ISSUE BRIEF

WHAT IS SO DISTINCTIVE ABOUT MASSACHUSETTS HEALTH CARE REFORMS?

Last year, Massachusetts faced the loss of $385 million in federal funding for Medicaid. That ominous possibility "motivated" the political parties to compromise on health care reforms to keep the funds from returning to Washington. In April 2006, then-Governor Romney worked with the legislature to enact reforms that promise to reach 95 percent of the 550,000 uninsured individuals in the state at a cost of nearly one billion dollars. Massachusetts has been experimenting with its health care system since Michael Dukakis' push to require employers to provide health care following his presidential bid in the late '80s. Maybe this is why eHealthInsurance, the leading online source of health insurance for individuals, families and small businesses in the U.S., found in a comparative pricing analysis of health plans that Boston was the least affordable city for health care in the U.S.[1] The new Massachusetts law[2] is a combination of non-group and small-group market reforms, safety net provisions, redirection of Medicaid subsidies away from institutions to individuals , and individual and employers' responsibilities Specifically, the reforms include:

- *The Insurance Connector (SECTION 101; CHAPTER 176Q).* The Commonwealth Health Insurance Connector (Connector) is a non-regulatory, independent public agency serving as a place where low-income families, non-group consumers (both individuals and families) and small business groups (in firm size less than 50 employees) can voluntarily join together and leverage their size to negotiate affordable rates and purchase insurance. An additional advantage is that participants linked to an employer will be able to purchase insurance with pre-tax dollars. However, individuals and families not linked to an employer will not receive an equitable tax advantage for their purchases. This benefit is possible because as a condition of joining the Connector, small businesses are required to establish Section 125 cafeteria plans. The Connector makes possible continuous coverage in the event participants change jobs or are unemployed. Families with multiple employers or part-time workers can request the employer contribute a pro-rated share to their insurance. The Connector is authorized to define and identify affordable health plans and to evaluate whether the health benefits they offer constitute creditable coverage.

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- *Insurance Market Reforms (SECTIONS 114 , 60, 56, & 90).* The law merges the non-group and small-group markets, a provision that will produce an estimated drop of 24 percent in non-group premium costs. The connector will offer a health savings account tied to a high deductible HMO plan *only* for participants above 300 percent of the federal poverty level or FPL (the FPL is $20,650 for a family of four in 2007). Older children will be able to stay on their parents' insurance plans for two years past the loss of their dependent status, or until they turn 25 (whichever occurs first). Young adults 19 to 26 years old will be eligible for lower-cost, specially designed products offered through the Connector.

- *Commonwealth Care Health Insurance Program (SECTION 45; CHAPTER 118H).* The law creates a program administered by the Connector to use government subsidies to pay premiums on a sliding scale. Insurance plans have to agree not to charge deductibles (which unfortunately has the practical effect of disallowing Health Savings Accounts, or HSAs.) Enrollees with incomes less than 100 percent of the federal poverty level will receive free health insurance. Families with incomes between 100 and 300 percent of poverty (about $60,000 for a family of four) will pay a monthly pro-rated portion of the premium, which is set at $268.

- *Medicaid financing (SECTION 45; 118H).* The law expands MassHealth coverage for children and parents with family incomes up to 300 percent of FPL. Medicaid beneficiaries will use Medicaid dollars to purchase private managed-care insurance. The public funding, including Medicaid, will be redirected away from subsidies to hospitals for uncompensated care toward premium-support for low-income families to purchase private insurance. In Massachusetts, reimbursements to hospitals through the Uncompensated Care Pool were higher than Medicaid payments. Hospitals had a great incentive to forgo enrolling patients into Medicaid when they present at the emergency room for treatment.

- *Individual responsibilities (SECTION 111M; CHAPTER 12).* For the first time in the country, Massachusetts will mandate that adults purchase health insurance, on the condition that the Connector offers plans that are "affordable." The individual mandate will be enforced by loss of Massachusetts state personal income tax exemption (approximate $218 for individuals and $418 for families) for those who decline to buy insurance. The State will assess a fine for subsequent violations equal to one half the cost of the lowest priced available health plan. Persons whose religious beliefs preclude use of medical care do not have to meet the health insurance mandate.

- *Employer responsibilities*[3] *(SECTION 48; CHAPTER 151F).* Employers have a "pay or play"[4] mandate. They can sponsor coverage or pay their "fair and reasonable" share of employee insurance. If employers do not sponsor insurance, an annual fee is assessed up to $295 for each uninsured employee. Only small employers can participate in the Connector. Small businesses save on

administrative costs associated with establishing and managing health benefits through participation in the Connector. As a condition of participation, small businesses (between 11 and 50 employees) are required to set up an IRS section 125 ("cafeteria") plan so that employees can use pre-tax dollars to pay for insurance. An additional mandate is a "free rider" surcharge on "non-providing employers" if the cost to the state of providing care to the employers' employees is greater than $50,000.

There are some special concerns about the new Massachusetts health law. First, the added mandates and bureaucracies could ultimately detract from the goal of providing affordable insurance to all. Although the Connector appears to have fairly benign powers, the instability of financing for reforms and the regulatory environment of Massachusetts raise the prospect that it could become more aggressive in the future. Indeed, the Connector already has certain potentially heavy-handed powers. It is authorized to assess "creditable coverage" that could affect what services are required or permitted in a health plan. Furthermore, it can determine what it thinks families can afford. If increases in health care costs continue to exceed the rise in personal incomes, as expected, that will make it harder to attract carriers to offer benefits that meet the affordability threshold necessary to enforce the mandate. Nancy Turnbull, President of Blue Cross/Blue Shield of Massachusetts, elaborates on the consequences of this likely scenario: "To keep pace with the cost of health insurance, the state will need to increase the affordability threshold, which would impose a greater financial burden on families."[5] Alternatively, the state could shave back benefits. But policy makers are likely to perceive fewer benefits as "underinsuring" families.

