

THE MASSACHUSETTS HEALTH PLAN

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States have become increasingly concerned not only about rising health care costs, but also the number of people without insurance to cover those costs.² The twin concerns are driven by several factors: increases in medical technology/cost, a high uninsured population which delays accessing health care until it is most expensive (in the emergency room and after failure to take prescriptions has caused conditions to worsen), Medicaid reimbursement which fails to cover hospital costs, and high malpractice insurance rates.³ All these costs are passed on to those who purchase health insurance. In the individual market, adverse selection has also contributed to high premiums.

To solve these problems, states have tried several approaches to address the most salient and politically pressing health insurance issues in their respective states. The federal government has not yet developed comprehensive health insurance regulation, although it indirectly controls state behavior by threatening to withhold Medicaid funding.⁴

Several states have enacted universal health care plans. The Massachusetts plan (the Plan) has received the most attention recently, in part because it provides a promising combination of non-partisan initiatives which could make it workable in other states.⁵

Key Features

The Massachusetts General Assembly enacted Massachusetts' new health care reform in 2006 to ensure that every resident gains access to health care and insurance coverage – and to ensure that those who can afford coverage contribute their fair share. The reform has several key provisions, including (1) employer responsibility for offering insurance coverage, (2) an individual mandate requiring those who can afford coverage to purchase it, (3) subsidies for those who cannot afford coverage, (4) increased benefits under MassHealth (Massachusetts' Medicaid program), (5) a Connector designed to facilitate individual and small group health insurance purchases, and (6) a requirement that employers offer Section 125 options (also known as "cafeteria" plans) to allow employees to purchase health insurance using pre-tax dollars.

1. Employer Responsibility

There are two components to the employer responsibility aspect of the Plan. First, there is a "free rider" surcharge placed on employers who fail to contribute toward their employees' health insurance premiums and whose employees access a certain amount of free health care services. Second, there is a "fair share" employer contribution imposed on employers who fail to contribute toward their employees' health insurance premiums regardless of how much free care the employees access. Prior to the employer responsibility provisions, employers who contributed toward employee health insurance had to pay premiums which included the cost of free care accessed by employees who were not provided health care by their employers.⁶ The employer responsibility provisions are designed to ensure that all employers contribute to their employees' health care costs.

The Division of Health Care Finance and Policy must assess a "free rider" surcharge on a "non-providing employer" under the Massachusetts Plan if the cost to the state of providing care to the non-providing employer's employees is greater than \$50,000. (*See* Massachusetts Health Care Reform Act, Chapter 58 of the Acts of 2006, H.B. 4479, sec. 44, amending ch. 118G, § 18B.) A non-providing employer is an employer which employs more than ten employees and employs at least one state-funded employee.⁷ A state-funded employee is an employed person who receives free care from the state more than three times during a one-year window, or employees of a company whose employees or their dependents access free care more than five times in a one year period in the aggregate.⁸ The free rider surcharge is to be between 10 percent and 100 percent of the cost to the state of services provided to the state-funded employee, but is only imposed if the state incurs more than \$50,000 in one year of free care services for an employer's employees in the aggregate.⁹

The second type of employer contribution is the "fair share" employer contribution. It is imposed on employers with 11 or more employees who do not offer group health plans to which the employer makes a "fair and reasonable" contribution.¹⁰ The maximum fair share contribution is \$295 per employee.¹¹ The difference between the free rider surcharge and the fair share contribution appears to be the \$50,000 threshold required for the imposition of the free rider surcharge and the lack of a cap on the free rider surcharge.

2. Individual Mandate: Chapter 111M

Under the Massachusetts Plan, all individuals who are residents or become residents must obtain health insurance coverage provided an affordable plan is available.¹² The Connector makes the determination as to whether an affordable plan is available.¹³ Every person who files a tax return must indicate on the return whether he or she had "creditable coverage" as defined by the Plan.¹⁴ If there is no indication or the person indicates that he or she did not have coverage, the taxpayer loses his or her personal exemption (estimated to be worth approximately \$150). Beginning in 2008, individuals without insurance will have to pay a penalty up to half the price of a health insurance plan. A taxpayer who disputes this finding has a right to a hearing through an appeals process to be delineated by the Connector.¹⁵

Under the Massachusetts Plan, individuals whose religious beliefs prevent access to medical care do not have to meet the health insurance requirement. However, if an individual claiming the medical exemption later accesses health care services, the individual's personal exemption will be lost.¹⁶

