SENATE FISCAL AGENCY
MEMORANDUM

DATE: April 19, 2006

TO: Members of the Senate

FROM: Steve Angelotti, Fiscal Analyst
David Fosdick, Fiscal Analyst

RE: Massachusetts Health Care Reform

Last week, Governor Mitt Romney signed legislation that significantly modifies the structure of health care in the Commonwealth of Massachusetts. The expressed goal of this health care reform package is to ensure insurance coverage for every citizen in Massachusetts. This memo will provide a summary of the reform plan, describe some of the advantages and disadvantages of the Massachusetts approach, and provide 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 state residents have health insurance by July 1, 2007; the commonwealth will require proof of coverage to be included with 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 in subsequent years. The loss of the personal tax exemption for a single individual making $30,000 a year who does not purchase affordable insurance will be about $190.

The purpose of the individual insurance mandate is to ensure that younger, healthy residents participate in the insurance market. This is especially important in Massachusetts because the commonwealth mandates the use of community rating for establishing health insurance premiums. The community rating provision prohibits insurers from adjusting premiums to reflect the probable cost each type of member would present. The effect of community rating is that a healthy 21-year-old would pay the same health insurance premium that a 55-year-old would pay even though the younger person is likely to be much less costly to insure. The use of this premium structure creates a strong financial disincentive for healthy individuals to purchase health insurance and often leads to a high proportion of participants in an insurance pool who are older and less healthy.

The individual insurance mandate is linked to several expansions of health coverage offered through the Medicaid program. Medicaid eligibility will be expanded to children up to 300% Federal Poverty Level (FPL), raised from 200% FPL. Massachusetts also will increase its efforts to identify Medicaid-eligible individuals who are not currently in the program. Medicaid funds also will be used to increase provider rates over the next three years.

In addition, the state will create a health insurance program for lower income residents who are not eligible for Medicaid. The Commonwealth Care Health Insurance Program will be available for individuals under 300% FPL who are not eligible for Medicaid. A sliding scale premium will be charged to recipients, with no premium from individuals earning less than 100% FPL. Employers will be able to make contributions to the cost of the premium through this program.

201 N. Washington Square • Suite 800 - The Victor Center • Lansing, Michigan
Telephone: (517) 373-2768 • TDD: (517) 373-0543 • Fax: (517) 373-1986

The health care reform package also creates a state authority that will serve as a conduit for small businesses and individuals seeking health insurance. The Commonwealth Health Insurance Connector is designed to lower the administrative cost to businesses seeking to contract with an insurer and create a single source available to individuals looking to purchase an insurance product. Health insurance purchased through the Connector will be portable from job to job and multiple employers can contribute to the cost of a policy.

Modifications are made to private insurance regulation in an attempt to make insurance more readily available. The State will merge the non-group and small-group markets, leading to a decrease in premium cost. Health maintenance organizations will not be permitted to link a health insurance product to individual health savings accounts (HSAs). Insurers will be permitted to create an insurance product specifically targeted to 19 to 26-year-olds at a lower cost. Parents will be permitted to keep their children on their insurance for two years after the children lose dependent status (up to age 25).

The legislation, as initially passed, included some mandates upon employers. Employers that did not provide health insurance for their employees would be charged a fee of $295 per employee per year. These funds would be allocated to a fund reimbursing hospital for free care provided to the uninsured. An additional surcharge would be imposed on businesses that had employees receiving uncompensated care over a predetermined cap. These provisions were vetoed by the Governor although the legislature is expected to override this veto. Employers would be forced to offer Section 125 plans (also known as cafeteria plans). Section 125 plans would allow employees to purchase individual health insurance and other health products with pre-tax dollars.

Advantages

The Massachusetts approach is quite 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.

The Massachusetts approach is also proactive. The commonwealth largely finances this plan with Medicaid funds that previously were allocated to hospitals to underwrite a portion of the cost of providing care to those on Medicaid and the uninsured. 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 more competitive.

The reform plan also uses some innovative insurance structures to provide more opportunities for residents to find affordable coverage. The legislation included a mandate that each employer provide cafeteria plans for its employees; this would permit individuals to use pre-tax dollars to purchase health insurance, and other health products. The package also recognizes some of the benefits associated with health savings accounts linked with high deductible plans (especially for younger, healthier recipients) and attempts to provide insurance products that are portable from one job to the next.

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 will be imposed upon citizens. Cost problems are overcome, to a large extent, through expansion of the Medicaid program and the creation of a state-sponsored health program with premium supports, for individuals who do not

qualify for these programs, however, this requirement will impose a significant 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.

Massachusetts also is taking on a fairly sizable administrative burden with this legislation. The commonwealth will be operating the Commonwealth Health Insurance Connector, a new state-operated health insurance program, and will have to enforce an insurance mandate through the tax system. This reform package will increase the administrative cost and complexity for Massachusetts.

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. 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 something that has to be included in long-run cost projections.

Applicability to Michigan

The Massachusetts plan makes use of a large pool of current Medicaid funding to finance a significant proportion of the new health structure. Massachusetts will use a $575 million fund previously used for Medicaid Disproportionate Share Hospital (DSH) payments and provide over $100 million annually of new funding to finance the health reform effort. The State of Michigan would have to identify similar sources of funds to finance any increase in health coverage; there are currently no such fund sources of sufficient size that could be shifted for a similar effort.

It should be noted that the State of Michigan has submitted a waiver to the Federal government requesting Federal matching funds for current State efforts to support the uninsured. If granted, this waiver would provide about $1 billion in Federal funding to finance a health insurance benefit available to low-and-moderate-income uninsured residents of the State.

Other reforms included in the Massachusetts plan would not be applicable in the State of Michigan. The program is largely designed to overcome some of the negative impacts associated with using community rating to set health insurance premiums. The State of Michigan does not mandate this methodology for rate setting. Massachusetts also modifies tax policy and insurance regulation to permit greater use of health savings accounts and cafeteria plans; Michigan currently permits health insurers to link benefit plans to HSAs and employers to use cafeteria plans.

It is our hope that this memorandum gives you a better understanding of the structure of the Massachusetts health care reform plan. If you have any additional questions about the issues discussed in this document, please let us know.

/wm

c: Gary S. Olson, Director
Ellen Jeffries, Deputy Director
Mike Hansen, Chief Analyst