Second, the individual mandate discriminates against faith-based, sharing networks that are non-risk-bearing (i.e. organizations not contractually obligated to cover expenses). Sharing ministries give cash to their members to pay medical bills directly to providers. Samaritan Ministries International (SMI), and other similar sharing networks, exercise the longstanding biblical instruction to "bear one another's burdens" where there is medical need. These arrangements are not insurance, but have a history of effectively meeting the medical expenses of their members (SMI contribution can go as high as $100,000 per episode, with guidelines for handling more costly incidents). The exemption in law for individuals whose religious beliefs prevent them from using medical care is inapplicable to this situation. The real effect of this law is to undermine completely the operation of these faith-based sharing arrangements in Massachusetts. This forces families currently satisfied with their care to enter an insurance system indifferent, if not hostile, to their family values. The individual mandate is tantamount to treating sharing ministries driven by sincerely-held dictates of their faith as "free-riders."

Third, there is no provision in the law for a subscriber's right of conscience. Without a conscience provision, the individual mandate can lead to abhorrent consequences that make a mockery of its justification on grounds of personal

responsibility. Affordability alone should not be the sole condition to trigger the mandate. For instance, although there is no explicit provision that requires insurance companies to provide abortion services, neither is there a prohibition precluding carriers from voluntarily including it in their benefit packages. The fact that the state's subsidized plans for low-income families offered through the newly established Connector cover abortion[6] should not divert attention from another fact that every family between 100 to 300 percent pay a graduated share of the premium with their own *private* funds. Moreover, there is no reason to think that insurance companies operating through the Connector restrict abortion coverage only to plans sold to low-income families. Enrollees at higher incomes, too, may be paying premiums for services that include abortion – albeit unwittingly. Thus, the individual mandate is not merely coercive, but morally abhorrent to large numbers of residents. At the same time, the law explicitly prohibits discrimination in a health plan based on sexual orientation, even though the state for more than a decade has precluded discrimination based on health condition through underwriting practices, permitting anyone to join a plan regardless of health condition (guaranteed issue) and to pay the same price as everyone else (community rating). Premiums could be used to pay for benefits, like abortion, that the subscriber finds objectionable on moral or religious grounds.

Less dramatic—but nevertheless significant—is the mandate's effect forcing subscribers to purchase plans lavished with services the subscriber may never use (e.g., alcoholism rehabilitation, hair prostheses, contraception, or in vitro fertilization – all of which are on the state's list of mandated and necessary health benefits). The Connector will offer a lower-cost plan to young adults (ages 19-26). This age group is the least likely to purchase coverage, typically because they have the fewest medical problems in the population. Thus, it is unclear whether their inclusion is driven by actuarial interests in financing the reforms, or to simply achieve universal coverage. Regardless, the specially designed policy could ultimately be a mechanism to redistribute the cost of a host of risky behaviors common to some in this age group to those who act responsibly.

Finally, it is disappointing that families below 300 percent FPL will not have the same opportunity to use the Health Savings Account (HSAs) as a mechanism to provide for and protect their future health as families at higher levels have. HSAs hold great promise in helping people to save toward self-sufficiency. Insurance companies have expressed surprise at the interest in this product nationally. That interest is no wonder, since this is the only product in the Massachusetts market that provides for real ownership and family control over health decisions.

Two aspects of the Massachusetts reforms may serve as an example for other states. Redirecting Medicaid reimbursements away from institutions and toward individuals creates a genuine safety-net for those in need. The challenge, however, will be to implement such a policy in states that lack an existing endowment for uncompensated care in order to offset the impact on community

hospitals. Similarly, a Connector could provide useful relief to individuals and small businesses, as long as it is not a regulatory entity. However, the "miracle" of Massachusetts also shows how social agendas can corrupt universal coverage as a legitimate policy goal. Those social agendas, plus the anti-market elements in the reform, limit the usefulness of the Massachusetts plan as a model for states seeking to extend affordable health care to all.

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[1]Cited from the Council for Affordable Health Insurance, "Massachusetts' Health Care Reform Plan" (May 2006). Aaccessed on January 17, 2006 at
http://www.cahi.org/cahi_contents/resources/pdf/massachusetts.pdf

[2] Chapter 58 of the Acts of 2006. Accessed on January 12 at
http://www.mass.gov/legis/laws/seslaw06/sl060058.htm

[3]Small businesses with less than 10 employees are exempt from the mandates.

[4] The employer mandates are not new to Massachusetts. Former Governor Michael Dukakis successfully advocated for a mandate, which was later repealed. The mandate is this law is softer.

[5] "The Massachusetts Model: An Artful Balance," *Health Affairs* 25 (September 14, 2006) w453-w56.

[6] See recommendations Appendix II (Outpatient Medical Carefor all plan types at the official website of the Commonwealth Connector: http://www.mass.gov/?pageID=hichomepage&L=1&L0=Home&sid=Qhic under "Designing Benefits and Enrollee contributions," accessed on January 22, 2007 at:
http://www.mass.gov/Qhic/docs/memo_enrollee_contribution.doc