Absent an individual mandate, individual health policy prices would remain inflated because only high-risk individuals would purchase health insurance. Forcing everyone into the market under the Massachusetts Plan is expected to reduce the average risk in the pool. This is in part because of the reduction in adverse selection and in part because the higher-risk individual pool will be combined with the relatively low-risk small-group pool through the Connector.¹⁷

3. Subsidies

The Massachusetts Plan establishes a new program called Commonwealth Care Health Insurance Program (the Program), which provides subsidies to individuals and families who cannot afford health insurance but whose income is too high to qualify for Medicaid.¹⁸ The Program is administered by the Board of the Connector, and eligible policies are offered through the Connector.¹⁹ To be eligible for the Program, an individual's or family's income must not exceed 300 percent of the federal poverty level and must not render the individual or family eligible for MassHealth coverage.²⁰ The individual's or family member's employer also must not have offered health insurance coverage within six months, a requirement designed to prevent employers from withdrawing health coverage and telling their employees to enroll in the Program.²¹

The Program offers additional assistance to residents with household incomes below 100 percent of the federal poverty level who are not eligible for MassHealth coverage (which generally is not available to young adults without children). These residents will only have to provide copayments for pharmaceuticals and the use of emergency room services or nonemergency services for which MassHealth participants would have to provide copayments. Otherwise, no premiums are required. The copayments can be waived by showing financial hardship.²²

To fund the Program, the Massachusetts Plan sets up a new fund called the Commonwealth Care Trust Fund. *See* Massachusetts Health Care Reform Act at sec. 12, amending ch. 29 by adding § 2000. Funding comes from the Health Safety Net Trust Fund (which covers uninsured patients), Massachusetts' Section 1115 Medicaid waiver, employer contributions, individual penalties for failing to obtain individual coverage (i.e. the amount the individual would have received for his or her personal tax exemption), and any amount of free rider surcharges.

4. Increased Benefits Under MassHealth (Medicaid)

The Plan restores the benefits that were available under MassHealth in 2002 (before benefits were reduced), including dental services.²³ The Plan also provides incentives for MassHealth enrollees to undertake healthy behaviors including smoking cessation, and preventive measures regarding diabetes, teen pregnancy, cancer, and stroke. If enrollees comply with the wellness provisions, MassHealth premiums and/or copayments will be reduced accordingly.²⁴

5. The Connector

The Connector is one of the more interesting features of the Massachusetts Plan, but also one of the least well-defined. Most of the operating procedures of the Connector will be determined by the Board, which began meeting on June 1, 2006. Currently the Board is headed by Jon Kingsdale, former head of the Tufts Health Plan.²⁵

The main purpose of the Connector is to reduce premiums for individuals and small businesses, making the purchase of health insurance less burdensome. First, it certifies plans as high-value and affordable, acting as a facilitator for individuals and small businesses who want to purchase health insurance. Second, it allows policies to be carried from one job to the next. Third, it allows part-time and seasonal workers to combine employer contributions toward health insurance. Fourth, it allows individuals and small businesses to purchase health insurance using pre-tax dollars (discussed below under heading 6). Finally, it sets the rules governing which plans qualify for the Program. How it will serve all these functions is to be determined primarily by the Board; however, some basic guidelines are available in the Act.

The Connector will act as a clearinghouse for insurance plans by certifying them as high-value and affordable.²⁶ By performing this initial clearing function, the Connector reduces administrative costs to individuals and small businesses seeking affordable plans.²⁷ The Connector does not act as an insurance company (it is not doing the underwriting), but as a facilitator of market transactions.²⁸ Insurance plans will still be regulated by the Division of Insurance; whereas, the Connector will certify that of the plans which meet Division of Insurance regulations,²⁹ those offered by the Connector meet an additional threshold for affordability and value.

Individuals and small groups (employers with fewer than 50 employees) can use the Connector as a site to purchase their insurance policies, although the policies will still be offered by private insurers. (*See Massachusetts Health Care Reform Act, sec. 101, adding ch. 176Q, § 1.*) The Program is voluntary, though all who can afford insurance must purchase it somewhere. Individuals ages 19 through 26, the group which is least likely to purchase insurance, can obtain lower-cost, lower-benefit plans through the Connector.³⁰

