

THE NUTS AND BOLTS OF MASSACHUSETTS HEALTH CARE REFORM

In 2006, the Commonwealth of Massachusetts passed landmark legislation with the goal of covering nearly all of its residents within three years.

The law represented the culmination of more than a year of negotiations and compromise between lawmakers and former Governor Mitt Romney. The law required the participation of both employers and individuals by a) placing responsibility on residents for acquiring coverage through an individual mandate that requires all who can afford insurance to obtain it, and b) requiring employers to make an annual “fair share” contribution.

- *Creation of Commonwealth Health Insurance Connector Authority (Connector).* The Connector is an independent, quasi-governmental state entity charged with helping small employers and individuals purchase affordable health insurance. Initially funded by \$25 million in state seed money, the Connector will eventually be funded by an administrative load collected from both the subsidized and private products it sells. The Connector facilitates the process of small employers offering Section 125 plans and offers newly developed Commonwealth Choice plans which are unsubsidized. Part-time and seasonal workers can combine employer contributions within the Connector. It also allows individuals to keep their policy even if they switch employees. The Connector is also the sole entity enrolling uninsured low-income populations (below 300 percent FPL) in the subsidized Commonwealth Care Health Insurance Program.
- *Individual mandate to purchase insurance.* When the individual mandate to obtain health insurance

took effect on July 1, 2007, the Massachusetts plan reached an important milestone. In fact, the state required individuals to begin purchasing coverage no later than July 1, 2007 but set December 31, 2007 as a deadline to obtain coverage or face financial penalties. With the six-month grace period, the July deadline became more of a “call to action,” according to Health Insurance Connector Authority Chair Leslie A. Kirwan. Residents who do not purchase coverage by the end of 2007 will lose their personal exemption allowance for tax year 2007 and, in subsequent tax years, incur a fine for each month without insurance equal to 50 percent of the lowest cost insurance product that the individual is deemed able to afford.

- *“Fair and reasonable” employer contribution.* The reforms are coupled with an employer requirement for “fair and reasonable” contributions to employees’ health insurance coverage. Employers with 11 or more full-time workers who do not contribute to their employees’ health care coverage must pay an annual “fair share” contribution capped at \$295 per full-time equivalent (FTE). Small businesses with fewer than 11 employees are not subject to this requirement. In addition, employers with 11 or more workers are required to adopt Section 125 cafeteria plans that permit workers to purchase health insurance with pre-tax dollars. This requirement is true regardless of whether or not employers offer health insurance to their employees. Employers with 11 or more employees who do not adopt a Section 125 plan may be assessed a “free rider” surcharge if their employees incur uncompensated care costs.

- *Insurance market reforms.* Insurance market reforms are an important component of the Massachusetts strategy; in July 2007, the state merged the individual and small-group insurance markets. A mandated study on the impact of the merger concluded that, on average, health insurance premiums for small employers would increase by about 1.5 percent but that premiums for individuals would decrease by 15 percent.
- *Premium subsidy and Medicaid expansion.* The various employer requirements and insurance market reforms are coupled with the establishment of a premium subsidy program (Commonwealth Care) and Medicaid expansion. With approximately 170,000 eligible adults, Commonwealth Care offers subsidized insurance to adults who otherwise lack access to health care coverage through an employer, Medicaid, Medicare, or the Veterans Administration. It aims to shift funding from direct payment of safety net providers (via the state’s free care pool reimbursements) to individuals through a subsidized insurance mechanism. It is important to note that the health plans currently serving the Commonwealth Care population are Medicaid Managed Care Organizations (MCOs) that include many of those safety net providers originally receiving direct payment through the free care pool. In fact, one of the program’s goals was to insure 54,000 adults who had previously received services paid for by the state’s free care pool. The program is available to adults with family income at or below 300 percent FPL.