines for subsequent violations.

Massachusetts will create an independent public authority to serve as a conduit between insurers and small businesses or uninsured residents seeking coverage options. The authority, known as the Commonwealth Health Insurance Connector, will establish quality standards for insurance products offered to these populations and then sell plans to individuals and businesses in need of insurance coverage. The Connector also will manage the premium contributions made by employers and covered enrollees. The establishment of this authority will permit multiple employers to contribute toward an individual's health care and make health coverage purchased through the Connector portable from job to job.

Individuals with income under 300% Federal poverty level (FPL) seeking insurance coverage through the Connector will be eligible for a premium assistance program known as Commonwealth Care. The extent of premium aid granted to each enrollee will be based upon a sliding scale tied to income. Individuals with incomes below 100% FPL will be provided a basic benefit plan and will receive a full premium subsidy through Commonwealth Care.

Massachusetts also will increase Medicaid eligibility to help low-income residents fulfill the insurance mandate. The upper-income level for children eligible for Medicaid will be increased from 200% FPL to 300% FPL. The Commonwealth also will expand its outreach activities to identify children and adults currently eligible for Medicaid coverage. In addition, the reform effort envisions an increase in Medicaid reimbursement to hospitals and physicians over the next three years.

Modifications are made to private insurance regulation in an attempt to make insurance more readily available. The state will merge the nongroup and small-group markets, leading to a decrease in premium cost. Insurers will be permitted to create an insurance product specifically targeted to 19- to 26-year-olds (offered through the Connector) at a lower cost.



Parents will be permitted to keep their children, up to age 25, on their insurance for two years after the children lose dependent status.

One of the more controversial aspects of the Massachusetts health reform effort is related to what are termed "employer responsibility" elements of the plan. Governor Mitt Romney vetoed several provisions related to employer participation but his veto was overridden by the Legislature. Businesses with 10 or more employees that do not provide health insurance must make a "fair share" payment to the Commonwealth of \$295 per employee per year. Employers that do not offer insurance also may be liable for a "free rider surcharge" imposed by the Commonwealth. This surcharge may be triggered if an uninsured employee has obtained free care more than three times during a year or if more than one employee from an individual firm has obtained free care more than five times during a year. The surcharge may range from 10.0% to 100% of the state's cost of providing care to these employees, exempting the first \$50,000 in cost.

The Massachusetts plan also mandates that each employer with more than 10 employees that does not offer insurance make Section 125 plans (also known as cafeteria plans) available to employees. Section 125 plans permit employees to purchase health insurance and other health products using pre-tax dollars.

Massachusetts estimates that the total cost of this effort will be about \$1.2 billion over the next three years. A significant portion of this cost will be covered through funds previously granted through the Medicaid program to safety net hospitals and dollars allocated to a fund to reimburse medical providers for uncompensated care. Additionally, revenue generated through "fair share" payments by employers and about \$300 million in general fund money will be used to help finance the project. Massachusetts assumes no general fund need after the initial three years of operation of this program.

Advantages

The Massachusetts approach is comprehensive in its design. The reform proposal recognizes the role that private insurance regulation, tax policy, and individual financial incentives play in increasing the number of uninsured individuals. Attempts to overcome these hurdles to greater insurance market participation may have greater potential for increasing the number of insured residents than just creating a state-subsidized health insurance program would have.

The Massachusetts approach is also proactive. The Commonwealth largely finances this plan with Medicaid funds that previously were allocated to providers who treated a disproportionate share of patients who were uninsured or enrolled in the Medicaid program. These funds will now be used to ensure that a much larger proportion of individuals seeking care are insured and that Medicaid payment rates are competitive.

The creation of the Connector also provides advantages to Massachusetts. The authority should decrease administrative cost to small business associated with contracting with a health insurer. The Connector also will permit the Commonwealth to pool residents entering the individual health insurance market, generating cost savings and increasing insurance



market participation. Linking insurance products purchased through the Connector to Section 125 plans, which will permit employees to purchase insurance using pre-tax dollars, makes insurance more affordable to residents who do not have access to employer-provided health coverage.

Disadvantages

The creation of an individual insurance mandate is a unique approach to ensuring health insurance participation, but this concept does present several significant problems. One element of the insurance mandate that seems problematic is the cost that could be imposed upon certain Massachusetts residents. These cost problems are overcome, to a large extent, through expansion of the Medicaid program and the creation of a state-sponsored premium assistance program. For individuals who do not qualify for these programs, however, this requirement will impose a financial burden. The creation of this cost for middle-income individuals without access to employer-sponsored insurance may make Massachusetts a less desirable place to reside.

The structure of the financial penalties for noncompliance with the insurance mandate also may lead to some difficulties. The fines levied on uninsured residents with access to coverage are well below the actual cost of an insurance policy. For example, the loss of the personal tax exemption for a single individual making \$30,000 a year is about \$190. The financial penalty for this individual of less than \$200 would be far cheaper than the cost of a health insurance policy. Residents who are not interested in purchasing coverage, specifically young people facing premiums much higher than expected health care costs, may likely find it preferable just to pay the fines.

The Massachusetts system also might increase the cost of providing insurance in the long run. Greater state influence upon the structure of health insurance packages will provide a target to lobbyists and advocates seeking to expand coverage to favored procedures and products. This problem has been anticipated, in the short run, with the imposition of a moratorium on changing benefits until 2008, but is still an issue that may need to be included in long-run cost projections.

Applicability to Michigan

The Commonwealth of Massachusetts in crafting this proposal took advantage of several circumstances unique to that state. The most significant of these circumstances is access to funds previously spent to provide care for the uninsured. Massachusetts previously had devoted several hundred million dollars for safety net providers through a free care pool and through enhanced payments to several urban hospital systems. Reprogramming these Medicaid funds provides the lion's share of the funding devoted to the Massachusetts program. Michigan does not have access to similar flexible fund sources to finance a comparable program.

It should be noted that the State of Michigan is in negotiation with the Federal government about the structure of a potential waiver application that would request Federal matching funds for current State efforts to support the uninsured. If granted, this waiver would provide

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about \$1.0 billion in Federal funding to finance a health insurance benefit available to low- and moderate-income uninsured residents of the State.

The Massachusetts legislation uses a number of strategies to achieve greater insurance market participation. While it is not likely that any other state could follow the precise strategy included in the Massachusetts plan, each state may find some element of this legislation useful in improving insurance access. The most significant element in the Massachusetts plan, the individual insurance mandate, is probably not viable in Michigan at this time. Michigan would need to find additional venues for low- and moderate-income residents to obtain low-cost health coverage, and probably expand Medicaid eligibility before an insurance mandate would be feasible. If a mandate were imposed without these elements, it would represent a significant financial burden to a large number of residents in this State.

Other elements of the Massachusetts legislation, especially the concept of a health insurance "connector", may provide some possibilities in Michigan. The connector could be used to reduce the cost of individual health policies by pooling uninsured individuals. The use of Section 125 plans by employers that do not offer insurance to employees also could provide marginal cost savings to individuals looking to purchase their own coverage.