The Connector will act as the primary point of contact for individuals purchasing insurance, which allows those purchasing insurance through the Connector to carry policies with them to new jobs. The new employer can then make a contribution to the employee's health insurance directly to the Connector. This assumes that the individuals remain eligible to purchase one of the Connector's plans at their new jobs. If an individual were no longer qualified to use the Connector's services (if he or she moved to a larger employer that offered health care), he or she probably would not be able to carry a plan to a new job. (*See Massachusetts Health Care Reform Act at sec. 101, adding ch. 176Q, § 1 defining an eligible individual as "an individual who is a resident of the commonwealth; provided however, that the individual is not offered subsidized health insurance by an employer with more than 50 employees."*)

Because the Connector is the point of contact for insurance purchases, it also can combine contributions from multiple employers for part-time and seasonal workers.³¹ By combining employer contributions, people who work multiple jobs should be able to access health insurance. Under most current health care systems in the United States, these types of workers would either have to rely on one employer to provide insurance (which might be a reduced-benefits type of plan), go without, or purchase expensive individual coverage.

Small groups will have to enter into an agreement with the Connector to access its services.³² The agreement is required to stipulate that (1) the employer will not offer eligible employees any separate or competing group health plan offering the same benefits as the Connector, (2) the employer reserves the right to determine criteria for

eligibility, enrollment, and participation in the Connector program, and (3) the employer will participate in a payroll deduction program which will facilitate employee tax deductions of premiums from gross income.

The Connector also determines if a person is unable to purchase insurance. If the Connector certifies that no affordable plan exists for an individual, that individual is exempt from the individual mandate.³³ The Connector has the power to establish the procedures for granting such an exemption.³⁴

Finally, the Connector oversees the Program, including setting the criteria for insurance products to be offered through the Program. The Connector is authorized to "develop criteria for plans eligible for premium assistance payments through the commonwealth care health insurance plan, initially publishing said criteria by July 1, 2006 for plans to be procured and implemented no later than October 1, 2006."³⁵ The Connector also oversees the Section 125 cafeteria plans offered by employers, which must be filed with the Connector.³⁶

6. Purchasing Insurance with Pre-Tax Dollars

All employers with more than 10 employees must offer "cafeteria plans" which allow employees to choose between benefits while retaining the ability to purchase a plan using pre-tax dollars. A cafeteria plan is defined in the Internal Revenue Code as "a written plan under which (A) all participants are employees, and (B) the participants may choose among 2 or more benefits consisting of cash and qualified benefits." 26 U.S.C. § 125 (2000). Under Section 125 of the Internal Revenue Code, such plans can be purchased with pre-tax dollars by employees. Section 125(a) states that "no amount shall be included in the gross income of a participant in a cafeteria plan solely because, under the plan, the participant may choose among the benefits of the plan." Essentially, requiring employers to offer cafeteria plans is a way of leveraging additional federal funding for Massachusetts residents by saving them federal tax dollars.³⁷

The Plan may include the ability for individuals to purchase insurance from the Connector using pre-tax dollars, which would be a new innovation. The state can allow individuals to purchase insurance with pre-state tax dollars; however, it cannot provide federal tax benefits absent federal support. However, Governor Romney's office and Senator Kennedy's office did not have any information regarding individual purchases of insurance using pre-tax dollars, though both offices seemed to think the Plan provided for it. This would enable purchasers to spend an estimated 25% less on insurance.³⁸ An individual at Governor Romney's office indicated last summer that the state was counting partially on the strong federal support they had received regarding this legislation to enable the pre-tax dollar provision to work. He also indicated that exactly how it was to work was not yet established, as the Board of the Connector had only been meeting since June 1 and was working to develop this aspect of the Plan.

Even if the Plan cannot leverage federal dollars for individual insurance purchases, President Bush hopes to initiate legislation that will allow individuals to purchase insurance using pre-federal tax dollars in the future.³⁹ This issue is on the federal health care reform agenda, meaning it could become a possibility for states seeking to implement Connector-like systems in the future.

Although several articles written on the subject seem to link individuals' ability to purchase insurance with pre-tax dollars to Section 125 under the Plan,⁴⁰ Section 125 only covers plans offered by employers. It would be a stretch to try to use it to cover individuals purchasing through the Connector. This piece of the legislation should be worked out over time, like the other ambiguous pieces of the operation of the Connector, by the Board.

The Plan allows individuals to satisfy the individual mandate by using Medical Savings Accounts,⁴¹ which offer tax benefits and can be purchased using pre-tax dollars.⁴² For higher-income individuals or those who wish to maintain higher deductibles and lower premiums, these plans are a different way to access health insurance using pre-tax dollars.

Funding for the Plan

The Plan relies on a combination of federal funding, funds shifted from the uncompensated care pool, employer contributions, individual penalties for failure to obtain coverage, and free rider surcharges. The federal government guarantees \$610 million per year through 2008, at which point the state will look to renegotiate funding.⁴³ The

state's charity care fund of approximately \$1 billion per year (about one third federal and two thirds state funding) is a significant source of the funding for the new Plan, particularly the subsidies for the Program.⁴⁴

Hospital Accountability and Increased Medicaid Payouts

Hospital Medicaid rate increases will be contingent on adhering to certain quality standards and performance benchmarks which will be developed by the Office of Health and Human Services. Reduction of racial and ethnic disparities is one of the performance goals to be monitored. Massachusetts Health Care Reform Act at sec. 25, amending ch. 118E by adding § 13B. By linking Medicaid payouts to quality and cost savings by providers, this aspect of the Plan provides an incentive for hospitals to reduce overhead costs and improve services.

Endnotes

¹ Charlie Richardson is a partner in the Washington, D.C. office of Baker & Daniels LLP. Jessica Lindemann, a summer associate in the firm, contributed to this article, as did Marcie McClintic, an associate in the firm's Washington office.

² See Richardson, Charles T. & Kosnoff, Scott M., *A Challenge For Us All: Insuring the Uninsured*, 15 FORC Q.J. no. 7 (Dec. 1, 2004), available at http://www.forc.org/index.php?option=com_docman&Itemid=31.

³ See Keenan, Patricia Seliger, *What's Driving Health Care Costs?*, The Commonwealth Fund, November 2004, p.1, Tab 11-B ("Economists agree that the main reason for higher spending over several decades is the advance in medical capabilities"), available at http://www.ksg.harvard.edu/socpol707/keenan_whats_driving_hlt_care_costs.pdf.

⁴ See, e.g., Helman, Scott & Kowalczyk, Liz, *Joy, Worries on Healthcare*, Boston Globe, Apr. 13, 2006, at 2, available at http://www.boston.com/news/local/articles/2006/04/13/joy_worries_on_healthcare.

⁵ Soon after the Massachusetts Plan was enacted in early 2006, Vermont also passed a universal health coverage bill instituting its program called Catamount Health: The 2006 Health Care Affordability Act. Prior to the Massachusetts Plan, however, Maine enacted a universal health program called Dirigo Health in 2003. A fourth program, Healthy NY, has been in place in New York since 2001 with some success.

⁶ See Massachusetts Health Reform PowerPoint presentation, available at <http://www.ncsl.org/programs/health/may2006webcast.htm#mass>.

⁷ Mass. Gen. Laws Ann. ch. 118G, §1 (West Supp. Aug. 2006).

⁸ *Id.*

⁹ The Division of Health Care Finance and Policy is to create regulations identifying the formula for imposing free rider surcharges. The formula is to include, at a minimum, "(i) the number of incidents during the past year in which employees of the non-providing employer received services from the uncompensated care pool, under chapter 118E; (ii) the number of persons employed by the non-providing employer; (iii) the proportion of employees from whom the non-providing employer provides health insurance." *Id.* at § 18B(a, b, c).

¹⁰ Mass. Gen. Laws Ann. ch. 149 § 188 (West Supp. Aug. 2006).

¹¹ *Id.*, § 188 (c)(10).

¹² Mass. Gen. Laws Ann. ch. 111M § 2 (West Supp. Aug. 2006).

¹³ *Id.*

¹⁴ Governor Romney proposed a solution which would have allowed individuals to self-insure by posting a \$10,000 bond; however, the Democratic legislature did not adopt that plan. However, the availability of an option to purchase a high-deductible plan or a Health Savings Account make the individual mandate less onerous. See Moffitt, Robert E. & Owcharenko, Nina, *Understanding Key Parts of the Massachusetts Health Plan*, Heritage Foundation WebMemo #1045, Apr. 20, 2006, available at <http://www.heritage.org/Research/HealthCare/wm1045.cfm?renderforprint=1> (last visited Aug. 17, 2006).

¹⁵ Mass. Gen. Laws Ann. ch 11M § 4 (West Supp. Aug. 2006).

¹⁶ *Id.*, § 3.

¹⁷ To hear remarks from Speaker DiMasi, Representative Walrath, Chief Health Counsel Hager, and Research Director Sherwood, visit *Health Reform in Massachusetts*, National Conference of State Legislatures, available at <http://www.ncsl.org/programs/health/may2006webcast.htm#mass>. A PowerPoint of the presentation is also available at that website.

¹⁸ Mass. Gen. Laws Ann. ch 118H (West Supp. Aug. 2006).

¹⁹ *Id.*, § 2.

²⁰ *Id.*

²¹ *Id.* at § 3.

²² *Id.* at § 6.

²³ Mass. Gen. Laws Ann. ch. 118E § 53 (West Supp. Aug. 2006).

²⁴ *Id.* at § 54.

²⁵ See *BMC HealthNet Plan to Provide Commonwealth Care Health Insurance*, available at http://www.bmchp.org/providers/provider_commonwealth_care.aspx.

²⁶ See Haislmaier, Edmund F., *The Significance of Massachusetts Health Reform*, Heritage Foundation WebMemo #1035, Apr. 11, 2006, available at www.heritage.org/Research/HealthCare/wm1035.cfm.

²⁷ See Massachusetts Health Reform PowerPoint presentation, available at <http://www.ncsl.org/programs/health/may2006webcast.htm#mass>

²⁸ This is a major difference between the Massachusetts reform and Dirigo Health and Healthy NY. The Connector will not design the products it offers nor regulate the insurers. Dirigo and Healthy NY both focused on designing one-size fits all plans for their low income populations. See Haislmaier, Edmund F., *The Significance of Massachusetts Health Reform*, WebMemo #1035, available at www.heritage.org/Research/HealthCare/wm1035.cfm. In theory, the Connector will allow for different types of plans customized to individual needs. See *id.* However, this aspect of the Plan also makes it somewhat risky, as it is dependent on insurers designing and offering plans which lower-income individuals and small businesses can afford.

²⁹ The bill does not, for example, change the current Massachusetts system of modified community-rating.

³⁰ See Health Care Access and Affordability Conference Committee Report: Summary available at <http://www.mass.gov/legis.summary.pdf> (last visited Aug. 21, 2006).

³¹ Mass. Gen. Laws Ann. ch. 176Q § 1 (West Supp. Aug. 2006).

³² *Id.* at § 6.

³³ Mass. Gen. Laws Ann. ch. 111M § 2 (West Supp. Aug. 2006)

³⁴ Mass. Gen. Laws Ann. ch. 176Q § 3 (West Supp. Aug. 2006).

³⁵ *Id.*, § 176Q § 3(a)(14).

³⁶ Mass. Gen. Laws Ann. ch. 151F § 2 (West Supp. Aug. 2006).

³⁷ See Mirel, Lawrence H. & Haislmaier, Edmund F., *Doing it Right: the District of Columbia Health Insurance Market Reform*, Heritage Lectures #936, May 15, 2006, p.10, available at <http://www.heritage.org/Research/HealthCare/hl936.cfm>, Tab 3-H.

³⁸ This estimate is from the question and answer session of a National Conference of State Legislatures webcast on the Massachusetts Plan. The particular estimate was offered by Speaker Salvatore DiMasi. This webcast is available at <http://www.ncsl.org/programs/health/may2006webcast.htm#mass>.

³⁹ See Moffit, Robert E. & Owcharenko, Nina, *State of the Union 2006: The Health Care Initiatives*, Heritage Foundation Web Memo, January 31, 2006, available at <http://www.heritage.org/Research/HealthCare/wm976.cfm>.

⁴⁰ See, e.g., Spencer, Anna C., *Massachusetts Going for Full Coverage*, National Conference of State Legislatures, April 17, 2006, available at <http://www.ncsl.org/programs/health/shn/2006/sn465.htm>.

⁴¹ See Moffit, Robert E. & Owcharenko, Nina, *Understanding Key Parts of the Massachusetts Health Plan*, Heritage Foundation WebMemo #1045, Apr. 20, 2006, available at <http://www.heritage.org/Research/HealthCare/wm1045.cfm> (last visited Aug. 17, 2006).

⁴² See *About HSAs*, U.S. Treasury Department, available at <http://www.treasury.gov/offices/public-affairs/hsa/about.shtml> (last visited Aug. 17, 2006).

⁴³ See Helman, Scott & Kowalczyk, Liz, *Joy, Worries on Healthcare*, Boston Globe, Apr. 13, 2006, available at http://www.boston.com/news/local/articles/2006/04/13/joy_worries_on_healthcare.

⁴⁴ See Haislmaier, Edmund F., *The Significance of Massachusetts Health Reform*, Heritage Foundation WebMemo #1035, Apr. 11, 2006, available at <http://www.heritage.org/Research/HealthCare/wm1035.cfm>.